

May 2013

# The Historical Influence of Politics and Society on Women's Experiences of Abortion

Sandra Ruth Schumacher  
*University of Wisconsin-Milwaukee*

Follow this and additional works at: <https://dc.uwm.edu/etd>

 Part of the [Nursing Commons](#), [United States History Commons](#), and the [Women's Studies Commons](#)

---

## Recommended Citation

Schumacher, Sandra Ruth, "The Historical Influence of Politics and Society on Women's Experiences of Abortion" (2013). *Theses and Dissertations*. 158.  
<https://dc.uwm.edu/etd/158>

This Dissertation is brought to you for free and open access by UWM Digital Commons. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of UWM Digital Commons. For more information, please contact [open-access@uwm.edu](mailto:open-access@uwm.edu).

THE HISTORICAL INFLUENCE OF POLITICS AND SOCIETY ON WOMEN'S  
EXPERIENCES OF ABORTION

by

Sandra R. Schumacher

A Dissertation Submitted in  
Partial Fulfillment of the  
Requirements for the Degree of

Doctor of Philosophy

In Nursing

at

The University of Wisconsin-Milwaukee

May 2013

## ABSTRACT

### THE HISTORICAL INFLUENCE OF POLITICS AND SOCIETY ON WOMEN'S EXPERIENCES OF ABORTION

by

Sandra R. Schumacher

The University of Wisconsin-Milwaukee, 2013  
Under the Supervision of Professor Patricia E. Stevens

One out of every three women in the United States will experience abortion (Guttmacher Institute, 2008). The purposes of this feminist qualitative research were to: 1) examine historically the context of legal abortion in the United States, 2) describe and explore women's experiences of abortion and 3) better understand the historical impact of the sociopolitical climate on women's perceptions of their abortion experiences. An historical review of political, legislative, and social contexts surrounding legal abortion revealed an increasingly hostile environment toward women seeking abortion since 1973. By challenging existing abortion laws in state and federal courts, anti-abortion legislators have removed federal and state funding for abortions, including insurance coverage. States have imposed mandatory waiting periods, biased counseling and consent procedures, parental involvement and/or notification for minors, and bans on funding and insurance coverage. All of these intrusions on women's right to choose abortion have resulted in the need for more than one clinic visit and delays in obtaining abortion services. Through violence, intimidation, and harassment, pro-life activists and extremists have successfully driven medical personnel out of the practice of abortion and intimidated women seeking abortion by exposing them to fetal images, calling them "baby killers", and forcing them to believe that life begins at conception. Within this historical context, a purposive sampling of ten women,

recruited via snowballing techniques, participated in repeated in-depth interviews. A multi-stage narrative strategy was used to analyze textual data. Participants' narrative summaries emphasized dismay at being pregnant, telling others, and making the decision for abortion. Women thoughtfully made the decision for abortion based on the circumstances of their lives at the time of the unintended pregnancy. Seventy percent of participants experienced abortion in the 1980s and recalled the ways in which religion, politics, and society have imposed shame, guilt, and judgement on them, constraining them from talking about their abortion experiences. Silenced, women only revealed their abortion when forced to do so by circumstances or to gain acceptance and understanding from others. Participation in the study allowed women an opportunity to talk about their abortion experiences, initiating conversations with friends, and raising consciousness.

---

© Copyright by Sandra R. Schumacher, 2013  
All Rights Reserved

## DEDICATION

My deepest appreciation goes to the women who participated in this study. With slight trepidation and some hesitancy, they eloquently voiced their abortion experiences, allowing me, others, and themselves to gain insight and understanding. Women voiced a desire to tell their stories, for others to hear and listen, and to be understood and accepted. Their willingness to assist me demonstrated their generosity of spirit and their longing to connect with other women who have experienced abortion. I hope I have faithfully and respectfully presented the stories they shared with me.

I am eternally grateful to my family for their unwavering love, their faith in me, and their financial, physical, and emotional support: Fern Rueppel, Orville and Darlene Vitzthum, Sharon and Todd Marks, Jay and Joann Arthur, Christine Phillips, Fran Weisensel, and Bob Marks. Your kindness, caring, and generosity helped me to complete this journey. Additionally I am thankful for Rose Marks and Beverly Weisensel who taught me about compassion and resilience in facing untimely death; they are with me in thought and spirit.

I am grateful to Pat Stevens, my major professor and committee chair, for mentoring me through the dissertation research, and especially for her knowledge and leadership in multi-staged narrative analysis strategies. I am thankful to Merry Wiesner-Hanks and Teresa Johnson, my committee members, for reading, reviewing, and providing me with feedback and support. I am also thankful to Barbara Daley and Heather Royer for reading my final dissertation and providing me with insight, support, and accolades.

A huge thank you to my dear friends who supported me along this journey, listening and encouraging me when I doubted my own abilities: Amy Morton-Miller, Leanne Carson-Stoker, Susan Schumacher, Judy Dallman, Bonnie Anderson, Bonnie Connolly, and Joan

Burr. I cannot imagine the completion of this project without your love and assistance; you made me laugh, gave me reality checks, listened when I needed to talk, helped me find balance in the chaos, and preserved my sanity. Thank you. A special thank you to Carol Wrabl, Chief Nursing Officer (retired), who encouraged me to begin this educational endeavor and mentored me as a nursing leader.

And last, but not least, a heartfelt thanks to my four-legged companions, Remington, Tag, Jake, and Duke, who so graciously stayed by my side, took me on walks, hogged the bed, helped reduce my stress, gave me peace, forgave my inattentiveness, and reminded me to take time to play and be joyful.

## TABLE OF CONTENTS

Abstract . . . . .	ii
Copyright . . . . .	iv
Dedication . . . . .	v
Table of Contents . . . . .	vii
List of Figures . . . . .	xii
List of Tables . . . . .	xiii

### Chapter 1: Introduction

Statement of the Problem . . . . .	1
Significance of the Problem . . . . .	3
Purpose of the Study . . . . .	4
Research Questions . . . . .	5
Theoretical Framework . . . . .	5
Feminist perspective . . . . .	5
Feminist standpoint theory . . . . .	6
Theoretical assumptions . . . . .	9
Feminist standpoint theory summary . . . . .	12
Operational Assumptions . . . . .	13
Definition of Terms . . . . .	13
Overview of Subsequent Chapters . . . . .	14

### Chapter 2: Background

Legalization of Abortion . . . . .	17
Recriminalization of Abortion . . . . .	19
Human life amendment . . . . .	19
Informed consent . . . . .	20
Restrictions on funding . . . . .	20
Political party interests . . . . .	23
More challenges to <i>Roe</i> . . . . .	25
<i>Continued restrictions on funding</i> . . . . .	25
<i>Restrictions on the practice of abortion</i> . . . . .	26
Anti-abortion movement . . . . .	32
<i>Anti-abortion violence and politics</i> . . . . .	32
<i>Anti-abortion violence, denunciation, and pro-abortion responses</i> . . . . .	34
<i>Judicial, legislative and political responses to anti-abortion violence</i> . . . . .	36
Change in Strategies . . . . .	38
Availability of Abortion in the United States in 2012 . . . . .	43
Abortion providers . . . . .	43
<i>Provider training</i> . . . . .	44



<i>Limitations on who can perform abortions</i> . . . . .	47
<i>Advanced practice clinicians</i> . . . . .	48
State mandated counseling and waiting periods . . . . .	50
Bans on abortion funding and insurance coverage . . . . .	52
Parental involvement and consent for minors . . . . .	54
The results of legislative, judicial, and political anti-abortion strategies . . . . .	56
Medical abortion . . . . .	58
Conclusion . . . . .	64

### Chapter 3: Review of Literature

Methodology . . . . .	66
Overview of identified sources . . . . .	67
Organization of this chapter . . . . .	68
Studies about Women’s Experiences of Surgical Abortion . . . . .	69
Summary critique of studies about women’s experiences of surgical abortion . . . . .	82
Implications for my study . . . . .	85
Studies about Women’s Experiences of Medical Abortion . . . . .	87
Summary critique of studies about women’s experiences of medical abortion . . . . .	96
Implications for my study . . . . .	100
Studies about Women’s Perceptions of the Long-term Significance of Abortion . . . . .	103
Summary critique of studies about women’s perceptions of the long-term significance of abortion . . . . .	115
Implications for my study . . . . .	119
Paucity of Studies about Under-Represented Women’s Experiences of Abortion . . . . .	120
Summary critique of the paucity of studies about under-represented women’s experiences of abortion . . . . .	123
Implications for my study . . . . .	125
Mental Health and Women’s Experiences of Abortion . . . . .	126
Methodology . . . . .	126
Philosophical perspectives . . . . .	128
Examination of reviews of empiric literature about abortion and women’s mental health . . . . .	129
Summary critique of reviews of empiric literature about abortion and women’s mental health and abortion . . . . .	137
Implications . . . . .	139
Final Remarks . . . . .	140
Need for the Current Study . . . . .	142

### Chapter 4: Methodology

Study Design . . . . .	144
Sampling Strategies . . . . .	146
Planned Parenthood . . . . .	147

Free and low-fee clinics . . . . .	148
Public Health Department . . . . .	149
Change in recruitment goals . . . . .	149
Word of mouth . . . . .	151
Participant referrals . . . . .	151
Participants . . . . .	152
Data Collection . . . . .	154
Data Analysis . . . . .	157
Stage one . . . . .	159
Stage two . . . . .	161
Stage three . . . . .	162
Stage four . . . . .	163
Protection of Human Subjects . . . . .	164
Rigor . . . . .	165
Organization of Results . . . . .	168

#### Chapter 5: Findings and Interpretations, Within Case Analysis

Donna . . . . .	169
Elizabeth . . . . .	181
Kathleen . . . . .	200
Rebecca . . . . .	217
Barbara . . . . .	230
Shirley . . . . .	243
Carolyn . . . . .	252
Maria . . . . .	263
Lindsey . . . . .	269
Amanda . . . . .	286

#### Chapter 6: Findings and Interpretations, Across Case Analysis

What are Women’s Experiences of Abortion? . . . . .	294
“ <i>This (pregnancy) wasn’t supposed to happen.</i> ” . . . . .	294
“ <i>I had no support (to continue the unintended pregnancy).</i> ” . . . . .	296
“ <i>I did what I had to do.</i> ” . . . . .	300
What women’s narrative didn’t say . . . . .	303
What Historical Influence has Political and Social Events had on Women’s Experiences of Abortion? . . . . .	305
Religion . . . . .	305
“ <i>I understood that my parents thought abortion was wrong.</i> ” . . . . .	306
“ <i>Getting an abortion is about the last thing that a good little Catholic girl would do.</i> ” . . . . .	306
“ <i>You don’t grow up steeped in Catholicism for 18 years and be able to just throw that off.</i> ” . . . . .	308
“ <i>You can’t belong because of their beliefs.</i> ” . . . . .	309
“ <i>I don’t really understand that abortion was a horrible thing.</i> ” . . . . .	310

<i>"I felt bad."</i> .....	310
Politics .....	311
<i>"I didn't feel like I was killing my child."</i> .....	312
<i>"Is that life?"</i> .....	315
<i>"I was very angry."</i> .....	316
<i>"I can't imagine living somewhere where abortion is not legal."</i> .....	317
<i>"Every woman has the right to choose."</i> .....	319
<i>"He left me with the responsibility of it all."</i> .....	321
<i>"Did I really do something terribly wrong?"</i> .....	324
Telling .....	324
<i>"She was very understanding."</i> .....	324
<i>"I just felt compelled to tell him."</i> .....	325
<i>"I would consider telling my children if they experienced an unintended pregnancy."</i> .....	326
<i>"I didn't want to tell my parents."</i> .....	331
<i>"My abortion is private; it's a deeply personal matter."</i> .....	332
<i>"If somebody asked me about the abortion or was struggling with the same decision."</i> .....	333
<i>"None of us had ever talked about the abortion."</i> .....	334
<i>"I wish I'd talked with her."</i> .....	336
<i>"I stopped talking about the abortion."</i> .....	337
Summary .....	338

## Chapter 7: Discussion

Summary of Results .....	340
What are women's experiences of abortion? .....	340
What historical influence has political and social events had on women's experiences of abortion? .....	341
Congruency with Extant Literature .....	347
Implications for Research .....	349
Limitations and strengths of the study .....	349
Research design .....	351
Directions for future research .....	352
Implications for Nursing Practice .....	353
Implications for Policy .....	356
Final Reflections .....	357
References .....	359
Appendices .....	381
Appendix A: Definition of Terms and Abortion Terminology .....	382
Appendix B: Studies about Women's Experiences of Surgical Abortion .....	394
Appendix C: Studies about Women's Experiences of Medical Abortion .....	400
Appendix D: Studies about Women's Experiences and Long-Term Significance of Abortion .....	405

Appendix E: Studies about Under-Represented Women’s Experiences of Abortion . . . . .	407
Appendix F: Exclusion of Reviews of Literature about Women’s Mental Health and Abortion . . . . .	408
Appendix G: Free Clinics in Wisconsin . . . . .	411
Appendix H: Participant Contact Information . . . . .	415
Appendix I: Informed Consent Document . . . . .	416
Appendix J: Demographic Information . . . . .	421
Appendix K: Interview Guide . . . . .	423
Appendix L: Field Notes . . . . .	427
Appendix M: Analytical Notes and Methodological Memos . . . . .	430
Curriculum Vitae . . . . .	432

## LIST OF FIGURES

Figure 1. Sampling Pattern of Participants Recruited through Snowball Techniques . . . . 152

## LIST OF TABLES

Table 1. *Participant Abortion Demographics: Ages, Dates, and Years Since Abortion(s)* 153

Table 2. *Participant Demographic Profile at the time of the Abortion(s) and Interview(s)*154

## Chapter 1: Introduction

### Statement of the Problem

Abortion is imbedded in the issue of reproductive rights and autonomy for women. “The ability to determine whether and when to bear children has become a prerequisite for women’s full participation in modern life” (Boonstra, Gold, Richards, and Finer, 2006, p. 6). Yet, despite the need for control over reproduction, unintended pregnancy remains a reality for almost three million women in the United States each year (Henshaw & Finer, 2006). Unintended pregnancy disproportionately affects women of color; recent data reveal that 40% of pregnancies among white women, 67% among black women, and 53% of pregnancies among Hispanic women are unintended (Finer & Zolna, 2011). At least half of all women in the United States will experience an unintended pregnancy by age 45 (Finer & Zolna, 2011). As long as the occurrence of unintended pregnancy remains a reality in the lives of women, abortion will be sought and procured as an option to child bearing and parenting.

About four in 10 unintended pregnancies end in abortion (Finer & Zolna, 2011) with 22% of all pregnancies in the United States terminated by abortion each year (Jones & Kooistra, 2011). Unintended pregnancy disproportionately affects economically disadvantaged women; 42% of women obtaining abortions have incomes below 100% of the federal poverty level and 27% of women have incomes between 100-199% of the federal poverty level (Jones, Finer, & Singh, 2010). At current rates, one in 10 women in the United States will have an abortion by age 20, one in four by age 30 and three in 10 by age 45 (Jones & Kavanaugh, 2011). Each year, two percent of women aged 15–44 years have an abortion (Jones & Kooistra, 2011); half of these women have had at least one previous abortion

(Jones, Singh, Finer, & Frohworth, 2006). While abortion data does not offer explanations, it does illuminate the ongoing reality of unintended pregnancy experienced by women in the United States and highlights the common occurrence of abortion.

Providing care to women as a certified nurse midwife (CNM) and women's healthcare nurse practitioner (WHNP) I have listened to women speak about their abortion experiences. Some shed tears, others sighed. Many women voiced satisfaction with their decision to terminate an unintended pregnancy. Some asked to have their abortion omitted from their medical record. No matter what the details were of each woman's abortion stories, every woman seemed grateful for an opportunity to talk about her experiences. A routine gynecologic visit became an opportunity for women to discuss their thoughts, feelings, and life situations at the time of the abortion, as well as reflections on their abortion experiences. How are nurses to respond to, care for, and assist women with the experience of abortion? How can women's experiences of abortion shape policy and inform judges, lawyers, policymakers and healthcare providers? To be able to answer these questions, research is needed to describe and better understand women's experiences of abortion from women's perspectives. What political and social events have occurred over time which prompts women to reflect on their abortion experiences? What thoughts and feelings are triggered for women by these events? How do women reflect on their own abortion experiences in response to these events? Do these events alter women's perceptions of their abortion experiences? Knowledge is needed about the historical influence of political and social events and issues on women's perceptions of their abortion experiences. Some researchers have explored changes in women's perceptions of their abortion experiences over time, but rarely have investigators ascertained the reasons for these changes or compared



changes in women's perceptions with the sociopolitical climate. What can women who have experienced abortion tell us about changes in their perceptions of their abortion experiences over time and in response to political and social events?

### **Significance of the Problem**

Too often the public debate about abortion is dichotomized into right versus wrong or woman versus fetus. Abortion is sometimes discussed by politicians and religious leaders as a single, isolated event in a women's life. In reality, women's experiences of abortion occur in the context of their lives and can only be understood in terms of the challenges that women face in realizing their lifetime goals and in the vision they have for parenting (Boonstra et al., 2006). Dialogue with women who have experienced abortion could foster understanding of these experiences, provide rich and detailed descriptions of abortion experiences, raise consciousness, and identify opportunities for political action to improve the lives and health of women. This information could expand knowledge about abortion experiences in the discipline of nursing, providing guidance to nurses regarding healthcare encounters with women who have experienced abortion. Women's experiences of abortion are a significant phenomenon as an area of interest for nursing research because nurses can learn from women firsthand about their needs in relation to their abortion experiences. Women's accounts of their abortion experiences can help identify areas of concern to women and help nurses evaluate the care being provided.

In addition to the discipline of nursing, women's experiences of abortion could provide knowledge to healthcare providers, administrators, and policy makers. This knowledge could translate into resources for public policy, healthcare practices, and guidance on legal issues. In-depth discussions with women about their abortion experiences could

facilitate understanding of abortion through every step of the process, from discovering and confirming the unintended pregnancy to obtaining the abortion and describing life after the termination procedure. Conversations with women who have experienced abortion could facilitate knowledge about the historical influence of politics and society on women's perceptions of their abortion experiences.

### **Purpose of the Study**

The purposes of this feminist, qualitative research were to: 1) examine historically the context of legal abortion in the United States, 2) describe and explore women's experiences of abortion and 3) better understand the historical impact of political and social events on women's perceptions of their experiences. My critique of empiric literature identified that most study participants have been white, well educated, employed, middle class women, who were primarily in their mid-20s at the time of the abortion. The few studies which included women of color and/or women living in poverty did not analyze women's experiences of abortion based on these factors (education, age, socioeconomic status, race, or ethnicity). The result is that little to nothing is known about the abortion experiences of women who are not white, well educated, employed, middle class, and in their mid-20s. A goal of this study was to include women who have been under-represented in previous research about women's experiences of abortion.

The review of literature also identified that a few researchers have investigated women's retrospective views of their abortion experiences. These investigators, Avalos (1999), Hess (2004), and Trybulski (2005) did not identify reasons for the changes in women's perceptions or offer explanations for these changes over time. A goal of this study was to investigate women's insights about their abortion experiences over time. Feminist,

qualitative inquiry allowed for an in-depth exploration of women's abortion experiences along with an examination of the historical influence of political and social events on women's perceptions of their abortion experiences.

### **Research Questions**

Research questions for this qualitative study included:

1. What are key political, legislative, judicial, and social events in the history of legal abortion in the United States?
2. What are women's experiences of abortion?
3. What impact have political and social events had on women's experiences of abortion over time?

### **Theoretical Framework**

**Feminist perspective.** As a nurse researcher I am concerned with whatever factors and issues women identify as important for themselves. It is for this reason that I chose a feminist perspective as the foundation for this study. Research done from a feminist perspective "centers and makes problematic women's diverse situations as well as the institutions that frame these situations" (Olesen, 2000, p. 216). A feminist perspective informed and guided this research about women's experiences of abortion, valuing women and their experiences of abortion as a basis of knowledge; recognizing that abortion occurs under conditions that oppress women; and identifying opportunities for social change and political action as a result of this investigation.

Hall and Stevens (1991) identified that "feminist scholarship endeavors not only to describe and interpret phenomena of women's lives but also to raise consciousness and bring about changes in the interest of the women studied" (p. 17). This feminist, qualitative study

was designed and conducted with the goal of providing for women knowledge and explanations that they need and want about experiences of abortion. A key element of a feminist perspective is the recognition that women's experiences of abortion are entangled with the larger political, social, and economic contexts of the United States. "Situating investigations in their broader historical, sociopolitical contexts is considered a necessary condition for an adequate science of women's lives" (Hall & Stevens, 1991, p. 18). A method of analyzing the social, political, and historical aspects of women's experiences of abortion in this study was derived from feminist standpoint theory in addition to the foundations of a feminist perspective.

**Feminist standpoint theory.** Emerging in the late 1970s and early 1980s, feminist standpoint theory grew out of the women's political movements of the 1960s and 1970s and in response to anti-positivist histories, sociologies, and philosophies of science emerging in Europe and the United States at that time. Prominent writers of feminist standpoint theory include: Dorothy E. Smith (1974, 1987, 1991, 1997); Nancy CM. Hartsock (1975, 1983, 1985, 1997, 1998); Sandra Harding (1983, 1986, 1987a, 1987b, 1987c, 1989, 1990, 1991, 1993, 2003, 2004a, 2004b, 2007); Hillary Rose (1983); Alison Jaggar (1983); Donna Haraway (1988); Patricia Hill Collins (1986, 1991) and bell hooks (1984, 1990, 2000). There has been much overlap in the work of these authors, often with intense, scholarly exchanges occurring. Intellectual discussion and multi-disciplinary interaction has fostered thinking and forced standpoint theorists to evaluate, revise, and re-evaluate the basis of their positions. With its foundation in socialist feminism and the theories of Marx, feminist standpoint theory has been the basis of research and philosophical discussions throughout the past 40 years.

Feminist standpoint theory developed from the writings of feminist theorists in the disciplines of sociology, history of science, philosophy, and political science. The early writings of these theorists expressed ways to analyze causes of the gaps between actual and ideal relations between knowledge and power, to reflect on the successes of feminist research in the social sciences and biology, to provide guidelines for producing empirically and theoretically more successful research, to understand how standpoint theory as an approach to research could empower oppressed peoples, and to argue that feminist political goals actually enable the production of more adequate scientifically supported claims of knowledge (Harding, 2007, p. 45). Feminist standpoint theory has been proposed as an explanatory theory and as a method or theory of method (a methodology).

As an explanatory theory, feminist standpoint examines relationships between the structures and practices of power and the production of knowledge. Standpoint theorists assert that there are some perspectives on society that are not perceptible to researchers. Investigators may not be able to come to understand the relationships people have with each other or with nature and the world. To express this contention, standpoint theorists (Smith, 1998; Hartsock, 1997; Harding, 2007) have articulated distinct epistemological and political claims. First, material life not only structures, but sets limits on the understanding of social relations; class position in society both enables and limits what people can come to know about themselves and the world around them. Second, when material life is organized hierarchically, such as in societies structured by class, gender, race, ethnic, religious, or other forms of oppression and discrimination, the vision and understanding of each group will tend to be opposed in certain aspects. The understandings of hierarchical relations available to dominant group members (rulers) will tend to support the legitimacy of its dominating

position. The understandings available to the oppressed group members (ruled) will tend to invalidate and delegitimize such domination. Third, the vision of the dominant group members (rulers) structures material relations (life) in which all groups are forced to participate (capitalism in the United States). The perceptions (false and perverse) of rulers (oppressors) are made real and operative as all groups are forced to live in societal structures and institutions designed to serve the dominant group members' understandings of themselves and society. These hierarchical structures and institutions engage in conceptual practices that solidify and disseminate their continued power as natural, inevitable, and desirable (science). As a result (fourth claim), the understandings available to oppressed groups must be struggled for and represent an achievement which requires both science and politics to see beneath, behind, and from outside the surface of the social relations in which all are forced to participate and live. Education and knowledge can only grow from the struggle to change those relations. All understanding is socially located or situated, and cannot completely escape its historical moment. Fifth, the understandings of oppressed groups bring about the achievement of a standpoint which carries with it the possibility of liberation from dominate relations. An oppressed group must become a group for itself in order to see the importance of engaging in political and scientific struggles which allow the group a vision of the world from the perspectives of their own lives. These understandings expose the real relations among human beings and allow for the creation of a better and more just world.

As a method or methodology, feminist standpoint theory guides investigations by designing a research process that provides resources for oppressed people (Harding, 2007). Employing feminist standpoint theory as a method entails beginning research in the

experiences of women as a basis for knowledge. Starting research from women's actual experiences takes into consideration the political, hierarchical, racist, classist, gendered, materialistic structures of women's everyday lives, which are always socially and historically situated (Smith, 1987). Research conducted from the perspective of feminist standpoint theory analyzes structures and power relations with the intent of political action for the improvement of women's lives and the removal of oppressive conditions. Data collection is essentially a dialogue between the researcher and the women who are sharing their experiences. Feminist standpoint theorists (Smith, 1987, 1997; Hartsock, 1983, 1998; Harding, 2004, 2007) have argued that the activity of conducting research is not free of bias or values. Applying standpoint theory in research requires the investigator to acknowledge the impact and place she has in the collection of data and the production of knowledge. Therefore, as the researcher, I needed to locate myself within the research and with the participants, identifying my interests and reflecting on the personal significance of this research (Smith, 1997). Using feminist standpoint theory as a method of research involves validating results from the study with participants to change conditions of oppression and political power identified and of concern to them. Data analysis and findings generated from this study did not simply describe women's experiences of abortion, but also focused on examining the historical influence of political and social events on women's perceptions of their abortion experiences (Harding, 2004b; Smith, 1987).

**Theoretical assumptions.** Research conducted from the perspective of feminist standpoint theory stresses a particular view that builds on and from women's experiences (Harding, 2007; Olesen, 2005). For this study about women's experiences of abortion and

the historical influence of political and social events, feminist standpoint theory contributed to the theoretical assumptions that guided this qualitative research.

1. The United States is a capitalist, patriarchal society. This societal structure of material life (money, knowledge and power) both enables and limits what women can know about themselves and the world around them. Within this structure, women have different everyday activities and experiences than men, which give women a different understanding of social relations. Women experience abortion in a world where gender, race, class, religion, and ethnicity structures, but does not necessarily determine, understanding of abortion experiences. Different women will experience abortion differently.
2. Material life is hierarchically organized in the United States because society is structured by class, gender, race, ethnicity, religion, and other forms of oppression and discrimination. When society is hierarchical, then the understandings of the hierarchical relations that are available to the “rulers” and “ruled” will tend to be opposed in certain respects. In U.S. society, women are part of an oppressed and subordinate group simply because of their gender. Women may also be oppressed due to race, class, ethnicity, or religion. Women access and experience abortion under a set of conditions set forth by legislators, judges, and pro-life activists, many of whom are male. Women’s experiences of abortion allow them to see both their position (oppressed) and that of the dominant group. The understandings of the dominant group (rulers) about experiences of abortion tend to support the legitimacy of its dominating position. This includes: protecting the rights of unborn children over the rights of women; limiting access to abortion procedures by limiting who can



- perform abortions and the type of procedure; mandating a waiting period prior to the abortion procedure; requiring parental consent or judicial involvement for minor women; coercing women with biased informed consent processes; criminalizing abortion based on morality not legality; and devaluing reproduction. These tactics maintain women in a submissive and oppressive position. The understandings of women who have experienced abortion will tend to delegitimize and invalidate the dominant (white, male) group's position and oppression.
3. The dominant (ruling) group's false and perverse perceptions of abortion are made "real" and operative for all men and women are forced to live in social structures and institutions designed to serve the oppressor's understandings of self and society. These hierarchical structures and institutions (state, church, healthcare, education) engage in conceptual practices that solidify and disseminate their continued power as natural, inevitable, and desirable. Research, policies, and laws regarding abortion, as well as resources for reproductive services, are limited to funding and institutions (state, church, healthcare, education) that support the views of the dominant (ruling) group.
  4. Both science and politics are needed to understand the experience of abortion from "behind", "beneath", or "from outside" the ruling group's institutionalized vision. This understanding will occur by starting off from women's experiences of abortion (oppressed group) in a historically and socially situated time and place. Political struggle is necessary to reveal either the falsity or the unjust political consequences of women's experiences of abortion. This includes the false assumption of the existence of multiple and complex untoward (negative) responses to abortion, as well as the

false belief that women are incapable of making decisions, without an imposed waiting period, parental or spousal consent, or coercion through biased consent forms. Unjust political consequences include the withdrawal and complete removal of healthcare insurance coverage and other funding for abortion. This unfair situation creates financial hardship for women and their families, devalues women over children, and imposes unnecessary life consequences on women who experience abortion. Women who have experienced an abortion have a view and understanding of many aspects that comprise the overall experience that men and women who have not had an abortion cannot know.

5. The achievement of a standpoint brings the possibility of liberation. Women who share and discuss their experiences of abortion with others may gain another perspective on their experiences, “seeing” some of the contradictions that currently exist in society. The process of participating in the research itself may provide resources for women who have experienced abortion. In addition, sharing the experience of abortion with others brings the potential for liberation at structural and societal levels, not just for the individual.

**Feminist standpoint theory summary.** “Feminist standpoint theory can be thought of as a distinct way to think about the links between experience, knowledge and political change, which aims to incorporate the multiple experiences and the positions of various oppressed social groups in society” (McLaughlin, 2003, p. 68). A specific feminist standpoint of women who have experienced abortion will not describe a universal experience, but identify some commonalities among women, as well as some differences between women’s experiences of abortion. Standpoint is a theory for approaching the

research process and a tool for understanding patriarchy and forms of oppression and domination, in an attempt to make changes to these structures. Women's relationships with the world and their experiences of abortion makes available a particular and privileged view, with the potential to generate different and better knowledge about this human experience for nurses, politicians, policymakers, institutions and women themselves.

Feminist standpoint theory has been utilized infrequently in the discipline of nursing; however, this lack of use in nursing research does not negate the utility of this theory and method. In fact, it may simply demonstrate what Smith (1997) and Harding (2007) have articulated – that standpoint theory looks different in the hands of researchers and theorists from different disciplines. Feminist standpoint theory provides a solid theoretical foundation for nursing research and a basis for analyzing structures and practices of power in women's experiences of abortion.

### **Operational Assumptions**

This study was based upon the following operational assumptions:

- Women accurately report their personal perceptions, experiences, and behaviors.
- Although the reality of another's world can never be completely understood, an improved understanding may occur when learning about their perceptions.
- Transcribed interviews are an accurate account of each participant's statements.
- Abortion is morally permissible (Boonin, 2003).
- Women have the right to choose to continue or terminate a pregnancy.

### **Definitions**

The focus of this study is on women's experiences of abortion and the historical influence of political and social events on women's perceptions of their abortion experiences.

Abortion refers to the elective termination of an unintended pregnancy and may be accomplished medically or surgically. The historical influence of political and social events refers to women's reflection on their abortion experiences in response to societal and political activities, events, and issues about abortion. Political events may include exposure to antiabortion tactics (bombing, murder, fetal images, picketers, sensationalized news reports about the risks of abortion), political activism, imposed state restrictions (withdrawal of funding for abortion, mandatory waiting periods, parental involvement/consent, counseling requirements, limits on who can perform abortion, limits on the type of abortion procedure), religious discussions of abortion (church sermons, rallies, Christian radio broadcasts), and high profile court cases related to the topic of abortion. Social events and issues may include comments by family members, friends, and/or significant others regarding abortion (supportive, unsupportive, judgmental), pregnancies (own, another woman), and/or other experiences with abortion. For additional information on definitions and terminology related to abortion see Appendix A.

### **Overview of Subsequent Chapters**

In order to understand women's experiences of abortion at any given point in time, Chapter 2 examines political and social aspects of legal, elective abortion in the United States from a historical perspective. This chapter explores the impact of politics, the judicial system, legislative changes, and the anti-abortion movement on women's experiences of abortion since 1973. An examination of the history of abortion revealed relationships and structures of power while constructing a background for both my review of empiric literature in Chapter 3 and my analysis of women's narratives in Chapters 5 and 6.

Chapter 3 provides a critique of published studies about women's experiences of surgical abortion, medical abortion, and the long-term significance of abortion in women's lives. These investigations focused on the actual abortion experiences of women and have been conducted by researchers from several disciplines. In critiquing this body of literature, I considered the breadth, depth, and relevance of the identified investigations for my dissertation research. Similarities and gaps in the literature were identified, as well as contradictions and inconsistencies. The impact of the social context on women's experiences of abortion was discussed and an appraisal of empiric literature pertaining to the affects of abortion on women's mental health has been included.

An overview of the methodological approach employed has been provided in Chapter 4. I describe the feminist, qualitative method I used to study women's experiences of abortion and the narrative analysis employed to examine the historical influence of political and social events on women's perceptions of their abortion experiences. Details about participants, data collection, and textual data analysis are included, along with strategies used to enhance scientific rigor and incorporate general features of feminist standpoint theory.

Study results are provided in Chapters 5 and 6. Narrative summaries compiled for each participant from textual data are provided in Chapter 5. The within case analysis examines women's experiences of abortion and stories about the influence of social and political events and issues on their perceptions of their abortion experiences over time. Applying the basic tenets of feminist philosophy, I identified areas of concern to women and explored structures and relationships of power. The results of my across case analysis is presented in Chapter 6 with the identification of themes around each research question.

In Chapter 7 I conclude this dissertation by briefly summarizing my findings, discussing my conclusions for each research question posed, comparing and contrasting these findings with extant literature, identifying strengths and limitations of the study, and highlighting the study's implications for future research, policy, and nursing practice.

## Chapter 2: Background

In order to understand women's experiences of abortion at any given point in time, it is important to consider the political, judicial, and social aspects of abortion from a historical perspective. As a nurse, I knew little of the history of abortion in the United States, despite working in women's healthcare for over twenty years. To understand the history of abortion in the United States, I reviewed and studied numerous sources. It is not my intent to review all I learned in this chapter; the reader is referred to several excellent sources for in-depth information on the history of abortion in the United States (Baehr, 1990; Bonavoglia, 2001; Burns, 2005; Chalker & Downer, 1992; Davis, 2005; Feldt, 2002; Gordon, 1974; Gorney, 1998; Kaplan, 1995; Kapparis, 2002; Mohr, 1978; Palmer, 2002; Reagan, 1997, 2000; Rowland, 2004; Sauer, 1974; Schoen, 2005; Solinger, 1998, 2005; Wilder, 1998). The purpose of this chapter was to provide the reader with knowledge about the political, judicial, and social contexts of women's experiences of elective abortion since legalization. The historical context of women's experiences of abortion in the United States revealed relationships and structures of power, in addition to providing a background for my review of empiric literature in the next chapter and my analysis of women's narratives in chapters 5 and 6.

### Legalization of Abortion

In 1973, the United States Supreme Court heard arguments that challenged existing state abortion laws. The Court's final decision about the legality of abortion in the United States encompassed two cases. Decided together, these cases demonstrated that the nation's century-old criminal abortion laws (*Roe v. Wade*) and the new abortion reform laws (*Doe v. Bolton*) were unconstitutional because they violated the rights of women and the rights of

physicians. On January 22, 1973, the decisions from these cases legalized first-trimester elective abortion in the United States, setting forth a cleanly-divided trimester framework to be used by the courts in balancing the rights of women against the interests of states. The court divided pregnancy into three-month periods, recognizing a different balance of rights and interests for each trimester. Privacy rights dominated in the first trimester, so that the abortion decision required only the agreement of the physician performing the procedure. In the second trimester, the state was permitted to place restrictions on abortion in the interest of the woman's health. And in the third trimester, the viability of the fetus could outweigh privacy rights. The Court ruled that "though the state has a compelling interest in a viable fetus and a woman's health as a pregnancy progresses, during the first trimester, a woman's choice of whether or not to continue a pregnancy could not be unduly burdened by the state" (Rowland, 2004, p. 123). The Court relied on medical technology to define viability as the point in time when the fetus was potentially able to live outside the woman's uterus, generally around 28 weeks gestation.

Making abortion legal dissolved the deadly and discriminatory system that existed with illegal abortion. Clinics provided women with open access to abortion and made the procedure widely available. Secrecy no longer shrouded the process of finding an abortionist as clinics and providers were listed in healthcare directories and telephone books. Legal, safe abortion became accessible to women irregardless of race and class as state and federal programs extended payment of abortion to low income women through health programs. Maternal mortality rates dropped dramatically resulting in an overall improvement in public health. Hospital therapeutic abortion committees disbanded and septic abortion wards closed. Groups that had helped women access safe illegal abortions disbanded. Many of



these groups changed their focus and redirected their efforts at providing reproductive care for women. Women all across the country from every class and race had unrestricted access to safe, legal abortion procedures. Many abortion proponents felt their hard efforts had paid off; the work was done, but they were mistaken (Reagan, 1997). Before abortion was legalized in the United States, various anti-abortion groups, specifically “right-to-life” committees organized by the Catholic Church, fought to halt legalization efforts and keep abortion a crime. After legalization, anti-abortionists came up with new strategies to attack women’s reproductive rights. Challenges to the *Roe* and *Doe* rulings came through the legislatures, state and federal courts, and the rise of the anti-abortion movement.

### **Recriminalization of Abortion**

**Human life amendment.** After the Supreme Court Justices handed down their decisions in *Roe v. Wade* and *Doe v. Bolton*, the anti-abortion backlash was immediate and intense. “Reeling from their stunning defeat, abortion opponents flooded congressional offices with mail calling for a measure more extreme than anything before: a constitutional amendment to criminalize abortion nationwide” (Wilder, 1998, p. 80). A full-scale campaign to secure a “human life amendment” to the U.S. Constitution was launched by November 1973. The amendment would declare the fetus to be a “human person” and abortion to be murder (Petchesky, 1990, p. 242). Advocates for a human life amendment continued to move the issue forward and in 1983 the only congressional bill to reach the floor was put to a vote. The bill was defeated, but more attempts to pass a human life amendment to the U.S. Constitution have continued, unsuccessfully.

Recognizing the ineffectiveness of attempts to amend the U.S. Constitution, traditional anti-choice institutions, which included the National Conference of Catholic

Bishops, the National Right to Life Committee, and Americans United for Life, prepared to challenge the legality of abortion in other ways. Anti-abortion lobbyists and legislators worked to enact carefully drafted statutes that would create “test cases”. These cases would challenge the rulings in *Roe* and *Doe* and allow an ever changing judiciary system the opportunity to reduce the constitutional protection of abortion. Based on the rulings in *Roe*, some state restrictions on abortion could be justified by the state’s interest in maternal health and fetal life. “The anti-choice movement hoped to expand the scope of permissible state restrictions by gaining judicial approval” (Wilder, 1998, p. 81).

**Informed consent.** One of the first cases of significance in challenging the scope and meaning of the rulings in *Roe* and *Doe* was *Planned Parenthood of Central Missouri v. Danforth* in 1976. The state of Missouri had passed a bill to control and regulate the practice of abortion during all stages of pregnancy. Two physicians, joined by Planned Parenthood of Central Missouri, filed suit challenging the Missouri statute. The Justices sided with the arguments raised by the physicians, striking down four of the statute’s provisions which included requirements for parental and spousal consent, mandatory fetal care, and prohibited use of saline amniocentesis. The Court upheld the requirement of informed consent, finding that a requirement imposed by the states for written consent prior to surgery was not unconstitutional. The ruling in this case “has been held to mean that while the ‘right of privacy’ at issue in abortion cases is an ‘individual right’, it may still be subject to minor intrusions by the state” (Rowland, 2004, p. 114).

**Restrictions on funding.** By the mid-1970s, in addition to direct attacks on the precedent of *Roe* and *Doe*, legislatures and lobbyists began to explore new ways to restrict abortion. One of the earliest legislative actions that restricted access to abortion was the

Hyde Amendment which targeted the ability (or inability) of women to pay for abortion. Sponsored by Representative Henry Hyde of Illinois and passed by Congress in 1976, the Hyde Amendment prohibited the use of public funds for abortion beginning in 1977. The only exception was to save the life of the pregnant woman. “By denying women the ability to pay for abortions, the state could deny them – if not the right to choose abortion – then certainly the means to achieve it” (Rowland, 2004, p. 115). Many insurance companies followed by refusing to provide healthcare coverage for abortions under any policies.

Three of the U.S. Supreme Court decisions issued in 1977 involved interpretations of welfare and Medicaid requirements in light of the Hyde Amendment. *Beal v. Doe* involved a challenge to a Pennsylvania Department of Welfare regulation which limited financial assistance for use only in “medically necessary” abortions. The plaintiff was a poor woman who was eligible for medical assistance under the federal Title XIX program. However, when she sought an abortion, she was denied financial assistance. The Justices found “that Title XIX did not expressly speak of funding for abortions. Rather, the statute spoke of furnishing medical assistance to people whose resources were insufficient and the services were necessary” (Rowland, 2004, p. 115). By a 6-3 vote, the Court upheld the Pennsylvania regulation. The six Justices concluded “that Pennsylvania’s refusal to extend Medicaid coverage to nontherapeutic abortions is not inconsistent with Title XIX. We make clear, however, that the federal statute leaves a State free to provide such coverage if it so desires” (Rowland, 2004, p. 115). Pennsylvania did not desire to provide abortion coverage. And neither did Connecticut.

In *Maher v. Roe*, two indigent women challenged the Connecticut law, alleging discrimination in violation of the Equal Protection Clause and arguing that similar

restrictions were not applied to other medical procedures. The Justices wrote “the Constitution imposes no obligation on the states to pay the pregnancy-related medical expenses of indigent women or indeed to pay any of the medical expenses of indigents” (Rowland, 2004, p. 115). By a vote of 6-3, the Justices held that even though the state provided funding for childbirth, the Connecticut law was not unconstitutional or discriminatory, because indigent women desiring abortion did not fall within the “limited category of disadvantaged class” traditionally recognized by the Court in equal protection cases.

The third and final decision in the trilogy of financial regulation cases decided on that same day in 1977 by the United States Supreme Court was *Poelker v. Doe*, which also involved an Equal Protection challenge. Jane Doe sought an abortion in one of two St. Louis city-owned hospitals and was refused. In a class action lawsuit against the Mayor and City of St. Louis’s Director of Health and Hospitals, Doe, who was poor, alleged violations of the Equal Protection Clause and argued that the policy was unlawful and discriminatory. The Supreme Court upheld the hospital’s refusal to provide publicly funded abortions and wrote, “We find no constitutional violation by the city of St. Louis in electing, as a policy choice, to provide publicly financed hospital services for childbirth without providing corresponding services for nontherapeutic abortions” (Rowland, 2004, p. 116).

All three of these U.S. Supreme Court cases upheld the Hyde Amendment and the right of states to place restrictions on the payment of abortions with state revenues. With the passing of the Hyde Amendment, federal funding for abortion was curtailed and by 1979 no federal funds could be used to pay for abortions or abortion-related services. The only exception was for a pregnancy that threatened the woman’s life, which was a rare occurrence.

Some states did pay for abortions using state revenues which limited the impact of the Hyde Amendment for women living in those states. Lack of funding was one of the earliest attempts by anti-abortion supporters to limit and decrease the number of abortions performed.

Abortion opponents seemed to be succeeding in restricting abortion despite their inability to outlaw it completely and to pass a human life amendment. In another strategy to recriminalize abortion, anti-abortion lobbyists and legislators attempted to overrule *Roe v. Wade* by changing the composition of the judicial system, primarily by endeavoring to secure five solid anti-abortion votes on the U.S. Supreme Court.

**Political party interests.** Through the 1970s, positions on abortion were not clearly divided by political party. Many antiabortion organizations were officially nonsectarian, while many members of Congress, both Republicans and Democrats were in favor of a women's right to choose abortion. However, "in the 1980s it became increasingly clear that the antiabortion cause was more welcome in the Republican Party, largely because the Christian Right became a significant wing of that party" (Burns, 2005, p. 229). Elected in 1980, President Ronald Regan was the first Republican president to collaborate with the antiabortion movement, giving symbolic and public encouragement to the pro-life cause. At the same time, pro-abortion groups became important supporters of the Democratic Party.

The Christian Right was comprised primarily of white, conservative evangelical Protestants who attempted to influence United States politics. "In the late 1970s and 1980s, the dominant Christian Right organization was the Moral Majority, founded by Rev. Jerry Falwell, and in the 1990s it was the Christian Coalition, led by Rev. Pat Robertson and Ralph Reed" (Burns, 2005, p. 236). These organizations pursued different tactics to recriminalize

abortion, working within legal political boundaries. The Christian Right emphasizes the importance of conservative religion in public life. Members take a very conservative view of sexual and reproductive matters, including the condemnation of homosexuality and abortion. The Christian Right holds very critical views of liberal approaches to sex education and sexual morality, advocating abstinence until marriage. The opposition of the Christian Right to abortion is a means to their larger goal of returning the United States to a society of “traditional Christian values” (Ginsburg, 1998, p. 229).

In 1980, the Republican Party platform called for the appointment of anti-abortion rights judges at every level of the federal judiciary system. This advanced the pro-life cause by moving the U.S. Supreme Court to the right. While in office, President Reagan courted and welcomed culturally conservative groups into the Republican Party, vocally supporting their missions and goals. During his eight years in office, “Reagan appointed more than half of the members of the federal bench and three new Supreme Court Justices” (Wilder, 1998, p. 81). Reagan and his successor, George H. W. Bush, moved federal policy in a pro-life direction; “both used federal funds and federal agencies to promote the pro-life agenda” (Burns, 2005, p. 230).

In 1984, Reagan instituted the “gag rule”, mandating that family planning clinics that received federal funding could not discuss abortion with patients. “Since that time, the gag rule has been in effect during Republican presidencies, but was nullified during Clinton’s democratic presidency (1993-2001). The second President Bush, who took office in January 2001, reinstated the gag rule” (Burns, 2005, p. 231). With the election of a democratic president once again in 2008, the “gag rule” was lifted by Barack Obama on January 23, 2009, promoting the use of U.S. funds for international health groups who perform abortions,

promote legalization of the procedure, or provide counseling about terminating pregnancies (Stein & Shear, 2009). With the re-election of President Obama in 2012, the “gag rule” remains revoked.

**More challenges to *Roe*.** During the 1980s, challenges to *Roe v. Wade* and *Doe v. Bolton* continued in the form of opposition to public funding of abortions, disputes over the locations where abortions could and could not take place, and articulation of specific definitions of viability and physician responsibilities.

***Continued restrictions on funding.*** In 1980 the U.S. Supreme Court ruled on two cases concerning public funding of abortions. In *Harris v. McRae*, a class of indigent women sued the New York City Health and Hospital Corporation for failing to provide abortions under Title XIX of the Social Security Act, alleging the Hyde Amendment to be unconstitutional. In a 5-4 vote, the Justices upheld the Hyde Amendment as constitutional. The Court ruled that although the government “may not place obstacles in the path of a woman’s exercise of her freedom of choice, it need not remove those not of its own creation. Indigence falls within the latter category” (Rowland, 2004, p. 125). The ruling agreed that the Hyde Amendment did not violate the Equal Protection Clause, even if it imposed hardship on some women’s right of choice. Decided the same day, *Williams v. Zbaraz* involved a class action lawsuit brought on behalf of poor women, who alleged that refusal by the State of Illinois to provide Medicaid coverage for abortions violated the Equal Protection Clause. The Court found, for the same reasons cited in *McRae*, “that the comparable funding restrictions in the Illinois statute do not violate the Equal Protection Clause of the Fourteenth Amendment” (Rowland, 2004, p. 125).

***Restrictions on the practice of abortion.*** Several cases heard by the U.S. Supreme Court in 1983 attacked the practice and availability of abortion; the first was the *City of Akron v. Akron Center for Reproductive Health*. In February of 1978, representatives of the City of Akron passed an ordinance setting forth seventeen provisions regulating how abortions were to be performed within the city limits. A lawsuit was immediately filed on behalf of several doctors and abortion agencies challenging the provisions. After decisions by the lower and appellate courts, only five of the challenged provisions remained to be heard by the U.S. Supreme Court in 1983.

The first provision involved the issue of whether Akron could require that all abortions in cases beyond twelve weeks take place in hospitals. By a 6-3 vote, the Justices struck this provision down as placing “a significant obstacle in the path of women seeking an abortion” (Rowland, 2004, p. 119). The Justices also struck down a provision requiring parental consent for minors seeking abortions. Such a requirement, the Court held, foreclosed a minor female’s right to exercise the right to choose an abortion in the event of a parental veto. Also struck down was a provision regarding disposal of fetal remains. Then the Court considered the provisions of informed consent and a required 24-hour waiting period. Both provisions were struck down with the Justices concluding that the underlying aim of each was to require doctors to recite a litany on the ills of abortion. That, the Court determined, went far beyond achieving informed consent. Accordingly, the Justices ruled that the ordinance had placed unreasonable “obstacles in the path of the doctor upon whom [the woman was] entitled to rely for advice in connection with her decision” (Rowland, 2004, p. 119). Finally, with regard to the 24-hour waiting period, the Court held that the City of



Akron had “failed to demonstrate that any legitimate state interest is furthered by an arbitrary and inflexible waiting period” (Rowland, 2004, p. 119).

Similar in breadth to the Akron ordinance was a challenge to a broadly worded Missouri statute in *Planned Parenthood Association of Kansas City v. Ashcroft*. By a 6-3 vote, the Supreme Court struck down the Missouri provision that would have required all second-trimester abortions to take place in hospitals. But the Court upheld, by a 5-4 vote, provisions requiring that two doctors are present during later term abortions, that parental consent be obtained for minors or a judicial waiver process exists, and that pathology reports were required following abortions.

The final abortion related case heard in 1983 by the U.S. Supreme Court was *Simopoulos v. Virginia*. By an 8-1 vote, the Justices upheld the conviction of a doctor, who performed a second-trimester abortion outside of a licensed hospital, as required by Virginia law. In comparing the Virginia regulations to the Missouri law, the Justices noted that the definition of “hospital” differed. But the goal of the two after the first trimester was the same: to preserve the health of women obtaining abortions.

The next direct challenge to *Roe v. Wade* came in 1986 in *Thornburgh v. American College of Obstetricians and Gynecologists*. The state of Pennsylvania has made many efforts over the years to recriminalize abortion. Beginning shortly after the legalization of abortion, the Pennsylvania legislature passed the Abortion Control Act of 1974, overriding a governor’s veto to do so. The Act led to protracted court action at the end of which several of the Act’s provisions were held unconstitutional. Even so, in 1978, the Pennsylvania legislature again tried to restrict access to abortion, this time by limiting funding. Again, the state went to court. Again, its efforts were declared unconstitutional. In 1982, the

Pennsylvania legislature enacted another version of the Pennsylvania Abortion Control Act. Six provisions in the Act went before the U.S. Supreme Court in 1986. Among the provisions was the requirement that physicians give women detailed information of the ills of abortion and the development of a fetus during all stages of pregnancy. The Justices, by a vote of 5-4, struck down the provision because it advanced “no legitimate state interest” (Rowland, 2004, p. 120). The second provision which required physicians to file reports following abortion procedures was also struck down. In reaching this conclusion, the Justices reasoned that “Pennsylvania’s reporting requirements raise the spectre of public exposure and harassment of women who choose to exercise their personal, intensely private, right, with their physicians, to end a pregnancy” (Rowland, 2004, p. 120). Several other provisions were also struck down one by one, and in the end, the Court found the 1982 Pennsylvania Abortion Control Act invalid.

The final legal challenge of the decade came in 1989 as the United States Supreme Court ruled on *Webster v. Reproductive Health Services*. “In 1986, the governor of Missouri signed into law Missouri House Bill No. 1526, which consisted of twenty provisions and a preamble declaring that ‘the life of each human being begins at conception’” (Rowland, 2004, p. 120). The Bill amended existing state law “to extend to ‘unborn children . . . all rights, privileges, and immunities available to other persons, citizens, and residents’ of Missouri” (Rowland, 2004, p. 121). The statute demanded that physicians perform viability tests on fetuses suspected of being 20 weeks gestation or older. It also prohibited the use of public employees and public facilities to perform or assist abortions not necessary to save the life of the mother. These were among the five provisions challenged along with the preamble. By a 5-4 vote, the Court upheld the foreclosure of the use of public hospitals and

facilities for abortion and requirements regarding gestational age tests. Finding that the preamble was merely “precatory” the Court passed on a decision regarding its constitutionality. Essentially, the Supreme Court ruled that states, if they so chose, could prohibit abortions in public hospitals (thus requiring that abortions take place only at privately owned facilities) and could require that physicians check for viability of the fetus at twenty weeks gestation.

After 16 years of being legal, abortion in the United States was once again close to becoming criminal. The Justices were divided in *Webster v. Reproductive Health Services*. For the first time, abortion opponents came within one vote of overturning *Roe v. Wade*; the long-term political plans of the early 1980s were beginning to show signs of success. Four justices voted to overturn *Roe* completely, which prompted Justice Harry Blackmun to write: “For today, the women of this Nation still retain the liberty to control their destinies. But the signs are evident and very ominous, and a chill wind blows” (Wilder, 1998, p. 85). Four justices voted to reaffirm the decision, and one sole vote, Justice Sandra O’Connor’s, became the controlling opinion. “Articulating a new legal standard, O’Connor found that the Missouri law was not an “undue burden” on the right to choose and was therefore constitutionally permissible” (Wilder, 1998, p. 85).

Up until this case, the U.S. Supreme Court had strictly protected a woman’s right to choose abortion. With less than a majority of the Justices voting to uphold the central ruling of *Roe v. Wade*, and the “undue burden” test undefined, *Webster* implied a reduction in the right of privacy in reproductive matters. The Court, in effect, changed the burden of proof. In the past the Court majority required proof that a restriction was clearly compatible with *Roe* before approving it. With this ruling, the Justices essentially declared that women would

need to prove that the restriction created a barrier to their ability to obtain an abortion before the restriction would be rejected by the court (Burns, 2005; Wilder, 1998).

The *Webster* decision was viewed by state legislators as an open request to challenge the laws and test how far the Supreme Court Justices would allow them to go. With renewed vigor and enhanced creativity, anti-abortion lawmakers introduced countless restrictive abortion bills, “including proposals to make all abortion illegal, prohibitions on abortion “as a means of birth control”, bans on abortion for sex selection, husband-consent laws, onerous clinic-licensing laws, and abortion-reporting requirements” (Wilder, 1998, p. 85). Between 1989 and 1992 more than seven hundred anti-abortion bills were introduced in state legislatures across the country. Some of the legislators’ ideas were new; many had been tried before; and all were designed to test the boundaries of the Court’s most recent ruling on abortion.

The ultimate test of the U.S. Supreme Court’s most recent ruling on abortion came in 1992 in *Planned Parenthood of Southeastern Pennsylvania v. Casey*. At issue before the Court were five provisions of the latest version of the Pennsylvania Abortion Control Act. In starting their analysis, a fractured majority expressly declared that the “essential holding of *Roe v. Wade* should be retained” (Rowland, 2004, p. 121). The Justices wrote “Liberty finds no refuge in a jurisprudence of doubt. Yet, 19 years after holding that the Constitution protects a woman’s right to terminate her pregnancy in its early stages, *Roe v. Wade*, that definition of liberty is still questioned” (Rowland, 2004, p. 128).

The Court decision in *Casey* upheld the provisions in the Pennsylvania Act that required a twenty-four hour waiting period, single parent consent requirements for minors, counseling on health risks related to abortions as well as on adoptions, and that physicians

keep records. Specifically, the Justices held that a 24-hour waiting period between the time when a woman formally requests an abortion and when the procedure may be performed was not unconstitutional. Next the Justices held that abortion procedure information that was truthful and not misleading could be given to women seeking abortions, even information that might tell of the ill effects of abortion. Women could be counseled using the presentation of pamphlets and other information about the procedure that were written from an anti-abortion perspective. Single parent consent requirements for minors were also upheld. And the Court upheld the portion of the Pennsylvania law that required doctors to keep records to the state, which could then be made public.

What was not upheld was a provision of the Pennsylvania Abortion Control Act that would have required that a married woman sign forms indicating that she had told her husband of her intent to have an abortion (whether he approved or not). The Court ruled that a pregnant woman could not be forced to carry a fetus to term or to become a “mother” by a partner or a husband. All of these central decisions were decided by 5-4 votes, reflecting a Court very divided on the issue of abortion. With the *Casey* ruling, the Court allowed new restrictions on abortion that it had rejected in a 1986 decision, *Thornburgh v. American College of Obstetricians and Gynecologists*. “In so doing, the Court weakened *Roe* by adopting the less protective standard of judicial review which permits states to impose restrictions as long as they do not ‘unduly burden’ a woman’s right to choose” (Wilder, 1998, p. 85).

What made *Planned Parenthood of Southeastern Pennsylvania v. Casey* most significant was the Court’s removal of the trimester framework. Under the precedent of *Roe v. Wade*, a woman’s right to choose abortion during the first trimester was almost absolute;

as the pregnancy progressed into the second and third trimesters, a state's interest in the viability of the fetus grew. This precedent had "served to demarcate the legal areas of competing interests" (Rowland, 2004, p. 122). In the *Casey* ruling, the Justices erased this framework, declaring it too rigid. In the end, the Court held that any law that places an undue burden on a woman's right to obtain an abortion before viability is unconstitutional. Viability, however, was left undefined by the Justices and open to state legislative interpretation.

**Anti-abortion movement.** By the late 1980s conservative politicians and abortion opponents were achieving their goals for legislative restrictions and judicial appointments in U.S. courtrooms. Despite their considerable success, some anti-abortion activists were infuriated by the inability of the movement to completely criminalize abortion. "Opting for a direct and frontal assault, new and more radical leaders rejected what they saw as the movement's obsession with the legal status of abortion and instead promoted direct action steeped in coercion and intimidation" (Wilder, 1998, p.81). As a result, the pro-life movement developed a more militant, increasingly confrontational approach. The initial tactics involved peaceful sit-in demonstrations at abortion clinics. But "what began as picketing in front of clinics turned into 'sidewalk counseling' and then escalated to full-fledged blockades" (Wilder, 1998, p. 82). Arson and bombings grew more frequent as death threats against abortion providers became commonplace. Two groups in particular gained strength during the mid-1980s: the Pro-Life Action League, established in Chicago in 1980 by ex-Benedictine monk Joe Scheidler, and Operation Rescue, founded in 1988 by Randall Terry. The Pro-Life Action League denounced violence and advocated the saving of unborn children through non-violent direct actions which included sidewalk counseling at abortion

clinics, public protests, and silent stand-ins. Operation Rescue was a more militant, well-organized effort to use civil disobedience to draw attention to what members saw as the evils of abortion. Operation Rescue attempted to close down abortion clinics by interfering with their daily operations; they targeted particular cities and concentrated all their resources for several weeks or months on closing down abortion in that city.

***Anti-abortion violence and politics.*** During the 1980s blockades, vandalism, arson, and bombings were given silent approval from abortion opponents. Attacks on abortion clinics were not only tolerated, in some cases they were encouraged by anti-abortion elected officials at the highest level of government. “Following President Ronald Reagan’s election in 1980, the number of violent incidents against clinics and clinic personnel, including vandalism, death threats, assault, arson, bombing, and invasion increased by almost 450 percent” (Wilder, 1998, p. 82). Speeches given by President Reagan to anti-abortion groups were often interpreted by extremists as unspoken endorsement of their violent actions and harassing activities. In 1983, when Don Anderson abducted an abortion provider and his wife at gunpoint and held them for more than a week in an abandoned ammunition bunker, he felt he had been given “a green light from the president” (Wilder, 1998, p. 82). For his entire first term, from 1980 to 1984, despite repeated requests to condemn the anti-abortion violence, President Reagan sat silent.

During the summer of 1991, the activities of Operation Rescue gained media attention as members targeted Dr. George Tiller’s abortion clinic in Wichita, Kansas. Known as the “Summer of Mercy”, thousands of pro-life protesters flocked to the Wichita Family Planning clinic where a large “rescue” involving members of the clergy took place. Over 1,600 arrests occurred during the first three weeks with a total of 2,600 arrests by the

conclusion of the six week long event. When a federal judge ordered the picketing to stop after three abortion clinics had been shut down, President George H. W. Bush (1989-1993) intervened on behalf of Operation Rescue in the judicial proceedings, contending that the judge had no authority to issue the order. “In another case, the Bush Justice Department filed a brief in the U.S. Supreme Court on behalf of Operation Rescue, supporting the group’s position that a federal civil rights law did not protect women from the blockades”(Wilder, 1998, p. 82). The repeated interventions on behalf of Operation Rescue by President Bush explicitly encouraged anti-abortion violence.

***Anti-abortion violence, denunciation, and pro-abortion responses.*** During the late 1980s and early 1990s, the extreme tactics of the anti-abortion movement provoked stern reactions and the pro-abortion movement greatly increased its activities and efforts. Clinic defense groups worked with local authorities to organize effectively against “rescues”. Injunctions began to hamper demonstrations and blockades. By 1990, court rulings and large fines against Operation Rescue and its leaders resulted from lawsuits brought by pro-choice organizations. Holding people personally liable for court fines tested even the most dedicated right-to-lifers. The election of Bill Clinton as President in 1992, a Democrat who supported women’s right to choose abortion, “brought even more stringent prosecution of individuals and organizations harassing clinics in rescues” (Ginsburg, 1998, p. 228).

In April 1992, the pro-choice movement sponsored a huge abortion rights march in Washington D.C. Operation Rescue responded with “Spring of Life” demonstrations. With fewer and fewer people willing to support protests that would result in lengthy jail terms and large fines, a decline in support for anti-abortion activists became clear. Additionally, as clinic defense groups mobilized across the country, rescues were increasingly met with



effective counteroffensives organized by pro-choice activists and local law enforcement officials. While Operation Rescue felt its actions curtailed, violence against abortion clinics and their staff escalated.

On March 10, 1993, Dr. David Gunn was shot in the back with a .38-caliber revolver during an anti-abortion demonstration outside the clinic where he worked in Pensacola, Florida. At the time many anti-abortion leaders insisted that the murder was the act of a single pro-life extremist, who was not a member of an anti-abortion group. However, that claim became more difficult to defend in 1994 when another pro-life activist, Paul Hill, fired a 12-gauge shotgun into the vehicle of volunteer clinic escorts James and June Barrett. James, a seventy-four-year-old retired air force lieutenant colonel and John Britton, the physician he was escorting, were both killed. June Barrett, James' wife, was injured when a bullet lodged in her arm. In 1995, two clinic employees, Shannon Lowney and Leanne Nichols, were murdered in Brookline, Massachusetts. Again, another anti-abortion extremist was blamed, but denial of any connection between the murderers and the anti-abortion movement was no longer credible with the public.

The slogan of Operation Rescue, "If you think that abortion is murder, act like it" was seen as creating an environment in which the murder of persons associated with abortion was viewed as justifiable homicide in defense of life. Controversial media coverage and law-breaking tactics in the late 1980s and early 1990s altered the public image of right-to-lifers from one of people motivated by civil morality to one of radical Christians, unwilling to accept the framework of secular law (Ginsburg, 1998). This change in public views divided the anti-abortion movement, especially with the escalation of violence in the 1990s. Recall that one of the main objectives of the anti-abortion movement was to gain credibility with the

public in order to gain support for a constitutional amendment that would recriminalize abortion. Direct action, especially violence, weakened this objective through increased publicity, which rallied advocates of abortion. Despite disapproving public views, the anti-abortion movement failed to control its radical activists and extremists. Inactivity and silence from the right-to-life movement regarding violence and murder occurred in part because confrontational, coercive, and violent tactics succeeded in decreasing the availability of abortion in the United States. The violent and murderous parts of the anti-abortion movement made anti-abortion legislators demanding restrictions on abortion seem moderate in comparison. However, in the public's view, the "pro-life" position became increasingly associated with cruelty and brutality. In response, Congress and pro-choice organizations began working in the courtrooms to put an end to the violence and stop the harassment of women and abortion clinic employees.

***Judicial, legislative and political responses to anti-abortion violence.*** In 1993, several abortion clinics filed suit under the "Ku Klux Klan" Act in *Bray v. Alexandria Women's Health Clinic*. The clinic wanted the Court to prohibit Operation Rescue and other anti-abortion groups and individuals from obstructing access to abortion clinics. While the idea was creative, the Justices held, by a 5-4 vote, that anti-abortion blockades and obstructionists were not engaged in gender-based discrimination, which was the premise of the statute.

In a 1994 case, *National Organization of Women v. Scheidler*, the pro-choice movement had an unexpected victory. The Court ruled, unanimously, "that a law originally intended to prosecute organized crime could be used against militant pro-life organizations who tried to close down legal abortion clinics" (Burns, 2005, p. 234). The Justices "held that

under the Racketeer Influenced and Corrupt Organizations (RICO) Act, the National Organization for Women did not have to show an economic motive to pursue a civil suit against antiabortion activist, Joseph Scheidler, and a coalition of antiabortion groups referred to collectively as the Pro-Life Action Network” (Rowland, 2004, p. 128).

In May 1994, Congress passed the Freedom of Access to Clinic Entrances (FACE) Act, making the blocking of entrances to abortion clinics and harassment or violence directed at women seeking care at such clinics a federal crime. The Act prohibits the use of intimidation or physical force to prevent or discourage persons from gaining access to an abortion clinic and created specific penalties for the destruction of, or damage to, a reproductive health care facility.

Two Supreme Court cases, *Madsen v. Women’s Health Center (1994)* and *Schenck v. Pro-Choice Network (1997)*, challenged state injunctions issued in Florida and New York. In *Madsen*, the Justices upheld the court-ordered injunction, ruling that a 36-foot buffer and quiet zone intended to keep anti-abortion protesters from obstructing clinic entrances and disturbing patients was permissible. In *Schenck*, the Justices upheld the injunction imposing a 15-foot “fixed bubble” buffer zone intended to facilitate persons and vehicles attempting to enter or leave abortion clinics in upstate New York (Rowland, 2004, p. 128). These challenges to the FACE Act were upheld by the Justices, strengthening the rights of women to have access to abortion clinics without the fear of harassment and violence.

Several bills were introduced into Congress in an attempt to write the content of *Roe* into statute law. As a federal law, women’s rights to abortion would be upheld even if the Supreme Court overturned *Roe v. Wade* (Burns, 2005, p. 237). During his eight years in office (1992-2000), President Clinton appointed two Supreme Court Justices, who supported

women's right to choose abortion. By 1994, Republicans attained a majority in Congress and moved quickly to bar health insurance coverage of abortion for federal employees, outlaw the use of U.S. military hospitals for abortions, ban federal funding of abortions for federal prisoners, and abolish federal subsidies for international family-planning agencies that provide abortions or abortion-related information.

State legislators, members of Congress, and pro-choice organizations were successful during the Clinton administration in countering the anti-abortion violence, blockades, and harassment of women, physicians, and clinic employees. Despite victories in both the courts and in organized defenses on the streets and sidewalks, picketing and intimidation of abortion providers and women seeking abortions had become routine. Supreme Court rulings allowed state-imposed restrictions on abortion while maintaining a woman's right to abortion. The decisions of the Justices caused both sides of the abortion debate to reevaluate their positions and strategies.

### **Change in Strategies**

Both pro-choice advocates and abortion opponents viewed the Supreme Court ruling in *Casey* in 1992 as a defeat. The anti-abortion movement had failed to recriminalize abortion while pro-choice supporters had failed to secure for women continued access to safe, legal abortion.

Pro-choice advocates had devoted time, energy, and money to counter the tactics of the anti-abortion movement. For the first time in over twenty years, pro-choice leaders began to articulate their vision of the legal status of abortion in bold, proactive terms. Pro-choice supporters recognized that the right to choose abortion was insufficient to provide women with liberty or equality unless abortion could be accompanied by the ability to make the full

range of reproductive choices. Consequently, pro-choice advocates joined other women's rights activists to fight more aggressively for policies that would reduce unintended pregnancy, promote comprehensive sexuality education, encourage contraceptive research and development, and increase the availability of prenatal care (Wilder, 1998, p. 87).

Anti-abortion leaders, confronted with their inability to make abortion illegal, despite a judicial system heavy with conservative judges, also began exploring new approaches to the issue of abortion. With the reputation of the pro-life movement harmed by the violent and confrontational tactics associated with anti-abortion activists, some abortion opponents proposed that the anti-abortion movement temporarily forgo a constitutional human life amendment and focus their efforts on enacting legal restrictions on abortion (Wilder, 1998). These emerging voices urged the anti-abortion movement to concentrate less on political goals and focus more on the immorality of abortion. During a six month period between 1995 and 1996, several articles appeared in leading opinion journals encouraging members of the anti-abortion movement to adopt the agenda of moral disapproval of abortion. Images of "a baby-like fetus, a fetus that sucks its thumb, an aborted fetus, [and] a fetus in a trash can" argued that the fetus was a complete human being who deserved protection under the law (Wilder, 1998, p. 91).

The immorality of abortion justified anti-abortion claims that anyone involved with abortion is morally tainted and acts of violence and murder are defensible (Fried, 1998, p. 216). Additionally, all involved with abortion are stigmatized, with women receiving the greatest impact of social disapproval. "Anti-abortionists have been able to portray women having abortions as selfish, sexually irresponsible, unfeeling, and morally blind individuals who kill their own children for 'convenience'" (Fried, 1998, p. 217). For women whose

pregnancies result from rape or incest, anti-abortion supporters argue for providing sympathy, not abortions.

With the ruling in *Casey*, the Justices upheld a woman's right to choose abortion before viability, which is primarily limited to the first trimester. With this decision, anti-abortion legislators and lawmakers focused their efforts on banning specific abortion procedures and imposing more restrictions on abortions performed late in pregnancy, including the Partial-Birth Abortion Ban Act (see Burns, 2005; Rowland, 2004).

A high-profile legislative battle occurred several times over the legal status of what the pro-life side calls "partial birth abortion" (Burns, 2005, p. 237). Medically referred to as intact dilation and extraction (IDX), this late-term abortion procedure has historically been used for less than one percent of all abortions. First introduced as a bill in Congress in 1995, the Partial-Birth Abortion Ban Act passed in both houses of the Congress in 1995 and again in 1997. Legislation was vetoed both times by President Clinton and efforts to override the veto failed.

Federal circuit courts were divided on the issue of "partial birth abortion" and held divergent views on the constitutionality and enforceability of state laws. In an attempt to settle the emerging and conflicting body of law in this area, the U.S. Supreme Court agreed to hear the appeal filed by Nebraska officials. In *Stenberg v. Carhart*, the U.S. Supreme Court held that the statute was unconstitutional. By a 5-4 vote, the Justices ruled that the Nebraska law "lacks any exception for the preservation of the . . . health of the mother [and] imposes an undue burden on a woman's ability to choose a D&E abortion, thereby unduly burdening the right to choose abortion itself" (Rowland, 2004, p. 312).

During 2003, the Partial-Birth Abortion Ban Act once again passed in both houses of the Congress and President George W. Bush signed the bill into law. The constitutionality of the law was immediately challenged. Judges in New York, California and Nebraska immediately blocked enforcement of the law. All three U.S. District Courts declared the law unconstitutional due to an omission of an exception for the health of the woman. The federal government appealed the district court rulings, which were then affirmed by three Court of Appeals. The U.S. Supreme Court, petitioned by Attorney General Gonzales, agreed to hear the *Carhart* case on February 21, 2006 and its companion *Planned Parenthood* case on June 19, 2006.

In *Carhart v. Gonzales*, the Justices held, by a 5 to 4 vote, that the Partial Birth Abortion Ban Act did not violate the Constitution. Justice Anthony Kennedy wrote the majority opinion which argued that the case differed from *Stenberg v. Carhart* in that the law defined the banned procedure more clearly. In dissent, Justice Ruth Bader Ginsburg argued that the decision departed from established abortion jurisprudence and that the lack of a health exception jeopardized women's health and placed doctors in an indefensible position, fearing prosecution.

The American College of Obstetricians and Gynecologists described the Court's decision as "shameful and incomprehensible", writing that "the Act will chill doctors from providing a wide range of procedures used to perform induced abortions or to treat cases of miscarriage and will gravely endanger the health of women in this country" (ACOG, 2007). Medical groups in general expressed concern that the Court endorsed the substitution of congressional legislation for medical judgment and the *New England Journal of Medicine* criticized the intrusion of politicians into the decision-making process.

Anti-abortion legislators and lawmakers used the judicial system to criminalize specific abortion methods and allow state-imposed restrictions in the form of waiting periods, mandatory counseling with inflexible and anti-abortion information, and required parental consent for minors. The use of fetal images served to convince legislators and the public that a fetus was a complete human being who needed protection under the law. These images also assisted abortion opponents in establishing abortion as highly immoral, contemptuous, and worthy of social condemnation.

At the same time, all across the nation, anti-abortion activists continued tactics of violence, harassment, and murder to intimidate abortion providers and women. On May 30, 2009, Dr. George Tiller, an abortion provider in Wichita, Kansas for more than thirty years and one of only a handful of doctors in the United States performing late term abortions, was shot and killed at church by Scott Roeder, an anti-abortion activist. Since 1977, the National Abortion Federation has gathered data from member clinics, the news media, and other pro-choice organization to compile statistics on incidents of violence and disruption against abortion providers. In 2010, there were more than 169,768 acts of disruption against abortion providers including hate mail, harassing calls and emails, bomb threats, picketing, and other suspicious acts; over six thousand (6349) incidents of violence against both abortion providers and abortion-related medical facilities occurred with hundreds of death threats, stalking, and vandalism (NAF, 2011). In a recent study analyzing access to abortion services, Jones and Kooistra (2011) identified that 57% of non-hospital providers and 89% of abortion clinics experienced at least one type of anti-abortion harassment in 2008; “The incidence of harassment varied by region; 85% of providers in the Midwest and 75% in the



South experienced any form of harassment, compared with 48% and 44% in the Northeast and the West, respectively” (p. 48).

Despite the inability of the anti-abortion lawmakers to recriminalize abortion, tactics of violence and disruption have reduced the number of abortion providers. Anti-abortion strategies of violence, along with judicial, legislative, and political attacks, have been successful in reducing the availability of abortion in the United States. These tactics have resulted in a decrease in the number of abortion providers, as well as limits on who can perform abortion and the methods that can be used. Women seeking abortion are now subjected to federal and state imposed requirements for mandatory delays, biased counseling, parental involvement and consent for minors, and lack of funding or insurance coverage for abortion procedures. Through these tactics, the anti-abortion movement has successfully impacted women’s accessibility to abortion in the United States.

### **Availability of Abortion in the United States in 2012**

**Abortion providers.** The climate of fear and terror created by anti-abortion violence has contributed to a significant reduction in the number of abortion providers. “Between 1982 and 1992, the nation experienced an 18 percent decrease in the number of abortion providers” (Wilder, 1998, p. 84). The number of U.S. abortion providers continued to decline between 1992 (2,380) and 2005 (1787), with a 2% decline between 2000 and 2005 (Jones, Zolna, Henshaw, and Finer, 2008, pp. 10-12). Between 2005 and 2008 (1,793) the number of abortion providers in the United States remained stable (Jones & Kooistra, 2011).

In 2008, the number of counties in the United States without an abortion provider remained at 87%; 35% of all women aged 15 to 44 years lived in those counties (Jones & Kooistra, 2011). Women who live in the Northeast and the West, where populations are

concentrated in metropolitan areas, were less likely to live in a county without a provider. Women who live in the South and Midwest, where populations are more dispersed, are more likely to live in a county without an abortion provider (Jones et al., 2008, p. 12; Jones & Kooistra, 2011, p. 45). Generally, abortion services are located in cities. However, in 2008, 69% of counties in metropolitan areas lacked an abortion provider; 25% of metropolitan women aged 15–44 lived in those counties. “Almost all non-metropolitan counties (97%) lacked an abortion provider, and 92% of women of reproductive age in these areas resided in those counties” (Jones & Kooistra, 2011, p. 45).

Between 2005 and 2008, the number of abortion providers decreased in 27 states and the District of Columbia, increased in 9 states and remained stable in fourteen (Jones & Kooistra, 2011). “The number of providers declined in the South (10%), the Northeast (8%) and the Midwest (5%). In contrast, it grew 15% in the West, largely because of a 23% increase in California” (Jones & Kooistra, 2011, p. 44). In states that had few providers to begin with, such as Arkansas, Mississippi, and North Dakota, declines in the number of providers further restricted access to abortion services and, in turn, contributed to lower abortion rates (Jones et al., 2008, p. 12).

***Provider training.*** In 1992, a study done by the American Medical Association (AMA) concluded that a shortage of abortion providers had “the potential to threaten the safety of induced abortion” (Wilder, 1998, p. 84). In response to these concerns, the Accreditation Council for Graduate Medical Education (ACGME), the agency responsible for accrediting medical residency programs, took steps in 1995 to address the lack of abortion training in obstetrical and gynecological residency programs. The ACGME adopted a requirement that all obstetrical and gynecological residency programs must include

education and training in induced abortion procedures to receive accreditation from the ACGME. The standard included an exception for medical students with religious or moral objections to performing abortions. Despite this attempt by the medical community to ensure adequate training on abortion procedures, Congress passed legislation that weakened the authority of the ACGME requirement. Instead of training programs being denied accreditation by the ACGME, and therefore federal funding, Congress passed legislation that declared “that any residency training program that loses ACGME accreditation because they fail to provide or arrange for abortion training will still be considered accredited and remain eligible for federal funding or other benefits or services” (NAF, 2003a). The National Abortion Federation surveyed medical schools in 1998 and found that training in first trimester abortion techniques was a “routine” part of residency training in 46% of obstetrical and gynecological programs in the United States (Almeling, Tews, & Dudley, 2000).

Efforts to expand the number of obstetrician/gynecologists trained to provide abortion services have had an effect on abortion provision after residency. Conducting a national survey of obstetricians/gynecologists, Steinauer, Landy, Filippone, Laube, Darney, and Jackson (2008) identified that completing a residency program with abortion training and performing a greater number of abortion during residency was associated with abortion provision in practice, despite pre-residency abortion attitudes (p. 39e1). The biggest factor which was negatively associated with providing abortion care was working in a practice or hospital that prohibited abortion (Steinauer et al., p. 39.e5). Of the 2149 respondents to the national survey (43%), 23% had provided elective abortion in the prior year; controlling for non-responders, this number would have decreased to about 10% (Steinauer et al., p. 39.e4). These authors concluded that “regardless of intention to provide abortion before residency,

abortion training availability was positively correlated with providing abortion in future practice” (Steinauer et al., p. 39.e1).

More recently, Freedman, Landy, Darney, and Steinauer (2010) interviewed 30 obstetrician-gynecologists who had graduated five to ten years earlier from residency programs that included abortion training. They found that 18 of the physicians had wanted to offer elective abortions after residency, but only three were doing so at the time of the interview. “The majority were unable to provide abortions because of formal and informal policies imposed by their private group practices, employers and hospitals, as well as the strain that doing so might put on relationships with superiors and coworkers” (Freedman et al., 2010, p. 146).

Abortion training for family practice physicians has also been encouraged as an attempt to increase the number of physicians available to provide abortion services (Bennett et al, 2007; Dehlendorf et al., 2007; Kumar, Herbitter, Karasz, & Gold, 2010). In evaluating three family medicine residency programs in California which integrated abortion training into routine gynecology rotations in academic years 2003-2004 and 2004-2005, Paul et. al. (2007) identified that abortion training could be safely integrated into family medicine residency programs, with a positive reception by both residents and patients (p. 184). Family medicine physicians also encountered barriers to incorporating abortion care into their clinical practices, more so than obstetricians/gynecologists. In addition to state-based restrictions, providers who wish to offer abortion care can encounter difficulty in obtaining medical liability coverage. Family physicians who desired to provide abortion services have been subjected to both denial of coverage by medical liability insurers and the imposition of large premium increases (Dehlendorf & Grumbach, 2008, p. 1770). For clinicians working

in community health centers, malpractice insurance is often accessed through the federal program for federally-qualified health centers (FQHC). This program specifically excludes malpractice coverage for abortion procedures; therefore, providers working in these clinics are unable to offer abortion services. This limitation on services from these community health programs limits reproductive care for over 16 million underserved Americans who receive their primary care at these sites (NAF, 2003a; U.S. Department of Health and Human Services, 2008).

*Limitations on who can perform abortions.* In 1973 when the U.S. Supreme Court declared abortion legal, the Justices ruled, without explanation, that states could require all abortions to be performed by a licensed physician. As of October 1, 2011, 39 states require an abortion to be performed by a licensed physician (Guttmacher Institute, 2011, State policies). Some states have successfully challenged the physician only requirement. In 1994, the New York Civil Liberties Union (NYCLU) obtained a Declaratory Ruling from the New York Department of Health (NYDH) stating that physician assistants could provide first-trimester abortions in New York under their practice act, despite the state’s physician-only law (CFC, 2009). The ruling recognized that the intent of the physician-only requirement and the physician assistant legislation were the same; the goal of both was to provide access to safe abortions. Support was received from the state of Vermont, which has allowed physician assistants at the Planned Parenthood of Northern New England (PPNNE) in Burlington to perform abortions since 1973. A comprehensive analysis of complication rates found that there was “no difference in overall, immediate, or delayed complication rates between physicians and PAs providing abortion care” (Freedman, Jillson, Coffin, and Novick, 1986, p. 550).

Litigation in Montana has both upheld and challenged the physician-only requirement. In 1997, the U.S. Supreme Court reversed a lower court ruling in Montana in *Mazurek v. Armstrong*. The Justices held “*per curiam*, that in applying the ‘undue burden’ test articulated in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the physician-only requirements are not unconstitutional” (Rowland, 2004, p. 129). In 1999, Montana’s prohibition against physician assistants providing abortion was struck down by the Montana Supreme Court in *Armstrong v. State*. The court held that the statute violated the right to privacy, “because the statute was a disguised attempt to limit patient access to abortion, and the legislation was not justified by a compelling state interest” (CFC, 2009).

***Advanced practice clinicians.*** Physician Assistants (PAs) have been providing abortion services at Planned Parenthood of Northern New England (PPNNE) in Burlington, Vermont since the legalization of abortion in 1973. Studies conducted in the mid-1980s and again in the mid-1990s have demonstrated favorable outcomes for women when abortions are performed by these providers. A sixteen-month study from July 1996 until October 1997 of 1,505 women having a first-trimester aspiration abortion compared the complication rates of PAs at PPNNE in Burlington, VT with physicians at the Feminist Health Center of Portsmouth, New Hampshire. The study confirmed the findings of Freedman, Jillson, Coffin, and Novick (1986) and again concluded that there were no differences in complication rates between physicians and PAs providing abortion care (Goldman, Occhiuto, Peterson, Zapka, and Palmer, 2004). PAs and Nurse Practitioners (NPs) provide 99% of all first and second-trimester abortions at PPNNE affiliates in NH and VT (CFC, 2009). The research and success of these advanced practice clinicians has influenced legislation in other states.

The Rhode Island Department of Health issued new regulations in 2000 which allowed licensed health care practitioners to provide medical abortion. In 2001, Connecticut's Attorney General issued an official opinion stating that Connecticut law permits Advanced Practice Registered Nurses (APRNs), Certified Nurse Midwives (CNMs), and PAs to provide medical abortions. In 2002, California passed the Reproductive Privacy Act, permitting any authorized health care provider to provide medical abortion. The Washington State Attorney General issued an official opinion in 2004 stating that nothing in State law prohibits NPs from providing medical abortion. In 2006, the Oregon State Board of Nursing determined that the performance of manual suction/aspiration abortion was not outside the scope of practice of a Family Nurse Practitioner (FNP) given that the FNP was both educationally prepared and clinically competent.

In 2007 the Access through Primary Care (APC) Project Demonstrating the Role of Advanced Practice Clinicians in Expanding Early Pregnancy Care provided a legal waiver for the provision of early aspiration abortion by clinicians trained and offered services through the demonstration project. In the same year, the New Jersey office of the Attorney General released a favorable opinion regarding the provision of medical abortion by a single advanced practice nurse in the state. In 2008, the Arizona State Board of Nursing determined that the performance of first trimester aspiration abortion was within the scope of practice of a nurse practitioner provided that the procedure was within the nurse practitioner specialty certification population, the nurse practitioner had met the education requirements, and there was documented evidence of competency in the procedure. Most recently, the Illinois office of the Attorney General issued an official opinion in 2009 stating that Illinois law permits NPs, CNMs, and PAs to provide medical abortions. While these legislative strategies have

clarified the physician-only qualification in *Roe* in some states, most states continue to limit abortion care to physicians, without evidence that such restrictions improve abortion safety (Guttmacher Institute, 2011, Overview; Taylor, Safriet, & Weitz, 2009). The provision of abortion services by advanced practice clinicians (APCs) has required not only education and training in abortion techniques, but also political organizing to achieve the necessary legal and regulatory changes (Joffe & Yanow, 2004; NAF, 2003a, 2010; Samora & Leslie, 2007).

“The largest, most influential and well-respected medical and health policy organizations in the United States have issued statements in support of the inclusion of CNMs, NPs, and PAs in abortion care” (CFC, 2007). In 1997, the American College of Obstetricians and Gynecologists stated their encouragement of programs to train physicians and other licensed health care professionals to provide abortion services as a way to address the shortage of health care providers who perform abortions. Additionally, the American Academy of Physician Assistants, the American College of Nurse Midwives, the American Medical Women’s Association, the American Public Health Association, the Association of Physicians Assistants in Obstetrics and Gynecology, the International Confederation of Midwives, the National Association of Nurse Practitioners in Women’s Health, and Physicians for Reproductive Choice and Health support the participation of these three professional groups in providing abortion care.

**State mandated counseling and waiting periods.** In August 1992, Mississippi became the first state to enforce a mandatory delay and counseling requirement in the wake of the *Casey* ruling. As of October 1, 2011, 34 states mandate that women be given counseling before an abortion; 24 of these states detail the information that must be given to women (Guttmacher Institute, 2011, Counseling and waiting). These state statutes usually



require counseling to include information about fetal development, the gestational age of the fetus, the risks of abortion and childbirth, and resources available for low-income pregnant women. In many states, mandatory counseling includes information on at least one of the following: the purported link between abortion and breast cancer (6 states), the ability of a fetus to feel pain (11 states), long-term mental health consequences for the woman (6 states) or information on the availability of ultrasound (10 states) (Guttmacher Institute, 2011, Counseling and waiting).

Twenty-five of the 34 states that require counseling also require a woman seeking an abortion to wait a specified period of time, usually 24 hours, between when she receives the counseling and when the procedure is performed. Nine of these states have laws that require the woman to be counseled in person, effectively mandating that the woman make at least two separate visits to the clinic to obtain the abortion (Guttmacher Institute, 2011, Counseling and waiting). Some state laws have been interpreted to mean that a woman can be counseled over the phone, through the mail, on the internet, or by faxing information.

Supporters of mandatory counseling and waiting laws argue that the state has a “duty to ensure that before a woman decides to terminate a pregnancy she has been given ample time, after having been given information about her pregnancy and abortion, to weigh her options” (Joyce, Henshaw, Dennis, Finer, & Blanchard, 2009, p. 3). Opponents argue that these state statutes are unnecessary because physicians and practitioners are required to obtain informed consent before all medical procedures, including abortion. Those opposed to these laws contend that mandatory counseling and waiting period laws impose an unnecessary burden on women seeking abortions; they assert that women are capable of making informed decisions about terminating a pregnancy without the imposition of the

state. Opponents further maintain that these laws serve no medical purpose and are only a ploy on the part of anti-abortion legislators to decrease the accessibility of abortion. The content and the complexity of state mandatory counseling and delay laws changes over time and continues to evolve.

**Bans on abortion funding and insurance coverage.** When abortion became legal throughout the United States in 1973, medically necessary abortions were covered under Medicaid, the joint federal and state health insurance program for eligible low-income families. The Hyde Amendment, passed by Congress originally in 1976 banned federal funding for abortion in all but the most extreme circumstances. Congress renews the Hyde Amendment annually, sometimes making modifications to the Amendment. The current version of the Hyde Amendment, approved in 1997, allows federal funding for abortion only in cases of rape and incest. In addition, this version of the Amendment permits payment for abortion when the woman's life is endangered "by a 'physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself'" (Henshaw, Joyce, Dennis, Finer, and Blanchard, 2009, p. 3). As of October 1, 2011, 32 states and the District of Columbia prohibit the use of their state Medicaid funds for abortions except in the limited cases outlined in the Amendment (Guttmacher Institute, 2011, State funding). South Dakota is currently in violation of the Hyde Amendment because it refuses to pay for abortions in cases of incest or rape, paying for abortions only in cases of life endangerment.

At the federal level, the Hyde Amendment has withstood challenges to its constitutionality and remained upheld. At the state level, the issue of Medicaid coverage for abortion has been somewhat more flexible. Attorneys have focused litigation in states whose

constitutions have been interpreted as providing strong protections for privacy rights.

“Currently, 17 states have a policy to use their own funds to pay for all or most medically necessary abortions sought by Medicaid recipients” (Henshaw et al., 2009, p. 3). Of these states, Hawaii, Maryland, New York and Washington adopted such a policy voluntarily, while the rest were ordered to do so by their courts under their individual state constitutions.

Besides Medicaid funding bans, other types of state bills also limit funding for abortions. Some state statutes prohibit “public funding for abortion for women whose health would be threatened by continuing their pregnancies. Other bills prohibit public funding for abortions for specific state employees, by insurance companies, or in other circumstances” (NAF, 2006). In 2010, President Obama signed into law the Patient Protection and Affordable Care Act, which, among many things, provides for the establishment of state-level health care exchanges to assist individuals and small businesses in purchasing a private health insurance plan. Currently, 6 states have laws in effect which restrict insurance coverage of abortion in all private insurance plans written in the state; these restrictions will also apply to the health insurance exchanges that will be established under the federal health care reform law (Guttmacher Institute, 2011, Restricting). Thirteen states have restricted abortion coverage in plans that will be offered through the insurance exchanges; fourteen states have banned abortion coverage in public employees’ insurance policies or in other cases where public funds are used to insure employees (Guttmacher Institute, 2011, State funding). Sometimes abortion coverage is permitted, but only if the woman purchases additional insurance at her expense.

**Parental involvement and consent for minors.** In 2008, 18% of U.S. women obtaining abortions were teenagers; those aged 15-17 years obtain 6% of all abortion, teens

aged 18-19 obtain 11% and teens younger than 15 obtain 0.4% (Jones, Finer, & Singh, 2010). “A majority of pregnant minors who seek abortion indicate that their parents are aware that they are doing so. Nonetheless, some of these parents do not approve of their daughters’ decisions, and some minors are unwilling to tell their parents” (Dennis, Henshaw, Joyce, Finer, & Blanchard, 2009, p. 3). Since the U.S. Supreme Court’s decisions in *Planned Parenthood of Central Missouri v. Danforth* in 1976 and *Bellotti v. Baird* in 1979, it has been legal for states to require minors who are seeking an abortion to obtain parental consent or to notify their parents. In requiring parental consent, states must provide an alternative approval mechanism, such as a judicial bypass procedure, which allows “minors to seek a court order rather than notifying their parents or obtaining their consent” (NAF, 2003b). Judicial bypass availability varies by state.

Over the years, an increasing number of states have instituted parental involvement statutes. Parental involvement laws include both parental consent and parental notification requirements. Thirty-six states currently enforce parental consent or notification laws for minors seeking an abortion; 22 states require one or both parents to consent to the abortion procedure, while 10 require that one or both parents be notified; 4 states require both parental consent and notification (Guttmacher Institute, 2011, Parental involvement). An additional seven states have laws whose enforcement has been legally prohibited from taking effect due to conflicts with state constitutions or the federal constitution (Dennis et al., 2009). These laws take a variety of forms in different states. Most require notification or consent from just one parent, usually 24 to 48 hours before the abortion procedure. “A handful of states require the involvement of both parents, and six states allow certain other adult relatives (such as grandparents) to approve an abortion” (Dennis et al., 2009, p. 3).

Supporters of parental involvement laws argue that excluding parents from their daughter's pregnancy decisions will infringe on the rights of parents and harm minors who seek terminations. Proponents also claim that the laws will facilitate and improve family communication and reduce pregnancy rates. "An implicit purpose of the laws is to prevent abortions by encouraging minors to continue their unwanted pregnancies" (Dennis et al., 2009, p. 3). On the other hand, opponents of parental involvement laws argue that these laws limit young women's access to abortion services, and "that requiring parental involvement may, for at least some teenagers, lead to family violence, force minors to continue unwanted pregnancies or delay abortions, thereby increasing the risk of medical complications related to the procedure" (Dennis et al., 2009, p. 3).

Some minors travel to other states which have no parental involvement laws to obtain an abortion. To be able to travel out of state a minor must have access to transportation and be within a reasonable distance of a state with less restrictive laws. The extent to which minors use this option varies by age, socioeconomic status, and access to public transportation. New parental involvement laws are attempting to "place restrictions on a minor's ability to travel to another state for an abortion. Such bills can penalize even family members who help teenagers" (NAF, 2003b).

The influence of parental involvement laws on minors depends in part on young women's awareness of these requirements. "Teenagers often learn of the requirements and the possibility of judicial bypass when they contact an abortion clinic" (Dennis et al., 2009, p. 4). Many states who already have parental notification laws have introduced additional legislation to impose new, stricter requirements. "For example, some states have added

notarization requirements, increased the requirement from notice to consent, and made the judicial bypass mechanism more difficult for minors to access and navigate” (NAF, 2003b).

Despite investigations indicating that a majority of adolescent females tell their parents (mother) about their decision for abortion (Henshaw & Kost, 1992; Griffin-Carlson & Mackin, 1993), states continue to impose parental consent and/or involvement laws on minors seeking abortion. Ehrlich (2003) conducted interviews with 26 minors in Massachusetts who obtained judicial authorization for an abortion without parental involvement. Reasons for not involving their parents included: “an anticipated severe, adverse parental reaction or anger; anticipated harm to the relationship; concern for a parent’s well-being; anticipated parental pressure to have the baby; and a problematic family relationship” (Ehrlich, 2003, p. 15). “Virtually all the minors reported being extremely nervous or frightened about going to court . . . the greatest fear was that the judge would deny them consent for the abortion” (Ehrlich, 2003, p. 18). These young women worried about making a mistake that would make them appear immature or stupid. They were afraid that their reasons for not involving their parents would not be acceptable to the court or that they would not be able to convey their maturity to the judge. The author concluded that “teens were neither flippant nor casual about the non-disclosure decision, and their reasons were well-grounded in the realities of their lives” (Ehrlich, 2003, p.25).

**The results of legislative, judicial, and political anti-abortion strategies.** By challenging existing abortion laws in state and federal courts, anti-abortion legislators have removed federal and state funding for abortions, along with insurance coverage. They have imposed mandatory counseling and waiting periods, required parental involvement and/or consent for minors, and banned specific abortion methods. Anti-abortion lawmakers have

attempted to limit abortion providers to licensed physicians and have guaranteed federal funding for OB/GYN residency programs that do not meet educational standards by providing training on abortion procedures. Through violence, intimidation, and harassment, pro-life activists and extremists have successfully driven medical personnel out of the practice of abortion, reducing the number of abortion providers and services. All of these challenges, despite the continued legality of abortion in the United States, have effectively decreased access to abortion for many women, resulting in a right to choose which has effectively been taken away. “The impact of eroding access to abortion has been felt most severely by low-income women, young women, and women of color, who comprise a disproportionate number of the poor” (Fried, 1998, p. 212).

In the United States, women of color are disproportionately likely to have an abortion because both Black and Hispanic women experience higher rates of unintended pregnancy than White women (Cohen, 2008, p. 3). White women were the most common racial and ethnic group among abortion patients, accounting for 36% of all abortions; African American women had the highest rate of abortion, 40.2 per 1,000, followed by Hispanic women, 28.7 per 1,000, and compared with non-Hispanic white women at 11.5 per 1,000 (Jones & Kavanaugh, 2011, p. 1361). This trend reflects widespread social and economic inequities such as lack of access to contraception, to affordable, quality healthcare, and to educational and employment opportunities (Cohen, 2008). Not only does race affect women’s experiences of abortion; in the past decade, more women seeking abortion have incomes below the federal poverty limit; 69% of women having abortions in the United States are economically disadvantaged (Jones, Finer, & Singh, 2010). Jones and Kavanaugh (2011) identified that patterns of abortion “by poverty status were the same across racial and ethnic

groups: abortion rates were highest for poor women and decreased with income” (p. 1363).

Poor white women accounted for 11.7% of abortions in 2008; poor African American women 14.1% and poor Hispanic women 13% (Jones & Kavanaugh, 2011, p. 1364). “Abortion is becoming increasingly concentrated among poor women, and restrictions on abortion disproportionately affect this population” (Jones & Kavanaugh, 2011, p. 1358).

**Medical abortion.** Abortion proponents hoped that medical abortion techniques would expand women’s access to abortion services in the United States and decrease the disparities that affect poor women, young women, and women of color. Medical abortion involves the use of medications to terminate a pregnancy instead of surgical instruments. RU 486, now known as mifepristone, was developed during the early 1980s by a team of researchers working for the French pharmaceutical company Roussel Uclaf. Clinical testing of mifepristone as a method of inducing abortion began in France in 1982. Results from these early clinical trials demonstrated that mifepristone by itself could induce a complete abortion in about 80% of women up to 49 days gestation (Creinen, 2000). By adding small doses of a prostaglandin a few days after administration of the mifepristone, investigators discovered that a complete medical abortion could be induced for nearly 100 percent of women (Bydeman & Swahn, 1985; Swahn, Cekan, Wang, Lujndstron, & Bygdeman, 1985; Joffe, 1999). Mifepristone blocks the action of progesterone, a hormone needed to sustain a pregnancy. Administration of mifepristone results in: changes in the uterine lining and detachment of the pregnancy, softening and opening of the cervix, and increased sensitivity to prostaglandin. Prostaglandin, most often misoprostol, causes the uterus to contract and helps the pregnancy tissue to be expelled (NAF, 2008a, 2008b).



In the late 1980s the Reproductive Health Technologies Project began as a citizens' campaign with the purpose of bringing RU 486 to the United States. Members of this group met periodically to bring reproductive leaders together, keep them informed of the progress on RU 486 in Europe and elsewhere, and develop common messages and themes. In September 1988, RU 486 was formally approved in France for medical abortion; however, the politics of abortion delayed the introduction of mifepristone in the United States. Initial research in the United States was interrupted in October 1988 when Roussel Uclaf announced that it was suspending the production and sale of RU 486. After enduring repeated protests from the French Catholic Church and anti-abortion groups, Edouard Sakiz, the president of Roussel Uclaf, reluctantly concluded that the public was not ready for RU 486. Two days later, the French Minister of Health ordered the drug back onto the market, declaring that the abortion debate would not be allowed to deprive women of a product that represented medical progress.

In 1989 the Federal Drug Administration (FDA), under pressure from the first Bush administration, banned the import of mifepristone for personal use in the United States. Shortly after his inauguration in 1993, President Clinton signed an executive order to encourage the testing, licensing, and manufacturing of mifepristone and similar medications. During the extended struggle to make mifepristone available in the United States, some physicians began to investigate the use of methotrexate in combination with misoprostol for medical abortion. Results were comparable; complete abortion occurred in 94- 96% of women up to 49 days gestation. Nonetheless, the methotrexate/misoprostol regimen generally took longer to result in termination of a pregnancy and the timing of vaginal bleeding was more unpredictable than the mifepristone/misoprostol combination (Kahn et al.,

2000; NAF, 2010; Pymar & Creinin, 2000). While not approved in the United States as an abortifacient, methotrexate is approved for other indications; therefore, physicians could legally prescribe methotrexate “off label” for the evidence-based indication of abortion.

In May 1994, Donna Shalala, Secretary of the Department of Health and Human Services, announced that an agreement had been reached with Roussel Uclaf. According to the agreement, the company would donate the production patent rights for RU 486 to the nonprofit Population Council in New York. The Population Council would be unrestricted to pursue getting the drug onto the market in the United States, which included identifying another commercial manufacturer for the product and a distributor. Roussel Uclaf made available a sufficient quantity of RU 486 for a clinical trial of two thousand women in the United States. Throughout 1995-1996, clinical research was conducted on the use of mifepristone by the Population Council and Abortion Right Mobilization (ARM). At the same time, the Population Council attempted to find investors and negotiate agreements with potential manufacturers and distributors.

Clinical trials conducted in the United States in the mid-1990s demonstrated feasibility, efficacy, acceptability, and safety of mifepristone (Aubény et al., 1995; Kahn et al., 2000; Koopersmith & Mishell, 1996; Peyron et al., 1993; Schaff, Stadalius, Eisinger, & Franks, 1997; Simonds, Ellertson, Springer, & Winikoff, 1998; Spitz, Bardin, Benton, & Robbins, 1998; Winikoff, Ellertson, Elul, & Sivin, 1998). In July 1996 the Reproductive Health Advisory Committee of the FDA voted to recommend mifepristone as safe and effective. In September the FDA responded to the advisory committee’s recommendation by issuing an approval letter, affirming the safety and efficacy of the drug for early abortion. When the manufacturing and distribution details for mifepristone were finalized by the

Population Council, the FDA fully approved mifepristone in a dose of 600mg, as an alternative to surgical abortion, in September 2000 (NAF, 2010). As early as 2001, an estimated 83% of providers were using 200mg of mifepristone which had been demonstrated in clinical trials to be as or more effective than the FDA approval dose (Finer & Wei, 2009, p. 623).

Mifepristone and misoprostol can be used for early abortion up to 63 days after the start of the last menstrual period. Side effects such as cramping and bleeding are expected with medical abortion and result from the abortion process itself. Side effects of the medications include nausea, vomiting, diarrhea, fever, and chills. In most situations, these side effects can be managed with counseling and symptomatic treatments, such as oral analgesics for pain. Complications of medical abortion are rare; vaginal bleeding requiring blood transfusion occurs in approximately 1 in 500 cases (Kahn et al., 2000; NAF, 2008a). Approximately 95-98% of women will have a complete abortion when using mifepristone and misoprostol; the remaining women (2-5%) will need vacuum aspiration (surgical abortion), either because of ongoing or excessive bleeding, an incomplete abortion, or an ongoing pregnancy (Kruse, Poppema, Creinin, & Paul, 2000; NAF, 2008a).

Even before FDA approval, many abortion proponents hoped that mifepristone would change the nature of abortion provision in the United States. Expectations were high that mifepristone would make abortion more widely accessible by increasing the integration of medical abortion into non-surgical clinical practices. In 2009, Finer and Wei examined the pattern of mifepristone uptake in the United States to determine whether the introduction of medical abortion had facilitated access to abortion services. These researchers identified that mifepristone providers increased from 208 in the last two months of 2000 to 700 in 2001, the

first full year of availability” (Finer & Wei, 2009, p. 623). The estimated number of medical abortion providers increased rapidly through 2004 to 877 providers that year and then more slowly through 2007 to 902 providers in that year (Finer & Wei, p. 625).

“The estimated number of mifepristone abortions increased from 55,000 (4%) in 2001 to about 158,000 (14%) by 2007. Again, the increase was steeper through 2004 and more gradual afterward” (Finer & Wei, 2009, p. 625). In 2008, medical abortion accounted for 199,000 (17%) of all non-hospital abortions (Jones & Kooistra, 2011). “In 2007, clinics represented about 46% of mifepristone providers but performed 88% of mifepristone abortions. Physicians represented 51% of mifepristone providers but accounted for just 11% of abortion, and hospitals accounted for 4% of providers and 1% of abortions” (Finer & Wei, 2009, p. 625). The proportion of abortions in each state performed using mifepristone ranged from 0% to 100% (Finer & Wei, 2009, p. 626). In 2005, 95% of surgical abortion providers were located in metropolitan areas; this was true for providers of medical abortion also, with 96% located in metropolitan areas, 3% located in micropolitan areas, and only 1% located elsewhere (Finer & Wei, 2009, p. 626). Therefore, the majority of mifepristone abortions are performed at or near facilities that also provided surgical abortion.

Finer and Wei identified that the numbers of mifepristone abortions and providers have both increased dramatically since FDA approval in 2000, even as the total number of abortions performed in the United States has declined consistently during the same time period. These researchers concluded that mifepristone has become an integral part of abortion provision in the United States and has likely contributed to a trend toward very early abortions. “The proportion of abortions at 8 weeks gestation or less has been increasing since the early 1990s, but the increase was steepest between 2000 and 2002, right after the

introduction of mifepristone” (Finer & Wei, 2009, p. 629). In 2008, medical abortion accounted for about one-quarter of abortions before nine weeks gestation (Jones & Kooistra, 2011).

Expectations that medical abortion would result in a wider range of providers offering abortion have not yet been realized and mifepristone has not brought a major improvement in the geographic availability of abortion (Finer & Wei, 2009, p. 629). Finer and Wei recognized that obstetrician/gynecologists have most commonly incorporated mifepristone into their medical practices with obstetrician/gynecologists providing 67% of all abortions between November 2000 and May 2007 (p. 625). These investigators identified that family practice physicians provided only a small percentage (11%) of medical abortions, perhaps due to an inability to obtain liability coverage. These authors and many others have speculated that the increasing role of advanced practice clinicians (physician assistants, nurse practitioners, certified nurse midwives) may have an effect on the distribution of mifepristone providers in the future (Berer, 2009; Finer & Wei, 2009; Jackson, 2011; Yarnall, Swica, & Winikoff, 2009), however, there are currently no statistics that clearly document the effect of advanced practice clinicians as abortion providers on availability and access to abortion services. One explanation is the way abortion data is collected; abortion providers are classified by number of abortion procedures performed and generally are categorized as abortion clinics, other clinics, hospitals, or physicians’ offices. In 2008, 59% of facilities provided one or more early medical abortion (Jones & Kooistra, 2011), but which practitioners provided abortion services remains unclear. Finer and Wei (2009) identified that “at one large provider network, more than half of mifepristone abortions are performed by advanced practice clinicians” (p. 629). Since the number of abortion providers has

remained stable in recent years, one must speculate that advanced practice clinicians are replacing physicians, not adding to the number of abortion providers in the United States.

### **Conclusion**

The purpose of this chapter was to provide the reader with knowledge about the political, judicial, legislative, and social contexts of women's experiences of elective abortion since legalization in the United States. Knowledge shared has allowed the reader to comprehend the impact of politics, the judicial system, and the anti-abortion movement on women's experiences of abortion since 1973, identifying the influence of these changes on women, especially economically disadvantaged women, women of color, and adolescents seeking abortion. The historical context of women's experiences of abortion in the United States has revealed relationships and structures of power evidenced through mandatory counseling, state-imposed waiting periods, parental involvement and/or consent for minor women, lack of funding for abortion, and decreased availability of abortion services due to limitations on abortion techniques and on who can provide abortion care. All of these intrusions on women's right to choose abortion have resulted in the need for more than one clinic visit and delays in obtaining abortion services, necessitating later abortion procedures which are more risky for women's health. Disparities in occurrence of unintended pregnancy and access to abortion services for poor women, women of color, and female adolescents have been discussed. This chapter has provided a historical context for women's experiences of legal, elective abortion in the United States and constructed a background for my review of empiric literature in the next chapter and my analysis of women's narratives in chapters 5 and 6.

### Chapter 3: Review of the Literature

The history of legal abortion in the United States has constructed a background for this investigation by providing political, social, and judicial contexts for women's experiences of abortion. The purpose of this chapter is to provide a critical review of empirical literature pertinent to women's experiences of abortion.

#### Methodology

To construct a foundation for this dissertation, I searched the health sciences literature (CINAHL, Women's Studies International, Medline, PsycINFO, Sociological Abstracts, Academic Search Complete, Dissertations & Theses: A&I) for empirical, primary sources pertaining to women's experiences of elective, legal abortion in the United States. Using electronic resources (JSTOR, EBSCO, ProQUEST, PubMed), I focused my exploration on studies: a) available in the English language, b) published in peer reviewed journals, c) conducted in the United States, d) since 1973, and e) located using the terms "women's experiences" and "abortion, induced". The search yielded books, reports, statistical data, bibliographies, oral histories, conference presentations, master's theses, doctoral dissertations, and peer-reviewed journal articles. Additional sources were identified by assessing reference lists and located online or through the University of Wisconsin – Milwaukee (UWM) interlibrary loan department.

Sources were reviewed for key concepts and excluded from the review if they focused on procedures for inducing abortions, management of spontaneous abortions or pregnancy terminations related to women's medical conditions or fetal anomalies. Also excluded were investigations specific to decision-making processes, counseling techniques, clinical standards and staffing, provider training, staff attitudes, moral considerations, men's

experiences of abortion, and hypothetical abortion situations. The resulting sources were read and reviewed for their applicability and appropriateness as foundational material for this dissertation.

**Overview of identified sources.** Reviewing the sources, I discovered that many published investigations relevant to women's experiences of abortion mirrored the history and politics of abortion in the United States. Studies in print between 1973 and the late 1980s (Faria, Barrett, & Goodman, 1986; Freeman, 1978; Smith, E. M., 1973; Zimmerman, 1977) focused on women's experiences of abortion as a newly legal and accessible option, exploring attributes of women seeking legal, surgical abortion. By the mid-1990s and into the subsequent decade, clinical trials were undertaken to establish the safety, efficacy, feasibility, and acceptability of medical abortion as a new technique in the United States (Schaff, Stadalius, Eisinger, & Franks, 1997; Spitz, Bardin, Benton, & Robbins, 1998; Winikoff, Ellertson, Elul, & Sivin, 1998). One study reported on women's experiences of medical abortion during the clinical trials (Beckman & Harvey, 1997), while more recent studies investigated women's experiences of medical abortion which included self-administration of misoprostol at home (Andrist, Simmonds, Liebermann, & Healey, 2006; Elul, Pearlman, Sorhaindo, Simonds, & Westhoff, 2000; Fielding, Edmunds, & Schaff, 2002). One investigation explored the social context and women's experiences of medical abortion (Fielding and Schaff, 2004). Near and beyond the millennium, researchers explored women's perspectives of the long-term significance of abortion in their lives (Avalos, 1999; Hess, 2004, Trybulski, 2005) and the experiences of African American adolescents (Andrews & Boyle, 2003).



I also discovered that one area of investigation, the affects of abortion on women's mental health, had consistently been examined and explored by researchers between 1973 and 2012. Among my sources were several publications specific to abortion and women's mental health (Shusterman, 1976; Adler, David, Major, Roth, Russo, & Wyatt, 1990; Coleman, Reardon, Strahan, & Cogle, 2005). Recalling the role of physicians, especially psychiatrists, in hospital committees (who granted women legal, therapeutic abortions during a time of strict criminalization of abortion in the United States during the mid-20<sup>th</sup> century), I anticipated an emphasis on psychiatric diagnoses and the pathologizing of women who sought abortion in the earliest literature. However, in reviewing sources, I recognized that some of the more recent publications also viewed abortion as traumatic for all women and continued to analyze results in a way that pathologized women who underwent abortion (Coleman et al., 2005; Hess, 2004; Trybulski, 2005). Many of my sources consistently reported that a majority of women experienced relief and positive psychological responses to abortion (Adler et al., 1990; Andrews & Boyle, 2003; Andrist et al., 2006; Elul et al., 2000; Freeman, 1978; Faria et al., 1986; Shusterman, 1976; Smith, 1973).

**Organization of this chapter.** In this chapter, I organized my review of empiric literature pertaining to women's experiences of abortion according to the historical timeline identified. I begin by reviewing studies about women's experiences of surgical abortion. Then I critique studies of women's experiences of medical abortion, followed by investigations of women's experiences of abortion over time (perspectives on the long term effects of abortion). Lastly I discuss the paucity of literature about under-represented women's experiences of abortion. In critiquing each section of this empiric literature, I considered the breadth, depth, and relevance of the identified investigations for this

dissertation. I identified similarities and gaps in the literature, as well as contradictions and inconsistencies. I summarized what is known about the impact of the social context on women's experiences of abortion within each group of studies. In the final section of this chapter, I appraised empiric literature pertaining to the affects of abortion on women's mental health.

### **Studies about Women's Experiences of Surgical Abortion**

The earliest studies identified for inclusion in this review of empiric literature focused on women's experiences of surgical abortion and reflect the novelty of abortion being legal in the United States. Three of the four studies sought to quantify and objectively describe women's experiences of legal, surgical abortion, including characteristics of the women themselves (Faria et al., 1986; Freeman, 1978; Smith, 1973). The fourth study (Zimmerman, 1977) employed narrative inquiry to examine women's experiences of abortion and the social context of these experiences in rich detail and depth. These investigators explored women's attitudes toward abortion, sexual activity and contraceptive behavior, reasons for the abortion decision, and the impact of the social context on women's experiences of abortion. Recall that between 1970 and 1995, abortion procedures were primarily surgical, with dilatation and curettage (D&C) the most common method until the mid-1980s when dilatation and evacuation (D&E), with manual or electrical suction, became the most common (and safest) surgical abortion procedure. Characteristics of these studies are summarized in Appendix B.

Identifying contradictory reports in the literature regarding the psychological effects of abortion, Elizabeth Smith (1973) sought to better understand the effects of abortion by asking women to evaluate their experience and describe their reactions to abortion. She reported on the characteristics of 154 women who contacted the Pregnancy Consultation

Service (PCS) in St. Louis, Missouri during its first year of operation (September 1969 through August 1970). Restrictive laws during this time prevented women from obtaining legal abortions in Missouri. The PCS, a non-profit, state-wide agency, was developed as a crisis-oriented counseling service to provide women with information about locations where legal abortion was available. Women were interviewed by medical students using a structured questionnaire designed to elicit social and psychiatric information, as well as attitudes regarding sex, contraception, pregnancy, and abortion. Women who requested abortions were typically single, white students of Protestant faith, in their late teens or early twenties. The age range was 14 to 42 years, with an average age of 21. The women were generally referred to PCS by friends or physicians and 76% were less than 12 weeks pregnant. Ninety-seven percent had not experienced a previous unintended pregnancy and 99% had not had a prior abortion. Less than half were using any form of contraception when pregnancy occurred. Single women sought abortion primarily due to the absence of marriage or a desire to continue occupational or educational pursuits. Married women most often requested abortion due to financial concerns or a lack of desire for additional children. The majority of women did not have a history of psychiatric problems.

All women who terminated their pregnancy (125 of 154) were contacted between one and two years after the abortion and asked to participate in a follow-up interview. Eighty (80) women completed the follow-up questionnaire by interview (12), telephone (42), or in writing (26). These women were single (61%), white (95%) students (36%) or professional workers (24%) of Protestant (48%) or Catholic (23%) faith. The mean age was 22 years. The women who participated in the follow-up interview were representative of the total population of women who obtained abortions during this time period.

The majority of women in this study reported that they did not experience any emotional discomfort as a result of the abortion. Seventy-eight percent (78%) of the women denied negative psychological reactions immediately after the procedure, and 90% denied psychological changes at the time of follow-up. Feelings of relief and satisfaction were reported by many women after the abortion. Symptoms of depression, guilt and sexual dysfunction were experienced by a small number of women; these symptoms were usually self-limiting and did not impair functioning or require professional help. Only six percent of the women sought professional assistance after the abortion. Most of the women felt the abortion had a positive effect on their lives, and only three percent strongly regretted their decision. Women reported that the abortion had allowed them to remain in school, to continue working in jobs they enjoyed, and/or to devote time to their families. Many of the women perceived the abortion experience as a growth producing or maturing process.

Examining women's relationship with their sexual partner, Smith found that 44% of the unmarried women had discontinued contact with the male partner at the 4-month follow-up; 13% had married the partner. Most of the women had talked with their sexual partner about the unintended pregnancy and the abortion; receiving both emotional and financial support at the time of the abortion. This investigator identified that two-thirds of the women reported positive feelings toward the male partner and attributed these findings to the support received at the time of the abortion. All of the women who were married at the time of the abortion had talked with their husbands about the unintended pregnancy and abortion; all but one was supportive and no women reported a change in marital status or relationships with their husbands as a result of the abortion.

From the follow-up data, Smith identified that all but 3 of the sexually active women were using contraception. “One married woman wanted to become pregnant, and two single women reported infrequent intercourse and did not feel they needed birth control” (p. 582). In addition to an increase in the number of women using birth control, the majority of women were also using more reliable forms of contraception after the abortion. Despite improved contraceptive behavior, six women (7%) experienced a second unintended pregnancy with five obtaining abortions and one aborting spontaneously. Smith recognized that “although the women found abortion a necessary solution to their unwanted pregnancies, they did not view it as a preferable means of birth control” (p. 585).

This researcher identified that women often expressed appreciation for the help they had received from PCS prior to the abortion. Pre-abortion counseling was helpful for 86% of the women who most frequently mentioned the emotional support they received from the counselor and the information they obtained regarding the abortion procedure. Women who found the counseling session least helpful were married or older single women who felt they had adequate information and were receiving emotional support from friends or their husbands. “Younger women and those who had not confided in anyone regarding the pregnancy found the counseling of most value” (Smith, p. 583).

Exploring women’s subjective attitudes and feelings about abortion, Freeman (1978) recruited women requesting first trimester abortions in June and July of 1975 at two outpatient abortion clinics in the Philadelphia metropolitan area. The 329 women who agreed to participate during the pre-abortion counseling session, completed self-administered questionnaires after their abortions. The questionnaire elicited demographic information and data on sexual activity, contraceptive behavior, attitudes toward contraception and abortion,

and the relationship with the male partner. Another self-administered instrument measured personality characteristics of the women. Seventy-six percent (76%) of the women consented to follow-up with 106 (42%) returning questionnaires four months after the abortion. The sample of post-abortion women closely resembled U.S. women who had abortions in 1975; the majority were under the age of 30 years, unmarried, and white; about one-third were teenagers and just over one-third were Catholic.

In assessing sexual activity and contraceptive use, Freeman identified that sexual intercourse was neither a new nor chance event for the majority of the women. Intercourse occurred at least weekly for approximately 75% of the women and 2 to 3 times per week for more than 40% of the women. Forty-five percent of the women had not used contraception at any time in the three to four months prior to the abortion. Women who had used birth control relied primarily on non-medical methods (withdrawal, rhythm, condom, spermicidal jelly, cream, foam, or douche). Age was a significant factor in use of contraception prior to abortion with 41% of teenagers, 61% of women in their 20s, and 80% of women over the age of 30 using some method. Four months after the abortion 93% of the women were using contraception with the pill, intrauterine device (IUD), diaphragm, and sterilization the most common methods. Freeman found that consistency of birth control use also improved and that changes in contraceptive behavior were significantly associated with personality attributes. “Among women whose self-described attributes suggested a positive self-image and less idealized femininity, 84% consistently used contraception after the abortion. In contrast, among those with a negative self-image or avoidance of feelings, only 43% said they always used contraception” (p. 154). Many women did not view themselves as actively managing their fertility by using more effective contraceptive methods until confronted with

the actuality of pregnancy. In this study Freeman found that women had conflicting attitudes about contraceptive use. They believed contraception was the woman's responsibility, but they also wanted to appear compliant and naïve in their approach to sexual activity. The women "perceived their personal situations as inappropriate for bearing children but did not take firm steps to prevent pregnancy . . . They did not plan on abortion, but viewed it as a 'necessity' after pregnancy occurred" (p. 154).

Freeman explored women's attitudes toward abortion and found that the women had not previously thought about abortion as a method of birth control. Only 28% of the women reported that they had expected to have an abortion in the event of an unintended pregnancy. Thirty-seven percent (37%) of the women were certain they would never have an abortion; 13% were undecided, 2% were unaware of abortion as an option, and 20% had previous abortions. Freeman identified that, for many of these women, the decision to have an abortion contradicted their perceptions of themselves.

Nearly all of the women in this study experienced some ambivalence and conflicting emotions at the time of their abortions. Only 15% indicated the abortion had been an "ordinary" experience. The most difficult time for many of the women was the time between confirmation of the pregnancy and the abortion procedure when 68% reported experiencing symptoms of anxiety and 48% reported depressive symptoms (p. 152). Four months after the abortion, 14% of the women reported anxiety symptoms while 13% reported depressive symptoms; Freeman concluded that abortion had resolved a distressing event in the lives of these women.

Focusing her analysis on resolution of feelings four months after the abortion, Freeman found that women in her study who resolved their feelings related to the abortion

experience described personality attributes that suggested a positive self-image, greater sense of mastery and achievement, as well as a willingness to express and cope with feelings. These women also perceived support from their partners for the abortion decision. Women who had not resolved their feelings about the abortion experience reported attributes suggestive of avoidance of feelings or a negative self-image; in addition, “every woman who reported the abortion experience as extremely upsetting four months later lacked support from her partner” (p. 153). Resolution of feelings associated with the abortion experience was not related to the abortion decision, the use of contraception, or the wantedness of the pregnancy. Almost two-thirds of the women in this study described the abortion experience as resolved at the four month follow-up interview. Over half of the women reported increased self-management; they felt stronger, more in control, learned they could make their own decisions, and could withstand social pressures. Freeman concluded that while nearly all abortion-seekers in this study were initially ambivalent about pregnancy and abortion, most of them recognized that the alternative to abortion was an unwanted child, with far more complex emotional and social ramifications than abortion itself (p. 154).

Also interested in women’s attitudes about abortion, Faria, Barrett, and Goodman (1986) asked 517 women at two outpatient abortion clinics in South Central Kansas to complete a questionnaire just prior to the abortion procedure. Included with other clinic forms, the questionnaire sought to collect data on demographic characteristics, attitudes about abortion, social networks, and decision-making. The majority of the women were single (59%), white (81%), Protestant (53%), completed high school (63%) and were employed (59%). For 53% of the women, this was not their first pregnancy; 36% had children, 25% had a previous abortion, and less than 10% had two or more previous



abortions. The authors indicated that these demographic variables compared favorably with national statistics.

These investigators found that women in this study generally had positive attitudes about abortion as an alternative to an unintended pregnancy. Women who were white, Protestant, older, with some college, higher incomes, and/or who used contraception had more positive attitudes about abortion. Women also had positive attitudes about their decision for abortion. Faria et al. identified that “nonwhite subjects felt more positively about their decision to have an abortion than did white subjects”, however, nonwhite women made up less than 20% of the sample population.

Investigating women’s social networks, these researchers found that 72% of the women in their sample reported that they sought help from someone regarding resolution of the unintended pregnancy. Women spoke with their partners (41%), friends (29%), a physician (21%), their mothers (15%), and other family members (10%). Women decided on abortion for a variety of reasons, and often for more than one reason. Faria et al. identified 16 categories of reasons women reported for the abortion decision with “parenting readiness” (34%) and “lack of financial resources” (26%) as the highest ranking. Comparing women who did and did not seek counseling, these authors identified that the counseling group sought help more often, including from a physician, and these women reported difficulties with their family of origin as a reason for the abortion.

From their analysis, these investigators concluded that “general attitudes about abortion are not necessarily good predictors of how a woman may feel about her decision to have an abortion” (p. 96). Most women seek help from someone in their social network in the process of making a decision about the unintended pregnancy; no one particular person in

women's social networks was consistently sought. Women arrive at the decision to have an abortion for a variety of reasons; each woman's circumstances are unique. Most women go through the decision-making process with no apparent difficulty (p. 99). For some women the decision-making process seems to be more problematic: non-white, non-Protestant, younger, less educated, with less income, non-contraceptive users, or lacking a supportive social network.

In her published doctoral study, Zimmerman (1977) explored women's passage through each phase of the abortion experience and described the impact of the social context on women's experiences of abortion. This investigator recruited women having their first abortion at a local clinic in a Midwestern city of the United States. She began interviewing women in February of 1975 and continued until 40 women had been interviewed 6 to 10 weeks after their abortion procedure. Interviews consisted of open-ended questions and lasted 1-2 hours; demographic data was collected through a questionnaire. The surgical abortion procedure was a D&C; women were less than 17 weeks pregnant. Women ranged in age from 14 to 39 years with the majority between 18 and 22 years; 85% were not married, 65% had no children, 67% were high school graduates or more, 88% white, 55% blue collar and 45% white collar. This investigator determined that women who participated in the study were representative of all the women seeking abortions at this clinic during this time period. Analyzing demographic data, she also identified that no differences existed between women who chose to participate in the study and women who did not.

During the interviews women described themselves during the two to three month period prior to the occurrence of the unintended pregnancy. Zimmerman qualitatively analyzed these narratives, identifying that the differences among the women revolved around

the nature of their integration into society. The women fell into two groups which this researcher labeled affiliated and disaffiliated. Affiliated women were securely rooted or enmeshed in social life (N=21); they participated in leisure activities (sports, clubs, hobbies, crafts), had close relationships with others (family members, friends, male partner), experienced continuity in the central activities of their lives (stable employment, living with the same persons in the same environment, unwavering obligations), and reported a definitive view of their future (goals, plan). In contrast, disaffiliated women were detached or loosely tied in to a social life (N-19); these women were not involved in any activities other than work and television, they had limited relationships with others, lacked continuity in their past central activities (dropped out of school, changed jobs, moved, changed living arrangements), and lacked a definite picture of the future (lived in the moment, disregard or ambivalence toward the future). Two variables, social class and stage of life, were identified by this researcher as interrelated with the affiliation-disaffiliation dichotomy. Women who were lower class (blue collar workers) also tended to be younger and single and disaffiliated; women who were middle class (white collar) also tended to be older and/or married and they were more likely to be affiliated (integrated into the social network).

Zimmerman explored women's prior attitudes toward abortion, finding that the women in this study had definite moral opinions but very little factual knowledge about abortion. All of the women interviewed in 1975 knew abortion was legal, but many knew virtually nothing more. About half of the women had either a friend or a relative who had experienced abortion. Despite this connection, few of the friends or relatives had discussed their abortions so even these women had limited knowledge about what was actually involved in the abortion procedure or a woman's feelings throughout the experience.

Zimmerman identified that this lack of knowledge was consistent with the cloak of secrecy typically cast around abortion. She also identified that the stereotypic view of abortion as unsafe, unclean, sinister, deviant, and distant from women's normal, everyday lives created a powerful lens through which most of the women had formed their prior abortion attitudes, as well as one through which each woman would perceive the events of her own abortion experience.

Zimmerman found that the prior abortion attitudes of these women indicated that abortion was considered acceptable only under specific circumstances. Most of these women disapproved of abortion unless the woman had been raped, had health problems related to the pregnancy, or was financially unable to care for a child. Interestingly, women's own abortions did not always fall within these circumstances, confirming what other researchers have identified, that abortion attitudes have been found to contain many apparent contradictions. The majority of women studied (70%) reported that they had disapproved of abortion to some degree prior to their own abortion experience (p. 70). This researcher found that complete approval of abortion occurred disproportionately more often among affiliated women while disapproval of abortion occurred more frequently among those women who were disaffiliated (socially disconnected).

This investigator also explored women's contraceptive behavior and found that during the six-month period prior to pregnancy women were generally conscientious birth control users (3), careless users (32), or completely indifferent (5). Conscientious users used a reliable method of birth control consistently (IUD, diaphragm) while completely indifferent users were those women who ignored birth control altogether. All of the conscientious users were over age 21 years. All of the nonusers of birth control were under 21 years of age; in

contrast, the completely indifferent group of women was all high school students living at home with their parents; 4 of the 5 young women were rebellious, reported doing poorly in school, and were categorized by this investigator as disaffiliated. Careless users (80%) referred to women who were unsystematic, using contraceptives during sex at some times but not at other times. Some of these women used reliable methods of birth control consistently, and then stopped suddenly without adopting another method of contraception. These women tended to be slightly older, married, and blue collar. Some of these women used a birth control method (reliable or unreliable) inconsistently. Young, white collar women tended to be sporadic users of unreliable methods. Zimmerman identified that conscientious use, as well as complete indifference toward birth control, seemed to be related primarily to the age of the woman. Careless use of contraception reflected not only age differences, but marital experience, social class, and educational differences as well.

Zimmerman utilized the affiliation-disaffiliation dichotomy as an analytic tool. She defined the abortion process as occurring in four phases (becoming pregnant, making the decision to abort, having the abortion, and moving on) and analyzed women's narratives by examining whether the affiliation-disaffiliation dichotomy was related in any way to each phase of the women's experiences of abortion. Zimmerman identified that affiliated women (those well integrated into their social networks) experienced relatively minor disruption in their lives because of the abortion experience. These women reacted rationally and pragmatically to the initial discovery and confirmation of the unintended pregnancy. They were certain of their decision for abortion from the beginning; they told the least number of people (1-4) about the situation and received no negative or opposing reactions from others. After the abortion these women reported no troubled thoughts or feelings (doubts, sadness,

guilt) and experienced only positive or neutral changes in their social relationships.

Disaffiliated women began their passage through abortion without social connections, experiencing a relatively greater degree of disruption in their lives due to the abortion. They reacted emotionally to the discovery and confirmation of the unintended pregnancy. These women were confused and vacillated in making the abortion decision. They spoke with more other persons (5-8) about the pregnancy situation and received at least one negative or hostile reaction from the persons told. After the abortion, disaffiliated women were troubled by the abortion; they reported experiencing guilt, regret, and/or sadness. Many of these women experienced disruptions in their relationships with others. In one phase of the abortion process, the actual abortion procedure, Zimmerman identified that the affiliated-disaffiliated dichotomy had little affect on women's experiences. She found that the nature of the abortion facility was the central discriminating factor in women's interpretations of the day of the abortion. When women's perceptions of the abortion facility did not align with their expectations, suspicions of illegitimate medical practice evoked stereotypes of abortion from the time of criminalization and influenced their experiences of the actual abortion procedure.

Findings related to these two patterns of abortion experience (affiliated-disaffiliated) provided insight into the discussion of whether abortion is a crisis or a simple medical procedure for women. Zimmerman identified that abortion can be a crisis for some women, but for others the termination of an unintended pregnancy is not fraught with adversity. This investigator concluded that the way abortion is experienced by women depends largely on each woman's particular roles in her social world, the reactions of others to her abortion, and her perceptions of the medical facility where the abortion was performed. These findings stand in contrast to past research which has tended to focus on personality characteristics,

attitudes toward abortion based on upbringing, and demographically determined explanations for women's experiences of abortion. Zimmerman concluded that some women have a smoother passage through abortion than others; whether a woman experiences abortion as a crisis is heavily dependent upon the quality and integrity of her relationships, social interactions, and social activities.

**Summary critique of studies about women's experiences of surgical abortion.**

These earliest studies in this review of empiric literature focused on the characteristics and attitudes of women seeking legal, surgical abortion in the United States around the time of national legalization. The majority of women in these studies were white, single, Protestant, and early to mid-20s. Approximately half of the women did not use a reliable birth control method consistently prior to the occurrence of the unintended pregnancy. In making the decision for abortion, a majority of the women sought support from someone significant in their lives, often the male partner or friends. Most women made the decision for abortion for a variety of reasons based on practical considerations and the circumstances of their lives. Many women who lacked support valued pre-abortion counseling and support received from healthcare providers.

According to these studies women experienced a variety of emotions in response to the abortion experience, including relief, anxiety, depression, confusion, and ambivalence. Findings suggest that anxiety and depressive symptoms were greatest during the time between confirmation of the pregnancy and the abortion procedure. Relief was the most common response immediately after the abortion. Women's ability to cope with emotions was dependent on their social network (Faria et al.), their personality characteristics (Freeman), support from significant others (Smith; Freeman), and their degree of social

connections (Zimmerman). The social context was identified in all four of these studies as significant by women in each phase of the abortion process. Support during the decision-making process was viewed favorably by women; emotional and financial support for the abortion was also positive. Lack of support negatively influenced women's ability to make the decision for abortion and deal with emotional responses afterward. Additionally, Zimmerman identified that women's perceptions of the abortion facility also impacted their experiences of abortion.

Conclusions from these studies suggest that many women viewed the abortion as necessary; a resolution to an unforeseen situation. Women reported increased maturity and personal growth as a result of the abortion experience; they were able to continue educational and occupational pursuits and/or to devote time to their existing families. After the abortion, a majority of women used more reliable, medical methods of birth control more consistently. Researchers identified that attitudes toward abortion did not predict women's behavior (Freeman, Zimmerman) and that "general attitudes about abortion are not necessarily good predictors of how a woman may feel about her decision to have an abortion" (Faria et al., p. 96).

Several limitations were noted in these four studies. These investigators used convenience samples; women self-selected to participate and were predominantly single, white women in their mid-20s living in major U.S. cities. Nothing is known about the experiences of women of color or women in rural areas. No comparison groups of women who were unintentionally pregnant and did not terminate the pregnancy were included (difficult to obtain, socially unacceptable to deny you "wanted" a child). Sample sizes were 80, 329, 517, and 40 women; only Zimmerman commented on the adequacy of her sample



size, identifying that a sample size of 40 women was chosen to provide an optimum balance between scope (large number of cases) and manageability (small number) (p. 43).

Investigators in three of the studies identified that between 1% and 25% of the women in these studies had previous abortions without addressing how prior experience with abortion may have affected these women's responses. Only Zimmerman controlled for the influence of prior abortion experience by including only women experiencing abortion for the first time. Freeman (1978) cited a 20% prior abortion history in her sample; did all of these abortions occur between 1973 and 1978? Or did some of these women experience illegal abortions and were therefore responding to legal abortion in light of illegal abortion experiences?

Three of these investigations employed the use of questionnaires; therefore, women's responses were limited to the items selected by the researcher. As a result, these studies focused on women's attitudes toward abortion as a newly legal procedure in the United States and characteristics of the women seeking abortion (psychological responses, contraceptive use, personality characteristics, coping ability). No information was provided on the reliability or validity of the instruments used; nor was any justification or explanation offered for the timing of data collection. Women completed questionnaires just prior to the abortion, 4 months afterward and 1 to 2 years after the abortion. Completing questionnaires before the abortion procedure could have enhanced researcher's access to women at the time of the abortion procedure. However, two of these three studies identified that the greatest time of emotional distress for women occurred in the time period between the confirmation of the unintended pregnancy and the actual abortion procedure. What impact did increased anxiety and/or depression during this time period have on women's responses when data

were collected prior to the abortion procedure? Zimmerman was the only investigator to employ interviews, conducted between 6 and 10 weeks after the abortion procedure. This investigator based this time frame on previous research findings and corroboration with social work staff at the abortion clinic. Six weeks was identified as a long enough period of time for women to “recover” from the abortion and to reestablish an everyday routine (p. 43). Six weeks was also considered an adequate amount of time for women to establish a definition and perspective on the entire abortion experience – a meaning for the act. Time constraints precluded Zimmerman from including longer intervals in her study. Overall, the impact of timing on data collection is not clear.

**Implications for my study.** I too will be using a convenience sample of women who self-select and volunteer to participate in sharing their abortion experiences. I’m not sure what an adequate sample size will be, but will look for data saturation and recurrent themes in data analysis. Important demographic variables to include are marital status, age, education, and socioeconomic status both at the time of the abortion and at the time of data collection. Additionally, data will be collected about ethnicity, race, pregnancy history, and abortion history. I plan to assess demographic data in an ongoing manner to determine the characteristics of my sample as data collection progresses. I won’t be collecting data from women prior to the abortion procedure, but will be interviewing women about their experiences of abortion after the actual procedure. I have found little in the literature that clearly discusses the advantages of a specific time frame. Depending on the characteristics of participants, I may analyze women’s narratives based on age at the time of the abortion, age at the time of the interview, and/or amount of time elapsed since the abortion. Most of the women in these studies were in their early twenties; however, I may have more variety in

ages of women, so will monitor both the ages of women at the time of the abortion and the interview, along with the time passed since the abortion procedure.

Collecting demographic variables with a questionnaire, I plan to ask women about their experiences of abortion in an interview. A semi-structured interview will allow me to obtain rich descriptions of women's experiences of abortion using a guide to provide some consistency and organization in approach to the interviewing process. From these findings I believe it will be important to ask women about their overall abortion experience, perhaps discussing the process by stages. Zimmerman identified the impact of the abortion clinic on women's experiences of abortion so I will ask women about their perceptions of the clinic where the abortion was performed and their interactions with healthcare providers. I do not intend to use questionnaires or instruments to measure personality traits or psychiatric variables, or to ask women about their previous attitudes toward abortion. Findings from the studies reviewed so far consistently identified the importance of the social context so I will ask women about the social aspects of their lives both throughout the abortion experience and into the current time period. The impact of social support on both the decision-making process and the ability to cope with emotional responses related to the abortion experience were also identified by these researchers as important so I will ask women for details about their social network and their perception of support. I may also ask about the effect or impact of the abortion experience on their lives. I will ask women about their feelings and experience of emotions throughout the abortion experience.

I believe that unintended pregnancy occurs for all of the reasons identified by these investigators; however, it is not my intent to explore women's sexual activity and contraceptive behavior. I accept that women view some pregnancies as unintended due to

timing, relationships, and/or socio-economic factors. I do not plan to examine how or why unintended pregnancy occurs; only to accept that pregnancy occurs for women at undesirable and unplanned times.

### **Studies about Women's Experiences of Medical Abortion**

In the mid-1990s, national clinical trials were conducted to establish the safety, efficacy, feasibility, and acceptability of medical abortion to women and abortion providers. As a new technique in the United States, these studies were necessary to achieve Federal Drug Administration (FDA) approval of mifepristone (RU-486). Funding for these national investigations was provided by the Population Council, the Abortion Rights Mobilization (ARM) Clinical Trial, and the Mifepristone Clinical Trials Group, who paid for medications and clinical fees in major cities throughout the United States. The reader will recall from chapter two that the medical abortion technique requires the administration of two medications, mifepristone (RU-486) and 1 to 3 days later, misoprostol. Mifepristone interrupts the production of progesterone, a hormone, causing the pregnancy to detach from the uterine lining; misoprostol causes the uterus to contract, expelling the products of conception, usually within 4 hours. In the earliest clinical trials, women came to the clinic for administration of all medications. On their initial visit they received the mifepristone; returning to the clinic 1 to 3 days later, they received the misoprostol and remained at the clinic for at least 4 hours, during which time the majority of expulsions occurred. During the final clinic visit, 7 to 10 days later, termination of the pregnancy was confirmed. Women had access to medical staff throughout the medical abortion process and were educated about warning signs (excessive bleeding, lack of bleeding, and pain).

Eight sources were identified for inclusion in of my review of empiric literature for this section on medical abortion. Reviewing these sources, I found that the earliest studies reported results from the large, multicenter trials, focusing on safety, efficacy, acceptability, and feasibility (Schaff, Stadalius, Eisinger, & Franks, 1997; Spitz, Bardin, Benton, & Robbins, 1998; Winikoff, Ellertson, Elul, & Sivin, 1998). One study reported on women's experiences of medical abortion during the clinical trials (Beckman & Harvey, 1997), while more recent studies investigated women's experiences of medical abortion which included self-administration of misoprostol at home (Andrist, Simmonds, Liebermann, & Healey, 2006; Elul, Pearlman, Sorhaindo, Simonds, & Westhoff, 2000; Fielding, Edmunds, & Schaff, 2002). One study specifically examined the social context and women's experiences of medical abortion (Fielding & Schaff, 2004). Characteristics of these studies are summarized in Appendix C.

In the United States, more than half of abortion providers offer medical abortion, which accounted for 17% of all non-hospital abortions and about one-quarter of abortions before nine weeks gestation during 2008 (Guttmacher Institute, 2008, Overview). Since the focal point of my dissertation is not on the safety, efficacy, acceptability, and feasibility of medical abortion in the United States, I will not review three of the identified sources (Schaff et al., 1997; Spitz et al., 1998; Winikoff et al., 1998). I have provided these resources as references for the reader and to acknowledge that the safety, efficacy, acceptability, and feasibility of medical abortion have been established and documented. My critique of the remaining five sources (Andrist et al., 2006; Beckman & Harvey, 1997; Elul et al., 2000; Fielding et al., 2002; Fielding & Schaff, 2004) pertaining to women's experiences of medical

abortion will be the focus of this section of my review of empiric literature and will serve as a foundation for my dissertation.

In their study, Beckman and Harvey (1997) examined the reasons why women chose medical over surgical abortion, their expectations and experiences, and their satisfaction with medical abortion. Part of the Population Council national clinic trial, 262 women were recruited at three locations; Portland, Oregon, Seattle, Washington, and Burlington, Vermont. Their ages ranged from 18 to 44 with an average age of 27 years; the majority of the women were non-Hispanic White (83%) and highly educated (67% some college, 27% college graduates). Seventy-two percent (72%) had experienced a previous pregnancy; almost 40% had delivered at least one child, and one third had a previous miscarriage. More than half of the women reported that they had experienced a previous abortion and 20% had two or more previous abortions. Women completed two questionnaires, one at their first visit for the medical abortion and one at their follow-up visit, approximately 2 weeks later. The initial questionnaire focused on reasons for choosing medical abortion, preferences, social contacts while waiting for the abortion to occur in the clinic, expectations of the abortion experiences, and demographic characteristics. The second questionnaire contained items which addressed women's experience of medical abortion and their satisfaction with this method.

Analysis of the data showed that women chose medical abortion because they wanted to avoid surgery (63%), believed that the method was safer than surgical abortion (56%), believed that mifepristone was a more natural method (41%), wanted a method that had the least risk of infection (35%), and believed it could be used early in their pregnancy (27%). More than half of the women with a history of previous abortion reported that they chose medical abortion because they did not like their prior surgical abortion experience. More

than two thirds (67%) of the women reported that they made the decision for medical abortion on their own; others were influenced by the sexual partner (16%), healthcare professional (13%), friend (8%), or family member (6%). While waiting at the clinic for the abortion to occur, half of the women preferred to wait with a partner, friend, or family member; they reported this was most comfortable to them and allowed them to share the experience with someone else. Similarly, the 18% of women who preferred to wait with other women also spoke of the importance of sharing the experience. Nearly a third of the women (31%) preferred to be alone, mentioning the need for privacy.

In comparing women's expectations with their actual experiences, these researchers found that women expected more discomfort than they experienced and experienced slightly more days bleeding than they expected. No differences were identified between women's expectations and actual experiences of anxiety and amount of bleeding. The majority (73%) of women in this study were very satisfied with their experience of medical abortion; another 16% reported that they were somewhat satisfied. Ninety-four percent (94%) said they would recommend medical abortion to a friend and 87% stated that they would choose medical abortion again. There were no differences in satisfaction, expectations, or experiences between women who had a previous surgical abortion and those who had no prior abortion experience.

To explore women's experiences with a home-use mifepristone-misoprostol medical abortion regimen, Elul et al. (2000) conducted in-depth interviews with 22 women who received abortions in the New York City clinic of the Abortion Rights Mobilization clinical trial. Women received 200 µg mifepristone in the clinic and were randomized to self-administer 800 µg misoprostol vaginally at home either 24, 48, or 72 hours later. One week

later, after their follow-up visit at the clinic, women were asked to describe their experiences during interviews which lasted approximately 30 minutes.

Analysis of narratives identified that women chose medical abortion because they wanted to avoid surgery, thought medical abortion was less invasive, more private, and more natural, and could be used earlier in pregnancy. Avoiding surgical abortion was important for many women with prior abortion experiences who reported a history of painful and/or humiliating situations; women with no previous abortion experiences voiced fears of complications from surgery. Many women believed medical abortion was more natural because the process was viewed as similar to menstruation or miscarriage.

In exploring women's actual experiences of medical abortion, Elul et al. found that women rarely experienced side effects from the mifepristone administered at the clinic; all of the women continued with their normal daily lives. Following self-insertion of the misoprostol at home, all of the women experienced physical effects of cramping and bleeding, which varied in intensity and duration. Nearly all the women reclined in bed or on a couch, watching movies, reading, sleeping, or simply waiting for the abortion to occur. Some women described the time as one of reflection; some women focused on the pain, finding the process to be somewhat cathartic. In addition to the use of pain medications, women used breathing, visualization, and imagery to ease their discomfort. Most women found comfort in the presence of others and the emotional support available; a few women reported that their partners were actually more distressed by the pain and bleeding than they were. A few women chose to be alone, receiving supportive phone calls from friends and family members, which they found to be adequate.



All of the women interviewed were very satisfied with their experiences of using misoprostol at home. They remained in control of the process and identified that an additional clinic visit would have been an inconvenience. Most women reported feeling more comfortable in the familiarity of their own homes; they prepared themselves for bleeding and pain, and when these side effects occurred, were able to handle them, as well as their expulsions, on their own. All of the women felt they had enough access to information and clinic staff, despite the elimination of the misoprostol clinic visit. Demographic data on these 22 women, all of whom had successful medical abortions, was reported elsewhere. From the larger clinical trial, 82% of the women were white with a mean age of 27 years; 72% had experienced prior pregnancy, 54% prior birth, and 46% prior abortion (Schaff et al., 1997).

Fielding et al. (2002) explored whether previous experience with a surgical abortion influenced women's perceptions of medical abortion. The researchers recruited 43 women; 22 who previously had an uncomplicated surgical abortion and 21 who had never had an abortion. The sample was sufficiently large to achieve the repetition of several themes (saturation). Each woman completed a brief questionnaire prior to receiving counseling and taking mifepristone; they completed the same questionnaire at their follow-up visit at the clinic, 4-8 days after taking the misoprostol at home. The questionnaire had two open-ended questions: "What feelings or concerns are you experiencing?" and "What does having this procedure mean to you?" Interviews lasting about 30 minutes were conducted with 30 women by phone or in person 1-6 weeks after their abortions, asking the same two questions. The women who participated were white (77%), single (75%), young adults (average 26 years), who were highly educated (mean 14 years), and worked full-time. These women

were representative of those in the overall Abortion Rights Mobilization (ARM) clinical trials.

On the initial visit to the clinic, women reported feelings of guilt, ambivalence, anxiety and uncertainty over efficacy; they were concerned about cramping and pain; they wanted to avoid surgery. Women's focus was matter-of-fact with many women asking questions such as "Will it work?", "Will it hurt?" and "Will there be any long-lasting effects?" (p. 36). Sixteen women reported their primary reason for choosing medical abortion was to avoid a surgical procedure. These researchers identified that avoiding surgery meant remaining in control of the abortion process, avoiding pain and physical trauma, reducing vulnerability to judgemental clinic staff, and minimizing guilt. Women stressed the importance of being able to select the type of abortion procedure, to maintain control over their future, and to preserve their family's quality of life, given their personal circumstances and constraints of time, finances and emotional resources.

During the follow-up visit, many women expressed relief; some reported feelings of relief and guilt. Eight women were eager to receive medical confirmation that the abortion had occurred and five women were concerned about whether there would be any long-term health effects from the medical abortion. Women continued to report the importance of control over their lives in having a medical abortion. For most women emotional distress decreased after the abortion. Throughout the interviews women continued to stress the importance of maintaining control over their lives, continuing school, devoting resources to current families and avoiding surgery. Eight women remained concerned about long-term health effects.

Fielding et al. concluded that medical abortion was overall an acceptable procedure to almost all of the women in this study. This study confirmed previous research findings that women choose medical abortion for its naturalness, for the privacy it affords and to avoid the perceived pain and trauma of surgery. These researchers did not find women's experiences of medical abortion to be dependent on whether they had had a prior surgical abortion.

Andrist et al. (2006) sought to learn more about women's experiences with the medical abortion process. Thirty-three women were recruited at a clinic in a large metropolitan city in the northeastern United States and interviewed at their 1-week follow-up visit by one of four researchers. A majority of the women were white (19) with 5 Hispanics, 5 blacks, 3 Asian Americans, and 1 other. No other demographic data was collected. The interview lasted 15 to 30 minutes and consisted of seven open-ended questions to which the researchers wrote down women's responses. Content analysis of women's narratives confirmed findings from the other three studies (Beckman & Harvey, 1997; Elul et al., 2000; Fielding et al., 2002).

After taking mifepristone, most women had no symptoms. A few women experienced nausea or felt fatigued; vomiting, slight fever, headache, and painful gums were rare. Following self-administration of misoprostol at home, twenty-two women reported cramping, which developed 30 minutes to 4 hours after misoprostol insertion. Women who reported experiencing severe cramps had not taken any pain medication; they did not anticipate the severity of the cramping. Fourteen of the women reported bleeding with an onset which ranged from 45 minutes to 4 hours. Bleeding lasted 4 hours to 1 week with most of the women reporting that heavy bleeding persisted for only a few hours or overnight.

Control over the abortion process was a key factor in women's decision for medical abortion. Women spoke of control in terms of privacy and naturalness, in their ability to choose the type of procedure, to avoid surgery and invasive techniques, and through their beliefs that medical abortion would be easier for them, both psychologically and logistically. One of the most important reasons women chose medical abortion was their ability to be at home. Experiencing abortion in the privacy of their own homes allowed women to determine the presence of support persons, to decide who those persons would be, and to employ comfort measures not available in a clinic setting.

Uncertainty about what to expect and when to expect it remained a major concern for women in this study. After taking each medication, a majority of these women expressed fear and anxiety about whether the medications were working; they reported concerns about the timing of symptoms which would indicate that the process was occurring as expected. Half of the women would recommend medical abortion to others. This study reinforced findings that medical abortion can be acceptable to women within the context of their life circumstances and feelings about being in control of the abortion process.

The final study in this section of my review of empirical literature explored the social context and women's experiences of medical abortion. Fielding and Schaff (2004) identified that how a woman defined her pregnancy influenced emotional responses after the abortion. Thirty-five out of 50 women seeking an abortion in Rochester, New York between November 1999 and January 2001 were interviewed 1 to 6 weeks after their abortion follow-up clinic appointment. Interviews were conducted face-to-face (3) and by phone (32), lasting approximately 30 minutes. This convenience sample was sufficiently large to reveal the lack of new information in the later interviews (saturation). Women in this study were similar to

the population of U.S. women having abortions in 2000 except that the sample had a higher proportion of white women (77% vs. 41%), women with some college or more (74% vs. 57%) and employed (85% vs. 57%). The women in this study had a lower percentage of prior abortions (37% vs. 48%).

The reasons women gave for choosing abortion included finishing school, getting started in their careers, avoiding poverty, taking care of their current families, and/or preserving their health. These researchers found that many of the women reported the importance of social support during the decision-making phase of the abortion experience.

Content analysis revealed the importance of whether a woman viewed her pregnancy as an actual baby or only as having the potential to become a baby. Many of the women who defined their pregnancy as a baby had family members opposed to abortion; these women did not want to tell them about the unintended pregnancy or the abortion. Most of the women who defined their pregnancy as a baby equated abortion with killing and believed that there were negative consequences. These beliefs contributed to the conflict that some of the women experienced in making their decision for abortion. Women who did not view the pregnancy as a baby tended to focus on physiological development; concern over morality was less intense for these women. For most of the women who defined the pregnancy as only having the potential to become a baby, emotional distress involved feeling upset, but justified. These investigators found that a higher proportion of women who defined their pregnancy as a baby indicated emotional distress during their in-depth interview compared to those who viewed their pregnancy as only having the potential to become a baby.

**Summary critique of studies about women's experiences of medical abortion.** In the studies just reviewed about women's experiences of medical abortion, researchers

identified that women chose medical abortion because they wanted to avoid surgery, believed that the method was safer, less invasive, and had a lower risk of infection than surgical abortion, could be used earlier in the pregnancy, was more natural, and provided privacy and control in the abortion process. Women found the discomfort, as well as the amount and length of bleeding, to be acceptable. The majority of women were very satisfied, would use medical abortion again, if needed, and would recommend the process to others.

Naturalness, privacy, non-invasiveness, and control in the abortion process remained key themes in the studies of medical abortion with home administration of misoprostol. In addition, flexibility with the abortion process emerged as important to women. Many women found side effects easier to cope with in the comfort of their own homes with someone familiar nearby for support. Excluding a clinic visit was not problematic for women; most felt prepared for the experience they encountered and competent in assessing any problems that arose.

As with medical abortion in a clinic setting, uncertainty remained a common theme in medical abortion with home administration of misoprostol. Women reported feelings of uncertainty about what to expect (timing, amount and duration of bleeding, cramps) and uncertainty about the effectiveness and completeness of the abortion process.

Similar to the studies reviewed pertaining to women's experiences of surgical abortion several limitations in the studies of women's experiences of medical abortion were identified. Four of these five studies recruited women for their investigations from women participating in national clinical trials of medical abortion. Many of these women had sought out medical abortion at limited clinical sites in major U.S. cities. Beckman and Harvey (1997) reminded readers that researchers have demonstrated that having a choice of abortion

method has been associated with higher levels of satisfaction (p. 259); the other investigations in this section on medical abortion experiences confirmed this finding. Since the women in these studies had the option of medical abortion, they may have increased satisfaction with medical abortion simply because of their ability to choose.

Women in these studies were generally not representative of women seeking abortion services in the United States; they were highly educated, older, white, and more likely to have experienced a previous surgical abortion. The 33 women in the study by Andrist et al. were gathered through a convenience sample at a reproductive health clinic in a large metropolitan city in the northeastern United States and were offered an incentive (\$20) to participate. The 43 women recruited by Fielding et al. was a purposive sample to compare prior surgical abortion experience with experiences of medical abortion procedures. Despite identifying various racial and ethnical categories, no analyses of data were provided by these investigators to explain variations in women's experiences of medical abortion based on race or ethnicity. No information is known about women in rural communities or those who traveled to clinical trial sites. No comparison groups of women experiencing unintended pregnancies and not choosing abortion were available.

Sample sizes varied and included 262, 22, 43 (22 and 21), 33, and 35 women. The largest sample corresponds to data collected through questionnaires, while the smaller sample sizes were found in qualitative investigations employing interviews. This reflects the reality and feasibility of studying women's experiences of abortion in depth. Two studies (Fielding et al.; Fielding & Schaff) reported that saturation of data was achieved with the purposive sample size of 43 and 35 respectively.

Beckman and Harvey (1997) employed a questionnaire, but did not report on the validity or reliability of the instrument. Andrist et al. (2006) collected information from women by using seven structured questions; no details about how these questions were developed were provided. Interviews were conducted over the phone or in person by multiple researchers. Reliability was ensured by using a uniform interview guide (Elul et al.), by training others in interviewing skills (Fielding et al.), and by ensuring rigor in data collection; “Credibility and dependability were maintained by researchers independently coding data and sharing with each other. Confirmability and transferability were assured by the researchers checking each other’s analysis, and discussing and sharing data and findings” (Andrist et al., 2006, p. 62). Interviews were recorded and transcribed in two of the studies (Elul et al., Fielding et al.); in one study (Andrist et al.) investigators wrote participants’ answers to the interview questions. This may have limited data collection if information was missed or not accurately recorded by the researchers.

Timing of data collection varied. Beckman and Harvey asked women to complete questionnaires during their initial visit and at the follow-up visit. Investigators in three of the studies interviewed women at the follow-up visit which was generally 7 to 10 days after the abortion, but ranged from 1 to 6 weeks. Fielding et al. indicated that the timing of data collection 1 to 6 weeks after the abortion was enough time for women to return to their daily lives and reflect on how their abortion influenced their lives (p. 37). Fielding and Schaff interviewed women 1 to 6 weeks after the follow-up visit. No other explanations or justification of the timing of data collection was offered by investigators.

Women were primarily interviewed at the follow-up visit, but information about the successfulness of the medical abortion procedure at home was not clearly reported. The



exception was the study by Elul et al. which indicated that all women interviewed had successful medical abortions and did not require additional doses of misoprostol or surgical intervention. Andrist et al. reported that only 14 of the 33 women reported bleeding during their medical abortion process. Did the women who had no bleeding have unsuccessful medical abortions? Did all of the women interviewed have successful medical abortions? What is the impact of interviewing women about their experiences of medical abortion if the medical abortion was not successful?

**Implications for my study.** Findings and limitations from these studies on women’s experiences of medical abortion substantiate my earlier discussion pertaining to sample size, demographic characteristics, timing of data collection, and interviewing techniques. Additionally, it has become clearer to me that despite the collection of demographic data specific to race and ethnicity, no analysis of women’s experiences of abortion based on these characteristics has been undertaken. Based on my sample size, variations in race and ethnicity, and saturation of data, I will consider the ability to analyze women’s narratives for implications based on race and ethnicity. In the United States, 36% of the women having abortions are white, 30% African American, 25% Hispanic, and 9% other (Jones, Finer, & Singh, 2010). Women of color are disproportionately likely to have an abortion because both Black and Hispanic women experience higher rates of unintended pregnancy; “the abortion rate among African American women is higher than the rate for both Hispanic and non-Hispanic white women: 40.2 per 1,000, compared with 28.7 and 11.5, respectively” (Jones & Kavanaugh, 2011). This trend reflects widespread social and economic inequities such as lack of access to contraception, to affordable, quality healthcare, and to educational and employment opportunities (Cohen, 2008). Despite my awareness of being white and the

impact that may have on participant recruitment, I would like to include women of color in my study to better understand their experiences of abortion.

Not only does race affect women's experiences of abortion, in the past decade, more women seeking abortion have incomes below the federal poverty limit (Guttmacher Institute, 2011, Facts; Jones et al., 2010). Women in the studies reviewed here were highly educated and employed. What are the abortion experiences of economically disadvantaged women? Based on my sample characteristics, I will also consider the ability to analyze women's narratives for implications based on economic factors.

Fielding et al. confirmed what other authors (Smith, 1973; Freeman, 1978) have previously identified, that women experience the greatest amount of emotional distress at the initial visit, after the unintended pregnancy has been confirmed and before the abortion procedure has been completed. These investigators suggested that clinicians could ease the intense feelings of many women during the initial visit by explaining that some feelings of uncertainty may be related to the uncertainties that any medical procedure poses (p. 39). While these authors have identified that women are concerned about the uncertainties of the medical procedure, they have not established why women are fearful and anxious. I wonder if more probing questions would reveal that the real fear is that the medical abortion won't be effective or that the surgical abortion won't be able to be performed, and therefore, the women will be forced to continue an unintended pregnancy that they have already decided to terminate for reasons related to their personal and life circumstances. Fear of a continued pregnancy, not the medical procedure itself, may be the basis for women's anxiety and emotional distress, especially at the initial visit with health care providers. Someone other than the woman herself has control over her future. During my interviews with women, I

will explore more details about feelings of anxiety and uncertainty while waiting for the abortion procedure to occur.

Fielding and Schaff concluded that abortion might be less difficult through public education about the different views of pregnancy and abortion throughout U.S. history. This supports my desire to publish the second chapter of this dissertation which explores the history of abortion in the United States. I want other women to understand the variations in how abortion has been viewed by women and society over time. The findings of this study suggest that I should ask women about how they defined their pregnancy and consider their responses in my analysis of their narratives, especially in analyzing the presence of emotional discomfort related to the abortion experience. At this time I am not sure how to approach such a question or how to define emotional distress. These investigators did not clinically measure distress, but rather based their theme of emotional distress on the perception of the first author (Fielding, sociologist and research assistant) of what women said and how they said it, providing examples in their publication (p. 617). Based on my clinical expertise, and perhaps in collaboration with a mental health nurse, I could approach analysis of women's narratives to confirm or refute the association of women's definition of the pregnancy with their experiences of emotional distress throughout the abortion process. Definition of the pregnancy highlights one aspect of the social context. The findings of these studies also emphasized the impact of social support, about which I plan to ask women.

Findings from the studies reviewed in this section clearly indicate the importance of choice in the type of abortion procedure. I will ask women about the type of abortion procedure they experienced, developing specific questions related to either surgical or medical abortion. I will also plan to ask women about their reasons for their choice.

In the study by Andrist et al., investigators wrote women's responses to interview questions. I plan to digitally record interviews with women, have the audio transcribed, and review the transcription while listening to the recording. This process will assure reliability of the transcribed narrative and allow me to familiarize myself with the data. This will be one aspect of rigor in my research.

### **Studies about Women's Perceptions of the Long-term Significance of Abortion**

Published between 1999 and 2005, the three studies (Avalos, 1999; Hess, 2004; Trybulski, 2005) included in this section of my review of empiric literature qualitatively examined the ways women described their overall experiences of abortion, exploring the meaning and long-term significance of abortion experiences in women's lives. Each investigator identified specific themes as key elements in depicting the totality of women's experiences of abortion. Characteristics of these studies are summarized in Appendix D.

Avalos (1999) explored how women retrospectively constructed meaning around their abortion experiences. A central aspect of her perspective was that women's accounts of their abortion experiences are socially constructed. This investigator recruited women through an advertisement in a free weekly newspaper widely distributed in a large city. Women who were interested in participating contacted the investigator directly and agreed on a date, time, and place for the interview. Interviews were unstructured and questions were only asked to clarify the meaning of what was being shared. At the end of the interview, a one-page demographic form was completed.

Twenty women reported 27 abortion experiences; 41% took place when the women were less than 25 years old and 59% when they were twenty-five or older. Seventy percent of the abortions took place when women were not married. Two of the women were

Mexican American, the others were white. About half of the women were working class, half middle-class, and two women were poor. The women ranged in age from 20 to 44 at the time of the interview; 16 to 36 at the time of the abortion. Nearly 75% of the women identified themselves as pro-choice, four identified themselves as pro-life, and two women did not identify with either category. No information on religious affiliation was reported. The women in this study were somewhat older, whiter, and more likely to be married than abortion seekers nationally in 1993.

From a larger study of abortion experiences, Avalos profiled four individuals in this article to demonstrate the diversity in women's retrospective accounts of their abortion experiences. She recognized that women's "satisfaction" with the abortion experience occurred along a continuum. Women's "satisfaction" included emotional reactions to the abortion in the years since the procedure, as well as the interpretive framework that women used to explain why they chose abortion and how they developed an understanding of the abortion experience (p. 40). The four critical points on the continuum of retrospective satisfaction with the abortion experience were: Looking back with satisfaction; Mild struggles with loss over time; Looking back with depth, complexity, and grief; and Seeking a safe place to explore buried emotions.

Looking back with satisfaction encompassed women who experienced the decision for abortion freely and uncoerced; their narratives presented straightforward accounts of their abortion experiences, without ambivalence or contradiction. Seven of the twenty women interviewed emphasized satisfaction with their abortion experiences. These abortion experiences were distributed over a broad range of time with two women having abortions more than seven years before the interview and the others occurring more recently.

Three women in this study experienced “Mild struggles with loss over time”. These women retrospectively maintained that the abortion was the right decision and felt relief afterward. Each woman’s understanding of the events and circumstances surrounding the abortion included some feelings of ambivalence, guilt, regret, or sadness. This contrasts with women who looked back satisfied and who stood by their abortion decisions fairly free of any significant negative emotions. Although each woman spoke of feelings of ambivalence, guilt, regret, or sadness, these feelings were limited in scope and complexity. Feelings of relief were still central to the retrospective emotions these women described.

The narratives of three women demonstrated “Looking back with depth, complexity, and grief”. These women spoke of powerful and intense emotions; they considered issues surrounding the meaning of fetal life. Their narratives were filled with reports of grief and loss as they wrestled with resolving these feelings in a society that they viewed as unsupportive and unaware of the significance of the abortion experience. In contrast to the women who looked back satisfied, these women framed their decision-making about the abortion in terms of negative structural constraints (unreliable partner, emotionally unprepared for parenthood, lack of financial resources) rather than positive goals (pursuing education, improving relationships). Adding complexity to the decision-making process, these women were concerned with making sense of the meaning of fetal life. They sought to define, understand, and weigh the claims of nascent life. Women who looked back with depth, complexity, and grief described a loss of relationship with a child they would never know. Their decision for abortion was emotionally wrenching and laden with a burden of responsibility for fetal life. Ideas and struggles never mentioned by women in the previous two categories appear as central issues for these women.

Long-term grief was a central component of seven women's experiences of abortion. All of the women in this category of "Seeking a safe place to explore buried emotions" had abortion experiences which occurred eight or more years ago. Four of the seven women had developed accounts of their abortions that diverged sharply from the understanding they had at the time of the experience, and they attributed the change to significant personal growth occurring in the time since the abortion. At the time of the interviews, the other three women were still struggling to validate and resolve their feelings. These three women gave numerous indications that the abortion experience was emotionally wrenching for them and that they continued to wrestle with depression. While one woman continued to affirm the abortion decision and the other two viewed their decisions as mistakes, none of the three had resolved feelings to the point that she no longer carried the weight of grief.

Avalos concluded that these profiles offered insight into the many emotional reactions and range of satisfaction levels that are possible after abortion. She identified that they demonstrate that retrospective interpretations of the abortion experience are subject to change over time, particularly as personal growth and changing circumstances prompt women to reevaluate the original abortion experience (p. 53). One aspect that was critical to women's retrospective understanding of the abortion experience was how the women defined the pregnancy problem initially. Women who were unimpeded by circumstances at the time of the abortion decision were more likely to feel happy or satisfied with hindsight. They were able to focus on the advantages of getting an abortion (continuing education, building career, working on a valued relationship); they were the least likely to feel forced or pressured into having an abortion. In contrast, the women who felt varying degrees of sadness, regret, or grief in looking back on their abortion experiences were more likely to

have experienced significant constraints on their original decision-making. These women usually emphasized the disadvantages of continuing the pregnancy (unreliable partner, lack of financial resources, emotionally unprepared for parenthood) rather than the advantages of getting an abortion. They felt pressured into the decision for abortion by people or circumstances rather than drawn to abortion as an appealing option. Avalos identified that time played an important role for women who struggled with significant feelings of loss or grief. Time allowed these women to address feelings and issues that they were not able to process or articulate at the time of the abortion. These women also related their ability to regain connection to their feelings through larger processes of healing, recovery, and personal growth.

Avalos concluded that these narratives could broaden understanding of women's experiences of abortion. She identified that the ways women speak about their abortion experiences years after the actual procedure are quite different than the dichotomized terminology often employed by politicians, judges, special interest groups, and society when discussing the topic of abortion. Avalos recognized the ease with which those persons with specific political agendas (pro-life or pro-choice) could pick and choose stories by women to support their particular political aims. She believed that the variety of women's retrospective accounts of their abortion experiences could be used to inform and transform the politicized abortion debate in the United States. Avalos concluded that using women's abortion narratives to support any one aspect of the abortion debate works against women's interests by subordinating women's experiences to the debate rather than subjecting the terms of the abortion controversy to the realities of women's experiences (p. 55). Instead of isolating and dividing women based on their experiences of abortion, the diversity found in women's



retrospective interpretations of their abortion experiences contributes to knowledge and understanding beyond the two-sided political controversy.

Using a phenomenological approach, Hess (2004) explored and described women's long-term postabortion experiences. She recruited women through flyers posted in abortion clinics, pregnancy care centers, and on university campus sites. Women interested in participating contacted the researcher directly or through a mutual acquaintance. Hess interviewed 17 women who had a legal, first trimester, induced, elective abortion more than 5 years before the study. Women were asked to describe the abortion experience, explain what effects the abortion had on their life, and describe what meaning the experience had in their life at the time of the interview. Interviews lasted from 30 minutes to 2 hours. Data collection and constant-comparative analysis were concurrent. Trustworthiness of the data analysis was established through measures taken to increase credibility, auditability, fittingness, and confirmability. Additionally a second interview with 15 of the 17 women was undertaken to discuss evolving themes and filed notes with the participants. The author indicated that women who had abortions represented several ethnic groups, religions, and occupations, and were single, married, or divorced, but provided no statistics. Six women had more than one abortion. The average number of years from abortion to interview was 18.9 (range 6-31). The age range at first abortion was 14 to 43 (average 23), and at interview was 23 to 60 years of age.

Analysis of women's narratives produced a composite description of the abortion experience in five major themes: Making the decision, Coping with the memories, Gaining perspective, Seeking help, and Recognizing its worth. "Making the decision" emerged as a theme as the women described their reasons for abortion, levels of ambivalence, and

significant relationships in their lives at the time of the abortion. Every woman in this study terminated an unwanted pregnancy, but their reasoning for doing so varied. The events and people surrounding the abortion process and procedure created impressions and memories resulting in the theme “coping with the memories”. For most women the preabortion counseling sessions and the day of the abortion were highly stressful; the impressions and memories created took some women many years to resolve. With the passage of time, most women gained different or broader perspectives on the abortion and its effects on their lives, resulting in the theme “gaining perspective”. For five women in this study, a religious conversion modified their perspective of the abortion experience. “Seeking help” included several women who described negative psychological reactions after the abortion and sought help and healing; some through postabortion support groups, others by volunteering at a pregnancy care center. “Recognizing its worth” was identified as many of the women articulated clear opinions about the effects and significance of the abortion experience on their lives years after the actual procedure. Some women became involved in pro-life or pro-choice activities. Each woman affirmed that the abortion experience shaped her life in a variety of ways.

Similar to Avalos (1999), Hess (2004) identified that the passage of time and intervening events could broaden a woman’s perspectives on her abortion decision and provide alternative meanings to the abortion experience. Hess found that changes in women’s lives which altered their perceptions, memories, and meaning were an essential part of the total abortion experience rather than a hindrance. While most women were satisfied with their decision for abortion, others were not. Hess recognized that a higher percentage of women in this study expressed negative effects than what has been found in short-term

studies. She explained that these findings may indicate that the percentage of negative long-term effects increases over time, or, they may indicate that women who had a positive abortion experience were less inclined to participate, assuming they had nothing significant to contribute (p. 196). Interestingly, Hess also identified that almost all of the women in this study used various avoidance strategies to cope with the memory of the abortion. Denial was the most frequently reported coping mechanism, while other women mentioned withdrawal, taking control, keeping the abortion a secret, fantasizing, and performing religious ceremonies. Religion played a major role in the post abortion lives of many of the women in this study, including five who experienced a religious conversion.

Most of the women who participated in this study were able to integrate the abortion experience into their lives and had found meaning in the abortion experience according to Hess. Some women were motivated to become involved in pro-choice or pro-life activities depending on their personal stance following their own abortion experiences. Hess identified that all of the women in this study acknowledged that their lives were shaped by their abortion experiences.

Reasoning that abortion affected women in both positive and negative ways, Hess concluded that nursing should encourage women to prevent unplanned pregnancies through fertility control. She identified that the decision-making process for abortion can be stressful for some women and that once the decision for abortion is made, women may experience significant anxiety during the waiting period preceding the procedure.

Like Hess, Trybulski (2005) conducted a hermeneutical phenomenological investigation to understand the characteristics of women's abortion experiences over an extended time. Women who had an elective abortion for nongenetic reasons at least 15 years

previously were recruited by flyers placed on bulletin boards in public places, an advertisement in a local women's magazine, and from referral by health care providers and laypersons familiar with the study. Women interested in participating in the study called the study phone number, were provided a brief explanation of the study, and invited to a private interview. The initial portion of the interview included a demographic questionnaire; interviews included open-ended questions and lasted between 1½ and 2 hours. A second contact with women occurred to review the anecdotal narrative constructed from the interview. Sixteen white, well educated, women who had an elective abortion for nongenetic reasons at least 15 years previously comprised the sample for this study. Women ranged in age between 38 and 92 years at the time of the interview. Religious preferences included Roman Catholic (7), No preference (3), Judaism (2), Non-mainline religion (2), Unitarian Universalism (1), and No response (1). Two women had illegal abortions and 5 women had more than one abortion. Reasons for the abortions focused on the unexpected and unintended nature of the pregnancies along with each woman's personal situation at that time in her life.

This study used phenomenological reflection to discover the meaning of the lived experience of abortion and to portray these experiences as themes that characterised an abortion experience. Nine themes emerged from the discussions with these 16 women: Caught up in the moment; Betrayed – by my body, by my birth control; Very personal, very private, very yours; The past reaches into the future; Embodiment – giving form to the child; Stowing away feelings about the abortion; Abortion disrupts aspects of life; Making sense of the abortion; and Relationships affected the abortion experience.

Women spoke of making their decision, determining who to tell about the unintended pregnancy, and quickly arranging for the abortion as all encompassing tasks in “caught up in the moment”. Time initially stood still as many of these women felt pressured to resolve the pregnancy situation quickly; some women wished for a magical solution. The theme “betrayed – by my body, by my birth control” portrayed the feelings of some women regarding intentional sexual activity with the unintentional pregnancy; some women also felt betrayed by their birth control method. Women expressed loneliness and feeling alone at the time of their abortion in the theme “very personal, very private, very yours”. Often the decision was theirs alone and many women felt alone with their thoughts. After the abortion, relief was the most common feeling. Women reported that the abortion had been the best decision for them at the time and that they had no regrets. Some women experienced thoughts of the abortion or the child years after the procedure in “the past reaches into the present”. Thoughts about their abortions were sometimes experienced as intrusive and without warning. These thoughts generated additional reflection on the abortion experience and produced new perspectives or insights for the women. Sometimes these insights gave comfort, other times they raised new issues. In the theme “embodiment – giving form to the child” women were able to recall the age that the child of the terminated pregnancy would have been at the time of the interview; at various times women were reminded of the pregnancy and that they could be mothers of persons of this age. For “stowing away feelings about the abortion” women stored memories and discussions of the abortion, in both conscious and unconscious ways. The experience of abortion became for many women an unspoken story. Persons allowed to hear their abortion stories had to meet certain criteria. For some women it was the fear of condemnation – from themselves, their families, friends,

or society in general. For others, the social rhetoric surrounding abortion acted as a silencing agent for fear of retribution. For some women, trust in telling others about the abortion was sometimes violated. The sense that a woman must be careful to whom one talks about the abortion was a common experience. The theme “abortion disrupts aspects of life” related to disruptions in women’s bodies, the rhythms of their lives, their views of themselves, the natural order, and their relationship with a higher power. “Making sense of the abortion” for some women involved validating the reasons for terminating the pregnancy and reflecting on the experience in the context of their lives. For many women, the concept of having an abortion was not problematic. For some women, the sense-making was consistent with their decision-making process at the time of the abortion; for others, making sense of the abortion experiences involved a reflective quality as they weighed their decision for abortion against the substance of their lives. Some women used spirituality and ritual as a means to make sense. In the theme “relationships affected the abortion experience” women sought connection in their relationships. For these women, discussions with others were shaped by assumptions about how others would react to the abortion. At the time of their unintended pregnancies, some women felt pressured by their partners to have an abortion; other women made assumptions and acted without consulting their partners. Women whose relationships already demonstrated disconnection were particularly vulnerable; they experienced fear and further disconnection in their relationships. Most women made their decision regarding the pregnancy with feelings about their relationships in mind.

Trybulski identified that these nine themes characterized an abortion experience, encompassing women’s experiences of abortion, their thoughts, and emotions over time. She concluded that these themes provide evidence that women’s lived experiences of abortion are

complex and have effects on women long after the actual abortion procedure. Similar to Hess, Trybulski found that the process of integrating the abortion experience into women's lives was more complex than demonstrated by other researchers and that when women's reports of negative psychological reactions (depression, anxiety, regret, guilt) occurred, the emotions were intermittent and present sometimes years after the termination procedure.

This researcher found that relationships were an influential factor for these women in making their decisions about the unintended pregnancy. Relationships influenced whom and what these women told about their abortion and their thoughts about the experience. The women in this study frequently reported how alone they felt in the decision-making process, even when surrounded by supportive family members or friends. Fear of condemnation and fear of retribution acted as silencing agents for some of these women.

I struggled with the critique of these two phenomenological studies. After reading and reviewing these publications, I desired to know more about these women's experiences of abortion. I wanted to know how many and which women fit into each theme that described certain aspects of the total abortion experience. I wondered if all of the women fit into every theme or if only some of the women fit into some of the themes. I thought about how the themes were interrelated or perhaps they were not linked in any way. I contemplated how a "composite" experience assisted researchers in understanding women's experiences of abortion, feeling that one characteristic experience of abortion negates the individual experiences of the women who participated in these studies. It seemed to me that the use of a phenomenological approach limits the researcher's analysis of women's narratives and influences the manner in which they draw conclusions.

**Summary critique of studies about women's perceptions of the long-term significance of abortion.** These three studies offer rich descriptions of women's experiences of abortion and their perceptions of the long term significance of these experiences in their lives. The impact of the social context was evident in each of the studies critiqued. Women's perceptions of support influenced their decision-making process for abortion and the integration of the abortion experience into their lives.

These studies asked women to recall details about their abortion experiences that some of the women had deliberately tried to forget for many years. Hess identified that while time and intervening events could change women's perceptions, memories, and meanings, these changes in women's lives were an essential part of their total abortion experiences, not a disadvantage (p. 196). Similarly, Avalos found that women reflect back on the abortion with a variety of emotional responses and with reactions that change over time as their lives also change (p. 40). Likewise, Trybulski recognized that for the women in her study, the abortion experience was a significant life event and integration of this event into their lives was more complex than previously demonstrated by other researchers.

The influence of the passage of time on women's retrospective understandings of their abortion experiences was identified as a key finding in all of the studies reviewed. For some women, time reaffirmed the certainty and clarity of their abortion decision; for other women, time served as protection from an abortion decision that was emotionally difficult, in some cases allowing women the ability to process the abortion experience in response to personal growth and changing life circumstances. Findings from these studies suggest women's understandings and the meanings of their abortion experiences are complex, contradictory, and continuously being re-evaluated.



Each researcher identified themes from their data analysis which described women's perceptions of the long term significance of experiences of abortion. Hess and Trybulski did not provide any information about the percentage or number of women to which each theme applied. Avalos reported the number of women that she placed into each category, identifying that an equal number of women looked back satisfied as those who experienced long-term grief. How do these numbers compare to the long term significance of abortion experiences for women in the general population? Perhaps they don't since at least one of these researchers (Hess) identified that the percentage of the women in her study expressing negative effects from the abortion was higher than that found in short-term studies. My review of the literature identified similar findings; the women who participated in these studies reported a higher incidence of negative emotional responses to the abortion experience compared with studies in the previous two sections on women's experiences of surgical and medical abortion. The increased occurrence of negative psychological sequelae over time may be a significant finding, however I am thinking that recruitment strategies, women's self-selection to participate, and philosophical perspectives of the researchers may be contributing to biased study samples and influencing these findings. I think there is more to the increased occurrence of negative psychological sequelae in response to the abortion experience than simply the passage of time.

Trybulski and Hess both employed phenomenological methods and based their review of the literature in psychology and psychiatry. Hess provided a very brief review of the literature with emphasis on psychological outcomes and the occurrence of psychiatric interventions in women after an abortion. Trybulski's review of the literature was grounded in psychology and psychiatry, providing the reader with the impression that the study

supported and reinforced a view already held instead of raising questions about the current knowledge about the long-term significance of women's experiences of abortion (McIntyre, 2005, p. 577). The perspective of these two researchers at the outset of their studies encompassed a view of abortion as traumatic for all women. Investigating women's experiences of abortion from this perspective and with this methodology limited their ability to analyze women's narratives. Neither researcher investigated the long-term significance of women's experiences of abortion with regard for the social, political, or historical context. The phenomenological approach used by both of these researchers limited their depth and exploration of women's knowledge (McIntyre, 2005). Each researcher explored women's responses and outcomes of their abortion experiences without consideration for the realities of women's lives. In contrast, Avalos employed feminist and sociological perspectives in her research which focused on the social context of women's lives and circumstances surrounding their abortion experiences. Despite these variations in philosophical perspective, recruitment strategies were similar, allowing women to self-select to participate in these studies.

Limitations in these three studies were similar to the limitations discussed in the previous two sections. Women who participated in these investigations self-selected as part of a convenience or purposive sample. The majority of women were white, well educated, and employed. The long term significance of abortion experiences for women of color, economically disadvantaged women, and women who chose not to participate is not known. Sample sizes were 20, 17, and 16 women, yet no author identified a rationale for these numbers. The 20 women in Avalos' study spoke of 27 abortion experiences; Trybulski identified that 5 women (out of 16) had more than one abortion, and 6 of the 17 women in

Hess's study had experienced more than one abortion. No comparisons were made about the long term significance of women's abortion experiences based on a single or multiple experiences of abortion. In addition to multiple abortion experiences, Trybulski reported that two of the women in her study had illegal abortions; however, she did not analyze differences in long term significance based on the varying political and social contexts of these experiences.

Time since the abortion procedure was important to these researchers in studying the long term significance of abortion in women's lives. Hess interviewed women whose abortion experiences had occurred more than five years previously; Trybulski more than 15 years. Avalos indicated that the women in her study had their abortions on average 9 years before the interview; however, one of the women profiled in her article had experienced two abortions in the three years preceding the study. How would this woman's narrative have been different if indeed nine years had passed? No researcher offered an explanation for more than 5 years, or more than 15 years. The significance of the amount of time since the abortion experience on women's perceptions of the long term impact of the abortion experience on their lives is not clear.

Additionally, these researchers did not analyze narratives based on women's ages or discuss the impact of age on women's experiences of abortion over time. Is there a difference in the long term significance of women's experiences of abortion if the woman is 45 and the abortion occurred when she was 18 compared with a woman who is currently 50 and whose abortion occurred when she was 44 years old? Avalos identified that the variation in women's ages and the time elapsed offered a diverse picture of circumstances surrounding women's abortion decisions as well as their retrospective interpretations (p. 40). More

knowledge could be gained by analyzing women's narratives categorically by age ranges or life stages. These findings suggest that attention to time since the abortion, age at the time of the abortion, and age at the time of the interview are important aspects to consider in the analysis of women's abortion stories.

**Implications for my study.** The higher than previously seen occurrence of negative psychological sequelae impacts my consideration of recruitment of women and the influence of self-selection in addition to the passage of time. I plan to identify women as potential participants through word of mouth among health care professionals and colleagues. While health care professionals might identify a woman as a potential participant in my study, the woman herself will need to initiate contact with me. This varies somewhat from self-selection that occurs when women respond to a flyer or advertisement. I will need to be aware that women who choose to participate in my study may or may not be dealing with increased emotional turmoil, guilt, or grief as compared to those women who self-selected to participate in these three studies. Since time may be an influential factor in women's long term experiences of abortion, I will need to be aware of timing in the ongoing narrative analysis. Asking women about changes in their perspectives of their abortion experiences over time will be important.

The findings from these three studies emphasize the need to ask women about social relationships and their perceptions of support at the time of the abortion, at the time of the interview, and during the time in-between. In keeping with the feminist philosophical perspective of this dissertation, I, like Avalos, need to consider the broader social and political effects on women as I analyze their narratives. Keeping political agendas in mind, while attempting to remain neutral and unbiased (although, of course, I am not), might help

to change the current political conversations and injustices for women who have undergone and will be seeking abortion. Hess was the only investigator to discuss rigor in her qualitative study, reminding me of the importance of employing specific techniques to ensure a rigorous investigation.

### **Paucity of Studies about Under-Represented Women's Experiences of Abortion**

In conducting this review of empirical literature pertaining to women's experiences of abortion, I looked for studies inclusive of all women. I sought to determine what was known through investigations and recognize gaps in research findings. My critique has identified that all of the studies reviewed have focused on the abortion experiences of white, well educated, employed, middle class women, living in the United States, who were primarily in their mid-20s at the time of the abortion. The few studies which included women of color and/or women living in poverty did not analyze women's experiences of abortion based on these factors (education, age, socioeconomic status, race, or ethnicity); this most likely reflects the small number of women in each category who participated in these studies. The result is that little to nothing is known about the abortion experiences of women who are not white, well educated, employed, middle class, and in their mid-20s. In my search of the literature, I identified only one study which attempted to fill this gap. Characteristics of this study are summarized in Appendix E.

In contrast to all other studies whose participants were predominantly white, middle class, and well educated women, Andrews and Boyle (2003) investigated how African American adolescents experience unplanned pregnancy and elective abortion. Their ethnographic investigation focused on a purposive sample of 12 African American females between the ages of 15 and 18 years, who were seeking abortion at a clinic in a large

southeastern city in the United States. None of the participants had ever been married, two had graduated from high school, one was in college; all others were still attending high school. The family incomes were all below \$40,000 per year, and none of the teenage girls were self-supporting. The majority of participants paid cash for their abortions, and only one filed for insurance coverage. Some of the young women traveled from adjoining states, spending the night at nearby hotels because of the distance. Travel and lodging expenses were issues of concern for nearly all of the participants.

Four of the adolescents were in their first trimester and 8 were in their second trimester of pregnancy at the time of the first interview, which occurred on the day of their elective abortion. Second and third interviews were conducted 6-8 months after the first interview and confirmed and clarified findings. A total of 27 interviews were conducted, each lasting approximately 1 to 1½ hours. The investigators used an interview guide, wrote field notes, and spent several days conducting participant observation experiences in the clinic. They were explicit about analytic strategies and steps taken to achieve scientific rigor.

Several themes were generated from their analysis of African American adolescent's narratives: relationships with partners, confiding in others and finding support, unselfish decision for self, resolution of the crisis, and empowerment. The themes are all interrelated and the theme of empowerment occurred throughout the experiences of unintended pregnancy and abortion.

“Relationships with partners” concerned two distinctly separate decisions: the decision to continue or sever the relationship with the partner in conception, and the decision not to become a mother. The teenage girls based their decision about continuing the relationship on the male partner's reaction to the news of the pregnancy. Those female

adolescents who continued the relationship described their partners as supportive and responsible. If the male partner refused to accept responsibility for the pregnancy, the young women viewed this behavior as a betrayal and a lack of commitment, resulting in the severing of the relationship. After confirmation of the unintended pregnancy and disclosure to the male partner, these young women sought assistance and support from others in dealing with their complex situations.

The young women revealed their unplanned pregnancies to family members and friends to gain help and support in “confiding in others and finding support”. All of the participants except one had told their parents about the pregnancy. For these young women, the unintended pregnancy represented a disappointment for their families and presented them with multiple and complex problems for which they needed support. The African American adolescents in this study needed assistance in obtaining transportation to the clinic and affording the expense of the abortion procedure versus the expense of raising a child. They needed support for their decisions which included dropping out of school or continuing with their education, and becoming teenage mothers or pursuing another future. As they dealt with these complex issues, these young women confided only in others they felt they could trust.

In “unselfish decision for self: weighing the consequences”, the unplanned pregnancy represented a crisis for these young women, who all took the decision for abortion seriously. They considered their present situation as well as their future; they recognized that raising a child was a serious financial and emotional responsibility; they thought about the impact of motherhood on the child, themselves, and their families. Many young women identified the difficulty and loneliness in making the abortion decision. They recognized that

the decision was theirs alone as they also considered how their decision would impact other people's lives.

In “resolution of the crisis”, the abortion was the solution to the unintended pregnancy situation. None of these young women wavered in their resolve during the second or third interviews; none of them expressed regret. After deciding to have an abortion, the young women received help from close friends and family members who rallied to lend support; money, travel, and locating abortion services. Learning about the abortion procedure was crucial as the young women worried about the amount of pain they might experience. While all of the African American adolescents wished that they had not had to go through the experience of unintended pregnancy and abortion, they all reported that they had matured and grown through the experiences.

“Empowerment” was the theme that was integrated in all the other themes, providing meaning for the young women and constructing reality around the experiences of unintended pregnancy and abortion. These African American adolescents gained control, refined their ability to make decisions, evaluated their relationships with men differently, and confided in others to gain guidance and support that helped them through the abortion process.

**Summary critique of the paucity of studies about under-represented women's experiences of abortion.** Andrews and Boyle concluded that their study contributed to the body of knowledge about women's experiences of abortion. By investigating the experiences of African American adolescents instead of middle class, well educated, white women, this study highlighted the influence of the social and cultural context on women's experiences of abortion. While this knowledge is limited by the small sample size and a



single geographic area, the authors' analysis revealed recurrent themes, indicating saturation of data.

In addition to contributing to the knowledge of women's experiences of abortion, the findings in this study, according to Andrews and Boyle, helped to dispel three pervasive myths about African American adolescents, unintended pregnancy, and abortion: 1) African American adolescents continue their unplanned pregnancies and raise the children from those pregnancies with their mothers' or their grandmothers' help, 2) Young women suffer psychological damage as a result of elective abortion, and 3) African American young women choose a resolution for unplanned pregnancy based on what their partners want them to do. Findings from this study suggest that female African American adolescents don't automatically continue unintended pregnancies, suffer psychological damage, or are influenced in their decisions by the male partner. They based their decision for abortion on their financial and emotional readiness to parent, consideration of their future, educational plans and goals, and the impact of having a child on their families. During the experience of an unintended pregnancy, these young women examined and evaluated their relationship with the male partner; they did not resolve the crisis situation based on the desires of the male partner. Instead they made decisions about the relationship with the male partner based on his reactions to the confirmation of the unintended pregnancy. Their decision-making for abortion was deliberate and serious, taking in considerations for the child, themselves, and others. The findings of this study revealed that although the young women experienced some sadness after their abortion, they did not report any psychiatric problems as a result of their abortions during the 6-8 month follow-up period. In contrast, many of these young women

felt empowered, reporting positive and maturing reactions in response to the experiences of unintended pregnancy and elective abortion.

**Implications for my study.** This study by Andrews and Boyle identified complex problems and barriers that these young women faced in seeking abortion. The importance of the social network and young women's perceptions of social support in their experiences of unintended pregnancy and elective abortion were evident in their narratives. African American adolescents relied on their social networks in locating abortion services, understanding the procedure, traveling to the clinic since many did not know how to drive or own a vehicle, finding overnight lodging if the clinic was some distance away, and obtaining money to pay for the abortion as well as other expenses.

Only one African American adolescent did not tell her parents about the unintended pregnancy. During a previous experience with an unintended pregnancy, this female adolescent had been accompanied to the clinic by her mother and aunt who dissuaded her from going through with the abortion. She had one child to care for and was certain this time that she wanted an abortion. Findings indicate that these young women needed someone to listen, with which to discuss options, and feel supported, whatever their decision. Lack of support, especially by the male partner, influenced the abortion experience for three-fourths of these female African American adolescents. Betrayal and lack of commitment from the male partner were seen as unsupportive by these young women, prompting them to sever the relationship. These findings stress the importance of asking women about their perceptions of support at the time of the abortion and since the actual procedure.

The paucity of research and data analysis about under-represented women's experiences of abortion is evident from this review of empiric literature. Knowledge about

the experiences of abortion for women who are not white, well educated, and/or middle class is scarce. In my study I will attempt to include women from various racial, ethnic, and socioeconomic groups in order to contribute to the body of knowledge about women's experiences of abortion and address this gap in knowledge.

### **Mental Health and Women's Experiences of Abortion**

Recall that in my initial review of my sources I identified one area of study, the affect of abortion on women's mental health, in which persistent investigation appeared throughout history. While the findings from most of my sources consistently reported that a majority of women experienced relief and positive psychological responses to abortion (Adler et al., 1990; Andrews & Boyle, 2003; Andrist et al., 2006; Elul et al., 2000; Freeman, 1978; Faria et al., 1986; Major et al., 2009; Shusterman, 1976; Smith, 1973), some studies viewed abortion as traumatic for all women and analyzed results in a way that pathologized women who underwent abortion (Coleman et al., 2005; Hess, 2004; Trybulski, 2005).

Attempting to understand these disparate findings and the influence of psychology and psychiatry on much of the published research about women's experiences of abortion, I decided to explore in greater depth the empiric literature pertaining to women's experiences of abortion and mental health. As I again searched the literature, I quickly realized that hundreds of studies pertaining to the affects of abortion on women's mental health had been published. In an attempt to manage the vast quantity of publications and to provide a summary of investigative findings about the affects of abortion on women's mental health, I focused my search on reviews of empiric literature.

**Methodology.** Utilizing the advanced search feature of EBSCOhost, I explored PsycINFO, employing the term "literature review" in the methodology field with the term

“abortion, induced” in the subject field. I focused on published, peer reviewed, reviews of empiric literature, available in the English language. My search yielded 121 sources which were further narrowed by eliminating reviews of empiric literature which critiqued studies conducted outside the United States. Also excluded were reviews of empiric literature that focused on only a single aspect of abortion such as pre- and post-abortion counseling, decision-making, late-term abortion, or relationship quality after abortion. From the remaining reviews of empiric literature, reference lists were examined, yielding additional sources which were located online or through the UWM inter-library loan department. My search resulted in the identification of 18 reviews of empiric literature pertaining to abortion and women’s mental health.

Focusing on reviews of the empiric literature helped me to manage the vast quantity of information. Reading and reviewing the 18 sources identified enabled me to recognize that the reviews of empiric literature (as well as individual studies) had been conducted by investigators from a variety of disciplines, with various philosophical perspectives, a range of methodological approaches, and diverse terminology. For example, Remeikis (2001), a psychoanalyst who works at a counseling center, identified that her publication was precipitated by her “observation that abortion was significant in the lives of many of the patients with whom [she] had worked” (p. 231). As a nurse I can empathize with her belief that all women experience trauma as a result of abortion; by virtue of her profession, those are the only women in which she would come in contact. However, as a researcher, I struggle to understand how this psychoanalyst and advanced medical candidate cannot reflect upon the biases inherent in her publication due to her interaction with a narrow and limited population of postabortion women, upon which she based her publication. Much of the

variability in findings from the reviews of empiric literature seems to stem from differences in terminology and particularly differences in philosophical perspectives and methodology. My understanding of the various methodological approaches and wide interpretation of findings in the reviews of empiric literature about abortion and women's mental health was enhanced by the realization that there are four major, different philosophical perspectives employed in investigating and critiquing the affects of abortion on women's mental health (Major et al., 2009).

**Philosophical perspectives.** Each conceptual framework used in studying the affects of abortion on women's mental health produce different research questions, dissimilar methodological approaches, diverse interpretations of findings and assorted conclusions. One perspective views abortion as a traumatic experience; these researchers argue that the intentional destruction of the unborn child is a violation of maternal instinct and results in unacknowledged grief. A second philosophical foundation considers abortion within a stress and coping perspective. This framework views abortion as a potentially stressful life event within the range of other normal life stressors. A woman's psychological reaction to the abortion experience depends on the meaning of the pregnancy and abortion, their significance in her life, and her ability to cope with these events; which are influenced by the social context and characteristics of the woman herself (personality, attitudes, values). A third perspective regards abortion as occurring within a sociocultural context. This perspective emphasizes the impact of the larger social context within which pregnancy and abortion occur on women's psychological experience of these events. A fourth perspective considers abortion to be associated with co-occurring risk factors. This conceptual framework emphasizes systemic, social, and personal factors that are precursors to

unintended pregnancy. These factors, such as poverty and intimate-partner violence, place women at risk for having abortions and/or predispose them to experience mental health problems regardless of pregnancy and its resolution.

These four perspectives represent the major philosophical foundations in the empirical literature and are important to understanding published findings. Each framework offers a different way of understanding the association between abortion and women's mental health responses.

**Examination of reviews of empiric literature about abortion and women's mental health.** An initial examination of the 18 identified reviews of empiric literature (Adler, 1979; Adler et al., 1990; Blumberg & Gollbus, 1975; Blumenthal, 1991; Bracken, Hachamovitch, & Grossman, 1974; Coleman et al., 2005; David, 1972; Keasling & Davis, 1975; Major et al., 2009; Mudd, 1973; Osofsky, Osofsky, Rajan, & Fox, 1971; Remeikis, 2001; Rogers, Stoms, & Phifer, 1989; Shusterman, 1976; Simon & Senturia, 1966; Turell, Armsworth, & Gaa, 1990; Walter, 1970; White, 1966) helped me determine further criteria for inclusion. Only those literature reviews that met the following criteria were included: a) offered a critique of extant research to synthesize results into a summary of what was and was not known, b) identified areas of controversy in the literature, and c) formulated questions that needed further research. Three reviews (Simon & Senturia, 1966; Walter, 1970; White, 1966) were eliminated because they were published prior to 1973 and focused on therapeutic abortions performed before the *Roe v. Wade* decision, which is beyond the scope of my dissertation. Of the remaining 15 reviews of empiric literature about the affects of abortion on women's mental health, eleven did not fully meet these criteria. An explanation of my rationale for exclusion of each publication is presented in Appendix F.

The remaining four articles (Adler et al., 1990; Major et al., 2009; Shusterman, 1976; Turell et al., 1990) represent comprehensive reviews of empiric literature pertaining to abortion and women's mental health and were included in my critique.

Shusterman (1976) conducted a comprehensive review of literature pertaining to the psychosocial aspects of abortion that was published between 1940 and 1974. Identifying the importance of the social context and the centrality of the woman in the abortion experience, she critiqued 84 studies. Recognizing that contradictory results existed in this literature, Shusterman attributed these divergent results "to methodological differences, differences in the variables investigated, sample differences, and theoretical differences. Many of the conclusions have been drawn from shoddy or nonexistent data" (p. 90). To address these concerns, she critically examined the research by separating investigations into three categories based on women's experiences of illegal abortion, therapeutic abortion (approved by a hospital committee when abortion was illegal), and abortion on request (legal, unrestricted).

From her critique, she concluded that no general statements could be made about the psychosocial factors of women undergoing illegal abortions; studies were of doubtful value and limited scientific worth due to lack of information about methodology, small sample sizes, inappropriate comparison groups, undisclosed manner of evaluating women's psychiatric state, and the influence of clinical opinions and strong anti-abortion biases. For women experiencing therapeutic abortions, Shusterman identified that the data showing favorable psychological consequences were stronger than the data indicating negative consequences. Similar to studies of illegal abortion, these investigations also showed evidence of methodological problems.

Like the studies of illegal and therapeutic abortion, Shusterman identified that investigations of elective abortion also evidenced methodological limitations. She found that “the studies used small, often unrepresentative samples, and measuring devices whose reliability and validity are unclear, or at least not reported” (p. 102). Despite these concerns, she acknowledged that more recent studies were significantly better than earlier research; “the analyses are less subjective, the measures are more reliable, comparisons are made with other groups of women, and, in some cases, statistical analyses are made” (p. 102). Shusterman concluded that “the psychological consequences of abortion on request appear to be mostly benign” (p. 79). Finding no studies in her critique that concluded that negative psychological sequelae occur for women from abortion on request, she identified that psychosocial effects of elective, legal abortion are negligible and may be favorable for many women. She identified that there appears to be a certain percentage of women who experience at least mild negative sequelae. The women most likely to experience negative responses to abortion “tend to be less certain about their decision to abort, to be involved in less stable heterosexual relationships, and to be more concerned about the consequences of abortion. In general, however, negative after-effects seem to be short-lived and rarely intense” (Shusterman, 1976, p. 102).

Based on the work of a panel convened by the American Psychological Association (APA), of which the authors were members, Adler et al. (1990) critiqued 32 studies published between 1973 and 1989. Criterion for inclusion included: 1) the research was empirical and based on a definable sample, 2) the sample was drawn from the United States, and 3) the women studied had undergone abortions under legal and nonrestrictive conditions. Like Shusterman, these authors identified that contradictory conclusions had been reached



from the extensive amount of literature published about the psychological consequences of abortion. Adler et al. identified that these disparate interpretations could be attributed to limitations in research methodology as well as to political, value, and moral influences. Despite diversity in samples, measures of response, and timing of assessments, the studies critiqued by these authors, when taken in aggregate, were found to be consistent in their findings.

Identifying that women's responses after abortion reflect the entire process of experiencing and resolving an unwanted pregnancy, these authors concluded that "although there may be sensations of regret, sadness, or guilt, the weight of the evidence from scientific studies indicates that legal abortion of an unwanted pregnancy in the first trimester does not pose a psychological hazard for most women" (Adler et al., 1990, p. 41). From descriptive studies, Adler et al. found that "after first-trimester abortion, women most frequently report feeling relief and happiness" (p. 41). These authors recognized that women showed little evidence of psychopathology after abortion; identifying that the instruments used to measure psychopathology were often designed to measure emotional distress in normal populations, not assess psychopathology in at-risk populations.

From their critique, these authors recognized that the time of greatest distress for women was likely to be before the abortion and concluded that "scientific studies on psychological responses to legal, nonrestrictive abortion in the United States suggest that severe negative reactions are infrequent in the immediate and short-term aftermath, particularly for first-trimester abortions" (Adler et al., 1990, p. 43). Additionally these reviewers identified that some women may be at relatively higher risk for experiencing negative psychological consequences. Factors associated with increased risk of negative

responses include women who terminated pregnancies that were wanted and personally meaningful, who lacked support from the partner or parents for the abortion decision, or who experienced more conflicting feelings or were less secure in the decision before the abortion. These factors are consistent with those reported in research on other stressful life events and “may also contribute to delay in obtaining abortions, potentially subjecting women to the greater stress of second-trimester procedures” (p. 42). In contrast, women who reported little difficulty in making their decision, who were more satisfied with their choice, and who terminated pregnancies that were unintended and that held little personal meaning demonstrated more positive responses after abortion.

In their review of empiric literature, Turell et al. (1990) focused on women’s emotional responses to abortion with an emphasis on demographic, social, and psychological factors. These authors viewed emotional responses as inseparable from the influence of the cultural climate in which abortion occurs. Similar to Adler et al., Turell et al. critically reviewed studies of women in the United States after the legalization of abortion. From the nine studies reviewed about emotional responses to abortion, these authors identified that much of the early research “was based on hypotheses stemming from Freudian beliefs about the role of motherhood for women. The focus of the studies is on unpleasant emotions such as anxiety, depression, anger, guilt, shame, grief, and regret” (p. 51). Methodological problems of philosophical bias, sample selection and attrition, retrospective design, timing intervals, operational definitions, and various methods for assessing the emotional state of women were evident in many of the studies. “However, even with these limitations, the data do suggest that for most women, relief is the predominate feeling after abortion, and that

severe emotional trauma is not prevalent. Nevertheless, there are a minority of women, perhaps as high as one-third, for whom abortion is likely to cause emotional distress” (p. 56).

Studies that were designed to identify these high risk women through demographic (12), social (9), and psychological variables (12) were reviewed by these authors. Turell et al. identified that the literature focused on four demographic factors: age, number of children, length of pregnancy, and religiosity; the predominant social variable was support from significant others; and the primary psychological variables were related to decision making and coping styles. From their critique, these authors identified that

Certain demographic variables, such as younger age, no other children, second trimester pregnancy, and strong religiosity, may be indicative of traumatic responses. Lack of perceived support from one’s significant others, whether partner or parents, may also negatively influence emotional response. From a psychological perspective, a woman’s coping style in crisis situations and her decision making style may also greatly impact her later emotional response to abortion. A woman who avoids responsibility or feels that the decision is not her own may experience greater emotional distress (p. 65).

In the final review of empiric literature in this section, Major et al. (2009) evaluated 81 studies addressing the relationship between induced abortion and women’s mental health. Studies included were published in English in peer-reviewed journals from 1989 to 2008 and compared the mental health of women who had an elective abortion with the mental health of various comparison groups. This literature review reflected and updated the report of the APA Task Force on Mental Health and Abortion (2008) and addressed two additional issues:

- 1) the relative risks associated with abortion compared with the risks associated with its

alternatives and 2) sources of variability in women's responses following abortion. The authors examined the influences of investigators' conceptual frameworks and the perspective from which research questions were stated on the findings of the publications.

These authors critiqued 58 studies based on U.S. and international samples comparing the psychological experiences of women after abortion with the psychological experiences of a comparison group and 23 studies based on U.S. samples that did not include a comparison group, but met all other inclusion criteria. They found that these investigations were relevant to predictors of individual variation in women's mental health following abortion. Their review of the selected studies "revealed that although research designs have improved in this area over the last 20 years, the majority of studies continue to be plagued by serious methodological problems" (Major et al., 2009, p. 870). Methodological concerns included inappropriate comparison/contrast groups, inadequate control for co-occurring risk factors, sampling bias, inadequate measurement of reproductive history and problems of underreporting, attrition, poor outcome measurement (timing, source, and clinical significance), statistical problems, and interpretational problems. Most of the studies reviewed suffered from one or more of these methodological problems, some more so than others.

Emphasizing the most methodologically rigorous studies, Major et al. based their conclusions on the entire body of literature reviewed. Three key findings were identified by these authors: "the relative risk of mental health problems among adult women who have a single, legal, first-trimester abortion of an unwanted pregnancy for nontherapeutic reasons is no greater than the risk among women who deliver an unwanted pregnancy"; "the claim that observed associations between abortion history and a mental health problem are *caused by*

the abortion per se, as opposed to other factors, is not supported by the existing evidence”; and “the majority of adult women who terminate a pregnancy do not experience mental health problems” (p. 885).

These authors also identified that some women do experience mental health problems after terminating an unintended pregnancy and it is important that women’s varied experiences of abortion be recognized, validated, and understood.

Abortion is an experience often hallmarked by ambivalence, and a mix of positive and negative emotions is to be expected (Adler et al., 1990; Dagg, 1991). Some women feel confident they made the right choice and feel no regret; others experience sadness, grief, guilt, and feelings of loss following the elective termination of a pregnancy. Some women experience clinically significant outcomes, such as depression or anxiety. It is important that all women’s experiences be recognized as valid and that women feel free to express their thoughts and feelings about their abortion regardless of whether those thoughts and feelings are positive or negative (p. 855).

Major et al. identified factors from their literature critique which were shown to be predictive of more negative psychological responses following first-trimester abortion among women in the United States. These factors include the extent to which a woman wanted and felt committed to her pregnancy, perceptions of stigma and associated perceived need for secrecy surrounding abortion, low perceived self-efficacy for coping with the abortion, low actual or anticipated social support for the abortion decision, and use of avoidance and denial coping strategies. These authors identified that “a history of mental health problems prior to pregnancy emerged as the strongest predictor of postabortion mental health “ and that “many

of these same factors also are predictive of negative psychological reactions to other types of stressful life events, including childbirth, and hence are not uniquely predictive of psychological responses following abortion” (p. 885). Major et al. concluded

Mental health among women who experience an unwanted pregnancy reflects a number of factors. It reflects preexisting and co-occurring conditions in a woman’s life that place her at greater or lesser risk for poor mental health in general regardless of how she resolves her pregnancy. It reflects her appraisals of the meaning of a pregnancy and abortion and her appraisals of her ability to cope with either option. It also reflects the coping strategies that she employs to deal with emotions she may experience as a result of her decision. The local and larger sociocultural contexts in which a woman lives also affect her mental health following an abortion. Perceived social stigma surrounding either continuing a pregnancy (e.g., in the case of an unwed teenager) or having an abortion can influence the decisions that women make, how they feel about their decisions, and how they cope with their feelings (p. 886).

**Summary critique of reviews of empiric literature about abortion and women’s mental health.** All of the authors of the reviews of empiric literature pertaining to abortion and mental health identified methodological limitations in the studies they reviewed. Earlier studies had greater or more numerous flaws, while more recent reviews indicate that investigations have become more methodologically sound over time, especially research focused on legal, elective abortion.

Despite methodological limitations, all of these authors identified consistent findings in their critiques of the extant literature, concluding that first trimester, elective abortion does not cause psychological trauma for a majority of women. These authors also recognized and acknowledged that some women do experience negative psychological sequelae as a result of their abortion experiences, often in conjunction with other factors. Predictive factors associated with women's experience of negative psychological sequelae in response to abortion seem to include: a pregnancy that was wanted and/or meaningful; conflict and/or uncertainty in making the decision for abortion; lack of social support; coping strategies involving avoidance and denial; strong religiosity; perceptions of stigma and need for secrecy; and prior history of mental health problems.

These reviews primarily reflect the three philosophical perspectives which emphasize the sociocultural context, coping and life stresses theories, and of co-occurring factors. While investigations by researchers emphasizing a conceptual framework of trauma and negative psychological consequences for all women experiencing abortion were included in these reviews of literature, the authors of the critical reviews of empiric literature identified that investigations that concluded abortion caused negative psychological sequelae for women were the most flawed methodologically, primarily due to researcher bias (e.g. – political agendas), inherent assumptions in participant selection (e.g. - only post abortion women currently in counseling), and outcome measures (e.g. - asked only about negative reactions such as anxiety, sadness, guilt, and regret).

An additional limitation of the studies included for review by these authors is the issue of non-responders. Women who had an abortion and chose not to participate in an investigation may be more satisfied with their decision and feel they have little to contribute,

that there is no need for them to share their thoughts and feelings. Alternatively, these women may be experiencing more emotional difficulties in response to the abortion experience (Adler, 1976; Freeman, 1978).

**Implications.** I began this review of literature desiring to focus on women's experiences of abortion. I had no idea I would find such a large volume of publications focused on abortion and women's mental health. I recognized that I was initially uncomfortable in dealing with the complexities and contradictions in this body of empiric literature. While my initial plan was to avoid focusing on the psychological and psychiatric literature about women's experiences of abortion, I could not conduct this critical review of literature with integrity without addressing the vast quantity of studies from these disciplines.

Despite my greatest attempts to remain unbiased in examining the available literature about women's experiences of abortion and the affects of abortion on women's mental health, I realize that my underlying bias is to support women's rights to control their reproduction by keeping abortion legal and accessible in the United States. My passion for women's rights tended to focus my attention to the "pro-choice" side of the dichotomized political debate that surrounds the topic of abortion in the United States. Conducting a search of the empiric literature specifically about abortion and women's mental health has taught me that women do not speak about their feelings related to their experiences of abortion in dichotomous terms. My examination of this literature has assisted me in understanding the variability of women's psychological responses to abortion and the importance of keeping this variability in mind while conducting my own research. Major et al. emphasized this concept when they wrote



women's psychological experience of abortion is not uniform; rather it varies as a function of their personal characteristics; events that lead up to the pregnancy; the circumstances of their lives and relationships at the time that a decision to terminate the pregnancy is made; the reasons for, type, and timing of the abortion; events and conditions that occur in their lives during and subsequent to an abortion; and the larger social-political context in which abortion takes place (p. 866).

I do not intend to use questionnaires or instruments to measure psychiatric diagnoses or psychological factors. I will ask women about their feelings and experience of emotions throughout the abortion experience.

### **Final Remarks**

The first three sections of this chapter have focused on the foundational research for my dissertation. I have critiqued this empiric literature about women's experiences of abortion to synthesize results into a summary of what is and is not know, identify controversy in the literature, and formulate questions that need further research. Feminist standpoint theory has been applied to the extant research to enrich the analysis of the literature by assessing critically the social, historical, and political contexts of the investigations. The final section of this chapter has summarized findings from reviews of empiric literature pertaining to abortion and women's mental health.

Of interest to me is that of all the publications I read and reviewed for this chapter, only one asked women about access to abortion services. During clinical trials for FDA approval of mifepristone in the United States, Elul et al. (2000) explored how women learned about and located one of the 15 national clinical trial sites offering medical abortion. When

these researchers asked women about finding a mifepristone provider, women reported that they learned about medical abortion services primarily by calling Planned Parenthood, talking with friends, or seeking information on the internet (p. 170). I often feel that society inaccurately equates national legalization of abortion with access to abortion services. The number of abortion providers in the United States remained stable between 2005 (1,787) and 2008 (1,793), but 87% of all U.S. counties lacked an abortion provider in 2008 with 35% of women living in those counties (Guttmacher Institute, 2011, Facts). Between January and June 2011, states enacted 162 new provisions related to reproductive health and rights with almost half (49%) of these new laws seeking to restrict access to abortion services (Guttmacher Institute, 2011, Overview).

In my search of empiric literature I identified several commentaries, reports, and statistical analyses on women's access to abortion services. Results from these publications indicate that women of color, poor women, young women, and women living in rural areas have a more difficult time accessing abortion services (Dehlendorf & Weitz, 2011; Harper, Henderson, & Darney, 2005; Jones & Kooistra, 2011). Reasons for decreased access to clinical abortion services included financial limitations and restrictive abortion laws. The expectation that the approval of mifepristone would result in a wider range of providers offering medical abortion has not yet been realized, and mifepristone has not brought a major improvement in the geographic availability of abortion (Finer & Wei, 2009). Additionally, more poor and young women are resorting to self-inducing abortions due to obstacles in accessing abortion services (Grossman et al., 2010).

Despite the lack of knowledge about women's experiences with finding an abortion provider in the United States, researchers from other countries have studied the phenomenon

of access to abortion services, some in great detail (Boyle & McEvoy, 1998 (England/Irish women); Halldén, Christensson, & Olsson, 2005 (Sweden); Harden & Ogden, 1999 (UK); Maforah, Wood, & Jewkes, 1997 (South Africa); Remennick & Segal, 2001 (Israel/Russian immigrants); Sethna & Doull, 2007 (Canada)). Based on the lack of information from women about access to abortion services in the United States, I plan to ask women about this aspect of the abortion process. I could inquire with a simple question, perhaps “How did you find someone to perform the abortion?” and explore their responses.

### **Need for the Current Study**

The empiric literature reviewed is a sign that the discipline of nursing is seeking to move beyond descriptions of women’s experiences of abortion into greater understanding. With many of the most recent studies having been conducted by nurse researchers (Hess, 2004; Trybulski, 2005; Andrist et al., 2006) this would seem to indicate that nurses are striving to increase understanding of this phenomenon and expand the body of knowledge about women’s experiences of abortion. Despite these research attempts, nurses must be more forthcoming with political agendas, personal biases, and consideration of the political, social, and historical contexts not only on women’s experiences of abortion, but also on themselves as researchers. It is important for nurses to gain knowledge about women’s experiences of abortion from women’s perspectives to foster understanding, adapt clinical procedures, provide compassionate care, address disparities in access to abortion services, and enhance awareness of political agendas.

This research study will focus on some of the gaps identified in this review of empiric literature, primarily the abortion experiences of low income women and women of color.

Using a feminist philosophical foundation, I will be able to concentrate on understanding this

phenomenon from the perspective of women who have experienced abortion. Conducting interviews with women will allow me to explore their abortion stories and contribute to the existing body of knowledge currently available on women's experiences of abortion in the United States.

## Chapter 4: Methodology

The review of empiric literature identified that most of what is known about women's experiences of abortion in the United States relates to the experiences of white, well educated, middle class women who were in their mid-20s at the time of the abortion. The literature reviewed also brought to light that little is known about the historical influence of politics and society on women's perceptions of their abortion experiences. The purposes of this feminist, qualitative research were 1) to describe and explore women's experiences of abortion and 2) to better understand the historical impact of political and social events on women's perceptions of their experiences.

### Study Design

A qualitative method was chosen because qualitative methods strive to achieve explanation of information and to discover understanding (Morse & Richards, 2002, p. 2). Investigating women's experiences of abortion through a qualitative research method allowed for an in-depth, holistic, naturalistic approach as a means of exploring the depth, richness, and complexity inherent in women's experiences of abortion, enriching and expanding the knowledge of the discipline of nursing and the larger scientific community (Burns & Grove, 2001; Polit & Beck, 2004; Denzin & Lincoln, 2000).

A feminist philosophical foundation was chosen for this qualitative study since this investigation was centered on describing and exploring women's experiences of abortion more fully from their perspectives. Research done from the perspective of feminist standpoint theories stresses a particular view that builds on and from women's experiences, taking into account the political, social, and historical contexts of women's lives (Harding, 1987, 2004b; Olesen, 1994, 2000, 2005). Dialogue with women who experienced abortion

fostered understanding of their experiences, raised consciousness for women and the researcher, and identified opportunities for political action and healthcare reform to improve the lives of women.

The narrative inquiry design of this feminist, qualitative study allowed women to describe their experiences of abortion by telling their stories in their own words, identifying events significant to them. Women were able to share their experiences of abortion in a manner that was comfortable and made the most sense for them. This approach allowed women an opportunity to describe their abortion experiences in rich detail, providing full descriptions and a comprehensive picture of their experiences. Through their lived experiences, the meanings of being a woman who has had an abortion were elaborated. Women's stories of abortion included relationships, suspecting and confirming the unintended pregnancy, talking with others, making the decision, arranging for and having the abortion procedure, and life immediately afterwards. Women reflected upon and shared what having an abortion has meant to them; they recounted tales of political and societal influences over time on their perceptions of their abortion experiences. Telling stories is a common format for communicating significant life events. Narrative inquiry is a means to study and learn from the stories told by women about their personal experiences (Stevens, 1998; Riessman, 1993).

Data were generated from interviews with women who self-reported a history of abortion. Women were recruited for participation in interviews through purposive sampling strategies including snowball techniques and participant referrals. The sources of data that entered into the analysis included digital recordings and transcripts of individual interviews, field notes about interviews, extant empirical literature, and historical information about

sociopolitical aspects of legal abortion in the United States. Qualitative data analyses were conducted along with and following data collection. Narrative analysis strategies incorporated both the context of the textual data and reflexivity, following the multi-staged technique for analyzing narrative data developed and employed by Dr. Stevens (1993, 1994).

Rigor in the study was established through dependability and scientific adequacy. Scientific adequacy of the interpretive findings was established through reflexivity, credibility, rapport, coherence, complexity, and relevance and by incorporating the active voices of participants. Appropriateness and significance of the study were validated with study participants. The degree to which the research reflected the complexity and reality of women's experiences of abortion reflected rigor in the study. All study procedures employed confidentiality as a critical component.

### **Sampling Strategies**

Initial recruitment strategies focused on low income women and women of color, an area of investigation identified as lacking through the critical review of extant literature. Low income women was operationalized as women who self-identified as economically disadvantaged at the time of their abortion. Women of color included women from any racial or ethnic background that were not white. Recruitment for participants was attempted through purposive sampling. This means of targeting women for participation was chosen because of the hidden nature of this population and the silence, secrecy, and political-societal pressures that surround the issue of abortion in the United States. Women who have experienced abortion are a hidden population because women who have obtained an abortion are concealed from the view of mainstream society and social control agencies (Watters & Biernacki, 1989, p. 417).

After obtaining approval from the Institutional Review Board for the Protection of Human Subjects (IRB) at the University of Wisconsin – Milwaukee, recruitment for participants was attempted through purposive sampling approaches which included provider referrals, and snowball techniques of word of mouth and participant referrals. I attempted to recruit women volunteers by connecting with clinic providers through electronic mail and telephone communication. Clinics were selected based on population served and logistical considerations. I focused on Planned Parenthood and free or low-fee clinics in Wisconsin. As I made contact with clinics, I asked nurses if they would be willing to post flyers and pass on information about the study to women by providing them with business cards containing my contact information. Women interested in participating in the study could then initiate contact with me directly.

**Planned Parenthood.** I identified 27 Planned Parenthood clinics in Wisconsin through their website, many of which were located in rural and underserved areas throughout the state of Wisconsin. I contacted the Vice President (VP) of Patient Services of Planned Parenthood of Wisconsin in Milwaukee and learned that I would need to obtain approval from Planned Parenthood Federation of America (PPFA) in New York. I completed and submitted all necessary paperwork. I followed up with the VP every 2-3 weeks via phone calls and emails and was hopeful of receiving approval from PPFA. By the 5<sup>th</sup> month I received no response to my calls or emails requesting information and updates; I abandoned the idea of Planned Parenthood clinics for recruitment of low income women and women of color. I never received acknowledgement or confirmation of approval to post flyers and conduct recruitment at Planned Parenthood Clinics in Wisconsin.



**Free and low-fee clinics.** My first success at accessing clinics for recruitment was a local community clinic which provides free and low-fee services to women and men. The director, a nurse practitioner, agreed immediately to assist with recruitment for the study. She posted flyers with my contact information in the clinic's exam rooms.

To identify possible clinics in Wisconsin, I searched online, locating a list of free and low fee clinics through the Wisconsin Department of Health Services (Appendix G). The listing provided the names, addresses, and other contact information for 56 clinics. I reviewed the list and omitted clinics which focused on dental care and services for men. I focused on clinics run by nurses and providing services to women. Clinics were selected based on population served and logistical considerations. I attempted to connect with the contact person listed by phone and/or email to discuss my study and determine their interest and ability to assist me in recruiting women for participation. As I spoke with nurses and other providers, most were quick to disengage from the conversation when they learned my study was focused on women's experiences of abortion. No one I spoke with was willing to meet with me in person. A few nurses were sympathetic, but feared losing funding and support for their clinics by agreeing to post flyers or participate in recruitment in any way. One nurse who was very familiar with the free and low-fee clinics in Wisconsin reviewed the list of clinics with me, identifying those clinics that she felt would absolutely not be willing to participate due to religious beliefs and affiliations. I excluded those clinics with a strong religious affiliation. As I spoke with nurses and others I explained the purpose of the study and asked if they would be willing to post flyers and pass on information about the study to women by providing them with business cards containing my contact information. I emphasized that they would not need to be directly involved with recruitment, that women

interested in participating in the study could initiate contact with me directly. All declined during my initial contact. No follow up phone calls were conducted and no follow up letters were sent.

As a final attempt to recruitment low income women and women of color, I contacted the directors of two nurse-led community care centers in Milwaukee who provide services to low income men and women. I explained my connection with the University of Wisconsin-Milwaukee College of Nursing and the purpose of my study during a phone conversation. Unfortunately neither nursing director was willing or interested in assisting me with study participant recruitment due to the topic of abortion.

**Public Health Department.** Several nurses I spoke with at the free and low-fee clinics encouraged me to contact nurses at area Public Health Departments. I visited and made phone calls to public health nurses in local and nearby counties. I explained the purpose of the study and asked nurses if I could post a flyer with my contact information, again emphasizing that women interested in participating could initiate contact with me directly. The timing of my attempts coincided with the essential recriminalization of medical abortion in the state of Wisconsin by Governor Walker. Nurses were fearful of governmental retribution and retaliation for any involvement with anything associated with the topic of abortion. No flyers or information was posted, no word of mouth referrals were an option. One public health nurse suggested a local community center for Asian and Hmong citizens. I identified and located the center, attempting several times to connect with the director. None of my phone calls were returned and no responses were received from emails.

**Change in recruitment goals.** After six months of recruitment efforts and limited success in gaining access to clinics serving low income women and women of color, I

consulted with Dr. Stevens. We discussed the situation and considered an alternative plan for recruitment. We agreed to forgo a focus on low-income women and women of color, as this population is indeed hidden and difficult to access, especially in the current sociopolitical climate. It was mutually decided that I would adjust recruitment strategies and focus on snowball techniques of word of mouth and participant referrals. We discussed the change in focus and anticipated that data collection would come from white, middle class, well educated women. We agreed to evaluate participant recruitment as data collection and analysis proceeded and to consider whether additional participants needed to be added to address specific questions that arose.

**Word of mouth.** As a doctoral student, a registered nurse, a certified nurse midwife, and a women's health nurse practitioner, I have colleagues in Wisconsin and other states who are nurses and nurse practitioners. I contacted 5 colleagues, 2 of whom were eligible to participate. Colleague A volunteered to participate (P03). Colleague B was eligible to participate, signed a consent form, but never scheduled an interview. She had reservations about others, especially her daughter, finding out about her abortion experience. Colleague B networked with neighbors, family members, friends, and other professional contacts. As a result, three participants (P01, P02, and P05) volunteered to participate in the study. Colleague C was not eligible to participate, but networked with family, friends, and other colleagues through word of mouth; as a result, two women considered participating in the study. One woman declined to participate out of fear her children would find out about her abortion experience; another woman (P08) agreed to participate. Colleague D knew of two eligible women, neither of which volunteered to participate in the study. As recruitment

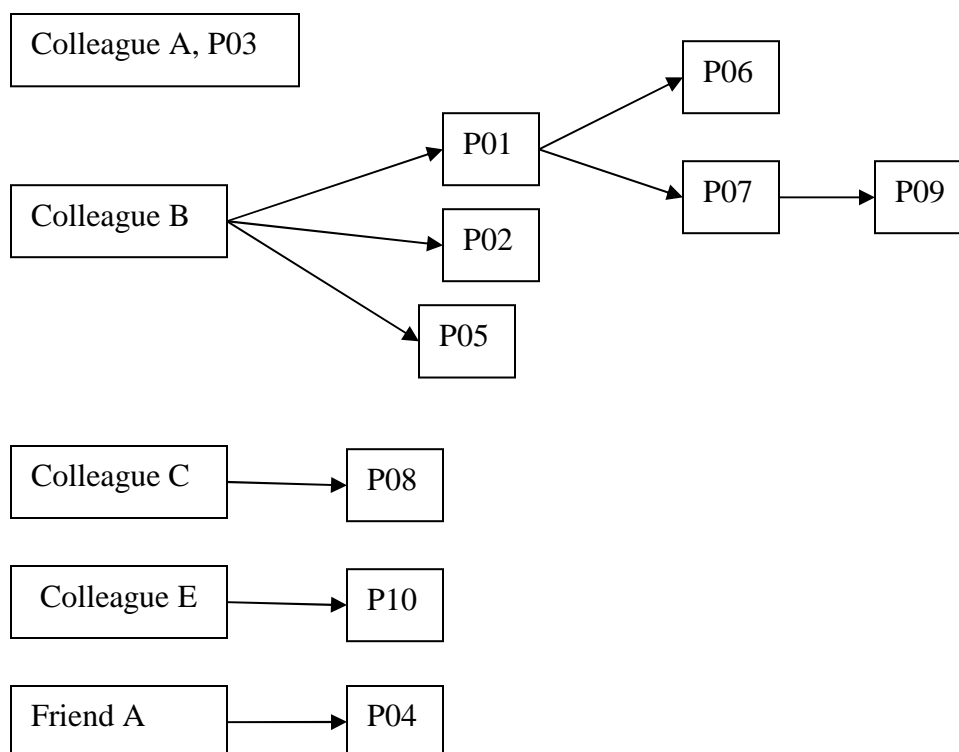
stalled, I reached out to Colleague E, who connected with friends and clients; one additional woman (P10) volunteered to participate in the study.

I also reached out to family members and friends. Despite eligibility to participate, no volunteers were recruited through connections with family members. One woman (P04) was recruited to participate in the study through a friend. Snowballing techniques of word of mouth limited recruitment to the social networks of the researcher; family members, friends, and colleagues, most of whom are white, middle class, and well educated, an anticipated result after changing sampling strategies.

**Participant referrals.** As women contacted me to participate in the study I asked them if they would be willing to pass on information about the study to women they knew who had abortions (Morse & Richards, 2002). Providing participants with my contact information, the women who were interested in participating then initiated contact directly with me. Two participants (P06 and P07) were recruited through a connection with P01; my ninth participant (P09) was recruited through connections with P07.

The goal of these sampling techniques was to achieve informational redundancy, ensuring adequacy of the sample size and enhancing the rigor of the study (Lincoln & Guba, 1985, 2000; Morse, 1994; Morse & Richards, 2002; Sandelowski, 1995; Stevens, 1993, 1998). According to Morse (1994) and Sandelowski (1995), a small sample size is at least 6 women. Quality, not quantity is the outcome for which I was striving in this investigation. Since the purpose of interviewing women about their abortion experiences was to produce thick, rich descriptions of their experiences and to understand the meaning of abortion in the lives of women, a sample of 6 to 10 women was targeted.

**Figure 1.** Sampling Pattern of Participants Recruited through Snowball Techniques



### Participants

The sample for the study consisted of ten women who shared their stories of 12 abortions. Participants met the inclusion criteria of being age 18 years or older, able to converse in English, and self-reported a history of abortion. Demographic data were gathered after enrollment, prior to the initial interview. All participants were Caucasian; one participant was part Hispanic. Women ranged in age from 18 to 66 years at the time of the first interview, with abortion experiences occurring as recently as 2 months and as long ago as 35 years. Abortion experiences occurred between 1977 and 2012, with a majority (8/12) of abortions taking place in the 1980s. All abortions were surgical; some involved dilatation of the cervix prior to suction aspiration.

**Table 1***Participant Abortion Demographics: Ages, Dates, and Years Since Abortion(s)*

Participant	Age at Interview	Age at Abortion(s)	Year of Abortion(s)	Years since Abortion(s)
Donna	56	21, 24	1977, 1980	35, 32
Elizabeth	51	19	1980	32
Kathleen	47	17	1982	30
Rebecca	53	24	1984	29
Barbara	58	24, 25	1984, 1985	34, 33
Shirley	62	35	1986	27
Carolyn	66	39	1988	27
Maria	43	24	1994	19
Lindsey	31	26	2008	5
Amanda	18	18	2012	0

In addition to age and time since the abortion experiences, women varied in amount of education (11<sup>th</sup> grade to graduate degree), income (\$500 - \$50,000/month), employment (unemployed, volunteer, retired, part-time, full-time), relationships (single, divorced, married, remarried, cohabitating, engaged, dating), number of children (0-6), and religion (Catholic, Methodist, Unitarian, non-denominational Christian). Geographical locations also varied with 3 women residing in the western United States and 7 participants being from the Midwest. Five women experienced abortion in locations near their current communities, while five women experienced abortion in different places.

**Table 2***Participant Demographic Profile at the time of the Abortion(s) and Interview(s)*

<u>Participant</u>	<u>Abortion(s)</u>			<u>Interview(s)</u>		
	Range	Mean	Frequency	Range	Mean	Frequency
Age (years)	17-39	25		18-66	48.5	
Education (years)	11-18	14		11-23	16	
Income (\$000)						
< 10			5			2
10-30			1			1
30-60			4			2
60-90			0			1
>90			0			4
Relationship Status						
Single			7			2
Divorced			2			3
Married			1			5
Children						
Without			7			2
With			3			8

*Note.* N=10**Data Collection**

Once a woman contacted me, established that she met the inclusion criteria and was interested in participating in the study, I created a page containing her contact information, including her preferences for communication (Appendix H). I reviewed the informed consent document (Appendix I) and sent her a copy (electronic or regular mail), requesting her to sign and return the last page of the document to me, either electronically or in a self-addressed stamped envelope that I provided. Thus, informed consent was obtained from the participant prior to the first interview. A date and time for the initial interview was discussed as well as the type of meeting, in person or by telephone. Demographic information was

elicited at the beginning of the first interview to help describe the social situation of each participant, both at the time of the abortion(s) and at the time of the interview (Appendix J). Information included race, ethnicity, age, education level, income, relationship with partner(s), number of abortions, time since the abortion(s), and obstetrical history.

Data collection consisted of two interviews with each participant. All of the interviews were conducted at a mutually agreed upon time and location. All interviews were digitally recorded with the participant's consent to ensure accuracy in data collection.

The first interview was designed to elicit women's stories about their experiences of abortion through semi-structured, open-ended, in-depth interview techniques. After exploring women's demographic characteristics through direct interview questions, I invited women to share their narratives with an initial prompt, such as "Tell me about your abortion experience" or question, such as, "What has having an abortion been like for you?" or "What was your first abortion experience like for you?" I encouraged and allowed time for women to tell their stories of their abortion experience(s) in their own ways, only using probes and reflexive, open-ended questions to encourage specific details about their abortion experiences and clarification as needed (Riessman, 1987; Stevens, 1994, 1998).

An interview guide provided some possible follow-up questions to ask women (Appendix K). The intent was not to have every woman answer every question, but rather to have a repertoire of questions in various categories available to me, a novice researcher, to prompt more storytelling or more detail and context as needed in eliciting women's abortion stories. Categories for interview questions were developed by me from the review and critique of empiric literature, discussed in the previous chapter. Since abortion has been identified by numerous researchers as a process, I listened to women's stories for aspects of



each step of the process. These chronological steps included discovery and confirmation of the unintended pregnancy, talking with others, the decision for abortion, arranging for the abortion, having the abortion procedure, time after the abortion, and life since the abortion. The influence of each woman's social context, including relationships with the male partner, family members, and friends were explored. I listened for interactions of power and control in women's narratives.

At the conclusion of the first interview, I asked each woman for feedback about the research process and scheduled a second interview within the following four weeks. Initial interviews focused on women's experiences of abortion and lasted between 23 and 52 minutes, with an average length of 40 minutes.

A second interview provided a means for me to review and clarify my understandings of the data from the first interview, checking with participants about my developing analytic interpretations of the growing data set. Additionally, the time that passed between interviews allowed each woman the opportunity to reflect on her abortion story. Reflection time prompted some women to be more forthcoming after they had time to think about their abortion experiences that were prompted in the initial interview. The second dialog with women allowed them to share additional information and insights gained in the time between interviews. Second interviews occurred 7 to 35 days after the initial interview and ranged in duration from 6 to 31 minutes with a mean of 17 minutes.

Immediately following each interview, I wrote field notes (Appendix L) about the data collection process. Field notes documented environmental circumstances, participant characteristics, nonverbal behaviors, affect, communication processes, rapport, power

dynamics, my own impressions of data collection, as well as any problems or issues that arose (Briggs, 1986; Mishler, 1986; Stevens, 1998).

### **Data Analysis**

Each interview was transcribed verbatim to create a textual database. The transcription process was accomplished by an experienced transcriptionist who had human subjects training. Digital recordings were identified with a number and participant code prior to the transcription to maintain confidentiality. All proper names were removed during the transcription process. Accuracy of the content of the interview was verified by reading the textual data while listening to the recording. Any potentially identifying information was omitted during my review of the transcripts. The analytic process began during the first interview and continued throughout the course of data collection. My analytical process was based on the narrative analysis techniques of feminist, qualitative researcher and professor of nursing, Patricia E. Stevens.

Stevens (1993, 1994) developed a multi-staged technique for analyzing narrative data which has successfully been implemented in a number of investigations (Stevens, 1993, 1994, 1996a, 1996b, 1998; Stevens & Doerr, 1997; Plach, Stevens, & Keigher, 2005; Buseh & Stevens, 2006). Devised from the narrative analysis methods of investigators in several disciplines (Riessman, 1993; Bell, 1988; Labov & Waletzky, 1967; Polanyi, 1985; Richardson, 1988; Potter & Wetherell, 1987), Stevens integrated and extended the procedure for examining and breaking down textual databases. First described in 1993, Stevens' analytical approach is flexible and creative in its stages to accommodate the purpose of the qualitative study, the textual database generated from women's stories of experience, and the researcher's preferences for displaying data.

Review of several studies by Stevens (1993, 1994, 1996a, 1996b, 1998, Stevens & Doerr, 1997; Plach, Stevens, & Keigher, 2005; Buseh & Stevens, 2006) revealed some distinct characteristics of the analytic process. All studies reviewed began the analysis process with the researcher reviewing the textual database for familiarity. This process was followed by differentiation of the boundaries of each story within each individual textual database. In the second or next stage, the researcher looked at the contents of story events and what they meant to the storyteller around the specific experience under investigation. Paraphrases were constructed to assist in this process. At this point in the analysis, the process shifted slightly based on the researcher(s) and the study purpose.

The next stage of analysis may involve the identification of specific stories related to the research questions or may progress to the stage of comparing and contrasting. During the compare and contrast stage, analysis involved searching stories for similarities and differences, both among individual participants and among sample subgroups. Examples of this included the analysis of “aftermath” for women discovering they were HIV infected (Stevens & Doerr, 1997) and the analysis of “positivity and negativity” in lesbian’s health care experiences (Stevens, 1998).

An alternative or additional stage used by Stevens (1994; Stevens & Doerr, 1997) was an analysis of the narrative in its entirety as a final step to reexamine the textual database. This step may be used to find narrative excerpts that best illustrate the analytic findings (Stevens & Doerr, 1997) or compare individual patterns “across participants to identify larger patterns that represented the experiences of the entire sample” (Stevens, 1994, p. 644). An analytical stage may also be included which provides data display or qualitative comparisons (Stevens & Doerr, 1997), depending on the preferences of the researcher(s).

Applying the foundational principles of Stevens' multistage narrative analysis technique, I analyzed the textual database in four stages. In the first stage I familiarized myself with the textual data and assigned pseudonyms. I demarcated the boundaries of stories within each individual database, conducting a structural analysis. In stage two I examined the contents of story events to identify their meanings and created paraphrases. I identified stories specific to the research questions. I constructed narrative summaries for each participant, conducting a within case analysis in stage 3. In the fourth stage I identified themes, analyzing each woman's narrative as a whole while conducting an across case analysis. I followed these stages sequentially for each participant, analyzing data through this multi-staged process concurrently as data collection ensued.

**Stage one.** First, I familiarized myself with the textual data base by reading transcripts and listening to digital recordings for each participant. I completed this stage for each interview as transcripts were available to me from my transcriptionist. The first time I reviewed the accuracy of each transcript and removed any potential identifiers. The second time listening to the recordings I adjusted the punctuation of textual data so the written word corresponded with the speech and inflections of participants' spoken words; I added comments like "sigh", "long pause", "sniffing", "chuckling", etc. The third time I simply listened to the audio recordings, sometimes with my eyes closed, attempting to understand the meaning behind participants' words.

I assigned pseudonyms based on participant's age; this helped me identify with participants on a personal level while keeping their actual names confidential and private. Assigning pseudonyms based on age helped to maintain the historical context of their abortion stories. I identified popular names by birth year from online websites. I was more

easily able to connect with and think about a woman and her abortion experiences by a name than by a label (i.e. P02).

I distinguished the boundaries of stories within each individual database. I printed out the textual data base for each participant and underlined every story; I used colored markers to highlight structural elements of the stories. “Stories have recognizable beginnings, middles, and ends. They include the events that occurred and the interpretations placed on them by the teller” (Stevens, 1998, p. 82). According to Stevens (1998), specific structural elements are necessary to designate text as a story. These elements are orientation, complication, evaluation, and resolution, as developed by Labov and Waletzky (1967).

1. *Orientation*: a recognizable beginning made up of statements that have a referential function; telling person, place, time, or behavioral situation. Often these references precede story action; sometimes they are found throughout a story.
2. *Complication*: the main body of story action which is comprised of a series of events that are linked temporally or causally.
3. *Evaluation*: descriptions and elaboration that suspend the action and make meaning of the events. These statements establish the storyteller’s point of view, indicate the relative importance of events, and show the storyteller’s attitude toward what is happening, the persons involved, and the context of the story. Evaluative clauses constitute the “soul” of a story and are especially important because they convey the teller’s understanding of what happened and why.

4. *Resolution*: a recognizable ending wherein results of the story are reported. The resolution may have a coda, which is a functional device for returning the verbal perspective back to the present moment (e.g., a story might end with a phrase like “And that was that.”) (Stevens, 1998, p. 82).

I specifically looked for women’s stories relating to chronological elements of their abortion experiences that I anticipated finding and sought through my interview guide. These elements included suspecting and confirming the unintended pregnancy, telling others, making the decision for abortion, arranging for and having the abortion procedure, and life immediately after the abortion. Additionally I looked for stories related to social and political events and issues that influenced women’s perceptions of their abortion experiences over time.

The areas of abortion experience and sociopolitical influences reflected the purposes of the study and related directly to the research questions. I also looked for other stories women told; as I identified trends in data, I incorporated specific questions into my interview guide with new participants. For example, I did not anticipate stories about telling daughters and sons about the abortion experience. During recruitment several women declined to participate for fear their abortion experiences would inadvertently be revealed to their children. Stories of telling children and stories of fear about children finding out about the abortion surfaced in interviews with participants. As a result I began prompting women who had children to talk about telling their children about their abortion experiences.

**Stage two.** After conducting a structural analysis, I examined the contents of each woman’s abortion story events and identified the meaning of these events for each woman around every abortion experience. I wrote labels in the margins next to each story using key

words or phrases to capture the heart of the story (i.e. suspecting pregnancy, had no support, difficulty waiting, gender inequity/angry, etc.). Women's stories were considered within their historical and social contexts, at the time of each abortion experience and in the time since the actual abortion procedure. Stories were examined for information from these women regarding influences of power and control related to their abortion experiences. I constructed an adequate paraphrase of each story to highlight the main plot and context of the action, persons involved, and participants' evaluations of story events (Polanyi, 1985; Stevens, 1993, 1994, 1998).

I compiled a narrative summary of each woman's experiences of abortion from textual data and organized each narrative summary around content areas. The initial subject matter of each woman's narrative addressed her abortion experiences. These lived experiences included chronological aspects of suspecting and confirming the unintended pregnancy, telling others, making the decision for abortion, arranging for and having the abortion, and thoughts and feelings immediately after the abortion. Women's narratives included women's experiences of telling others about their abortions, as well as stories about the influence of society and politics on women's perceptions of their abortion experiences over time. Women offered insights into their abortion experiences and provided advice for other women experiencing unintended pregnancy and abortion. The depth and specificity of content in women's narratives varied based on women's experiences of abortion and the amount of time which has lapsed since the actual abortion procedures.

**Stage three.** Narrative summaries were created by organizing women's stories chronologically and in a parallel fashion. As I assembled each narrative summary, I provided interpretive insights and personal reflection, conducting a within case analysis. I organized

participants' narrative summaries chronologically by the date of occurrence of the abortion procedure; from oldest to most recent. During this analytical stage I also made comparisons among individual women's experiences of more than one abortion (N =2) by comparing and contrasting experiences of the first abortion with the second. No participant had experienced abortion more than twice.

**Stage four.** During the final stage I identified themes in each woman's narrative summary and conducted an across case analysis by searching for similarities and differences in the abortion experiences between participants. In distinguishing the diversity of women's experiences of abortion and its meaning, I compared and contrasted women's experiences of abortion according to women's stage of life (based on age, social situation) and socioeconomic circumstances (operationally differentiated in this study by education and income level at the time of the abortion and at the time of the interview). I originally planned to compare women's experiences of abortion based on ethnicity and race, as well as type of abortion procedure (medical/surgical); however, these comparisons were not possible due to the homogeneity of the sample. Analysis of women's experiences of abortion based on length of time since the abortion was also limited as the majority of participants (7/10) experienced abortion during the 1980s (1990s = 1, since 2000 = 2).

In this fourth stage, I analyzed women's narratives of their abortion experiences in their entirety. Narrative was operationalized as the whole scheme of events which comprised each woman's experiences of abortion. All abortion experiences were taken into consideration to determine if there was a pattern of influence of the abortion experience over time on each woman's life. These individual patterns were compared across participants to



analyze variability and to identify the existence of larger patterns that may represent the experiences of the entire sample (Stevens, 1994, p. 644).

During the data analysis process, at times I would become excited about finding similarities and differences among participant's experiences. As a result, I would begin looking at other participant's textual database to see if I could find similar findings. Sometimes I would skip a stage in the analytical process during my excitement and wonder, only to realize later I hadn't thoroughly and systematically analyzed the data. Then I would return to my plan and proceed orderly through each stage of the analysis. Analytical notes and methodological memos (Appendix M) were made throughout the data analysis to document decisions made relative to methodological and analytical processes along with personal reflections. This included decisions regarding thematic identification and classification and changes incorporated into the data collection process.

### **Protection of Human Subjects**

Approval for this study was obtained from the Institutional Review Board for the Protection of Human Subjects (IRB) at the University of Wisconsin – Milwaukee prior to beginning participant recruitment, data collection, and data analysis. Data were considered confidential, with the assignment of discrete codes based upon interview number, dates and times; pseudonyms were used to designate participants. The master list of codes and pseudonyms was stored in a locked file, accessible only by me. Digital recordings and transcribed data were coded and stored electronically on a password protected personal computer. Participant contact information, textual data, the master list of codes and pseudonyms, analytical notes and memos, and Informed Consent Documents (ICDs) were

stored separately in a locked file. The identities of participants will not be discernable in any verbal presentations or written publications generated from this study.

### **Rigor**

Throughout the process of this study, adherence to standards of rigor in feminist research as articulated by Hall and Stevens (1991) supported the dependability and scientific adequacy of this study of women's experiences of abortion. Dependability refers to the research process (Hall & Stevens, 1991, p. 19) and was determined by keeping an audit trail of methodologic and analytic decisions. Analytical notes and methodological memos were discussed with Dr. Stevens, my major professor, throughout data collection. Thematic descriptions from the textual database were also reviewed with her.

Adequacy refers to the whole process of inquiry. "Adequacy of inquiry implies that research processes and outcomes are well grounded, cogent, justifiable, relevant, and meaningful. Results are adequate if analytic interpretations fairly and accurately reflect the phenomena that investigators claim to represent" (Hall & Stevens, 1991, p. 20). Scientific adequacy in this study was demonstrated through reflexivity, credibility, rapport, coherence, complexity, and relevance.

"A reflexive approach to research fosters integrative thinking, appreciation of the relativity of truth, awareness of theory as ideology, and willingness to make values explicit" (Hall & Stevens, 1991, p. 21). A reflexive approach in this study was accomplished by me being aware of my thoughts, attitudes, and feelings about the experience of abortion. During the research process, I wrote notes after each interview and during data analysis about the thoughts and feelings I experienced during the researcher-participant interaction and as a result of analyzing the textual database.

“A feminist research report is credible when it presents such faithful interpretations of participants’ experiences that they are able to recognize them as their own” (Hall & Stevens, 1991, p. 21). Credibility was enhanced in this study by reviewing the thematic descriptions from the textual database with Dr. Stevens and other feminist scholars. Conducting a second interview with women allowed for clarification of information and a means to determine if I had indeed captured the essence of each woman’s story about her experiences of abortion.

“Rapport is a criterion of adequacy reflecting how well participants’ reality is accessed” (Hall & Stevens, 1991, p. 22). I evaluated rapport in the study by examining the depth and specificity of information shared by women about their abortion experiences. I considered the verbal and nonverbal indications of women’s comfort and openness, their willingness to be involved over a period of time, and their inclination to recruit other participants. An examination of methodological notes and memos assisted me in evaluating rapport with participants in this study.

According to Hall and Stevens (1991),

Research conclusions are coherent if they are well founded in and consistent with the raw data, systematically connected in a logical discourse and faithful in principle and interests served to the stories women tell, the behaviors they demonstrate, and the sentiments they communicate. Coherence is a quality indicating a unity in the research account derived from all the observations, records, responses, and conversations involved in the research process (p. 23).

To achieve coherence, I questioned the data and the emerging analytical insights throughout the research process, discussing findings with Dr. Stevens and other colleagues.

Documentation of these conversations also served as methodological memos and analytical notes.

“Rigor in feminist inquiry includes the degree to which research reflects the complexity of reality” (Hall & Stevens, 1991, p. 23). Women experience abortion in a world where gender, race, class, religion, and ethnicity structure their understanding of the experience. Different women will experience abortion differently, just as the same woman may experience abortion differently at separate times in her life. I analyzed the textual database for each participant, comparing and contrasting themes within a single participant’s interviews and across interviews. This process identified not only the similarities in experiences of abortion, but also the dissimilarities. The entire research process was designed to capture the complexity of women’s experiences of abortion by starting with women’s lived experiences of abortion, exploring the historical influences of society and politics on women’s perceptions of their abortion experiences, and offering a comparison of historical information with textual data from women’s accounts of their experiences of abortion.

“Feminist researchers judge the appropriateness and significance of research by whether the questions address women’s concerns and by whether the answers to those questions can serve women’s interests and improve the conditions of women’s lives” (Hall & Stevens, 1991, pp. 24-25). The study of women’s experiences of abortion was relevant to me as a researcher and I was able to determine the significance of this research with the women who participated in this study and from the information they shared. Findings from this feminist, qualitative investigation can potentially be used by nurses, other researchers, and politicians to change the conditions in which women experience abortion in the United

States. Findings can also be used by women individually and/or collectively to expand their own consciousness and gain broader understanding about their abortion experiences within social, political, and historical contexts.

### **Organization of Results**

Results of the multi-staged narrative analysis of the interview data are presented in the next two chapters. Findings and interpretations from the within case analysis are reported in Chapter 5, followed by results from the across case analysis in Chapter 6.

## Chapter 5: Findings and Interpretations, Within Case Analysis

This chapter presents the findings from my within case analysis. Each woman's narrative summary is organized around content areas. The beginning section of each woman's narrative summary refers directly to her experiences around the time of the abortion procedure. These lived experiences include chronological aspects of suspecting and confirming the unintended pregnancy, telling others, making the decision for abortion, arranging for and having the abortion, and thoughts and feelings immediately after the abortion. While women mentioned these chronological elements in their experiences of abortion, most did not tell stories specific to confirming the unintended pregnancy, arranging for the abortion, and having the abortion procedure. Stories focused primarily on telling others about the unintended pregnancy and the process of making the decision for abortion.

Other content areas of women's narratives include women's experiences of telling others about their abortions, reflections on religious and philosophical beliefs, as well as stories about the influence of society and politics on women's perceptions of their abortion experiences over time. Women offered insights into their abortion experiences and provided advice for other women experiencing unintended pregnancy and abortion. Participants are presented in chronological order according to the year in which the abortion experience occurred, from oldest to most recent.

### **Donna**

Donna is a 56 year old Caucasian female of Northern European descent; she is half Irish and half Slovak. She has been married for 26 years and associates with the Unitarian Church. She holds an associate degree in Arts and works part time in retail sales at an independent book store. She and her family live in a suburb of a large Midwestern city.

Donna is an advocate and activist in progressive causes such as environmental concerns, social justice, human rights, and civil rights for gay and lesbian couples. Donna has been pregnant 4 times; she has 2 children, a daughter age 22 years and a son age 20; she has had 2 abortions. Donna found out about the study from a friend in her book club. She was hesitant at first, but decided to participate after I offered to visit her to conduct the first interview in person. She was so touched by my gesture that she felt comfortable with conducting the interviews over the phone.

At the time of her first abortion in 1977, Donna was 21 years old and living overseas in a European country where abortion was illegal. She had completed high school and a year and a half of community college and was working full time as a nanny.

It was terrifying. I was in a foreign country; abortion wasn't legal; it was a medical clinic. My colleague was a dentist; she lined the abortion up and went with me. I couldn't speak the language. I was far from home, alone, and pretty much on my own, so it was scary and disorienting, traumatic.

Donna does not recall how she confirmed the unintended pregnancy, but knew that she was pregnant. "I had missed my period and I didn't feel well. I was tired, tired, tired, tired; getting all the signs of pregnancy - tender breasts and typical physical signals. I can tell you I was definitely pregnant."

She only told her one friend about the unintended pregnancy; "that was it". Donna did not communicate with the male partner involved with the unintended pregnancy as the relationship had ended; "nope . . . not a bit . . . that was over and done with." She did not talk with family or friends back home due to the distance and difficulty of communicating; "not at that time. You have to remember this is 1977 and phone calls were expensive; you'd write on little onion skin paper and mail it and things would take weeks to go back and forth." Far from home, without much support, Donna made her decision for abortion. She feared

judgement from others for having a child out of wedlock and she did not feel she could raise a child on her own. Donna felt certain about her decision to terminate the unintended pregnancy.

At that time I just didn't think I could turn around and come home and say 'I'm home, I'm pregnant'. I would say it had more to do with social judgment. I just didn't think I could have a baby. It was like 'I can't have a baby', 'I don't know what to do' and 'I don't know how to do this' and 'this is not a good thing', so it was pretty clear to me.

As a dentist and native of the country, Donna's friend had ties to the medical community and was able to make arrangements for the abortion. Donna could not speak or understand the local language.

She was from that city and had gone to medical/dental school there, that's her home. She had all these contacts; she knew the physician world and she knew what to do. I couldn't speak the language to conduct something like this, so she conducted it.

Donna was terrified on the day of the abortion. In telling her story she sobbed as she recalled little flashes of memory. She paused often and told me she needed to close her eyes to help her remember. She found comfort in her friend's presence with her that day and because the atmosphere reminded her so much of the medical clinics she was familiar with in the United States. Not being able to understand or speak the language through the abortion procedure process was disconcerting and very frightening for Donna, perhaps contributing to her feelings that the process was robotic and impersonal. She was especially terrified when her arms and legs were tied down as she lay on the operating room table. The surgical abortion procedure was done by a male physician under general anesthesia. Afterwards Donna felt nauseated and unwell; she and her friend took a cab home.

I'm on the bus. We're in the clinic. It was a real clinic, even though abortions in that country were illegal, that was comforting to me. It was a gynecological clinic, so I felt safer. It was clean; medical personnel and equipment, stainless



steel and linoleum floor, curtains that pull. I really wasn't certain of what I was getting in to; it was very impersonal, like going through a drive-through car wash. The abortion process felt very factory-like, but this could have to do with not understanding the language, being shepherded around versus being able to communicate first hand. The doctor was a male, there was the nursing staff; I don't remember where my friend went, if she stayed with me or sat out. I was on a gurney and what was spooky was they strapped my arms and my legs down. It was very frightening. I suppose it was so I wouldn't fall off the table when they put me out, but that was really spooky. I remember not feeling very well when I was done. I had a lot of cramping, a lot of pain, and I couldn't pull out what was from the anesthesia versus the procedure itself. But I didn't feel good; felt pretty shitty physically. And then we took a cab home.

Donna and her friend didn't have much money but somehow they scraped together enough to pay for the abortion. After the abortion, Donna rested in bed, changing pads, and putting hot or cold packs on her abdomen. She felt "pretty punk" and "low physically and emotionally."

At the time of her second abortion in 1980, Donna was 24 years old and back in the United States. She had completed a technical degree in culinary arts and was working as a gourmet cook, living "hand to mouth". The unintended pregnancy occurred in a steady, but ending relationship. Donna and her boyfriend had been dating for several months, but he had left the area to pursue additional education. Donna hoped the relationship would continue long-distance, but he did not want to maintain the relationship with her or have a child.

He left for graduate school before I discovered the pregnancy. I talked about it with him over the telephone. We were gonna try to keep in contact; I wanted to continue the relationship and he did not. He did not want to have a child; he did not want to have this happen.

Donna sought support from friends in deciding the outcome of the unintended pregnancy. She thoughtfully evaluated her life circumstances and her ability to care for a child on her own.

I talked with my girlfriend about the pregnancy. I was living in an apartment with 3 friends. I didn't have a car. I was working a job that didn't pay very much. I just didn't see how that was possible, again, to take a child on. I said, 'I can't do this alone'; 'I'm not that kind of person'.

Donna reconciled her hopes and dreams for the relationship with the reality of being on her own with limited resources for parenting. She considered continuing the pregnancy but did not desire to raise a child without a partner. Donna compared her life circumstances in 1980 with her situation in 1977 when she'd had her first abortion. She expressed sadness about her circumstances along with relief that she was back in the United States, had friends for support, and access to a safe, legal abortion procedure.

I had that 'oh, well, maybe this will work out' kind of viewpoint, and it didn't. He was like 'nope, I'm on my way to get my graduate degree and we're done'. I probably, if I'd had support of the father, kept that fetus and carried the pregnancy to term. So it was different, I mean it was sad 'cause I didn't want to terminate the pregnancy, but I didn't have a partner and I thought that was important. And the relationship was ending, so I didn't feel like I could have a child alone. I was at home, I was with a support group, with good friends, and a good situation, so it was safe and not as physically difficult, but it was sad.

In the process of making her decision for abortion, Donna recalled her contraceptive methods and blamed herself for the occurrence of the unintended pregnancy. She reflected on her astonishment of being pregnant and accepted complete responsibility. She did not place any responsibility or blame for the occurrence of the unintended pregnancy with her boyfriend.

I don't know why I was so naïve; I know how babies get made, I've known it since I was a young girl. I wasn't using protection and we were in a relationship; I was using the old rhythm method. I was surprised; this wasn't supposed to happen.

As Donna decided to terminate the unintended pregnancy, she struggled to negotiate the influence of her religious upbringing on her self identify, her own beliefs, and the

decision she felt she needed to make. She described the shame and guilt she felt imposed upon her by Catholicism.

I had some shame. I was raised of Catholicism, from birth to senior in high school; I drank the ‘kool-aid’ of Catholicism that you do not have an abortion, you have a child. So it was very difficult for me to philosophically come to terms with my decision morally.

Donna was involved in social activism at the time of the unintended pregnancy, but participated in no specific religious or worship activities. She contrasted that with her involvement with pro-life activities in high school in explaining her struggle philosophically to have an abortion.

I was an adamant pro-life group member in high school; I was an organizer, I went and did protests, and flip flop that to making the choices that I needed to make and then coming to terms with my philosophical shift was hard. I firmly believe that I made the right choice and I have the right. But coming to terms with teachings and the poisoning that is anti-choice philosophy was really hard. It’s taken a long time to have compassion for myself that I needed to make those decisions for abortion.

At age 56, Donna reflected on herself in her early 20’s. She’s been negotiating the discrepancies between her own beliefs and actions and those of her Catholic upbringing for the past 30 years. She is confident that she made the right decisions for herself in having the two abortions. After pausing to reflect on her life circumstances and decision making process, Donna continued with her abortion story. She confirmed the unintended pregnancy at an inner city clinic. Arranging for the abortion “wasn’t very hard at all”.

I had a confirmation of pregnancy with a gynecologist. I knew I needed to terminate the pregnancy and they helped me find a place. It was a lot easier; I made the arrangements.

On the day of the abortion procedure, one of Donna’s girlfriends, who lived with her in an apartment, went with her to the clinic. Donna had a surgical abortion procedure at a

women's reproductive clinic in a large Midwestern city in the United States. She remembers the clinic feeling familiar and safe.

My good friend went with me. I'm sure we bussed down 'cause she was just a student and I had a low income job. It was much more comfortable than the first time; familiar and safer feeling. There was a normal waiting room that I'm familiar with, a receptionist, some other gals in the clinic who were waiting; it just seemed like a regular health clinic. There were little desks, bad coffee, magazines, and uncomfortable chairs; medical routines that I was accustomed to.

Donna did not have general anesthesia with this abortion as she had the first time in 1977. Donna felt safe and cared for by the nurses and doctor; they gave clear explanations about the abortion procedure. She was comforted by the nurse who talked her through the procedure and held her hand.

I wasn't put out for this abortion. There might have been some topical gel or something for the procedure, but I know I wasn't put out. I was talked through it. 'This is what we're gonna do' and 'just so you know what we're doing', like I would expect from a physician. The nurse held my hand. I remember being more comforted.

Donna did not have much money or health insurance; her boyfriend paid for the abortion. After the abortion, Donna and her friend took a cab home. When they returned to the apartment, Donna's friend was very nurturing. "She just was great and all my roommates then, everybody was really kind and helpful. They made tea, assisted me in the bathroom; they were just very nice."

During the telling of her second abortion story, Donna often compared her experience with the illegal abortion overseas in 1977. Her first abortion experience was traumatic and terrifying for her. She told her first abortion story in bits and pieces; she was emotional and sobbed quietly. The clandestine nature of her first abortion experience imposed fear and secrecy on Donna. The telling of her second abortion story was less emotional and more

matter of fact. She spoke often of feeling safe, cared for, and not alone. The availability and ease of obtaining a legal abortion in a familiar setting was much less traumatic for Donna. In both experiences, however, Donna felt confident about her decision for abortion.

During our phone conversations, Donna struggled at times to talk about her first abortion. She was tearful and I could audibly hear her crying at several points during the interviews. Donna's delivery of speech was broken at times as she would pause, telling me she was closing her eyes, gathering her thoughts, and reflecting on her experiences. After a period of silence she would share details of her abortion experiences. Donna's demeanor was open, but cautious. Her first abortion experience was traumatic and terrifying for her. She could only tell the story of her first abortion in bits and pieces; she was emotional and sobbed quietly. The clandestine nature of her first abortion experience imposed fear, shame, and secrecy on Donna. Despite the complexity of talking about her first abortion, Donna wanted to tell her story; she wanted someone to listen. Telling her abortion stories provided Donna with a means to continue to process these life experiences; she wanted to help others understand at the same time gaining insight herself. Donna's story of her second abortion demonstrated much less trauma for Donna. Her words flowed freely, describing in a matter of fact way her experience of abortion. Her descriptions included the steps she took to negotiate the abortion process along with her thoughts and feelings. Donna was grateful for the ease with which she could obtain a safe, legal abortion; she spoke without fear or hesitation.

Donna was explicit and assertive in assessing her personal situation when the unintended pregnancies occurred. She was thoughtful as she gathered up energy and resolved to come to a conclusive solution. Donna considered her current life circumstances,

her future aspirations, and imagined what life would be like for this child and herself. She made her decision for abortion and once decided, took action with the support of friends. She resolved the unintended pregnancy situations by making a decision for abortion; then Donna did what she needed to do to carry out those decisions.

Thirty-five years have passed since Donna's first abortion. During that time she has reflected on what it has meant to her to be a woman who has had an abortion. Donna shared that having an abortion has meant that she understands that no birth control is 100% effective; she believes in educating young people about preventing pregnancy. Having an abortion has meant that she strongly supports women's reproductive rights and believes the current political climate is a threat to women's wellbeing.

It's meant that I'm very clear with my children about birth control; the only 100 percent safe birth control is abstinence. Having an abortion has strengthened my belief in the great need for education to young people of how to prevent pregnancy.

It's meant that I'm stronger in my position that women should have a choice to do what they need to do. I firmly believe that the decision to terminate a pregnancy is not made lightly. I don't believe in ever changing the right for that freedom; every woman has the right to choose. With the political tenor in the country there's political division regarding the right to abortion; times are threatening, the possibility exists to make abortion illegal or difficult. There is so much judgement about women's sexuality, like the Senator who believes that if a woman is raped, she wouldn't conceive because her body would miraculously stop pregnancy. These huge, malicious, scientific untruths are setting a tone that blames a woman for her ability to conceive, as if it is a horrible thing, monstrous. We should worry about women who have had abortions and their feelings when these events occur in the news.

During the past 3 decades, Donna has rarely talked about her abortion experiences. She has shared her stories with some friends and her husband, but has only had the opportunity to talk about her abortion experiences if she brings up the topic in conversation.

When Donna's daughter was 16 years old she wanted to be sexually active, she wanted birth control. During the discussion, Donna considered telling her teenage daughter about her abortions, but did not. Donna felt her daughter was too young and she did not want information about her abortions made public, especially if the information could potentially be shared by adolescents at a high school.

At age 20, Donna's daughter had unprotected intercourse and was concerned about unintended pregnancy. Donna supported and assisted her daughter with obtaining Plan B, a contraceptive pill which prevents a fertilized egg from implanting in the uterine lining. The conversation provided an opportunity for Donna to tell her daughter about her abortion history, but this proved difficult for Donna. "She was okay. It was a lot harder for me than it was for her." Telling her daughter was more of a disclosure, than a sharing of information between two women. Donna offered her abortion experiences as a means of teaching her daughter about available options when an unintended pregnancy occurs. It is unclear if Donna and her daughter have ever discussed Donna's abortions since that one encounter.

Donna wishes women could talk more freely with their daughters about their abortions, but is not sure how to gauge the right age or situation for telling. Donna is not sure how she might have begun a conversation with her daughter if the opportunity had not presented itself.

I'd like women to be able to talk with their daughters, but how? When a girl's a little more mature? Or if she gets pregnant? This just happened; it was the right time, sittin' on the dining room window seat.

Donna attributes the difficulty in talking about abortion to growing up in a constrictive time before the legalization of abortion in the United States. Despite discomfort and fear of talking about abortion, Donna feels it is very important to do so, as young women

may need support and assistance in the event of an unintended pregnancy. She believes there is power and connection in talking with young women about abortion. Donna compared telling about her abortion experiences with disclosure of homosexuality, a huge personal matter.

It's my generation that has trouble, it's more our concept that's hard and our perceptions than for the young people 'cause we grew up before *Roe v. Wade*, during *Roe v. Wade* and out of a very constrictive time. It's not as horrible as we think, and actually it's a very good thing to do because you're saying 'somethin' could happen to you too' and 'I want you to be able to come to me'. Our girls could possibly need to make these decisions too, so be there for younger girls. For us to talk to our daughters about our experiences is power and connection. It's kind of like coming out of the closet. I'm not gay so I don't know what that is like, but this is a big thing. It's a very large personal experience.

Donna wishes she could have talked with her own mother years ago when she experienced the two unintended pregnancies and abortions, but talking about abortion was forbidden. She still wishes she could tell her mother, but does not envision that ever happening. Donna believes telling her abortion stories to her mother would be therapeutic.

I wish my mom had been there for me, but it was taboo. My mother doesn't know about my abortions and that's hard. I wish I could talk to her about it. I wish I could. I think that would be really good for me. It would be terribly difficult, more difficult than me talking to my daughter. Well, it is. I haven't done it and I really haven't made a plan to.

Donna gets very emotional when telling her abortion stories. She doesn't understand completely why she has these feelings, but attributes discomfort and fear of talking about her abortions with feelings of guilt, shame, and judgement. She continues to accept full responsibility for the occurrence of the unintended pregnancies.

My abortions are very personal but yet very deep. It's emotional. I don't know why I get so emotional, but I do. I don't know if it's guilt or shame, or embarrassment. I'm smart, why did I have this happen, I know better. I don't know if others have judgment or if I feel judgment, but it's a tricky situation



for me. I don't run around saying, 'oh yes, I had two unintended pregnancies' and I'm not sure why. I think it's complicated.

Donna would like very much to have a place where she could safely share her abortion stories with others. She questioned the secrecy that surrounds talking about abortion and considered the possibility of talking about abortion just like any other medical procedure.

I wish there was a place to come together and talk with other women about our experiences. Abortion is not something you're gonna shout from the rooftop, but why not? I would talk about a knee surgery or lots of things, but why is abortion a hush-hush kind of a thing? I think there needs to be a forum or a discussion group offered for women to come in a safe place and share whatever it is that they need to share.

When a woman at Donna's church openly talked about her abortions, Donna was stunned and unable to share her own abortion experiences. She wishes she could feel comfortable and secure enough to share her abortion experiences openly.

At my church, people were just hanging in the kitchen where lots of conversations take place. An older lady who I knew quite well, like my mother's generation, she would have been late 70's, early 80's, and we were standing together talking about something and she said 'oh, yes, we didn't have the money back in the 40's and I had to terminate 2 pregnancies 'cause we couldn't afford to have more kids'. And I thought, 'wow that was amazing', just jabber, standing next to me and openly say that. It was just like a big wash coming over me. It's very wonderful to share that in a way just like, 'well we just couldn't do it and I had to terminate those pregnancies'. I wish I'd talked to her about that and I didn't. I'd like to know other people's stories, I'd like to know all women's stories and I'd like to share in that way, it'd be healing for me.

Donna has a great desire to connect with other women and share her abortion stories; however, fear of judgement and condemnation keep her silent. Did she fear that this woman's reason of poverty was more valid than her own reasons for abortion? Was church too public of a place to disclose such a personal life experience? If so, why was this so for Donna and not the other woman? Why is one woman able to openly discuss her abortion experiences while another woman remains silent? It's possible that fear keeps Donna from

talking about her abortion experiences and connecting emotionally with other women. By not telling, abortion remains a hidden life experience; a secret that prevents Donna from connecting with other women who share in this common life experience. Fear of judgement and condemnation has robbed Donna of a deeper intimacy in relationships with the people closest to her.

Donna offered advice to other women and reminded them that they are not alone. She encouraged women experiencing unintended pregnancies and considering abortion to seek support from others and process the experience.

You're not alone. This decision is yours, but get support from the people who care for you the most, and if there aren't people in your life, close people, find a professional who can support you and comfort you and help you with the process. Don't stuff it, process through what's happening and you'll be in better shape. You're not alone; historically there are other women who have had pregnancies they have not wanted. It's not shameful. We can have a child or we can not have a child; we have a choice.

Overall Donna seemed satisfied with her decisions for abortion. She expressed growth as a person; she negotiated her religious upbringing with the reality of her life circumstances and world. Donna's underlying philosophical values toward abortion changed from morally wrong, to acceptable in some situations, to necessary. Donna has protected herself from religious condemnation by removing herself from the Catholic Church. She has found comfort and acceptance for herself as a person in the Unitarian Church, where abortion is sometimes talked about openly and without social judgment. Donna has avoided societal judgement of her person and for her decisions for abortion by keeping her abortion experiences secret.

**Elizabeth**

Elizabeth is a 51 year old Caucasian female of European descent who has been married for 21 years. She has a Master's of Science degree in education and is employed full time as an Executive Director of a small family foundation. She earns approximately \$50,000 annual with a household income of about \$150,000. Elizabeth associates with the Unitarian Universalist Church. She has been pregnant 3 times; she has two sons, ages 17 and 18; when she was 19 years old, she had a surgical abortion in 1980 at a reproductive health clinic in a large city in the Midwest.

At the time of the abortion, Elizabeth was a college student, majoring in health and physical education. She was working 3 part-time jobs and barely getting by financially. All the money she made went for tuition and school supplies. She and her boyfriend had been dating about a year. She was using oral contraceptive pills when the unintended pregnancy occurred and felt devastated when the pregnancy test was positive. Neither she nor her boyfriend was in a position to raise a child.

He was at the same college and we'd been together for about a year. I was on birth control pills, but I got pregnant. Neither one of us were in a position to get married, to be committed to each other; not emotionally or financially. I missed my period and I did a pregnancy test; it came up positive. I remember feeling devastated.

Elizabeth's Catholic upbringing influenced her beliefs and her abortion experience. She was young, frightened, and terrified of talking with anyone in her family.

When you grow up Catholic and in a large Catholic family, guilt and shame is a huge part of your upbringing. You're raised as a group and there's something about 'towing the line' that's part of your upbringing as well; and towing the line means being a good little Catholic girl. And getting an abortion is about the last thing that a good little Catholic girl would do. I was 19 years old; I was scared; I couldn't tell anyone in my family. I felt like I would have been ostracized from my family if they would have known.

Elizabeth's Catholic world opened up a little for her when she attended a public high school, but more so once she was away at college.

I was so entrenched in this huge Catholic family that lived in this big Catholic parish and we were taught that we only played with Catholic children. As I got older I did have friends that were not Catholic; when I got into high school, I was at a public high school. That was a big change; all of my older brothers and sisters had gone to Catholic high schools, but the bottom 6 did not, we went to public. I came into the public system younger, so my world opened a little bit more.

Just prior to the occurrence of the unintended pregnancy and abortion, Elizabeth took an Introduction to Religion course in college which broadened her perspective and helped her clarify her own beliefs. The class stimulated Elizabeth to explore other religions in more depth, comparing and contrasting with her rigid Catholic upbringing.

One of the first classes I had when I got to college was an Introduction to Religion and I learned about all these other religions that were out there; blew my mind. Talking about Buddhism and Hinduism started me down a path that is this interest in all religions - what do they have in common, what's different about them, and what makes sense and what doesn't. I have a strong spiritual life; I believe in a higher power, in something greater than myself. I have a lot of negative feelings about our religious organizations that were created by men that we have on this earth, particularly in the United States. I moved away from the Catholic Church in college and I started visiting different religions.

Elizabeth knew immediately that news of the unintended pregnancy would not be welcomed by her boyfriend. She found a quiet place where they could talk; he wanted her to get an abortion and she agreed. She did not feel like she was in a position to raise a child by herself.

I knew pretty much right away this was not gonna be happy news for him. So we sat down in a quiet place together and I told him. He, of course, was upset and I was upset; he was trying to be there for me and supportive of me, but was very clear about not wanting a baby. We talked about it and it was an emotional discussion; then leaving it for awhile and then coming back the next day, coming back and talking about it again. We made the decision together. He really wanted me to get the abortion and I agreed; understanding that he

didn't want a child, I wasn't in any position to raise a child, and I agreed to the abortion.

In making the decision for abortion Elizabeth considered adoption and imagined what parenting a child might be like for her.

Adoption was the third choice and I didn't consider that; I knew that I couldn't carry a baby in me for 9 months and then hand it over to somebody else. I just didn't feel like I could've done that. I felt like my two choices were have this child and live with the consequences of having a baby out of wedlock, at 19 years old, without a job and without an education, or have the abortion.

Once the decision for abortion was made, Elizabeth contacted the local reproductive health clinic where she had obtained her contraceptive supplies and made an appointment. She and her boyfriend went to the reproductive health clinic together; he was with her through the abortion process. During their first visit, they were counseled about options and given information about the abortion procedure. Elizabeth was confident in her decision for abortion.

We went to the local reproductive health clinic together; he was with me through the process. I remember going to talk to somebody at the clinic first, did a counseling session; 'Are you sure you want to do this?' They must have given me other options like adoption and keeping the baby. They were trying to help me look at all of my options, think clearly, and explained the procedure; gave me more information about the procedure and helped me to make sure that that was the right thing for me to do. I was really sure that I wanted the abortion.

Throughout the counseling session and the abortion procedure process, Elizabeth found the reproductive health clinic staff to be very understanding and empathetic; she was comforted and felt they genuinely cared about her. The caring atmosphere and the fact that all the reproductive health clinic staff was female were helpful for Elizabeth.

When I had the procedure and in the counseling session I remember them being very empathetic, I remember feeling like I was being cared for. They were giving the information that I needed and there was a sort of professionalism about them, particularly when I went in for the procedure

itself. They explained everything and that was really helpful for me. I felt like 'they've done this before', 'they understand what I'm going through here', 'they understand the procedure', 'they know what I'm gonna feel like and what this is going to be like for me', and there was comfort in there. Interestingly enough, they were all women, which was also helpful

On the day of the abortion procedure Elizabeth felt scared and uneasy. Driving to the clinic with her boyfriend, she worried about possible negative outcomes. Elizabeth felt nervous as she entered the clinic and checked in for her appointment. Once she was inside, the reproductive health clinic felt safe and she was reassured.

I remember my boyfriend and me getting in his car and driving other there and just being really nervous. You start to worry about 'am I ever gonna be able to have children once we do this?' All the fears of what could happen are with you all the way to that procedure. I checked in and felt like I wanted to sneak in a backdoor somewhere. I came in and then, reading, and then going in, just being very anxious the whole time; but, again, once I got back into the clinic, I felt like 'I'm in good hands, they know what to do'.

The actual abortion procedure was simpler and easier than Elizabeth anticipated. She was disturbed slightly when they discussed the use of vacuum suction to empty the contents of the uterus. Initially frightened, Elizabeth was surprised by how quickly the procedure was completed; she was uncomfortable, but experienced no pain.

In the explanation of the abortion, that they were gonna be sucking the tissue out of me was distressing. I remember being scared, but the actual procedure didn't seem like it took very long and it didn't seem like it was a huge deal. The abortion procedure was uncomfortable, but I didn't have any pain. It was uncomfortable and then I felt weak and worn out. They didn't put me under, but, they must have given something to relax me. Afterwards, once I was ready, they took me back to my boyfriend. The procedure itself didn't seem like it was that big of a deal.

The reproductive health clinic had a sliding fee scale which was helpful for Elizabeth and her boyfriend, as they were both college students. He had more of a job than she did at that time, so he paid for the abortion.

After the abortion procedure, Elizabeth's boyfriend drove them back to his apartment, where she rested. They talked and cried; held each other and felt sad. Despite the sadness, Elizabeth felt they did what they needed to do and that the abortion was the right decision.

He was living in an apartment off campus at that time so we went back to his apartment and I just rested. I remember crying and being very emotional and being very tired; 'was that the right thing to do?', 'am I gonna be okay?' I remember a sadness, just feeling really sad. It's a feeling of 'we did, I did what I had to do' but, just really sad. I lay on the couch and him sitting with me. I remember crying together and him holding me, and then talking about it and talking about that we didn't feel like there was anything else we could have done. As sad as it was, having the abortion was still the right decision for us. I saw the writing on the wall; I felt like I would have had to drop out of college, get a job; I would have had to raise that baby by myself. And I would've lost the boyfriend for sure, lost my family; I mean my entire support system would've been gone. In the sadness of what we did was the feeling that the alternative would've been terrible too.

Elizabeth did not think much about the legality of abortion at the time of her abortion. At the age of 19 she was focused on her own life. She was aware that safe abortion was available and accessible and was very grateful for access to legal abortion without the risk of death.

I honestly don't think I thought about the legality of abortion. When you're 19 years old, you can't see much past your own life. I was really caught up in, 'oh, my God, what do I, what do we do?' and 'what do I do about this?', and 'how's this gonna affect me?', and so I must have been aware that abortion was legal at that time. I remember feeling so grateful that the reproductive health clinic was there for me because you hear stories of women havin' to go into these dirty, icky places, in other countries, and die from having abortions. I do remember feeling like, 'oh, my God, thank God the reproductive health clinic is here and they do it in a clean, sterile, safe way'.

Elizabeth did not talk with anyone except her boyfriend about the unintended pregnancy and abortion. Within 6 months of having the abortion, she was struggling emotionally and confided in her closest friend, who is also her sister-in-law. Her friend

listened to Elizabeth tell her abortion story, cried with her, and cared for her emotionally.

Elizabeth felt secure in sharing her secret with her sister-in-law.

Shortly after it happened I talked to my closest friend who is also my older brother's wife. She came into my life when I was in 7th grade; she and I have always been very close. After I had the abortion I was struggling with depression. I went to her first and told her all about it. She was wonderful; she listened and cried. She's always been there for me in that way, where she listens and cries with me and takes care of me emotionally. So I told her.

About a year after the abortion, Elizabeth and her boyfriend got married in the Catholic Church. They talked about having children together once she finished school, but they never discussed the abortion again.

We never talked about the abortion. I remember us talking about wanting to have a couple of kids, but we never talked about the abortion again. It was as if the unintended pregnancy and abortion didn't happen. I still had a year left of school and so we weren't gonna have children right away, but we had talked about how many children might we have together, but we never talked about the abortion again. It was like this little blip that we wanted to put behind us. He wasn't a big talker anyway, so he would not have brought the abortion up. He was just relieved that we got it taken care of and in his mind, 'whew, that's behind us' and 'movin' on'.

Elizabeth was reminded of her abortion during her last year at college when she had to do some student teaching as part of her degree in physical education and health. The teacher gave her the topic of sex education. Elizabeth wanted to make sure high school students understood the physical and emotional aspects of sexual activity, as well as the correct use of condoms and contraception.

I think because of my abortion experience and that I was majoring in physical education and health at that time, when I did my student teaching in health, there I was a student teacher and the teacher gave me the sex education unit to teach. I remember thinking, 'oh my God, you've gotta be kidding', but I went into it and I taught those kids. That teacher gave me complete leeway to do what I wanted to do and so I taught them the physical part and I also talked about the emotional part. I had a representative from the local reproductive health clinic come in and talk about birth control. I was really a strong proponent of birth control, even though the pill had failed me. I felt like all of



the hormones going on in people of that age group, the need for connection, the exploring of relationship, and the biological sexual drive, that kids needed to know about birth control and how to use it. I had the banana and taught 'em how to put the condom on the banana. I was all about 'you have to know how to do this' and what the birth control pills look like.

After completing her college degree, Elizabeth struggled to find a teaching job in physical education and health. The relationship with her husband deteriorated and after three years, they divorced. Within a few years, Elizabeth met the man who would become her (second) husband. They dated on and off for 6 years before they got married. At some point, when Elizabeth felt the relationship was going to continue long term, she felt compelled to tell him about the abortion because she wanted him to know. They were sitting in a bar when the topic of abortion came into their conversation. Elizabeth told her future husband that she had had an abortion when she was in college. Initially he was shocked because of her strict Catholic upbringing; he listened, was nonjudgmental, and empathized with her situation. He validated the difficulty of her situation and was accepting of her decision and her as a person.

We were sitting in a bar and I think we were sitting at the bar. I mean, how much more public can you get? People are everywhere, it's not even like it was a private place. We'd been together for a long time and we were talking about the issue of abortion. I don't know if it was on the news or why it came up in our conversation. We were talking about abortion in a general sense and then I just felt compelled to tell him. We were in this conversation about abortion and so it felt like the right time to tell him, and I remember him being shocked. He was shocked because well, he would have never, ever guessed it because of the family that I came from. At that point he knew my family very well and because of the family that I came from, he was just shocked. So probably the fact that we were sitting in a bar, I just casually said, 'well, I had an abortion when I was in college' and he was shocked and kinda taken off balance there for a minute. And then he said, 'really, what happened?', and I told him the story and he listened and he said, 'wow, that must have been tough.' I remember feeling sad about it and feeling like, 'yeah, that was really hard'. And then we just kinda went on.

For the past 15 years Elizabeth has not talked with anyone about her abortion experience; only her husband and her closest friend knew her story. While at lunch with a

close friend, the topic of abortion came up in the conversation. Elizabeth's friend disclosed that she'd had an abortion in college and talked about participating in the study. Elizabeth was shocked to hear another woman openly admit that she had had an abortion. As they talked, Elizabeth felt comfortable and was prompted to admit she also had had an abortion in college.

Those two people are the only people I've ever told. Well, until I was at lunch with my friend. She talked about you [researcher] and told me how she'd had an abortion in college. Honestly, that is the first person that has ever just openly admitted that they'd had an abortion. I was just kind of in shock at first; then she talked about how important it is that abortion is something that we all hide. And she said that since she's been talking about her abortion, she's amazed at how many other women also had abortions in college. So then I just felt compelled to say, 'well so did I'. We talked about how important it is to help those coming behind us and why, she talked like it was important to be part of the study and so then I got your name and number, so that's three people that I've told.

After talking with her friend, Elizabeth considered telling her abortion story as a participant in this study. She took some time to consider her own feelings and then she talked with her husband about telling her story to me. Similar to the first time she talked with him about her abortion 25 years ago, he was surprised. After discussing her reasons for wanting to participate, she felt supported by him. Interestingly, during our second interview I asked Elizabeth if she and her husband had discussed her participation in the study any further and they had not.

I didn't even tell my husband right away that I was thinking about calling you. I just thought 'this is my deal' and 'I need to think about this myself for a little while'. And then after a week or two I said to him, 'I'm thinking about talking to this woman that's doing a study about abortion' and again it took him off guard. He was surprised. He said, 'really, what's this about? What are you thinking about doing here?' And I just told him, I said 'it's important to share this story and if I can help, by sharing this story, if I can help other women, it is well worth it'. 'I think I'm willing to do this', and he was completely supportive. I mean he was like, 'oh, absolutely, if you think that that's the right thing to do, that sounds like a great thing for you to do if you can do it.'

He was very supportive. Although I have to honestly say that once I called you and we set up the time, he's never asked me about it since. I hadn't really thought about that, but he hasn't talked to me; 'have you talked to her?' and 'how's it going?' It's actually interesting, isn't it?

Elizabeth knew that her husband was aware of our second phone meeting as he was working from home and had a contractor coming to take some measurements. She did believe that knowledge of our second phone conversation might prompt her husband to ask her about the experience later that evening. Elizabeth reflected on what talking about abortion might be like for men.

I work from home and my husband works from home some days. He had set up somebody to come and measure our windows this morning at this same time. I had asked him a couple of times, 'what time is that person coming and what day?' I knew it was sometime this week, but I didn't know what day. He couldn't remember; he had it written down on his work calendar. So then this morning as I'm preparing to come into our bedroom, which is where one of the windows is gonna be replaced, he said, 'oh, by the way the guy's comin' at 9 this morning to measure our windows'. And I just looked at him, and said, 'this is one of the times I'm talking'. So, I'm in my son's bedroom, but that's the only other time this has come up. I'm sure now that he's aware that I've talked to you today, later tonight I would imagine that he's gonna ask me, 'so how did it go?' When I think about that, I can't imagine what it's like for men. I think that they feel like that's a very touchy subject and they're not sure what to do with it, maybe; because abortion can't be part of their own personal experience. I think it's difficult for men too, trying to figure out how to talk to women about abortion; 'is it okay to bring it up?' I'm sure that's hard for them because the fact that they can't carry a baby, they can't have those experiences that women can have and so it's hard for them to completely relate. Besides everything else that's around abortion, for men, gosh, they don't know what to do with that really.

As we talked, I asked Elizabeth to share with me her conditions for telling others about the abortion. What situations feel safe to women for disclosure of their abortion stories? Elizabeth told me that she has to feel emotionally safe; free of judgement or condemnation from others for making the decision for abortion. Elizabeth's family of origin is strictly Catholic and most of her family members are conservative Christians; telling any

of them, except her one sister-in-law, cannot even be considered due to the threat of judgement and disownment. If there is any potential in the situation to feel threatened personally or concerned about attacks on a child, spouse, or career, then the situation is not considered safe enough to share the abortion story. Elizabeth protects others from outside judgement for her abortion decision; at the same time, she denies herself connection and intimacy in relationships through the telling her abortion story.

You have to be in a place that's safe emotionally. It's not something that you're proud of. There's so much in the way of moral judgment. I grew up in a very traditional Catholic family and I'm the 11th of 13 children; although the whole family isn't Catholic anymore. My parents who are in their late 80s, early 90s, are very Catholic. My brothers and sisters are either Catholic, Lutheran, or born again Christians; very conservative Christian people. I could never share this with any of them other than my sister-in-law, that's just not a safe place. It has to be a place that feels safe and where there are not going to be any ramifications on my kids, my husband, or my job.

Elizabeth identified a lifelong connection with teaching and sexual education, which began when she was in college, student teaching. Her abortion experience enhanced her belief that young people be educated about sexual education and birth control. She started talking with her sons about sexuality when they were young and birth control when they were in high school and were dating. She never told her sons about her abortion.

When I had my own kids I started with a couple of books that you read with your kids about human sexuality; about homosexuality and heterosexuality, they're fact based, 'this is what sexuality is'. And then when they got older and started to have girlfriends, when they got into high school and the girlfriends would be around for a little while, then we would talk about, 'are you having sex?' They understood completely that if they were gonna take that step, they had to have birth control and they had to be talking about that with their girlfriend. I recommended that the girl be on the pill and they use condoms. I never told them why, but I was always, 'you just want to be so safe' and 'you do not want an unintended pregnancy because you have no good options at that point'; 'you don't want to have to be in that position to make those choices.' I think I probably talked with them about it a lot more than other moms and maybe to a point where my husband would get a little bit uncomfortable with it.

Elizabeth received validation that her teaching efforts about preventing unintended pregnancy paid off when she and her husband helped her oldest son move into college. When Elizabeth saw a box of condoms, she felt that she had done a good job of teaching her son about sexual education over the years and no longer needed to have a conversation with him about prevention of unintended pregnancy and safety in sexual activity.

My oldest is at college and his girlfriend was there visiting last weekend. I don't feel like I have to have the conversation with him anymore, I've had it with him enough. He knows where I stand. When we moved him into college he had a box of condoms, I saw it and I thought 'good'.

Elizabeth taught sexual education at the Unitarian Church, similar to the curriculum and approach she used in the public school, compared with a religious view similar to her Catholic upbringing.

There is almost a theme in my life about unintended pregnancy and abortion and teaching; feeling so strongly that teenagers need to know about contraception. I did teach for a couple years in our Unitarian Church. Most churches have a faith based curriculum, but the United Church of Christ and the Unitarian Universalist Church have a very different sex education curriculum. It's just like when I taught in the public school, very much about contraception and taking responsibility for your body and your reproductive system.

The themes of teaching, sexual education, and teenage unintended pregnancy continue in Elizabeth's life through her current employment. Her work as an executive director of a small family foundation has influenced Elizabeth's thoughts and feelings about her abortion experience. She sees herself in the young women, struggling to raise their children without support, in poverty. At age 56, Elizabeth reflected back on how young she was at age 19 when she experienced the unintended pregnancy and how similar her situation was to the young women she now helps – ostracized by family, no support from the father,

unemployed, homeless, poor, hopes and dreams for the future shattered. Elizabeth feels grateful she chose abortion back in 1980.

I work in a job where we give funding to children who are in large part due to unintended pregnancies. We do a lot of funding for homeless families who are largely single women who've had children when they were between the ages of 16 and 21; they struggle, they're in poverty, and they're homeless. They struggle to get on their feet because they can't get a job because they have this baby and they're so young. I look back and think 'oh, my God, that was me, I was so young'. You just don't even realize how young you are until you're looking back. Interestingly enough, the family that I work for would not fund organizations that handed out contraception. That's changed since I've been there; they see the importance of contraception for young people.

What has really influenced how I feel about the abortion more is this job that I ended up in, where I see the consequences of unintended pregnancy and what it does to people's lives, what it does to the women and their hopes and dreams for their future, what it does to the children who are raised in poverty. So often, particularly at the homeless teenage youth shelters, where it's young girls and their babies, every story, because that's why they're there, this young girl has been kicked out of her family's home and basically ostracized from her family. In my work I have the opportunity to see what my life would have been like, and it's almost like I'm being shown over and over and over again what that other choice would have looked like. I feel grateful that I can see what my life would have been like, probably, and that makes me feel grateful that I made the decision that I did.

Elizabeth considers abortion to be a solution for the life of poverty that young women and their children become trapped in due largely to unintended pregnancies. She recognized that because of the moral influence of religion on society, the public opinion may not support the idea that abortion could be an answer.

The reality is that those young teenage women and women in their early 20's, that are not financially self-sufficient, that get pregnant unintentionally, they're considered to be what people think of as the drain on our society and what a lot of our social services are around. Yet, from a moral standpoint, people will never, I don't see that the general public will support abortion, and it's largely due to religious beliefs. 'When does life begin?' 'When is the spirit in that unborn child?' All of those discussions that we hear.

Elizabeth's childhood, her religious upbringing, and her personal experience with abortion were influenced by and influenced her philosophy of parenting. Elizabeth was intentional about having and raising children. As the 11<sup>th</sup> child in a large Catholic family of 13, Elizabeth grew up feeling like an unwanted child. Her parents hoped and planned to have 3 children; however, because of their Catholic beliefs her mother only had the option of natural family planning, which was ineffective in preventing pregnancy for her parents. Feeling unwanted, Elizabeth also felt like she was a burden on her parents, which was emotionally difficult.

When you're the 11th child in a family of 13 you have a strong sense that your parents didn't really want to have this many children. I didn't know this until later, but my mom wanted 3 kids and that's what she and my dad wanted together was 3 kids. Because of the Catholic Church and the way the priest talked to them, and the natural family planning didn't work for her, I grew up feeling like an unwanted child. I did not want to put that on any child. That's not a good feeling to grow up with; feeling unwanted and like you are a burden on your parents. By the time my mom had me she was pretty depressed and for the child, you feel like you caused that, so, really the emotional ramifications of being an unwanted child, there probably isn't enough out there on that.

She felt strongly that when she had children, they would be wanted; Elizabeth would become pregnant and parent intentionally. As a result, she and her husband planned for their two sons; emotionally, physically, and financially. She stayed home with her sons when they were young, tending to their needs. As her sons got older, Elizabeth returned to working part-time until her sons finished high school. She felt responsible for them and wanted them to feel loved, welcomed, and cared for.

I felt really strongly when I married that I wanted 2 children; that was all we were gonna have and then one of us was gonna get fixed. I felt like that's what my husband and I could handle emotionally and financially; I was very intentional. I didn't work once I had my boys; I stayed home when they were young because I felt responsible for having them and for raising them. I worked part time when they got a little bit older. I continued in the workforce

on a part time basis, but I had a really strong feeling of responsibility for raising the children that I do have. I think that might come from my childhood experience and also from the abortion, of feeling like I want to intentionally have children and welcome them into my life and let them know that they are a joy to us.

Elizabeth has continuously questioned the beliefs imposed upon her by her strict Catholic upbringing. She has sought information about other religions and spiritual beliefs, beginning with the college course during her freshman year. Her personal experience with unintended pregnancy and abortion has prompted Elizabeth to further investigate religious dogma and negotiate those teachings with her own beliefs and spirituality. After Elizabeth and her boyfriend, the one involved with the unintended pregnancy and abortion, were married in the Catholic Church, they didn't attend church services. After the marriage ended in divorce, Elizabeth did not go to church for a long time; she moved away from the Catholic Church and began her personal spiritual journey. She found a very liberal Catholic church which she attended for awhile.

I've been married twice; in fact I married the boyfriend that I was with when I had the abortion. We got married in a Catholic Church; we didn't really go to church after that. And then we divorced after about 3 years and then I didn't really go to church for a long time. I don't feel terribly connected to any one religion. There's a very liberal Catholic Church that I like because of the social justice work that they do in the community; I go there now once in awhile.

When Elizabeth got married again, she and her husband did not want to raise their children in the Catholic Church. They felt the most welcomed by the Unitarian Universalist Church; Elizabeth felt completely accepted for who she was, faults and all.

When I married my current husband we decided to raise our boys in a Unitarian Universalist Church. It was the church that felt the most welcoming; the very first line that they say is, 'come in with all of your vulnerabilities and strengths, whoever you are it doesn't matter, just come on in', and that felt good to me. 'Wow', here's a religion that's gonna accept me with all my warts and my strengths.



Elizabeth was excited to feel welcomed and accepted by a religious organization; she wanted to raise her sons in an organization that did not belittle women.

Really, to get out of the Catholic Church and not raise my boys in an organization that holds up men as closest to God and women as something less than . . . I just wasn't gonna raise my boys that way, so we raised them in the Unitarian religion, and now they're pretty much on their own.

Making the decision for abortion prompted Elizabeth to examine how she felt accepted and treated by a religious organization in the face of needing to do what she felt she had to do.

When you have an abortion, you don't feel like you belong to this religion where certain things are expected of you and you're expected to be this certain kind of person when you know inside that you're not. The Catholic Church doesn't believe in birth control; I had my own ideas of what made sense and they didn't line up with the Catholic Church.

Elizabeth continues to negotiate her spiritual beliefs, her Catholic upbringing, her decision for abortion, and her views of society through reading and exploration of religions.

I buy books on spirituality; I read about Buddhism; I read about all kinds of things. I would say that it's my hobby; I think that I'm searching and I'm trying to figure out what is the spiritual aspect, how does it fit into my life, the reality of my life and who I am and the decisions I've made, and how does it fit in my view of society.

Elizabeth reflects upon her abortion experience every time abortion comes up as a topic politically or in a pro-life message. She knows that she made the right and best decision by choosing abortion; however, emotionally the messages cause her to pause and question her beliefs and her action. She believes that religion has greatly influenced the public's opinion of abortion and that pro-life activists try to dissuade women emotionally from having an abortion. In looking back, she's sure her life and the life of that child would have been completely different than the two boys she intentionally raised.

Every time abortion is brought up, I mean, you can't help but think back. Any time abortion is brought up politically, and it's often, every time I go by a truck that has the picture of a fully formed child and some pro life message. A lot of times I can look at those messages and think 'they're putting misinformation out there to try and hook people emotionally', so that they won't get abortions. Logically, I see that and I know that, but there was a life in me and I chose to extinguish that life. I don't know if people ever feel comfortable, totally, fully, emotionally comfortable with that. I've obviously not reached that point. As logical as I can be about having an abortion, as I can be that my life would've been so completely different and the child's life would've been so completely different than the two boys that I had.

Elizabeth has never talked with another woman who has had an abortion. She thinks it is hard for women to talk about abortion in a society that is dominated by religion and absolutes.

I've never talked to anybody else who has had an abortion. Do you ever think, 'oh, my gosh, that was a terrible thing that I did there and maybe I shouldn't have done it?' I wonder . . . there's always a little bit of that maybe. I think it comes from religion. I think that what's out there in public is coming from religion. It comes from basically growing up in a religious culture; you don't kill other life or you go to hell basically and you're punished by God. You don't grow up steeped in that for 18 years and be able to just throw that off.

Elizabeth believes abortion could keep women and unintended children from a life of poverty, if society could move beyond the dogma of religion.

I think that if the religious aspect were completely gone, our society could look at some of our social problems and might be able to look at abortion as an answer almost . . . except for that it's not that easy. I guess because of the religious aspect of where we are and how we live, I don't really see that becoming an answer to how to keep people out of poverty, how to keep children and women out of poverty, at least not accepted as mainstream.

Elizabeth would like to know the thoughts and feelings of other women who have also experienced abortion; when do they think life begins? How do they negotiate the decision they needed to make with society and religious organizations judging women who have had an abortion? She does not recall that women were condemned by others for having

an abortion in 1980; Elizabeth feels like pro-life politics have obscured the facts about unintended pregnancy.

I think about the noise and commotion of all of the talk about abortion. I don't think that back in 1980 abortion was something that was as political as it is now. So much of the facts, of the science, of the biology of unintended pregnancy get lost in all of the politics of abortion. When you hear all of that you can't help but think, 'gosh, did I do something really terribly wrong here?'

Society and anti-abortion politics raise questions for Elizabeth when she reflects on her abortion experience. She wonders 'when does life begin?' and what does having an abortion really mean to women.

I felt like it was such an early abortion - is that life? I think the whole discussion about when does life begin, is there an answer to that yet? I'm not sure. I would say that that question's still hanging. Did we just take out a mass of cells that were developing? Or could you say that was a human life? I don't know; I'm not sure. How much of it is blown way up to get people to believe so that they won't have an abortion? So that they'll see abortion as bad and immoral? In some religions, God will punish you. Everyone has to go through their own faith journey about what's right in their life and what's not right, and yet you're not doing that in a bubble. So all of that noise and commotion going on around you absolutely makes you think, look back at that experience and think, 'what was that really?' and 'what does it mean to me?'

Elizabeth has been curious about how other women have felt about having an abortion, especially since no one talks openly about their abortion experiences. She would like to have the opportunity to talk with other women, to gain insight into her own abortion experience and to compare experiences. Elizabeth was surprised by her emotions in talking about her abortion experience; she was also struck by the fact that having the abortion was one of the best decisions she has made in her life. She hopes other women have the chance to process their abortion experiences and have support with emotions that result years after the actual abortion experience. Elizabeth is grateful for her best friend and for the

opportunity to talk about her abortion experience. She hopes other women are helped by hearing her abortion story.

What's so hard is because women don't talk about abortion; it's hard for me to know how anybody else has felt about it or dealt with it. For me personally, logically I can go to that place where it makes complete sense and I'm so grateful that I made that decision, but emotionally, I'm a little surprised at how emotional I feel talking about it after all this time. Emotionally it has a much bigger impact I would say than you may even realize at the time. Probably there should have been ongoing counseling, but I think that I just wanted to put it behind me and be able to keep going down my life path as a 19 year old. I probably didn't deal with having an abortion emotionally like I should've; other than talking to my sister-in-law; I don't recall getting any other emotional help. There's a stigma for getting mental health help; back in 1980 I'm not even sure I would have know how to do that. I wonder if the reproductive health clinic offered me counseling afterward and I turned it down because I don't think I went back there. There needs to be counseling to deal with the abortion emotionally and not just think, 'okay, that's done, I'm goin' back to my regular life and I'm putting this behind me', which is what you want to do because you don't want to think about the abortion too hard.

Reflecting on her abortion experience, Elizabeth was surprised by the recollection of how young she was, how difficult the unintended pregnancy was, how the decision for abortion was a really good one, and how helpful telling her abortion story has been.

I was struck by just how young you are at 19 years old and how hard I was working to get that degree; working 3 jobs and going to college. I was determinedly on this path of wanting self-sufficiency in my life and wanting to be a teacher. The insight was I was young, I was working so hard, and then the unintended pregnancy happened; how difficult that is for such a young person; I haven't really thought about how that abortion experience impacted my life. I thought, 'oh my gosh that was the best decision'; maybe one of the best decisions I've made in my whole life actually. I mean my life path would have changed so drastically. It was really helpful for me to share my abortion story; I didn't even realize how helpful it would be.

Elizabeth spoke frequently of the inter-connectedness of teaching, sexual education, negotiating her Catholic upbringing, defining her own beliefs, and her experience of abortion. She desired to help other young women so they would not experience an unintended pregnancy as she had. Through constant and consistent messages to young

people, including her sons, and foundation board members, Elizabeth has instilled in others the necessity of contraception and its correct use. Adamant about preventing unintended pregnancy so no one else would be faced with the decision for abortion, she has remained silent about her own contraceptive failure and abortion experience. Elizabeth had told only 2 people about her abortion in 35 years; her friend at lunch was number 3 and I was number 4. A friend talking about abortion in a conversation at lunch prompted Elizabeth to disclose her own abortion history. Up until that day, she may have had a desire to share her story, but had never felt safe and comfortable enough to do so. There seems to be a contradiction in Elizabeth's life; if having an abortion was one of the best decisions she ever made, then why has she not been able to talk about her personal experience in all the teaching she has done about contraception and sexual education? Shame and guilt imposed by her strict Catholic upbringing and fear of judgement and condemnation have kept Elizabeth silent about her abortion. Perhaps her understanding of her decision for abortion has become clearer through her ability to talk about her experiences of abortion with her friends and through participation in the study.

### **Kathleen**

Kathleen is a 47 year old, Caucasian woman who is of Scandinavian descent. She grew up Lutheran and currently attends a Methodist church; she considers herself to be a non-denominational Christian. Kathleen lives in a rural town in a Midwestern state. Kathleen has an associate's degree in Health Science and is working on a BS in Health Administration and Nursing. She works full time as a Certified Nursing Assistant (CNA) at a home health care agency. She also works part time at an assisted living facility. Kathleen earns between \$21, 000 and \$23,000 per year.

Kathleen was married in her 20's and has two children from that relationship, a 21 year old son and an 18 year old daughter; the marriage ended with divorce. After getting divorced, Kathleen began dating and experienced an unintended pregnancy; she has a 13 year old son from that dating relationship; she and her son's father did not get married. She is currently involved in a serious relationship; she and her boyfriend of 4 and a half years are engaged to be married. They each have children from other marriages/relationships and presently live in two different geographical locations about 40 miles apart. She has been pregnant 4 times, but has never verbalized that fact before this interview; "I usually just say '3'; I was told that no doctor would ever know I had an abortion." Kathleen learned about the study through a mutual acquaintance; she was somewhat nervous and very talkative during our interviews.

Kathleen was 17 years old when she had the abortion. She was a senior in high school and had just started dating. As an adolescent, she was learning about relationships, sexual activity, and birth control, mostly from her girlfriends. She and her boyfriend had been together for about 4 months when the unintended pregnancy occurred.

I was in high school and in my first relationship; serious relationship with somebody. I was at his house and we were listening to music in his room, he went to the bathroom and came back naked. I'd never seen him naked before and I was like 'oh, my god'; then 2 weeks later we had sex. It was probably like in October I started dating and by March I was pregnant. I had girlfriends telling me what to use and what not to use; I was just playing Russian roulette with birth control.

Kathleen suspected she was pregnant when she missed her menstrual cycle and began experiencing nausea and vomiting. She feared that her parents would discover that she was pregnant, so Kathleen made up excuses for her morning sickness, blaming the vomiting on

illness and over consumption of alcoholic beverages. When her mother directly asked her if she was pregnant, she said “no”.

I skipped my period. I was throwing up and my mom’s like, ‘are you pregnant?’, and I said ‘no’, ‘I was out at a party’ or ‘I just don’t feel good’, and she’s like ‘you didn’t have your period, are you pregnant?’ and I said ‘no’.

Kathleen was scared that her strict, pro-life parents would find out about the unintended pregnancy. As the only girl and the oldest child, Kathleen was always getting into trouble; she was grounded by her parents when her brothers were not. She did not want to confront her parents; she handled the unintended pregnancy situation by herself.

I was deathly afraid of my parents even knowing; my parents were very strict. I was the oldest child and I was a girl and always got in trouble. I always got grounded and I always got in trouble and my brothers didn’t; I just didn’t want to confront them about anything, any of my troubles so I just tried to take care of the pregnancy myself.

In trying to decide what to do about the unintended pregnancy, Kathleen read the bible searching for answers.

I read the whole bible when I was going though that, trying to find the answer in the bible. ‘What should I do?’ I was so mixed up; 17 years old, with no going to church, no listening to sermons.

Kathleen was upset with herself. She did not want to be pregnant and her boyfriend, the father, was already dating somebody else. He did not break up with Kathleen, just simply started dating another girl. Kathleen told him about the pregnancy and he laughed at her, accusing her of trying to get him back as a boyfriend. She assured him that she was serious.

I was just upset with myself; I didn’t want to have a baby and he was already dating somebody else. He didn’t really break it off with me, he just started dating somebody else and I heard about it. I went to tell him and he basically laughed in my face and said ‘you’re just trying to get me back’, and I said ‘no, I’m serious’. I was totally serious.

Kathleen was alone. Her boyfriend of several months had left her for another girl; she was afraid to tell her parents. She did not want to have a child; she felt a child would ruin her plans of going to college in the fall. Kathleen wanted to continue with her life plan.

He left me with the responsibility of it all; he left me in that situation. I didn't have a boyfriend, I didn't have a partner; I felt on my own. I didn't tell my mom or dad. I didn't want to ruin my life. I was planning on going to the university that next fall and I was signed up and ready to go. I just didn't want to upset my whole life plan.

One of Kathleen's girlfriends at school told her she had had an abortion. Kathleen didn't realize that her friend had ever been pregnant; she explained how to contact the clinic in the city. Together they made an appointment and drove about an hour to the reproductive health clinic. The staff at the reproductive health clinic counseled Kathleen about her options; she had already decided on abortion. Since Kathleen was under 18 years of age, the reproductive health clinic provided an advocate for Kathleen to assist her through judicial bypass, the process by which she could obtain permission for an abortion without her parents' knowledge. Kathleen remembered that the lady was helpful. When going to see the judge, Kathleen heard anti-abortion protestors calling her a "baby killer"; the advocate protected her and helped her move through the process. Kathleen had made her decision for abortion; she went into the court room to say that she was afraid to tell her parents. The judge granted her request for an abortion.

She helped me through the process. I'd already made my decision pretty much before I even got there. A judge had to okay it. I remember walking down the road and I heard people saying 'baby killer' and this lady said 'just ignore it, just keep going'; I didn't see any people around. She told me what to do and what steps to take. I think there was a scheduled time, but I don't remember all the details . . . 'just go in there and say you don't want to tell your parents' and then you went and did it and they said 'okay'.



On the day of the scheduled abortion procedure Kathleen was ill. She stayed home and rescheduled the abortion for the next week. The next week when she went to the abortion clinic, they told her she was almost past the first trimester, almost too far along in the pregnancy for the abortion. Kathleen felt awful.

All I remember is when I went to go get the abortion, the day I was gonna get it, I got a really bad cold so I called 'em and said I was sick. I couldn't go when I was sick, so then I stayed home and I went the next week. When I got the abortion the baby was almost past due the time it was supposed to be aborted they told me; I felt bad.

Kathleen remembered little about the actual abortion procedure except for the suction machine. She was awake and aware of what was going on but did not watch. Kathleen has blocked much of that day out of her mind. The surgical abortion procedure was done at a reproductive clinic in a large metropolitan area in the Midwest.

It was all a blur, scary; just go through the process. I remember a machine, I just blanked it out 'cause I didn't want to watch; you didn't have to watch. You were awake and aware. I just remember a machine being there and that's all I remember, I don't remember a lot.

Kathleen does not remember spending much time with the nurses or doctor. After the abortion Kathleen stayed a "little bit, and went home. I don't remember how long". She doesn't recall much discomfort or needing to take any medications. Kathleen's girlfriend went with her on the day of the abortion and paid for the abortion. At age 17, Kathleen earned money babysitting, about \$200 per month during the summer. Kathleen's girlfriend took money out of her bank account; when her parents found out that several hundred dollars had been withdrawn, they accused her of having an abortion. Kathleen's girlfriend made up an excuse and put money back into the account later that summer when Kathleen could repay her.

My girlfriend had money in her bank account and then I paid her back when I got my summer job. Her parents accused her of having an abortion, 'where'd the money go?' They were watchin' and she just kinda flubbed it up; she always figured out a way to flub it up on her parents.

Kathleen went for a follow up appointment and "everything was fine".

About a week after her abortion, Kathleen learned about fetal development when a girl at school gave her a pro-life pamphlet. Kathleen wondered why the reproductive health clinic had not shown her these pictures. Looking at pictures of a developing fetus made Kathleen question what she had done in having an abortion.

In school somebody must have told somebody and then one of the girls gave me a pamphlet of what a baby looked like. They didn't give me those things; they didn't talk about those things when I was pregnant, at the reproductive health clinic. You see a baby grow in your stomach at 7 weeks old and it's almost fully formed. The pictures made me think, 'what did I just do?'

In talking about her abortion experience, Kathleen at age 47 reflected on the circumstances of becoming sexually active and her decision for abortion 30 years ago. She felt influenced by her girlfriends later in high school to be sexually active. She compared these girlfriends to previous friends she had earlier in high school when she was a Girl Scout. Kathleen rationalized that if she hadn't hung around the girls she did she may not have become sexually active and therefore would not have experienced unintended pregnancy and abortion.

I felt some of those girls I knew from way back when I was in Girl Scouts, when I was younger, but I didn't hang around with them when I got older. So maybe it was the girls I hung around with when I got older that influenced me to do the sexual activities compared to the other girls.

In thinking about her first experiences with sexual activity, Kathleen feels that she was date raped by her high school boyfriend. She has tried to justify her participation in sexual intercourse.

After reading and thinking about it, I was date raped, he was a predator. I guess I have justified it, but I was an active participant and it takes two to tango, so I was part of it too, I made the decision.

Kathleen seems to vacillate between accepting responsibility for her participation in sexual activity and blaming her behavior on others and the circumstances in which she found herself. Perhaps she feels guilty and ashamed for her sexual activity, especially because of the occurrence of the unintended pregnancy and abortion. As Kathleen reflected on her sexual encounters as a teenager, she revealed that she believes that society had changed a lot since she was a teenager. Kathleen thinks adolescents learn more about sexual activity from the media than she did. She was sheltered from sexual activity; her parents did not teach her about sexuality.

Kids see more on TV, at younger ages, they grow up faster. They know what's going on in the world. I was sheltered from it. My parents protected me from all that stuff. Kids see it more. Schools teach and talk about things different.

Kathleen also believes that parents are more involved in their children's lives now and aware of their activities. Kathleen's parents were not involved in her life when she was 17 years old; they were focused on their own lives and did not question her actions. As long as she was quiet and unobtrusive she was considered well behaved and a good daughter.

It's different now with girls; parents are more active with their kids and involved with their lives more. They want to know more; they're asking questions like 'do you smoke?', 'do you drink?' My parents never asked me that stuff; they weren't involved in my life, they didn't know what I was doing. They were involved in their own lives; your kids are your kids, you behave, you do what you're supposed to do. It's like 'do what you're told' but then they don't watch you. I think parents are more watchful of their children's actions, behaviors.

In reflecting on her abortion 30 years ago, Kathleen feels that having a baby without being married is more accepted in society now. Kathleen believes that young girls who

continue the pregnancy are courageous, unlike her, who chose to have an abortion. She recognized that when she was 17, she felt having a child would have been difficult with no support from her boyfriend; judgement, condemnation, and potential disownment from her parents. With hindsight and 30 years of maturity and wisdom, Kathleen acknowledged that she could have continued the pregnancy, but was afraid and alone. She was unaware of the option of adoption, her mind was made up that she was going to have the abortion and go to college. In reflection, she now realizes that other young, unmarried women made the decision to continue an unintended pregnancy when she chose abortion. She rationalizes that the young women who continued the pregnancy without support struggled.

I look at people that don't get abortions, they have courage to do that, and then I feel like I don't and that's where you start feeling down on yourself; you get down on yourself for what you did. I look at girls that have courage to have the baby and give it up for adoption, but I didn't realize that at the time. I had it set in my mind that I was gonna have the abortion; adoption wasn't an option then. But now it's like hindsight, 20/20, and you kinda think about it and then you see other girls that got pregnant and had the baby out of wedlock, who didn't get married to the guy, they had to struggle through things.

Kathleen's words convey much controversy and contradiction. Young women who continued unintended pregnancies in 1982 struggled; Kathleen didn't want that life; she wanted to graduate from high school and go to college, she wanted to continue with her life plan. Her mind was made up to have the abortion; she could not entertain the idea of continuing the pregnancy to parent or to place the child for adoption. At the time, all she wanted to do was resolve the unintended pregnancy situation so she could get back to her life as a 17 year old high school senior. Kathleen now looks back and feels like she was a coward for having an abortion; she believes that a strong, courageous woman would have continued the pregnancy. Kathleen does not see herself as strong or courageous; she feels

disappointed with herself, that she was weak. Kathleen revisits her lack of options and blames not knowing about adoption as the reason why she had an abortion. She is conflicted and seems to really wish her life situation had been different. Perhaps she secretly wanted to continue the unintended pregnancy but isn't able to verbalize these sentiments. It may be possible that if Kathleen had had support from her boyfriend or if she hadn't been afraid to tell her parents, she might have felt she had options and could have made a decision other than abortion. The responsibility for becoming sexually active, which resulted in the unintended pregnancy and necessitated the decision for abortion, seems to weigh heavily on Kathleen.

After graduating from high school Kathleen attended the state university for about 2 years. She did not date much in college; Kathleen felt she had learned her lesson about sexual activity in high school, when she thought everyone was having sex. She justified being sexually active at age 17 because she knew of girls who were also sexually active despite being much younger than she. She again reflects on the consequence of being sexually active, the occurrence of the unintended pregnancy, and the lifelong impact of making the decision for abortion.

I kinda learned my lesson with sexual activity early. In college I wasn't that promiscuous; probably when I was 17 I thought that's what everybody else does at 17, I knew there were younger girls. You're stuck with that responsibility, that decision for a long time.

During her time at college, Kathleen's father asked if she was going to participate in an anti-abortion rally. Kathleen was shocked; she could not imagine protesting against abortion after she'd terminated the unintended pregnancy in high school. After talking with her father she understood his pro-life perspective. Kathleen felt her father would see her as a hypocrite for attending an anti-abortion rally after having an abortion. From his words,

Kathleen concluded that he would have wanted her to continue the unintended pregnancy and have the child.

When I was at college my dad said, ‘why aren’t you down at the union?’ and I’m like ‘why?’, and he said ‘there’s a big anti-abortion rally going on’, and I thought ‘why would I want to be there?’ It was like, ‘oh God, I don’t want to do that’. I don’t want to go and be an advocate, rally for stuff like that. He’d probably see me as a hypocrite, but I knew where he stood about abortion then. He probably would have stood behind me and said ‘you’re having this baby and you’re dealing with it’.

At age 18, just a year after her abortion, Kathleen was still very much afraid of her parents, especially her father, finding out about the unintended pregnancy and her abortion. She felt her father would consider her a hypocrite for having an abortion and being involved with a pro-life rally. Kathleen’s words are unclear and somewhat confusing when she suggests her father would have “stood behind” her. This seems to be suggesting that her father would have made her continue the unintended pregnancy. Her words do not seem to convey that her father would have supported her in her decision for abortion. It is possible that Kathleen is conflicted about acceptance and love from her parents, their beliefs, and her decision for abortion. Kathleen seems to have secretly wanted to have continued the unintended pregnancy and had the child. She was afraid to tell her parents, yet in this passage she seems to look back and feel that they would have made her do what she really wanted to do – keep the child. Kathleen made the decision for the abortion within the circumstances of her life at age 17; she was afraid of her strict, pro-life parents, she felt pressured into sexual activity by peer pressure from girlfriends and her first boyfriend, she lacked knowledge about human sexuality, birth control, and fetal development; her only income came from babysitting during the summer months; she was planning to go to college; yet after she had the abortion procedure she seems to second guess her decision based on new

information over time and perspective gained with mature; as she learned about fetal development, considered acceptance and support from her parents, didn't attend college as she anticipated, as her life unfolded differently than she had planned.

After about 2 years of attending college, Kathleen returned to her hometown. She got a job and met the man who would become her husband. At age 25 when she became pregnant Kathleen compared her life circumstances at the time of that pregnancy with those of the unintended pregnancy at age 17. Her husband was laid off from his job and they didn't have health insurance. Kathleen was scared, but knew she could continue the pregnancy because she had a partner; when she had her abortion in high school she did not have a supportive boyfriend.

When I was married, my husband was laid off from his job and I got pregnant. We didn't have insurance and it was scary; the first pregnancy with my husband, marriage was scary. He was laid off from his job and it was pretty scary. It's like you can go through a lot of scary things and still make it through a pregnancy because I had a partner. With the abortion I didn't have a boyfriend, I didn't have a partner; he wasn't supportive of anything I did.

While working in her hometown, Kathleen ended up working with the sister of her high school boyfriend, the male involved with the unintended pregnancy that Kathleen aborted. His sister told her that several other girls who had been sexually active with her brother had also experienced unintended pregnancies and abortions. Kathleen was very angry. She expressed her frustration and rage at his behavior and lack of responsibility; she again referred to the occurrence of sexual activity as date rape, negating the girl's role in sexual activity or the possibility of consensual sexual intercourse.

I found out later from his sister who worked with me, this is her brother that I had the abortion with; he had done it to 5 other girls, so how many did he do after me or before? I was really mad. I was mad at the 5 other girls that got raped, or raped like that and murdered a baby, it's just sick.

Kathleen's high school boyfriend became a successful realtor in her hometown. She would see his picture on billboards and bus stop signs. She was angry; he was successful. Kathleen did not want to be around a man who abandoned her when she needed him; a man who didn't care about her. When Kathleen's husband had a job opportunity in a neighboring state, they moved. Kathleen did not want to be around the man who had abandoned her in high school to handle the unintended pregnancy on her own.

I moved because I'd see his picture all over the place; he was in real estate. He's doing well; his business and he was married and had 3 boys and he lived next door to one of my friends. I heard about stuff that he did and I just don't want to hear it anymore. My husband got an opportunity; I moved from my hometown because I just did not want to be around him anymore. Every time you see his picture on the billboard or on the bus stop or wherever, I, 'oohh', see him in the parade, I'm like, 'oohh' . . . hurts . . . you shudder, you just don't want to be around somebody that didn't care.

Kathleen's high school boyfriend continued on with his life, unaffected by the occurrence of the unintended pregnancy and abortion which seem to have affected Kathleen so deeply. Kathleen has continued to relive the experiences and be angry about having to deal with the situation alone. After 30 years she continues to struggle to negotiate and internalize the decision for abortion that she felt she needed to make when she was 17 years old. She seems to constantly reevaluate her abortion decision in light of additional knowledge and new perspectives; it is possible that Kathleen has never been able to accept herself and the decision she made for abortion when she was 17 years old.

Kathleen described her relationship with her husband as abusive. She went to a domestic violence rally once; she voiced rage at gender inequity.

I was in an abusive relationship with my husband when I was married and I went to a domestic violence rally, and I'm like 'this could get nasty'. Domestic abuse is something that's controversial, I think. Women want to say they're beaten and then the men say 'I didn't do it', so it's always against women; men just do whatever they want and they get away with it.



After Kathleen and her husband got divorced, she became pregnant by another man and had a son; they did not get married. Kathleen verbalized that she went from one bad situation to another, “went from one frying pan to the next”. Kathleen battles with her ex-husband and ex-boyfriend through the judicial system for child support. To avoid paying child support, these ex-partners do not work; Kathleen is angry and frustrated. She believes she would have been fighting with her high school boyfriend for child support too if she had continued that unintended pregnancy and had a child.

Through the court system I fight with my husband and ex-boyfriend now for support. So it’s just a constant battle with the court systems. So the men just don’t work; they don’t work so they don’t have to pay child support, it’s pretty sad. I would have been fightin’ for 18 years with the guy to get any support.

Kathleen is currently embroiled in a custody battle over her 10 year old son. Since she was not married to his father, they had nothing in writing. One day her ex-boyfriend picked her son up from school and took him; she has had limited contact with him since then. As Kathleen talked about the court battles for her children she sighed and said “I sometimes feel like I’m being punished for the stuff I did before . . . the huge mistake I made, the mistake of having the abortion.”

Kathleen continues to be aware of gender inequity when an unintended pregnancy occurs. She recently heard a story on the news about a young woman who was being kicked out of school for getting pregnant, while no action is being taken against the male partner. She voiced anger and frustration at men, rage at society for always holding the woman accountable for the unintended pregnancy while the man takes no responsibility for a sexual act in which both participated. Kathleen feels there should be consequences for men, not just women.

What did I see on the news or on the internet? Some girl can't go to school because she's pregnant. They were gonna kick her out, why don't they kick the guy out too? It's always the responsibility on the woman; that makes me angry. If they're gonna come at the woman for getting pregnant, they should go after the guys for having sex with girls. It's not just the woman's problem; it's also the man's. The boys need to be aware, care about these women that do get pregnant. It's not just the woman that has to deal with it. I think they should have said 'who's the guy?' and drag him in there. It's not just girls having babies, it's the boys doing the stuff that they're doing and they think it's okay.

Kathleen continues to believe that abortion should be legal. Despite her thoughts that everyone has a right to choose, she would not and did not terminate another unintended pregnancy. She does not feel that abortion was the correct decision for her; she feels that she was not aware of the long term emotional consequences. Kathleen blames her own fear and cowardice; she encouraged other women to not use fear when solving the dilemma of an unintended pregnancy.

I think everybody should have a choice, but you have to know the consequences and how it's gonna affect your life. And you don't know until you do it. I would say I wouldn't do it, I wouldn't recommend doing it. I would talk to my family instead of hiding away from it. But I was scared; don't use fear as a way to solve your problems. I'm still emotional about it in some ways; that doesn't go away.

Kathleen's perspective on her abortion experience has been influenced by her Christian beliefs. Comments on Christian radio programs make her feel bad about her decision for abortion. Kathleen felt she had a choice; she wants understanding and acceptance for who she is as a person, as a woman who has had an abortion. She finds Christianity to be judgemental instead of accepting. She would like to be able to talk about her abortion experience with Christian people, with her pastor, but she is afraid. Kathleen is afraid of being judged and condemned by the same people from whom she seeks acceptance and understanding; she still feels alone. Kathleen is searching for qualities of acceptance and

understanding in her spiritual life and a religious organization; she wants to experience a sense of belonging.

I'm listening to the Christian radio and they start saying abortion's murder and it makes you feel bad, 'cause I am Christian, but you also have a choice, you do. On the Christian radio they talk about abortion; they don't know my decision; they don't know my feelings about my abortion. They're saying that they're against abortion; all they talk about is how bad it is to have an abortion. I was listening to that radio station thinking 'really?', 'cause I'm forgiven. They're one sided about abortion. If you're Christian you should be accepting and they're not accepting. So that gets you sad. So you don't even want to call them and talk to them. You don't want to go to your clergy, you don't want to go anywhere 'cause you're scared to go talk to them. So you don't have anybody to talk to. It's like you can't belong to anything; you can't belong to a church because of their beliefs and you can't belong to a group because of their beliefs.

Just as Kathleen struggles to find understanding and acceptance from religion, she also feels displaced politically because of being a woman who has had an abortion. Since abortion has become such a political issue, Kathleen wrestles with voting for a candidate that represents her views and opinions. She often feels she's picking a candidate based on their stance on abortion instead of being able to consider all the characteristics and qualities of the person. Kathleen struggles to feel connected to a specific political party and fears feeling disliked because she has had an abortion.

It's like the politics too. One doesn't want abortion, one's pro-choice and you pick because of that? You're picking a candidate because of their opinion, and sometimes you have to go against your opinion 'cause you like other qualities about them, so it's hard. It is a lot, trying to decide who you're gonna vote for or what group you're gonna be in because you might be ostracized because of one thing you did.

Fear has prevented Kathleen from talking about her abortion experience. The topic of abortion is controversial for Kathleen; she needs to feel comfortable and safe in deciding to tell her story. It is difficult for Kathleen to know who to trust with her secret. She considers her abortion experience to be private.

It's private. Abortion is a hard subject to talk about 'cause it's a controversial thing. Some people like it, some people think its okay, and some people don't. And you don't know who to trust. I didn't want to tell my parents. When you start telling everybody about it you don't know who you told, it's like a lie. You don't know who you told and who you didn't, so then you just assume everybody knows. I think it's private; abortion is something that you can decide to tell people or you don't have to.

Five years ago, when Kathleen and her current boyfriend started dating, she found out that he had been involved with an unintended pregnancy and has a daughter. In the conversation, Kathleen told him about her unintended pregnancy in high school. Her words seem to indicate that his girlfriend made a better decision by continuing her unintended pregnancy than Kathleen did in making her decision for abortion.

I told my boyfriend about the abortion when we started dating; it was hard. I found out that he had a baby girl and then I told him. I said 'it could be worse, you could've had an abortion; at least you know you had a daughter somewhere'.

In disclosing her abortion experience, Kathleen questioned her decision for abortion. While talking to her boyfriend about his ex-girlfriend's decision to continue her unintended pregnancy, Kathleen apologized for not continuing her unintended pregnancy. Kathleen expressed guilt and sadness of not knowing the child she aborted. She has forgiven herself for having an abortion and hopes to meet that child someday in heaven.

I coulda gave her up and then wondered and seen her some other time. It's been 30 years and I don't know if my unintended pregnancy was a boy or girl, I just wonder; it's the choice I made. I've forgiven myself. You have to forgive yourself. It takes a long time to forgive yourself for something that, for having an abortion. I can't wait to see that baby someday; I'm waiting to see that baby 'cause I'm sorry (crying). I'm sorry I did it, I'm sorry I had an abortion 'cause I love babies; if I would have known I would never.

Kathleen's final words in this passage seem to imply guilt and remorse. It's possible that she is referring to the long term emotional consequences that she feels she has endured because of her decision for abortion. Perhaps if Kathleen had known about the conflicted

feelings, the guilt, shame, and embarrassment, she would associate with having an abortion, then she wouldn't have made that decision. Kathleen's words and their meaning are unclear.

Fear, guilt, shame, embarrassment, and judgement have kept Kathleen from talking about her abortion experience during the past 30 years, since she was 17 years old. She has not told her 18 year old daughter about her abortion; she worries mostly about her sexual activity. Kathleen does not want to talk about her abortion with her daughter because she views her abortion as a negative reflection on her own person; she wants to do positive things with her daughter. The need to be positive with her daughter is particularly important now as she vies with her ex-husband over who is the better parent.

I didn't tell my daughter about my personal abortion, I think it's a choice, and I didn't want to talk about it. Her sexual activity is what I worry about. I don't like to bring the abortion up 'cause it brings up problems and then she starts thinking negative things and I just want to try to do positive things with her. She lives with her dad; she chose that about 2 years ago. It's been a war with him over who's the better parent, and who can give 'em more, it's just a contest all the time.

Two weeks prior to our first interview, Kathleen learned that her ex-husband had told their two children, a 21 year old son and 18 year old daughter, about Kathleen's abortion. Her daughter was angry and called Kathleen derogatory names. Kathleen's fears of condemnation and judgement from her own daughter came true. Kathleen feels that her ex-husband told their children out of spite, to make her look like a less than ideal mother. She is hurt and angry. Her abortion was a private matter and she should have been able to decide if and when to tell her children. Now she worries if she should tell her parents; she fears that they may already know about the abortion.

Two weeks prior to me meeting you I found out my kids found out about the abortion through my ex-husband. He told 'em. My daughter was mad at me; she's 18 years old and she calls me a cunt whore, she was just really nasty. I called my older son who's 21; he goes 'yeah, dad told us'. It really hurt me, I

was so angry. He's probably doing it out of anger and being mean to me. That's the vilest thing I've ever heard anybody do to anybody. It's my private life, and that was my private decision and everybody has a choice; it makes me mad. I wasn't ready to tell 'em I guess, and maybe when my husband told 'em they needed to hear it, but I don't think they needed to hear it as an evil thing, like 'mom's bad, she had that done'. I haven't even told my mom or dad, should I tell them now that I know my kids know? It's gonna come out some day.

Kathleen's abortion experience has recently surfaced into her present life, despite her desire and efforts to keep her experiences quiet and secretly tucked into her past. As she tries to accept herself and her decision for abortion, she is constantly made to feel bad through political campaigns, pro-life advertisements, Christian radio talk, and her daughter telling her she is a bad person. Kathleen is conflicted and emotional about her abortion experience. What a difficult place for Kathleen to be at in her life.

### **Rebecca**

Rebecca is a 53 year old Caucasian woman with a German heritage. She is a progressive Catholic and has been married for 23 years. Rebecca and her husband have two children, a 21 year old daughter and an 18 year old son; they live in a suburb of a large metropolitan area in the Midwest. Rebecca took a few graduate courses after completing a BS degree. She currently works part time on a local school board for a quarterly stipend of about \$1000; her husband is an attorney and the primary financial support for their family.

Rebecca had an abortion in 1984 when she was 24 years old. She was working in sales and receiving commissions, totaling about \$40,000 annually. Rebecca and her boyfriend had been dating for about half a year.

We were dating, we were a couple, and we were probably together for 6 months or maybe 8 months, I don't know if it was that long. For me it was just a relationship of convenience. I hate to say that, but at the time I wasn't madly in love and probably shouldn't have been in the relationship, but anyways, that's what it was. At the time it worked for some reason.

Rebecca suspected the unintended pregnancy when her breasts became tender and increased in size; her menstrual cycle was late. Suspecting she might be pregnant, Rebecca knew almost immediately that she would terminate the unintended pregnancy. She went to a local reproductive health clinic and talked with a counselor. This visit was emotional for Rebecca as she talked with the counselor about her sister who had recently continued an unintended pregnancy and had a child after much contemplation. Rebecca was sure she wanted to have an abortion; the clinic referred her to a private physician's office.

I went to the doctor right away 'cause I knew that if I wanted an abortion it had to happen soon, in the first trimester. I went to a reproductive health clinic actually and they were really good, they did the exam and confirmed it. I remember talking to a counselor there and we talked about my sister just having her baby, but I wanted to have an abortion. It was difficult for me to talk about it, it was emotional, but I was sure that's what I wanted to do. I started to cry and she said 'are you sure this is what you want to do?', and I said 'yes, I am', and she said 'okay, I think this is something you should maybe do' and she gave me a referral and sent me to a doctor. I was offered sedation and I took it. I remember that they were nice and they were respectful

Confirmation of the unintended pregnancy caused Rebecca to reflect on her relationship with her boyfriend. She wanted an abortion and realized that the relationship was not the right one for her for the rest of her life. She did not feel she could count on him; she recalled his immaturity.

I wanted an abortion because I knew I didn't want to be with him. Things became clear to me at that point, when I found out I was pregnant; all of a sudden you realize where you are and what your relationship is and you see it more clearly. I just knew he wasn't a guy I wanted to be with long term; I didn't really want to be a part of his life or have him be a part of my life forever. I didn't feel like I could count on him; he was really immature in a lot of ways.

Rebecca talked with her boyfriend about the unintended pregnancy and her desire for abortion. She does not recall the exact conversation, but remembers he was not upset by her

decision and seemed relieved. She did not feel he was ready for a commitment or the responsibility of a child.

I did tell him about it, but I don't remember the conversation specifically. He seemed to be okay with the whole idea; he didn't seem too torn up about the whole deal. I don't think he was ready for a commitment either, he didn't seem too upset. I wanted to have an abortion and I don't think he was ready for responsibility. I think he was probably relieved.

Rebecca felt like she would be alone in raising a child if she continued the unintended pregnancy. She would have been financially, physically, and emotionally responsible for the child by herself and she didn't feel prepared for parenthood at that time. She wanted to work for awhile or go back to school. She could not envision herself marrying her boyfriend and she couldn't see herself raising a child by herself. Rebecca considered adoption, but didn't feel capable of continuing the pregnancy and giving the baby to someone else.

I didn't think he would be there for me or for our child. I felt like I was going to be handling this by myself if I did have a child. I would have 90 percent of the responsibility and financially I couldn't see that really happening. I guess I felt like I wasn't ready for the responsibility or for the financial responsibility, I mean the whole deal, the whole package. I had other goals; I wanted to work for awhile and possibly go back to school and I wasn't going to marry him. I just didn't see myself raising a child by myself; that was not an option in my mind. And giving it up was . . . I thought about it, but I really didn't feel like I was capable of doing that. I just thought once I had the child I would feel like I couldn't let it go and so I didn't feel like I could emotionally handle having a child and then giving it to someone else. Adoption didn't seem like an option to me, it seemed too hard.

Rebecca's boyfriend accompanied her to the doctor's office for the abortion procedure. She was sedated for the procedure and had few memories of the actual day or procedure. She remembered having to insert something into her vagina the evening before the procedure to soften her cervix. The doctor told her a joke prior to administering sedation medication; they used suction for the abortion procedure and Rebecca had some cramps. She and her boyfriend split the cost of the abortion.



He did go with me to the doctor's office, once I had the actual procedure scheduled. I think he was with me through the procedure, or waited for me in the waiting room. I do remember parts of it, so I don't think I was completely sedated. I had to put something in my vagina to soften my cervix the day before or night before. They used suction and I remember having some cramps, but nothing that bad; it was sedated cramps. I don't know if my memory is completely accurate about it either . . . it's a long time ago, like 30 years. I remember the doctor or the anesthesiologist telling me a joke before I went under so I must have been sedated. My boyfriend offered to pay for half of it or something; I think we split the cost.

After the abortion procedure, Rebecca felt nauseated, especially during the car ride home. She felt relieved that the abortion was done and grateful that everyone at the clinic was respectful and nice. Abortion was the right decision for Rebecca; she did what she needed to do and has no regrets.

After the abortion, I remember waking up and everyone was very nice. I was very nauseous from the anesthesia and so I just remember going home and being nauseous in the car. It wasn't traumatic really, everyone was respectful and that was nice. It wasn't a huge ordeal; I felt relieved afterwards. I really felt like this was the right decision for me at that time. I felt like I needed to do this and this was the right thing for me and I didn't regret it. I don't have regrets.

Rebecca was sure of her decision for abortion. She felt a slight sense of loss one morning upon waking, about a year after her abortion. She didn't understand the feelings, which didn't last long. Rebecca separated her abortion from the rest of her life, isolating her experience.

I do remember one time waking up about 9 months or a year later. It was kinda weird and at the time I didn't really calculate it 'cause I think I was a little afraid to go there. I woke up one morning and I did feel sad; it was kinda weird, it was like why today? Why do I feel like this today? That was the only day, the only time that I really felt like there was some loss there. Other than that time, I think I compartmentalized the abortion experience pretty well, in a way. I didn't feel a huge sense of loss. I felt like I did what I needed to do and I wasn't gonna judge it.

Later in her life, Rebecca may have wondered at times if the abortion was the right decision, but not to the point of wishing she hadn't done it. She did not judge herself for her decision. She questioned whether abortion really was such a horrible thing and whether there was really any need for forgiveness from God.

I think later on in my life I may have wondered if I did the right thing, but not to the point of wishing I hadn't had the abortion. I mean praying about it and asking God for forgiveness, if abortion was a horrible thing, then I apologize. I don't really understand that abortion was a horrible thing, but if it was, I guess in that respect I probably sought some kind of forgiveness.

While Rebecca did not specify a particular time when she questioned the morality of her abortion decision, it is possible that the changes in the sociopolitical climate over the past thirty years have influenced Rebecca's reflection on her abortion decision, perhaps imposing guilt and uncertainty, neither of which she expressed at the time of the actual abortion procedure. Rebecca reflected upon her abortion experience when she was pregnant with her daughter. She thought she might feel a sense of loss around the abortion, but she did not.

I guess there were a couple times in my life where I've thought about the abortion; maybe processed it is a better way to describe it. Like when my daughter was born, I remember being nervous about having her and wondering if I was going to then feel the loss from my first abortion, from that first pregnancy, but I didn't. I felt glad about that just because all these powerful things, emotional things you just don't know. I think sometimes 'where's it gonna take you?', but I was fine after I had her and so it wasn't ever a big deal.

Rebecca has read about other women's abortion experiences and believes a lot of women's stories that are shared publicly are politically motivated, especially stories of regret, remorse, and grief. She did not experience these emotions.

I've read a lot about other people's abortion stories and sometimes I think a lot of it's politically motivated actually; that these women have this terrible grieving and loss and they regret it forever. I never felt like that and I'm glad I didn't.

Rebecca has processed what having an abortion has meant to her. She realized her boyfriend was not the kind of person with whom she wanted lifelong ties. She believed staying in that relationship and/or having the child would have altered her life dramatically in negative ways. Rebecca sees her decision for abortion as a positive event in her life; she believes women have the right to choose abortion.

I guess I was just trying to be open to processing the abortion experience. I thought it was a good decision. In retrospect he was not the kind of person I would have wanted to have lifelong ties with. I think it would have altered my life dramatically if I had stayed with him and kept the child or even kept the child and had that tie to him as a parent. It would have changed my life in negative ways, so for me, having the abortion was a positive thing that I did. I had control of my life. I think abortion is a very personal choice that can only be made by a woman, perhaps with input from others, but they don't get to decide. For me having the abortion was a very positive thing.

Rebecca did not talk with family members or friends at the time of the unintended pregnancy; only her boyfriend knew about her decision for abortion. At the time of the abortion, Rebecca did not live near her family, who were Catholic and pro-life. The distance and their religious beliefs prevented Rebecca from talking with them about the unintended pregnancy and abortion; she feared condemnation and rejection from family members.

I moved back to a large city in the Midwest within a year or so and my family never knew about the abortion, partially because they were Catholic. My parents were pro-life and I was nervous that they might disown me if they knew.

After moving closer to her family of origin, Rebecca told her sister about her abortion. Her sister had also experienced an unintended pregnancy, but after much thought and reflection had decided to have the child. Rebecca felt safe in disclosing her secret to her sister and was rewarded with empathy and understanding.

She's a beautician and she was cutting my hair and I told her. She's a very non-judgmental person and she believed in abortion rights even though she had had a baby herself. She got pregnant and wasn't planning on having kids

at all and was married; she really soul searched about what to do. She wasn't sure that she wanted to keep her baby and then she decided she did; that turned out to be a happy ending and they have a child and they love her to death and it's been wonderful. She was very understanding of my situation and that I was unmarried and I didn't want this relationship and she wasn't judgmental at all. I would not have told her if I thought there was any judgment in her heart towards me. She's been great; she's never said a word to anybody.

Rebecca didn't tell anyone else about her abortion experience until two years later when she met the man who would become her husband. She told him when they were dating and getting serious.

So, I didn't tell anyone. Nobody else knows really, but my sister and my husband. I told my husband when we were dating and getting serious, because I probably met him like 2 years later. I told him about the abortion and he was very non-judgmental about it and compassionate; I didn't feel judged at all. That was a good thing for us.

For over 30 years the only two people that knew about Rebecca's abortion were her sister and her husband, until the week before our first interview. While at lunch, Rebecca told two girlfriends about participating in the study and disclosed that she had had an abortion in college. She trusted her friends and felt safe in sharing her abortion story. To her surprise, one of her friends shared that she had also had an abortion in college. None of them had ever talked about their abortion experiences before.

So it's just my sister and my husband that knew about my abortion for 30 years. But then I told 2 friends at lunch last week that I was gonna be interviewing with you and that I'd had an abortion. I trust them both immensely and I knew I was safe with them. I said you're the only 2 people that know, besides my husband and my sister, and they laughed. And then my girlfriend said, 'well I had one too'. And it was like, 'wow'. None of us had ever talked about this before.

Rebecca felt unsettled by the fact that they had been friends for decades and had not been able to talk about their abortion experiences. She attributed their silence to the current sociopolitical climate and the moral battle that surrounds the topic of abortion. Rebecca feels

women who choose abortion have been demonized in the public view and treated harshly, unfairly.

It's crazy to not be able to speak about our abortions; that does bother me. I think abortion has just become such a political thing; a very manipulative tactic. Unfortunately there's a battle; abortion is an ideological battle, and I believe if my statistic is right that 30% of women have abortions; so I'm surprised that the political climate we live in is allowed to exist. I feel like there is a very harsh attitude towards these women, towards me; it's really sad that we're demonized. I think that's why abortion is not discussed.

In the conversation at lunch Rebecca identified that neither she nor her friend have told their children about their abortions. Rebecca has talked with her daughter and son about sexual activity and contraception; she has attempted to communicate to them that abortion is not murder or evil. She wants her children to understand that an unintended pregnancy involves difficult decisions; she wants them to protect themselves against ever being in this situation.

My friend said nobody knows; she said 'my kids don't know, of course'. She's given them the talk that she wants them to use birth control, as I do. I've had that talk with my kids as well, that I want them to use birth control if they're even thinking of having sex. I told them that I didn't think that abortion is murder, but I do think it's not a situation I would want anyone to have to be in to choose whether to have to have an abortion or to have a baby or to give one away. I said those are really, really difficult decisions and I wouldn't wish that on anyone. I wanted them to be intentional about when to have sex and having kids. I wanted them to protect themselves and I wanted them to know that I didn't think abortion was an evil thing.

Rebecca would consider telling her daughter about her abortion experience if her daughter experienced an unintended pregnancy. She feels her daughter would not be judgemental and that they could discuss the abortion. Rebecca would share her experience as a means of supporting her daughter through an unintended pregnancy situation.

I would probably consider telling my daughter if she had gotten pregnant or if she would get pregnant. She's the kind of person . . . she's fairly non-judgmental. I don't think she has any real negative opinions or beliefs about

abortion so I feel like it's something we could discuss; I feel like I could tell her and confide in her. Certainly if she was in that position I would share probably with her my experience and support her through it.

Rebecca would probably not share her abortion experience with her son out of fear of judgment for her decision. She feels he is young, immature, and influenced by pro-life religious beliefs. She might consider telling him about her abortion if he was involved with an unintended pregnancy.

My son is a little young. He's 18, but I don't think he'd be ready for this information. He's a kid that is more religious, he's more attuned to the rules of religion, and so I wouldn't maybe tell him just because I don't want to be judged by him. I'm not sure if he would judge me, but he might. So I probably wouldn't tell him, unless he was in a similar situation. I guess if he got into an unintended pregnancy situation, my abortion could become part of the conversation. I'm pretty honest with my kids; I'm quite open with them normally, but I guess I'd have to think about that.

Rebecca has not told her children about her abortion because they live in a conservative, religious community and she fears that knowledge of her abortion would be a burden for her children. She does not want her kids to feel judged for her actions; she also does not want them to have the burden of keeping her abortion a secret.

I haven't told them primarily because we live in a community that is pretty conservative and religious. I feel that it would have been a burden for them to know because I think that there are a lot of pro-life people here that wouldn't be accepting of that or that they would be judgmental and I wouldn't want them to feel judged. It's more the fear of them being judged or them being hurt by it. And I guess if I told them it might not, no one else might ever know, but I wouldn't want to give them that burden to keep my abortion secret either.

In some ways Rebecca sees the differences in her beliefs and those of her community as an opportunity for her son to be exposed to various religious views. She has tried to teach her children that she and her husband support women's reproductive rights, along with homosexual rights. Rebecca communicates her perspective in an indirect, non-personal

manner to protect herself and her children from criticism, judgement, and condemnation.

She wishes abortion was something she could talk about more openly, without fear.

I don't feel like I can speak about it openly without being condemned. Abortion is a huge issue in my community; that's what gets a lot of my son's friends to the polls, his friends' parents actually. They've had some influence on my son as well because he spends time at their homes. In a way it's nice that he can understand both our faith which is a lot more progressive and open-ended and holistic, and their faith which is a lot more rigid. I didn't realize that we moved into such a community like this, but there are a couple fundamentalist churches nearby. Abortion seems to be a huge issue with them, and then, of course, gay marriage is the other one; anti-gay marriage. I don't even think from what I've gathered in talking to some of the other parents that they are really aware of much else in terms of politics; domestic policy, foreign policy, it's really just those social issues. I think my children knowing about my abortion would have been really uncomfortable. I just wouldn't want to put them in a position that would be difficult to navigate. So we just say that we support abortion rights, we support the rights of women, we support gay marriage, but we don't really talk about our personal experience.

Rebecca supports and believes in the legality of abortion and keeping that freedom of choice for women. She feels strongly that women have the right to choose abortion and glad she had that option. She believes control over her own destiny, including when to have children, is a basic human right. Rebecca fears losing the freedom of choice, believes men cannot possibly understand an unintended pregnancy situation, and wishes women could talk openly about their abortion experiences.

I think it's a pretty important right (reproductive choice) for women to have and I'm glad that I had that right. I think it would have been a lot more devastating to me not to have the right and to be forced to carry that child to term that I did not want, and then have to deal with whether I was gonna raise that child or give it away. I think that is a lot crueler. I feel that we have the right to make those choices for ourselves and I'm glad that I could do that, I think it's a basic human right to control my own destiny. We can't control everything in our lives but I do think that is something that we have the right to control, whether we have children or not. I think women are at a huge disadvantage because men don't have to make this choice, they don't have the same consequences that we do. It's important to me to keep that freedom; I do give money to organizations supporting reproductive health services and I do

vote for choice at the polls. I think it would be awful if we went back to abortion not being legal; that's gonna be a horrible situation, a horrible mess if that right is taken away. I do wish abortion was something I could talk about more freely without fear of being condemned or ostracized.

Despite her strong beliefs in women's reproductive rights and her positive experience of abortion, Rebecca is unable to talk about her abortion to her family members, friends, or neighbors. The fear of condemnation and judgement from society and politics has imposed silence on Rebecca, robbing her of connection with others and a deeper intimacy in relationships. Her abortion remains a secret, one that she might consider telling only if someone was in a similar situation of experiencing an unintended pregnancy. She has not talked about her abortion experience as a means of having a conversation with friends, except for a disclosure and beginning dialogue prompted by her participation in this study. Rebecca was positive about her decision for abortion at the time the unintended pregnancy occurred; since 1984 she has been bombarded with societal, political, and religious messages that have caused her, on occasion, to reflect back on her abortion experience as something other than it was at the time. Rebecca believes that women should be valued and accepted for the decisions they make and for the life circumstances in which they find themselves when unintended pregnancies occur.

Throughout her life, Rebecca has been exposed at various times to situations that forced her to clarify her own thoughts and beliefs about abortion. Over time Rebecca's family of origin have relaxed their pro-life, Catholic views on abortion. Her mother, now 78 years old, has told Rebecca that she thinks abortion is a personal choice. Acknowledgement that abortion can be an acceptable option was completely opposite from the beliefs Rebecca learned from her parents while growing up.



Over time my family has gotten more pro-choice, even my mother, who is now 78 years old, has told me that she thinks abortion's a personal choice. And that was huge, that was a huge 180 degree turn.

Rebecca talked about attending a political caucus with her parents when she was in college in the Midwest, before her own abortion experience. Abortion was a big topic that year, causing contention as it came up for a vote in the caucus. Struggling to clarify her own beliefs about abortion, while avoiding a public confrontation and risking disapproval from her parents, Rebecca abstained instead of casting a tie breaking pro-choice vote.

When I was in college, before I even moved west, before I got pregnant, I went to a Democratic Farmer Laborer (DFL) Party caucus with my parents. They invited me to come because they thought I was politically interested and I was. That was the year that the Democratic platform went from pro-life to pro-choice 'cause they didn't have support to keep the pro-life initiative in their platform. I remember being at this caucus meeting and I guess there were 30 people there and they had a vote. We voted on different things on the platform and then they did abortion and people gave their views and opinions about whether they thought the platform should include choice or be pro-life. I remember they divided up the room; they said 'okay everybody who is pro-life go over here' and 'everybody who is pro-choice go over there', and I just sat in my seat and counted everybody. It turned out to be 15 and 15 and I was the deciding vote. My parents were in the pro-life group and it was very awkward. They asked me to choose and I said 'can I abstain' and they said 'yes', and so I said that I'm abstaining, so I just sat in my chair and the initiative failed. That was an awkward ride home with my parents, but at the time, when I was younger, I was pro-life probably in high school because they were, and then as I got to college, I realized that there are so many individual situations and you can't really walk in another person's shoes. At that point, I believed that abortion should be legal and safe. I had to make up my own mind and I did. I don't know if I was uncertain about what I believed or I just didn't have enough guts to walk over to the pro-choice section, so I abstained instead of directly opposing my parents because it was uncomfortable.

In college Rebecca took courses in child development and learned that 50% of pregnancies spontaneously abort before a woman ever realizes she is pregnant. For Rebecca, this information dispelled the perspective that life begins at conception.

I've taken classes in child development and I learned that it's about 50 percent of pregnancies are spontaneously aborted, most of the time even before a

woman knows that she's pregnant. For me that kind of dissolved the idea that life begins at conception. I believe that life and a soul come in at a later date. I don't know when, maybe it's during birth. I don't know when life begins exactly, but to me that whole idea gave me some comfort that life doesn't begin at conception.

Rebecca believes that, overall, the decision for abortion is not easily or thoughtlessly made. She encouraged other women experiencing an unintended pregnancy to listen to their own heart, follow their intuition, and do what's best for them. Rebecca advised other women to avoid letting others influence their decision. She does not regret her decision for abortion; Rebecca is glad the abortion process was respectful and not a traumatic experience for her. She hopes other women have similar experiences with abortion. Disrespectful treatment by abortion providers could make some women feel degraded and ashamed; Rebecca did not feel this way. She felt like she had the right to make her decision for abortion and that having an abortion was the right choice for her.

I would say that overall abortion is a difficult choice. You need to listen to your own heart and your own intuition and do what's best for you. Don't let anybody else tell you what's right for you because you know. I think we all know what's best for us. Have the courage to do what you need to do. I don't regret my decision; generally the abortion process was very respectful, I don't know if I could say positive, but respectful. I hope that women are treated respectfully. It wasn't a traumatic experience for me; I think that probably had a lot to do with it. If a doctor or obstetrician or nurse treats you as if abortion is a shameful thing, that's very degrading and I can see that it would have been a lot harder; it could have been a lot more shameful, but I didn't feel shamed. I felt like I had the right to have an abortion and that I did the right thing for me.

Rebecca believes that the shame and guilt that some women feel after having an abortion are imposed by society and politics. She does not feel ashamed and is glad she was treated with respect and dignity. She acknowledges that people are entitled to their own beliefs, but that we live in a country where we have freedom of religion, so others' beliefs should not be forced upon us. Rebecca did not experience judgemental attitudes during her

abortion experience; acceptance from others has eased her feelings about her abortion experience. She did the right thing in having an abortion and she wishes the sociopolitical climate was different so women could openly discuss their abortion experiences.

I don't think having an abortion is something to be ashamed of. I think it's a cultural thing where people want to shame you because they want you to do what they think is right. I think people have the right to believe whatever they want to believe about when life begins, but I don't think they have the right to legislate their religious beliefs on others. That's why we have freedom of religion and our Constitution. I think it's a wonderful thing because it allows everybody to practice their own religion, but to not force that on others. I didn't run into judgmental attitudes and I'm thankful for that 'cause it would have made it a lot harder, more emotional for me. I felt like I was doing the right thing. I wish things were different in our culture so that people could speak out a little bit more about these kinds of things.

Rebecca wishes she could speak more freely about her abortion experiences, especially with other women. Despite her desire to tell her abortion story, Rebecca has remained silent for over 3 decades. She has told only 2 people, her sister and her husband. Participation in the study prompted Rebecca to disclose her abortion experience to close, long time friends whom she trusted. Rebecca needs to feel safe in disclosing her abortion, she needs to feel confident that she will not be judged or condemned for her decision for abortion.

### **Barbara**

Barbara is a 58 year old Caucasian woman who works full time as a registered nurse at a large medical center in a Midwest city. She has completed a doctoral degree in nursing and earns about \$90,000 annually. Barbara was raised Methodist and associates with non-denominational Christianity. She does not identify with a particular ethnicity. Barbara is currently not involved in a relationship. She has been pregnant 4 times; she has two daughters ages 16 and 18, she has had two abortions.

Barbara was 24 years old when she had her first abortion in 1984. She had earned a Bachelor's of Science degree in nursing and was working two part-time jobs as a registered nurse in a large city on the west coast; one job on a medical/surgical unit in an acute care facility, and the other job at a home health care agency. She does not remember her specific income, but recalls that she was doing okay financially. Barbara was in a steady relationship and was very interested in continuing the relationship. She believes the unintended pregnancy occurred as a result of inconsistent use of her birth control method.

I was involved with a man and I was very interested in this person, and I just wasn't very smart about birth control. I had been on the birth control pills for a few months in the past but I didn't like them or something, so I had been using a diaphragm. I think what happened was that I just got lax in using it.

Barbara suspected that she might be pregnant when she missed her menstrual cycle. She went to a local pharmacy and bought a pregnancy test. Confirming the unintended pregnancy by herself was upsetting. Barbara didn't have any family members or close friends nearby, but she did confide in her mother, brother, and old friends about the unintended pregnancy situation.

I didn't really give the possibility of pregnancy a lot of thought until my period didn't show up. I lived kind of close to the marina section of town and I went to the local pharmacy down there and got a pregnancy test. It was very upsetting, buying a pregnancy test and then doing it and finding it positive and then 'what are you gonna do?' It was a hard period because I didn't really have any friends or family around. I think I told my mom, and I told an old friend; they were supportive. And then I told my best friend back in the Midwest, and she was supportive. I did have a brother nearby, I told him.

Barbara was afraid to tell her boyfriend about the unintended pregnancy; she suspected he would be angry and blame her. "I was scared 'cause I thought he would blame me for getting pregnant, because I shouldn't have gotten pregnant. I thought he would be very upset and angry; he wasn't ever very emotionally warm."

For about a week Barbara considered continuing the pregnancy and having a baby. She thought about how she would manage on her own. Faced with the reality that she was alone, without a commitment from her boyfriend, Barbara did not feel she could continue the unintended pregnancy.

At first I thought about, for about a week, I thought about 'well what if'. 'I don't really have to have the abortion, I could have a baby'. Having a baby just didn't seem like it was gonna be a realistic thing for me, 'cause there was only me. The person that got me pregnant wasn't really interested in getting married or even being fully committed to me as one person to one person. So, it didn't seem like I had a lot of options.

Once Barbara had made her decision for abortion, she contacted a reproductive health clinic. She functioned automatically and with little emotion as she made arrangements for the abortion procedure. Barbara recalled that the clinic wasn't overly busy or empty and that the clinic staff was acceptable. She doesn't remember many details about her first abortion.

As soon as I knew I wasn't going to complete the pregnancy then I was pretty step by step, mechanical almost. I just made the arrangements and followed through on them. I made an appointment with the clinic and a couple weeks later my procedure was scheduled. The clinic wasn't bad. I remember it being not overly busy, but it wasn't like I was the only one there. The people were okay, I don't remember too much about the first abortion procedure.

Barbara handled the unintended pregnancy and abortion by herself; she took the bus to her appointments and paid for the procedure. After the procedure she went back to the reproductive health clinic for a follow up visit. The clinician questioned Barbara about sexual activity and was surprised she had not resumed sexual intercourse despite being told to wait. Barbara followed directions and did what she was supposed to do.

I had the procedure on the scheduled day and then I had to go back for a follow-up appointment; the young woman said to me, 'well, have you had any intercourse since the abortion?', and I said 'no', and she said 'why not?', and I said, 'well, because you told me not to' and it was just sort of like 'okay'; I think she was shocked or surprised maybe that I didn't have sexual activity after the abortion. I pretty much did what people told me to do.

One difficult aspect of the abortion experience for Barbara was the time period between her decision-making and the actual abortion procedure; the waiting. Barbara was working as a nurse, but she didn't want others to know she was pregnant. Women who are pregnant should not be around certain patients whose illness or disease may cause birth defects for the fetus.

It was a difficult period between when I decided I wasn't going to have the baby and the actual abortion. I think that was the most difficult part because I was a nurse and I had a baby inside, but I didn't want to tell anybody I was pregnant so I didn't really want to tell people 'I can't take care of that patient or this patient or whatever'.

Additionally Barbara experienced fatigue and morning sickness while trying to maintain her full time employment as a nurse and keep the unintended pregnancy a secret. She would vomit on her way into work. She was so tired she would go directly to bed when she got home from work; she'd sleep until the next morning when she had to go back to work. The weeks of waiting for the abortion procedure were difficult for Barbara; she tried to take care of herself on her own.

I remember going to work . . . I worked at 7:00am . . . and just being really nauseated; I had morning sickness and I'd vomit on the sidewalk. That period between having the appointment and really having the abortion, that time was really the hardest, the secrecy about it. I was really fatigued. I would come home and go directly to bed and I'd sleep until the next day when I had to get up. It was a difficult waiting period; I just kind of took care of myself.

Barbara's second abortion occurred about a year later in the fall of 1985. She continued to live in a west coast state, but in a different town. She worked as a registered nurse at two jobs; one at a visiting nurse association and the other at a local university student health service. She did not experience any financial struggles. Barbara believes the unintended pregnancy occurred as a result of inconsistent use of the diaphragm.

I think probably I got pregnant 'cause I didn't use the diaphragm one time or something; I wasn't consistent. I was consistent when I thought it was a dangerous time (ovulation), and then I thought the times that I wasn't in danger of getting pregnant, then I might not use it every time.

Similar to her first experience with an unintended pregnancy, Barbara considered continuing the pregnancy and parenting. She thought perhaps she could raise a child by herself and vacillated between continuing the pregnancy and having the abortion.

That one too, I had toyed around with maybe carrying the pregnancy to term because I just thought, 'well maybe I can just do it on my own'. Having an abortion wasn't as quick a decision for me; I sort of went back and forth as to whether or not I was gonna have an abortion or not.

Barbara didn't tell the man involved with the unintended pregnancy as she was unsure of paternity. She was sexually active with more than one man when the unintended pregnancy occurred. Embarrassed and ashamed of being in the same situation, she told neither partner nor any friends or family members.

I ended up, again, not telling the person; I had two men in my life at that point and I wasn't sure who the father was so I didn't tell either one of them. I don't even think I told too many people, I was very embarrassed about having gotten pregnant again. I felt so bad that I just didn't. I don't know what those other people would have done really; I don't know what real help they could have given me. It was still gonna come down to my decision, and it was my responsibility basically.

Barbara was disappointed in herself; she criticized herself for the occurrence of the unintended pregnancy. She did not consider either male partner responsible or hold either one accountable. Having previous experience with an unintended pregnancy, she handled the situation alone.

Being in the same situation as I had previously, I kind of berated myself for making the same mistake again. I was disappointed in myself. The first time I was really surprised and shocked; the second time it was just like, 'Oh god'. I knew what was gonna happen from the previous experience so I just didn't tell anyone. I just took care of everything myself.

Barbara had a lot of uncertainty about having a second abortion. During the pre-abortion counseling process, she experienced a strange encounter. One of the clinic staff showed her pictures of animal fetuses and tried to minimize the impact of having an abortion. Barbara did not find this approach to abortion helpful; she considered the early pregnancy to be a baby.

I do remember from the second one that in the pre-procedure phase I had a counselor and she was showing me pictures of how a human fetus looks like this and it's not really too much different from a cow fetus and a sheep fetus. I always remember that as being kind of bizarre. I think it was so I would think of this as not really a baby, you know, it was a fetus just like any other kind of animal. I think she was trying to minimize the impact of it, but I felt it was a baby.

Barbara was really upset about having to go through the whole experience again. She had a lot more discomfort emotionally about having a second abortion. She attended several counseling sessions to clarify her decision for abortion. When she went in for the abortion procedure, however, she was crying so much that the doctor did not feel the abortion procedure should be done.

I had a lot more discomfort about having a second abortion. I was really upset about just having to go through the whole thing again and I remember that I had some counseling sessions. I went to the clinic and they hooked me up with a counselor to make sure that having an abortion was what I wanted to do. And I remember the first time I went to actually have the procedure, I was crying so much that the doctor said 'we're gonna wait on this 'cause this doesn't feel good' or whatever . . . I was just too emotional about it.

Barbara continued counseling sessions; she was really grieving but decided she was sure about having another abortion. The counselor told the doctor that Barbara might cry and react emotionally during the procedure, but that Barbara was certain of her decision for abortion.

I continued to have these sessions with this woman and eventually I knew that that's what I wanted to do, but I was really grieving; I was really sad about the



whole thing. And so she told the doctor that I was probably gonna cry but that I had made my decision and that it was okay to proceed. So then the procedure was done; the doctor was a woman doctor, she was nice; the procedure went fine.

Barbara did not return to the reproductive health clinic for any follow-up visits, but she did experience heavy vaginal bleeding a few weeks after the abortion. She was at work at the time and ended up going home. Once the left behind tissue was expelled from the uterus, the bleeding subsided and Barbara recovered; she did not seek medical care.

I don't remember going to follow-ups, but the thing I remember with that one is that a couple of weeks after it was all over I had a huge sort of residual hemorrhage of blood; I was at work at that time. I ended up going home just because all of a sudden I was expectorating a bunch of residual; birth tissue and clots. It stopped after a few hours; it was like it had to get expelled and then it was over and I was okay.

Barbara remained on the west coast for several years during which time she struggled emotionally with her abortion experiences. She felt guilty. She attended an abortion survivor's support group at a Catholic Church. She was comforted in learning that there were other women who had had as many or more abortions than she had experienced. She was surprised that they did not seem to feel guilty or ashamed.

I was in the same area for a number of years and I struggled with the issue for a number of years, into my mid 30s. I had a lot of guilt. I went to some sort of Catholic abortion survivor's group. I don't remember too much about it. I do remember there was this one woman who looked like she was maybe in her early 20s and by that time I was in my mid 30s. She had had 5 abortions, so I was like, 'wow'; I didn't feel so bad because I'd had 2. It wasn't really a very nice thing to think maybe, but I didn't feel so much alone 'cause other people had had abortions too, more abortions than me. She didn't see it as much of a problem; it didn't appear that she felt very guilty about it at all.

Barbara experienced periods of depression. When her mood would be blue and down, she would revisit her past abortion experiences and feel very guilty. Her abortions

troubled her for years; she felt bad about the circumstances of her life until she had her daughters.

I had a lot of problems with depression and when my mood would be bad then I would revisit my past. I would feel very guilty and the abortions were very troublesome for me for awhile, for a number of years. From the time that I had my abortions and up until, well actually until I had my children, I always felt bad about the whole thing.

Once when Barbara was struggling emotionally, she even had to contend with a coworker who referred to abortion as “baby killing”.

I remember at the clinic where I worked, at the university student health services, one of the nurses said ‘yeah, we do all our baby killing on Friday’ ‘cause they had an abortion service at the student health service on Fridays. That was always like, ‘wow’; that was a comment that’s stuck with me; it was a difficult time.

Barbara met her husband and got married. She never told him about her unintended pregnancies and abortions; perhaps because she felt too ashamed, embarrassed, and guilty. When she went to the hospital in labor with their first child, the admitting nurse asked Barbara about her obstetrical history. Barbara’s husband was sitting beside her when she explained that this was her third pregnancy and that she’d had 2 abortions. Disclosure of her secret at the time when she was preparing to give birth to her daughter was awkward. Barbara and her husband never spoke of the incident or her abortions; she thought he was surprised, but supportive.

When I went to have my older daughter at the hospital, and the nurse was admitting me, she wanted to know my pregnancy history, and my husband was sitting there with me and I hadn’t told him. So then it came out that I’d had these 2 abortions right at the time I was giving birth, that was kind of weird. We never really talked about it; he was surprised but supportive.

Barbara did not offer any explanations of how she perceived her husband as supportive; perhaps not judging her in public or condemning her for her abortion decisions was viewed

by Barbara as supportive. Interestingly they never discussed the incident or her abortion experiences again; there was unexpected disclosure of her abortions and then those life experiences returned to a hidden, secret place.

Barbara has never talked with anyone else about her abortion experiences. I asked Barbara whether she would ever tell her daughters, now ages 16 and 18, about her abortions. She indicated that she wouldn't tell them because of the emotional struggles she has experienced; the guilt, shame, and embarrassment. Barbara believes abortion should remain legal and accessible to women as a necessary option, but she is distressed by the emotional consequences she has suffered as a result of her abortion experiences.

I don't think I've told my daughters 'cause it's still something I'm not proud of. I've pushed my abortion experiences away; it was a very difficult time. I think abortion is very necessary and should be legal and easily accessible, but it's still an emotional nightmare.

Barbara at age 58 years reflected on her abortion experiences over 25 years ago during our conversations. She was glad that the services and choice of abortion was available to her when she experienced the unintended pregnancies. At the same time that Barbara made the choice for abortion, she also endured deep feelings of guilt, shame, and remorse for years after her abortions, making the decision for abortion and having the procedure a traumatic life experience for her. Barbara has felt bad for years and has only begun to come to terms with her choices in the past decade.

The experience wasn't horrible and I was very glad that the services were there. I'm very much a pro-choice person. I think absolutely there should be things in place for women to get abortions, absolutely, but at the same time, for me, having an abortion was a difficult thing; it was very traumatic to me for a lot of years. Only in the last decade or so have I been able to sort of come to terms with it and not feel so bad about the abortions. But I carried the guilt for many, many years after the abortions.

Barbara believes time and maturity have assisted her in gaining perspective about her abortion experiences. She doesn't feel so angry at herself; she accepts that she was young and lacking in knowledge about contraceptive use and effectiveness. She is learning to forgive herself, but still feels guilty about her abortions when she gets depressed.

I think it's time, and sort of getting older; you get more circumspect about what has happened. I don't feel so angry at myself 'cause I was stupid, 'cause I was young. I didn't know what the heck I was doing. You sort of forgive your lapses in judgment; you're just a young person and you don't know what you're doing half the time, so I think that more than anything else, just time and maturing has helped me sort of put the abortions behind me. As I've gotten older, I've had children, I've been married, I'm divorced, I don't really think that much about the abortions. If I do it's when I'm depressed and then I begin to feel guilty, especially if my mood is not very good.

As Barbara explained her change in perspective over the past 25 years, she encouraged other women to be forgiving of themselves for being human. She does not feel that anyone purposefully or willfully desires to experience an unintended pregnancy; accidents and mistakes happen.

Don't be too hard on yourself because I don't think anybody goes out of their way to get pregnant, to have an unplanned pregnancy; it's an accident. You just mess up a little bit and it really has huge consequences; but, it's like you didn't do it on purpose, so it's not like you're evil, you're just a normal person who screwed up a little.

Barbara supports women's rights for abortion. She is aware of the changes in political and social aspects of abortion, but avoids getting involved. Barbara considers her abortion experiences to be private and separate from the public debate about abortion. She believes public policy is separate from women's individual feelings about abortion, especially if abortion is to remain legal and accessible for women.

I've always sort of followed the abortion debate but I never really got emotionally involved with it. It was like my experience was my experience. My abortions didn't really affect my intellectual thoughts about what should or shouldn't happen. It's a public policy thing and I don't think you can

involve feelings. Having a discussion on abortion based on how somebody might feel wouldn't make sense. If women want the right for abortion, we can't be worried about how someone else might react to it; it's just a fact of life.

Barbara once saw anti-abortion protestors on the street with picket signs and pictures of fetuses. She doesn't understand why these people have the need to push their views and beliefs on others. Barbara believes that the decision for abortion is personal and private; that no one else should be able to force their beliefs and views on women. She wants freedom of choice for all women; women should at least have the right to decide when, where, and with whom to have children.

I remember seeing protestors on the street with picket signs with pictures of fetuses and I just don't understand those people. They call themselves pro-life, anti-abortion people, but to me it's their choice. If you get pregnant and you don't believe in abortion, then that's fine, that's your decision, but you shouldn't be forcing your beliefs on other people. It just seems common sense, talk about freedom, freedom, freedom; everyone should have the freedom to do what they want with their own bodies at least.

The current sociopolitical climate seems unpromising to Barbara. She fears the legality of abortion will be overturned and our country will return to a time when women died trying to control their reproductive health; a time when abortion and women were criminalized by men.

It's lookin' real bleak for everybody. Until we have to go through a very dark period and have all these horrible things happen to people before people wake up and see how abortion is necessary.

Barbara thinks law makers and politicians, especially men, should not be involved with the abortion debate. She believes there should be sanctions, such as fines and mandatory vasectomies, for men who disregard their duty in sexual activities and child rearing.

They should mind their own frickin' business. If they don't want to allow abortion then they should give a vasectomy to every father of every baby 'cause that person isn't responsible. Or they should fine them; hunt them down and make them pay. Abortion is just none of their business.

Barbara is angry that men are not held accountable for their actions and can avoid all responsibility when an unintended pregnancy occurs. She is irritated about gender inequality in the United States and believes pregnancy and child rearing would be valued if men could experience pregnancy and were more involved with parenting; men are often absent fathers and women do not receive the resources necessary for raising children on their own.

If men were carrying children maybe it would be different, but they shouldn't have any right to say what a woman does because they weren't responsible; they got the woman pregnant and they act like it's all the woman's fault. You have to have both people involved for the pregnancy to occur and there's no talk about any sort of retribution or punishment for the other half of the event. Generally the men aren't around or they don't want to be around, so it's all on the woman. Women aren't supported with child care and they don't get the stuff that they need to successfully raise children.

The political abortion debate became a real dilemma for Barbara during the summer when her 16 year old daughter experienced an unintended pregnancy shortly after her state's governor essentially made medical abortion, the safest means of terminating a pregnancy, illegal. Barbara assisted her daughter in arranging for a medical abortion in a neighboring state and helped her manage the medications and their effects.

She wanted a chemical abortion and she couldn't get it here in our state, so she went to a neighboring Midwestern state, to a reproductive health clinic in a large urban city. I was worried about her and tried to help her. She came back Sunday morning and she was sick for a couple days. I helped her; she had directions like 'take this at this time' and then you take this and then you wait and so I was there for her.

Barbara was surprised by how different her daughter's attitude was about having an abortion compared with her personal feelings. Her daughter did not seem upset; she called the unintended pregnancy a fetus, not a baby. Barbara was distressed that the unintended

pregnancy seemed like a mere inconvenience to her daughter instead of a major emotional trauma.

She called it a fetus; I was more upset than she was. The unintended pregnancy and abortion were more of an inconvenience for her; where for me it was more of an emotional event. I've never really ever been that kind of person; ever since I was a girl I wanted to have children. Abortion wasn't like that, for me it was very emotional.

Barbara was angry, especially with the young man who was involved with her daughter's unintended pregnancy. She wanted him to take responsibility, to pay for the abortion.

I don't know inwardly what she thinks, but I was angry. I read the riot act to the young man that was involved. I told him 'you have to take responsibility' and 'you're gonna have to pay for half of this'; I was like momma tiger. I haven't gotten a dime from him, but he's a young kid too.

Barbara hopes her daughter does not suffer emotional trauma from her abortion experience like she did for so many years. She was surprised that her daughter wasn't very upset. Mostly her daughter seemed inconvenienced and anxious to get back to her life as a high school sophomore.

I just hope that she doesn't have any problems from the abortion; emotional problems from it, like the ones I had. So far she doesn't seem to be exhibiting anything like that and she didn't really cry about it or anything. I noticed that she didn't seem to be very upset. The unintended pregnancy was just an inconvenient sort of couple few weeks; she was nauseated, she couldn't eat anything, she was having early pregnancy signs and she was vomiting.

Barbara recognized that the time between confirming the unintended pregnancy and actually having the abortion procedure was difficult for her daughter; just as the waiting had been challenging for her.

It was hard because she found out right away and then there's a waiting period before you actually have the procedure. So, again, that period between making a decision, knowing what you're gonna do, and then actually having the procedure done is the toughest.

Barbara's daughter was open about the occurrence of the unintended pregnancy and her desire for abortion. She talked with Barbara and her older sister. Barbara thinks she told her daughter about her own abortion experiences, but does not recall a specific conversation. She disclosed her abortions as a means of teaching her daughter a lesson; to avoid having to go through the abortion process another time.

She told her sister and me, my daughter was fairly open about the unintended pregnancy and abortion. I don't think we had a real heart-to-heart talk about it, but I did think I mentioned my abortion experiences 'cause I don't want her to have another one. I don't want her to have to do it again.

Barbara was reminded once again about her own abortion experiences as she helped her daughter. She is angry about the gender inequity surrounding the occurrence of an unintended pregnancy. Similar to her own experiences, the young man involved with her daughter was not responsible. He was not accountable for his actions and when Barbara tried to get him to at least pay for the abortion, he did nothing. Her daughter's experience rekindled Barbara's feelings of guilt, shame, and embarrassment around her own experiences of unintended pregnancy and abortion. Barbara only told her daughter about her abortion history as a means to caution her about possible long term emotional consequences and hope that she does not have to experience abortion more than once like Barbara did.

### **Shirley**

Shirley is a 62 year old Caucasian woman who is retired from a clinical practice in mental health and therapy. She worked as a marriage and family therapist and also specialized in alcohol and other drug treatment. Shirley possesses Bachelor's and Master's degrees and held a national certification in marriage and family counseling. She worked



primarily independently in her own practice, earning approximately \$45,000 annually.

Shirley does not associate with a specific religion but upholds her own spiritual beliefs. She and her current husband have been married for 13 years. Shirley has a 29 year old son from a previous marriage. She has had one abortion.

Shirley was 35 years old and married to the father of her son, her first husband, at the time of the unintended pregnancy and abortion. She was working part time as an independent therapist, making about \$10,000 per year. Shirley and her husband were establishing themselves in their careers while raising their 3 year old son, who had some medical problems. They had relocated their household on several occasions within a short time frame. Shirley was struggling and remembers the mid-1980s as an emotionally difficult period.

I was really early in my career and it was early also in my husband at that time's career and we were a young family. At that time my son was already born, he was probably about 3 years old. It was a difficult time, it was a real struggle. I don't remember it being financially as difficult as it was just emotionally difficulty because we had made two moves in a fairly short period of time to another community and then moved back. We were living in one town in a Southwestern state at that time and we moved to a larger city for a period of time, for a couple of years, and that wasn't a very good experience for either one of us professionally, so we ended up moving back to the smaller town. It was a real emotionally difficult time for my husband and I; we were trying to figure out what we were doing and to be together on things; we had a young child who required a lot of attention. It was a very emotionally stressful time.

Shirley did not realize she had become pregnant. She doesn't recall the conversation with her husband, only that she felt overwhelmed. She did not feel she could continue the unintended pregnancy; she did not feel her husband was supportive.

I didn't realize I was pregnant; it wasn't a planned pregnancy. And then when I realized I was, I don't have any idea how I told my husband. I just remember it being something that I just thought, 'I don't think I can have another child, I

can't do it'. I think partly because I didn't feel like I had the support of my husband.

Shirley wanted to feel like she and her husband were partners; she wanted his input when deciding the outcome of the unintended pregnancy. Instead he left the entire decision making process up to her. She was angry, uncertain about the future, and alone. She felt overwhelmed and couldn't manage another child with everything else going on in her life.

He just indicated 'whatever you want to do is fine', and the real issue to me was like, 'no, I want you to be a part of this decision', and he really put all of that on me. I remember being so angry with him about that and feeling so overwhelmed; there was a lot of uncertainty. I thought 'I can barely manage what I'm managing right now; I don't think I can manage anything else'. At the time I knew having another child was more than I could take; I knew I couldn't do it.

Shirley remembers the decision for abortion was difficult and emotional. She struggled; she could not envision having a child and giving it up for adoption. She was conflicted by already having a child; she was overwhelmed. Shirley made the best decision she could based on her life circumstances at the time the unintended pregnancy occurred. She made the decision that was right for her; she did not feel she was killing her child.

Making the decision for abortion was probably the hardest because it was so emotional. I remember struggling with the whole thing and thinking I couldn't put the child up for adoption, I didn't feel like I could do that. I think I was very conflicted already having a child. I was overwhelmed. At that time it wasn't anything more than just 'this is how my life is right now', and 'this is the decision that I unfortunately need to make'. I didn't feel like I was killing my child.

Shirley went to a local reproductive health clinic for assistance. She didn't feel ashamed and didn't hide the unintended pregnancy from others. She and husband went through the pre-abortion counseling together; he was detached and she was angry because she wanted his input.

I went to a reproductive health clinic in the community. I didn't feel shameful about it in terms of I didn't hide that from people. I remember going to the clinic and talking with a counselor. Going through the counseling with my husband and him being so detached from it and saying, "whatever she wants I'll support, I'm just fine with it". And my trying to say, 'no, I want you . . . don't just put this on me, this is an 'us' kinda thing, you need to, I want to hear what you think about it'. And nothing ever happened. It felt to me like the counselor at the clinic was not very supportive; kept saying 'you know it is your decision, it really is yours and not your husband's', which wasn't what I was trying to do. I was trying to engage him in the discussion of 'what are we going to do?' and that never happened so that was very frustrating.

Before leaving the reproductive health clinic Shirley decided to proceed with an abortion. Since no abortion procedures were available in the local community, Shirley's abortion was scheduled at a clinic in a larger city. Shirley and her husband drove an hour and half to get to the clinic on the day of the abortion. Once they arrived Shirley was given some medication to soften her cervix and help it begin to open before the surgical abortion procedure. She had to wait 4 hours for the full effect of the medication to occur. Since she and her husband were still not talking about the unintended pregnancy and pending abortion, they went to see a movie to pass the time. Shirley was very emotional and cried throughout the movie.

I remember it being quite a solemn ride to the larger city; my husband and I went together. They gave medication and said, 'okay, you have to wait 4 hours now before we can actually do the procedure'; I'm guessing that was for dilation. So we went to see a movie, because we still couldn't talk about it very much. And I remember sobbing because I had so much emotion. It wasn't even anything like that in the movie, but just the emotion of it really connected with me and I remember crying a lot during the movie. Then we went back to the clinic for the procedure.

Shirley was put into an examination room and the abortion procedure was explained to her; the clinic staff told her what to expect and what they would be doing. They covered the suction machine with a towel; Shirley didn't watch. The doctor and an assistant came into the room and the female assistant made an inappropriate comment about her desire in

men's penis size. Shirley was shocked and could not believe what she was hearing. She doesn't remember much about the actual procedure only that afterwards she couldn't wait to get out of the clinic; she left sooner than recommended.

I remember being put in the room and they're telling me what to do, 'you're gonna lay here', they're saying 'this is what we're going to do'. They put a cloth over the machine where it evacuates the pregnancy and I don't know if they said 'you don't want to be looking at this' or if I just knew what that was. I remember being in the room for awhile and then the doctor and the assistant come in and the young assistant was saying, 'what I like in a man is a good 10 inches' and that was such a startling thing for me to hear, it was just a disconnect, like, 'what?', 'I'm hearing this?'. I don't remember much about the procedure occurring and then they have you wait after. I remember 'I just need to leave', I didn't even stay there as long as I was supposed to because I just had to get out of there.

Shirley was in pain after the abortion. She and her husband stopped at a store to get some pain relievers. She slept during the hour and a half drive home. It was dark when they arrived home. Shirley kept her follow up appointment at the local reproductive clinic and reported the inappropriate comments made by the clinic staff, which really tainted her abortion experience.

I remember that it was quite painful afterwards. We stopped and got some Tylenol at the store; I didn't go in and get it, but then taking that and sleeping on the way home. It was about an hour and a half drive; I remember it being dark when we got home. I did go back to the local reproductive clinic for a scheduled appointment and reported that event that was just so bizarre and so inappropriate.

After the abortion Shirley felt relieved and glad the procedure was over. She had other things in her life to tend to; the abortion became a thing in the past as Shirley resumed her life as she had known it.

I felt very relieved; I don't remember feeling anything else but relief. That the abortion was done and I did it and I had a lot of other things I had to deal with then; so whatever I was feeling, it just went underground.

Shirley and her husband talked about the unintended pregnancy and abortion with friends, neighbors, and family members. They were not ashamed of the decision for abortion; they were prominent professionals in a small community and were open about their experience. They received no condemning or judgemental remarks from others; they didn't feel like they had done anything wrong.

At that time I was very open about it. I talked to friends about the abortion and I talked to my sisters. I was very open about the unintended pregnancy and abortion; I talked to people on the phone about it, friends that weren't close by. I didn't feel like I'd done anything wrong or shameful at that time. We were very open about it. We were both professional people in a very small community and I don't remember getting any negative feedback about the abortion.

Shirley did not feel like she was killing her child at the time of her abortion or during our interviews. She reflected on the changes in society during the past 27 years; in the current anti-abortion political climate, she understands why women begin to think that abortion is the same as murder. She has been faced with the same thought more than once.

I didn't feel like I was killing my child, that's such a strong word, but I didn't feel that. I don't feel that now, although with all the current political things going on, that is in my face a lot. I understand how people, how women, begin to think that abortion is killing. It isn't that I haven't had that thought go through my mind either; I have, actually, I have.

Shirley identified that abortion has become shameful and equivalent to murder; abortion is viewed as a simple issue that is right versus wrong, when in fact the decision for abortion is complex and made thoughtfully by women. Shirley believes many women understand this on a basic level, but society does not portray women who have abortions as human beings in unpredicted situations, trying to make the best decision they possibly can.

That's very different than now I think. Socially abortion is shameful, it's killing. Abortion is black and white, there's no gray in the decision making or the judgment of women having abortions now. It's real clear socially, in the

open, but behind closed doors I think people understand that women don't go through having an abortion lightly, like it's portrayed.

Shirley experienced pro-life violence first hand while working at an abortion clinic in 1991. As a counselor and therapist, she enjoyed helping young women understand their options and make decisions when faced with an unintended pregnancy. She was surprised by people's negative reactions to abortion.

I did some part time work at an abortion clinic around 1991. I was doing work with helping young women decide what they wanted to do, which direction they wanted to go, or what options they had, and helping them in that process. I actually liked working with those young women; some went one way, some went the other, and that always felt really good to me that they really were able to make up their own mind about it. It was just at the beginning of when people were really starting to be negative about abortion. At one point the clinic has a couple of picketers and then someone threw a rock through the window; I remember being so surprised that people felt that way about abortion.

Shirley and her husband separated, got back together, and then divorced. She was never able to talk with her husband about the abortion experience, to resolve her feelings with him. Over time abortion became shameful to talk about in public, to admit that you were a woman who'd had an abortion. Shirley quit talking about her abortion experience. She doesn't really remember how that occurred over the past decades, only that she doesn't talk about her abortion anymore. Her personal life experience has become secret; hidden from others in an attempt to avoid judgement and condemnation for a decision that was well thought out and the best decision for her life circumstances at the time. The silence around abortion had kept Shirley from talking about her abortion experience with others, robbing her of a deeper intimacy in relationships.

My husband and I separated and then got back together, and then divorced, but our relationship didn't make it through the abortion. I was never able to talk with him, to really resolve that with him. And then it became very shameful publicly to even mention that you've had an abortion. I stopped

telling anybody about it. I have no idea how that came about; I don't remember any specific event, but I stopped talking about it.

Shirley reflects on her abortion experience privately. Time and maturity have provided her with perspective on her life situation at the time of the unintended pregnancy. She sometimes wishes she could have made a different decision, especially based on who she is now and what she knows and understands about life. She imagines that she could have continued the pregnancy and had another child, but as soon as she uttered those words she recalled the circumstances of her life back in 1985 and acknowledged that abortion was the best decision she could make.

I have an older perspective and more mature perspective. I recognize I would have been able to have managed that somehow . . . as soon as I say that I think back to that time and of all the things, the other layer of complications that that added to life. That sounds so callous in a way, but I just couldn't manage another child.

Shirley feels sad that she never had another child, that her son never had the experience of being a big brother. She's grateful she made the decision for abortion, she has no regrets. The reality of her life circumstances did not allow for subsequent pregnancies. Shirley feels sad and grateful.

I feel very sad that I was not able to have a second child, another child. Sad not in the terms of the loss, but sad that my life was such at that time that I couldn't do it. It's that loss of having a second child. I feel a loss for my son, also, that he wasn't able to have a sibling. I'm very grateful, I don't have regrets. Having an abortion was what I had to do at the time. There's a loss there in lots of different ways; it was more the reality of the circumstances of my life that really didn't allow childbearing again. So I feel sad, I feel grateful, I feel both.

Shirley has not talked about her abortion experience in the past two decades, except to tell her son. She can't recall what prompted the conversation, but felt he should know

about her abortion. He was in his early 20s; they didn't discuss her abortion experience; the conversation was succinct, more of a disclosure.

I haven't; well, I did tell my son. He was probably in his early 20s. I can't quite remember why I thought this was important for him to know and I'm not quite sure what the circumstances were that came up that I thought that, but then I'm sure there was something. We didn't discuss it much, but I remember telling him because I thought it was important for him to know. It was pretty short. I didn't know what else to say and I think that was probably something for him to digest. I wasn't sure if he already knew, if his dad had mentioned that or not to him, but my guess was that he hadn't. He didn't say very much.

Working as a therapist and counselor, sometimes it was difficult for Shirley when other women talked about abortion. She recalled a spontaneous discussion about abortion with a young woman she was counseling for another issue. Shirley became engaged in the conversation and revealed her own experience with abortion as a means of connecting with this young woman and assisting her to not feel so alone.

I think sometimes in doing therapy it was difficult when women were talking about abortion. Not the young women that were going through the experience of trying to decide, but women that had talked about abortion in some other way. I remember one woman I was seeing for something and it just came up that she found out she was pregnant. Her life circumstances were such that continuing the pregnancy wasn't gonna work for her. She was pretty clear she was gonna have an abortion. At one point I was so engaged with the conversation, she asked me if I'd had an abortion and I told her 'yes', which wasn't a very good thing for me to do probably given the relationship, but at the time it felt right. It felt like it was appropriate to share that information with her so she didn't feel so alone. I remember trying to support her in the decision she had made.

Shirley has knowledge and personal experience to share with others, but abortion has become such a disputed topic for discussion that she felt bad when she "accidentally" disclosed her own abortion decision as a means of connecting with a young woman. How can older women with the life experience of abortion share their wisdom with younger women? How can this common life experience be talked about across generations before a



young woman experiences an unintended pregnancy and might need to make a decision for abortion?

### **Carolyn**

Carolyn is a 66 year old Caucasian woman who has retired from the school system after working 22 years as a social worker and special education coordinator in a large city in the Midwest. She has a Master's degree in social work and has completed post-graduate studies in counseling. Carolyn works part-time as a psychotherapist, earning about \$80,000 annually with retirement benefits. She has been married for 24 years; she and her husband associate with the Unitarian church. She has been pregnant 4 times; she has a 42 year old son from her first marriage and a 23 year old daughter with her current partner. Carolyn has had one abortion and a pregnancy terminated with the removal of an IUD.

Carolyn was a divorced, single parent in September 1988 when she experienced abortion. Her son had graduated from high school and was gone to college. Carolyn and her current husband had been dating for 2 months; the unintended pregnancy occurred the first time they engaged in sexual activity. Carolyn was shocked that she became pregnant while using a contraceptive sponge.

The first time we made love I got pregnant. I hadn't been on a regular birth control like the pill, but we did use a sponge and I got pregnant with the sponge. It was like, 'oh, my gosh'. I wasn't ready to be in a committed, let's get married situation; at that point in time it just didn't feel like it was right, I just wasn't ready. So, that I had gotten pregnant using the sponge was shocking and pretty difficult.

Carolyn suspected the unintended pregnancy immediately when her menstrual cycle was late and her breasts became tender. She took a home pregnancy test that was positive. Carolyn did not talk with anyone about the unintended pregnancy; she knew she would choose abortion.

I had really regular periods, so when I was even a few days late and my breasts were tender, I knew right away. ‘Oh, my gosh, could I be? Oh my gosh’. I got the home pregnancy test. I didn’t talk to anyone else about my suspicions because I knew I would terminate.

Thinking back Carolyn was surprised that she didn’t tell her sister about the unintended pregnancy at the time as they are very close. Carolyn speculated that perhaps she had felt embarrassed or ashamed.

I don’t want to say there was some shame attached to having an abortion, or embarrassment, but maybe there was some of that because my sister and I were really close and I didn’t tell her.

As a counselor in the school system working with adolescents, Carolyn had helped teenage girls who were experiencing an unintended pregnancy. She assisted them in obtaining information, making decisions, and navigating the legal system to procure an abortion. She did not need assistance with resources; she felt certain about her decision for abortion.

I didn’t need any direction. I was a psychotherapist and I worked in a school system and helped young girls who got pregnant and needed to know what to do. I had helped them be able to get to the resources that they needed to get to, so I didn’t need any direction in who to call or what to do or how to manage. I felt clear in what I wanted to do.

Carolyn was sure about her decision for abortion. She wasn’t ready yet to marry the man she had been dating for 2 months; their relationship was not at that point. Carolyn did not want to raise a child by herself. She was positive she wanted to terminate the unintended pregnancy, but she also wanted her partner to accept and support her in the decision for abortion.

I felt pretty sure about what I wanted to do. I wasn’t ready to say, ‘okay, well let’s get married’; we weren’t at that point in our relationship. I wasn’t ready to bring up a child on my own. I was like 90 percent, that’s where I was, but I needed, I wanted a partner to be with me in making that decision and saying,

‘yes, I support you absolutely’ and ‘I’ll be there with you’; this was us together.

Carolyn considered continuing the pregnancy; she imagined what her life would be like if she was pregnant and walking down the halls of the school where she worked, single and 39 years old. Society’s judgement of single, pregnant women entered her thoughts, but was not the reason she chose abortion. She knew she could have another child if she wanted to; she was financially stable; she did not want to raise a child by herself.

I was working and I thought, ‘well, okay, how would it be to be pregnant and to be single and walking down the halls?’, ‘cause I was working in a school district. How would I walk down the halls of the school and be pregnant at 39 years old? I did think about the social aspect of having a child out of wedlock; it pinches a little bit, but in a way it’s also kind of like, ‘yeah, you can do it’, ‘having a baby as a single woman is an okay thing to do’. I’m pretty gutsy. I thought about it, but it’s not anything that made me have the abortion. Economically, I had enough money, I guess I could have had another child, that wasn’t really the reason; I didn’t want to raise a child by myself.

Carolyn made her decision for abortion on her own and then went to her partner’s house to talk with him. She drove 45 minutes to his house, on a week night, which was out of the ordinary; she usually went to his house on weekends. She felt that she really needed to tell him about the unintended pregnancy. After the long drive she was anxious to talk with him, but he had a colleague at his house; they were discussing work. Carolyn tried to wait patiently, but felt a sense of urgency in wanting to talk with him. Time ticked on as the two men talked about a work project; Carolyn felt like she was keeping the secret all by herself. She needed to tell her partner; she needed to know his thoughts, she wanted to know whether or not he’d support her and her decision for abortion. Over an hour later, the work colleague finally left and Carolyn was able to talk with her partner. She told him she was pregnant and waited for his response. He listened and asked her about her thoughts and feelings. He

agreed with her decision for abortion and said he would accompany her to the clinic. She felt deeply connected with him and supported by him.

I really wanted to make the decision, 'cause I really felt it's my body, I'm the one who's got to live with the outcome. I went over to his house to tell him. He lived maybe 45 minutes away, and so, I went over, which was no big deal, but it was during the week, when I found out. And so I went over to tell him and he had a workmate there and I had this thing that I had to tell him and I had to tell him and he had this workmate there and he was just still talkin' to him and explaining stuff to him and it was like, 'yikes!' Here it is 7, now its 7:30, now its 8 o'clock and I've got this big thing hanging on me. The hardest part of it was just waiting while that guy was there, knowing I had to tell, knowing we weren't together yet on it. I felt like I was carrying it by myself and that was hard. And so once I told him and said 'well I've got something really big to tell you', 'oh my gosh, I'm pregnant, the sponge didn't work'. So once I told him, he asked, very openly, 'what are your thoughts?', 'what are you thinking about this?' We'd had the safe sex talk, but we had never talked about abortion. So, it was like, well, this is my thought and what are you gonna think, are you gonna be okay with my decision for abortion? There was a little anxiety with that, not knowing what his thoughts and feelings were about it. And once he said, 'yeah, I fully support you', it was like, 'ahhh, okay, that feels good'. 'I'll be with you, I'll take the day off, we'll go together, and I'll be with you'. Then it was like that just cemented us; it was good. It's not that I really needed anybody else to talk to; I didn't feel like I was shouldering it by myself.

During our second interview, Carolyn identified how much emotion there was for her in wanting to tell her partner and then having to wait until they could be alone. She compared the waiting to standing on top of a diving board, poised and ready to take the plunge when an unforeseen delay occurs; the interruption and postponement are almost unbearable.

It's like you're standing at the top of a high dive and you've worked up all your guts and your energy and you're getting ready to jump and you can't jump yet and having to stand there; that's what it was like. Being prepared, making the 45 minute drive, okay I'm coming over there, he doesn't know I've got a big deal to talk to him about, I'm just comin' over as I might one day a week or he might come over to my place, but it's a little different 'cause it's during the week, not the weekend, and I gotta get back home and go to bed and work the next day. But, here I am standing at the top of this high dive

and it's scary and I've gotta tell him and I'm waiting and I can't because he's got this workmate there.

After Carolyn talked with her partner, she called her physician, explained the situation, and made an appointment. For Carolyn, the emotions around telling her partner about the unintended pregnancy and her desire for abortion were her strongest memories. She felt emotionally alone until she knew that he agreed with her decision for abortion and supported her; until she knew that he would be with her for the procedure. The physical aspects of the clinic were less distinct for Carolyn; the clinic seemed like any other medical facility except the staff counseled her about options before the abortion procedure.

I made an appointment; I just called my medical provider and explained the situation and they made the appointment for me. The emotions are stronger about telling my partner and that sense of aloneness, that emotional aloneness, until I felt the partnership with him and knew he'd be with me. The physical part of it . . . I don't even remember the building we went to. It was just a regular clinic that you went to and the procedure was done. So other than that someone talked to me ahead of time about options and alternatives, it was a pretty non-descript place.

Carolyn's partner accompanied her to the clinic on the day the abortion procedure was scheduled; he waited in the waiting room during the actual procedure. Carolyn was glad he was there; she felt supported and emotionally comforted. Despite being positive in her decision for abortion, she still felt sadness at ending a potential life. Carolyn did not feel guilty; she did not feel she was doing anything wrong by having an abortion. She did not feel judged by clinic staff or encounter condemning attitudes from others; Carolyn felt supported in her decision for abortion.

I went in and my husband went with me, he wasn't my husband yet but he went with me. The pregnancy was very early; as soon as I found out I was pregnant I terminated right away. My partner was right there, he was in the waiting room, and I was very glad that he was there to drive me and emotionally; I mean, even though you've made your decision that having an abortion's what you're gonna do and I felt 100% absolutely very strong, but

still you're taking away, stopping, what could be a life, depending on how you look at it. So having an abortion is not the easiest thing to do and there's still sadness. I didn't feel guilty; I didn't feel like I was doing something wrong. I don't recall wondering if anyone would judge me for having an abortion; when I went for the abortion, I didn't feel that.

The abortion procedure was not traumatic or painful for Carolyn. The most difficult aspect of the abortion process for Carolyn was the waiting; once she had made her decision for abortion, she was ready to have the procedure completed. Carolyn had easy access to safe, legal abortion; she had insurance coverage and no financial issues; she had transportation and support from her partner. The emotionally challenging aspect of the abortion process for Carolyn was waiting to have the procedure completed; she considered herself fortunate.

The abortion procedure itself was not terribly painful; that wasn't the traumatic part, it's the waiting. Once you make up your mind, once you're decided then you're decided, and then it's a matter of just doing it. Once I make up my mind and I'm ready to do it, then I'm ready to do it. For other women it might be 'Do I have access to it?', 'Can I scrape together the money or borrow the money?', 'How am I gonna get there?' I was lucky; I didn't have any of these worries, I only had the difficulty of waiting.

Carolyn's abortion occurred just prior to a holiday weekend. After the procedure she went to meet her partner's parents, her future in-laws. She didn't feel quite normal physically, but felt well emotionally. The situation seemed a little strange to Carolyn; they did not say anything to his parents about the abortion. Carolyn was confident in her decision to terminate the unintended pregnancy.

I do remember it was over Labor Day weekend and that was the weekend that I went for the first time to meet my partner's parents. That was a little strange, 'Oh guess what, I just had an abortion'. I felt a little off, but emotionally I felt okay about the abortion. I knew it was a well thought out decision.

Carolyn considered herself privileged in her life circumstances surrounding her abortion experience; she had no issues with access to safe, legal abortion services, transportation, finances, or support from the male partner involved with the unintended pregnancy. She expressed anger when women who have decided to terminate an unintended pregnancy are incapable of doing so due to limited resources. Carolyn identified a great injustice toward women who are forced to continue unintended pregnancies when they've decided on abortion simply due to lack of funds and/or insurance coverage.

I think about myself and my ability; I had the money, I had the insurance, I didn't have to pay anything, I had the emotional support, I'm a therapist, I had myself, I had resources, I had everything. I think about women who have to scrounge for money to be able to have an abortion; it infuriates me that women who make a choice 'I don't want to give birth' are in the situation where they have felt forced to go through with their pregnancies.

Over the past 25 years, Carolyn has talked about her abortion experience only when the topic of abortion has come up in conversations or when she has felt someone would benefit from knowing about her abortion experience. She does not openly tell others that she's had an abortion; neither does she feel her abortion experience is a secret. Carolyn has been selective with whom she has shared her abortion story. She is cognizant of potentially condemning and judgemental attitudes from others; especially family members who are Catholic or in a situation where she does not know people's views on abortion.

I'm sure I have told some people as it might have come up in conversation. My abortion doesn't feel like anything that I would keep secret or that it was a deeply painful thing. I never felt that 'I have to tell this', because it does seem like a deeply personal matter, but, as appropriate, I would certainly. If somebody was struggling, certainly a friend or a relative who was struggling with making that decision, I'd feel free to share as something to ease them or to help them, just to say 'I had an abortion'. I wouldn't hesitate to say I made the decision for abortion and it was a really good one for me. My abortion is not anything that I'm ashamed of. If they're thinking, 'oh, gosh, what would people think of me?', I'd tell them you don't have an 'A' on your forehead when you have an abortion; people don't know, your abortion experience is

something you carry inside you and you can decide to tell people or not. I guess part of what makes it easier is if you know, if you strongly suspect what people's feelings are on abortion, it makes it easier to share. It's a little harder if you don't know. I wouldn't tell, for instance, my mother-in-law; my husband's folks come from a Catholic background and somehow I have felt that there might have been some judgmental thing about my having an abortion; I don't think I'd necessarily offer that information up to her.

Carolyn's words seem to convey complexity and some contradiction. She did not talk about specific examples of telling others about her abortion experience, but rather discussed potential situations in which she might disclose her abortion. It's hard to discern if Carolyn has indeed felt comfortable in sharing her abortion story or if disclosure has occurred briefly, as a means to warn about what may occur or commiserate with others. Why is a life experience that is "not a secret" or "a big disclosure" so rarely discussed? Appropriate conditions for Carolyn to disclose her abortion included knowing the other woman (a relative or a friend), that person experiencing an unintended pregnancy and needing assistance with decision making, and already knowing that the person believed in and supported abortion as a reproduction option. Carolyn's sharing of her abortion story seems to be more of a confession than an actual conversation with others about her experiences.

Carolyn has talked with each of her children about her history of abortion. She does not recall details about specific conversations with her son and daughter, but is confident that her children know that she has had an abortion. Carolyn believes she talked with each of her children about the unintended pregnancy and abortion during a time when the topic of abortion came up in a conversation.

I really don't know, I don't think it would be a problem at all, I think I've told her. We certainly had the, 'if you're gonna be sexually active, make sure you're on birth control pills' talk. I don't think I would have told her right out then 'I did get pregnant'. If she had asked, I would have answered truthfully. I would not have lied. So my instinct is that I must have told her at some time, it must have come up in the conversation. She's never been pregnant;



she is on birth control pills now. I'm pretty open with her, I just don't remember. The abortion is about one of my most secret things, if you say secret things, but it doesn't feel like telling her about my abortion was a big dramatic thing, that I'm sharing this big, deep, dark secret. I don't think I would have told her [daughter] right out then, 'I did get pregnant'. If she had asked, I would have answered truthfully. I would not have lied. So my instinct is that I must have told her at some time, it must have come up in the conversation.

I'm pretty sure I didn't tell my son at the time that I had the abortion because he had just graduated from high school and was going on to college. I don't specifically remember telling him, but I feel pretty certain that he knows; once again, it wasn't some big disclosure.

Carolyn offered insight into why women don't tell their children about their abortion experiences. She suggested that women don't want to give their adolescents the impression that having sex, having an abortion, and/or doing drugs are appropriate activities; they want their children to be safe and avoid risky behaviors.

Stuff gets really mixed up in your head when you're parenting your teenage daughter because you don't want your teenage daughter having sex and you certainly don't want her getting pregnant; you don't want her having to get an abortion. You don't want all of those things to happen and so somehow if your kid finds out, 'well you used drugs', 'you smoked cigarettes', 'you've had sex', 'you had an abortion'; not like 'why can't I?' I think parents often want to have a 'do as I say, not as I did kinda thing'.

I shared with Carolyn that some women declined to participate in the study out of concerns that their daughters would find out about their abortion; she offered her reaction.

That's too bad, really sad; but that shows how something that happened 20 years ago or whatever for this person, how they still have shame about the unintended pregnancy and abortion. Their perspective might change once their daughters are older, say 25, when they're out of the house and they're not under their parent's roof. It's pretty scary to think about children finding out that their mom was screwing around or not on birth control.

Carolyn has been a supporter of women's reproductive rights her whole life. She has demonstrated at clinics to ensure women are able to obtain safe abortions; in the 1970s she wore a pin on her lapel with a hanger on it. Abortion-rights activists designed this pin to

represent the era of back alley abortions in the mid-20<sup>th</sup> century; the message was “no more back alley coat hanger abortions for women – keep abortion legal and safe”. Carolyn wanted people to remember how unsafe and dangerous abortion used to be for women before 1973; people in the United States should never want abortion to be illegal again.

I actually did wear that pin a long time ago. The pin reminded people that this is how it used to be for women; they had to go places where it was dirty, providers weren't licensed, it was somebody who did the abortion in a back room. We don't ever want to get to that point again.

As a social worker in the school system, Carolyn identified that she “had gone to court a couple times with girls to ensure that they could have an abortion because they felt their parents would be abusive to them if they found out.” Carolyn associates with the pro-choice movement, participating in protests to protect women's reproductive rights. Reflecting on her own abortion experience, she realized that she had all the resources she needed to make the choice for abortion; she identified the inequity for women who cannot afford an abortion and are therefore forced to continue an unintended pregnancy and parent a child for whom they are not financially or emotionally capable of caring.

I did some protesting to say, ‘I want to be here as a support’, whatever I can do to ensure that if someone has made the decision for abortion, they have access to safe, legal abortion. I think about my abortion experience; I had all the resources to be able to obtain an abortion. I think about how many of my ‘sisters’ have not had that; have not been able to get those resources and the inequity of that. The inequity of here I could have an abortion, I had access, money, support and it was easy. At the same time it is so hard for other women to be able to obtain an abortion. They end up not being able to get an abortion ‘cause they can't afford the price of it; they end up having a child that they can't economically or emotionally support; very difficult.

Carolyn has not been involved with women's reproductive rights recently as she no longer works in the school system or with adolescents. She has actively supported homosexual rights and recognized increasing barriers on women's access to abortion.

I haven't been involved in the pro-choice community since I got out of the school system; I'm not working as much with adolescents. I've been more involved in gay rights and so I'm not as aware of the difficulties and setbacks in pro-choice activism.

Carolyn had some advice for other women experiencing an unintended pregnancy. She encouraged women to consider all options, to really think about the impact of having a child and parenting, placing the child for adoption, or terminating the pregnancy. Carolyn encouraged women to talk with others and find someone who can be supportive of whatever decision is made.

Talk to several people; don't just talk to one person, consider alternatives. If they're just not sure what to do, I think it makes you feel better if you have gone through, 'okay, well what would happen if I parented this child myself?', 'how would that affect me financially?', 'how would it affect me emotionally?', 'could I manage getting up at 3 in the morning and 5 in the morning?', 'could I do all this on my own?' Then think about, 'okay, what if I placed this child for adoption?', consider that. What would that be like? And then abortion as well. I think once you've considered all the choices it helps, makes you feel like, 'okay I have made a well thought out decision here'. Try and find somebody supportive to talk to; if you make the decision to have an abortion and you feel like you need some support, there are people out there who could be very supportive of that.

Carolyn believes strongly in women's reproductive rights and their choice for abortion. She is appalled that women who are economically disadvantaged are forced to continue unintended pregnancies due to lack of funds and/or insurance coverage. She has supported women in making the decision for abortion through protesting, her work as a social worker, and in her role as a counselor. She felt supported by her partner in her decision for abortion and had all the resources needed to act on her choice; she feels fortunate. Carolyn was the only participant in the study who remains in a relationship with the male partner involved with the unintended pregnancy and abortion that occurred in 1988;

she was also different from the other women in that she was slightly older at 39 years of age when she had the abortion.

### **Maria**

Maria is a 43 year old, single, white-Hispanic woman who is currently not employed. In the past she has worked as a dancer and at a bar, usually part time, earning about \$1000 per month. Maria has a high school diploma. She is currently not involved in a relationship; she has been married and divorced in the distant past; presently she lives with the father of her 3 year old son, but is no longer involved with him in a relationship. She identifies with non-denominational Christianity. Maria has been pregnant 9 times; she has 6 children, ages 23 (son), 21 (daughter), 16 (daughter), 14 (daughter), 8 (son), and 3(son). She had one abortion and two miscarriages. Maria lives in a large city in the Western United States.

Maria was 24 years old in September of 1994 when she had the abortion. She was single and working part time as a waitress, earning about \$500 per month. She was going through a divorce and battling for custody of her three oldest children. Maria had just moved to the city; she did not have a permanent residence. She did not know many people; Maria was away from family and friends and had little support. She did not have a permanent residence and was drinking a lot of alcohol.

I was going through a divorce actually; just gone through a separation. I had just moved to the city. I didn't have custody of my kids; I was going through a really ugly custody battle and I didn't even have my own children. I didn't have a place to provide for anything. I had nobody basically. I didn't have anything to offer anybody. I had a heavy alcohol history at that time.

Maria suspected she was pregnant when she missed her period. She was “really nervous, just freakin’ out” because her cycles were usually very regular. When she missed

her period she took a home pregnancy test and confirmed her suspicions that she was pregnant.

Maria didn't really believe in abortion, but felt she had no other options given her life circumstances. "At the time, abortion wasn't something I really believed in, but I felt I didn't really have a choice. I was involved in alcohol; I was pretty much a mess. I thought at that point that I had no other alternative but to have an abortion."

Maria was involved with more than one male partner at the time the unintended pregnancy occurred; she was uncertain of paternity. "I was dating two guys at one time; I wouldn't even call them relationships, we weren't committed to each other. I wasn't actually sure who the father was."

Maria knew she could not continue the unintended pregnancy, but was not sure what to do. She talked with a girl with whom she worked who told her about a local reproductive health clinic. Maria called the clinic. She remembered talking with someone, but not much else about the clinic due to the influence of alcohol.

I talked to a girl that I worked with and she was telling me about a local reproductive health clinic. I can't remember much; but I remember I went and talked to somebody at the clinic. I just called 'em and I went in; pretty much all I can really remember was just going in and doing it. Like I said, things were really kinda blurry back then.

Maria recalled few details about the abortion clinic, the procedure, nurses, provider, or if someone accompanied her to the clinic. She remembered that the abortion clinic seemed "like a regular doctor's office". Maria did not miss work and used her own money to pay for the abortion; "it must have been my own money; I don't recall asking anybody for it. Nobody helped me out." Once Maria decided to terminate the unintended pregnancy, she scheduled the procedure and had the abortion within a week. She was surprised that having

an abortion was not as difficult as she had anticipated. Maria did what she felt she had to do.

After the abortion, Maria locked the abortion experience into the back of her mind.

I really don't remember much about the procedure itself at all, other than coming out and getting antibiotics, and just dozing off. It really shocked me because the abortion wasn't as hard as I thought it would be for me. I generally was raised not to do that. So, it was just kind of like 'I have to do it' type of thing and I did; then I just blocked the thing out of my mind.

Maria took antibiotics at home and some pain medication; she returned to the clinic once after the abortion procedure. "They gave me antibiotics to take at home. I remember having some discomfort; I think they might have given me a mild pain medication. I think I had to go back once." After the abortion Maria consumed a lot of alcoholic beverages and tried to forget. "I pretty much self-medicated, continued to use alcohol, so I really just pretty much blocked it out."

Maria still feels guilty about having an abortion. Terminating the unintended pregnancy went against her Christian beliefs. She did not feel that she had any other choice at the time; she does not recall considering adoption. Maria comforts herself by reminding herself that she was a different person then; she was using alcohol heavily and was not in a good place. In retrospect, Maria wishes she would have known more about adoption and considered that option instead of abortion.

I still have guilt about it. It just went against my Christian beliefs, and honestly, at that time, I didn't know there might have been other options. I don't recall being informed about other options, like adoptive options or anything. I think that at the time, the situation that I was in, I pretty much have to just remember that I was in a different mindset, that's kind of how I comfort myself. I was not in a good place at the time. I wish I would've known more about the adoptive process; I would have liked to have gone that route if possible.

Maria indicated that the abortion was in the past for her. "I have to look at it that way because it's something that happened, it's something that I can't change." For Maria, having

an abortion has definitely made her more appreciative of life, especially children. “I’m extremely protective of children. I guess I’m just very nurturing, I’ve always been that way, so this probably actually made it a little bit stronger.”

Maria has rarely shared her experiences of abortion with others. She hasn’t thought or talked about her abortion except on one occasion when she gave a roommate a ride to and from the reproductive health clinic. Maria disclosed that she had had an abortion, but did not talk about her experience. She focused on assisting her girl friend and went through the motions robotically. Maria felt sad about her friend’s situation.

I had a roommate that I actually gave a ride to, went and picked her up when she had her abortion. So that’s the only other woman that I’ve really talked to about it; not really spoken about mine or went into detail or anything like that. That’s the only time that my abortion has ever come up, because she was going to hers. I can’t recall having a deep conversation about how she felt or how I felt; it was just like basically I became kind of cold to the situation, matter of fact about the abortion. I didn’t let my feelings interfere with anything, kind of closed myself down I guess. I do recall feeling bad for her.

Maria does not talk about her abortion with others; she does not feel the need to talk about it. She continues to feel guilty and ashamed; she really doesn’t want anyone to know, especially family members. Maria would consider sharing her abortion story if somebody else brought up the subject of abortion, if she felt comfortable with that person, and especially if another woman needed assistance, guidance, and/or information. Marie would need to feel comfortable to share her abortion experience with others.

I don’t feel a need to talk about my abortion. It’s not something I’m . . . of course you wouldn’t be proud of it, but it’s embarrassing to me . . . and people that I would know, especially family. If somebody brought it up or asked me a question about it, I wouldn’t lie to them. I’d have to feel comfortable with that person . . . if they were looking for help or some kind of guidance or some sort of information, I wouldn’t deny my experience to anybody that had questions. That’s a pretty private topic for someone to bring up, so obviously you’d have to think that someone would feel comfortable with you by even bringing it up.

In her family of origin there were no conversations about sexual activity or pregnancy when Maria was growing up. They really never talked; Marie learned that abortion was sinful in church and at her private, religious school. The unspoken understanding in her parent's household was that abortion was wrong; they never had an open discussion about sexuality, pregnancy, or abortion.

We never talked about anything like pregnancies or sex so I was really naïve. It was my school and my church, 'cause I went to a private school, that instilled in me that abortion was wrong. We never really talked about it with my parents; I understood that they thought abortion was wrong, but we never had an open conversation about any of that.

Maria has not spoken with any of her children about her abortion and has no intention of telling them. During our interview, her 3 year old son wandered into the bedroom while Maria and I were talking on the phone. As she looked at her son, she explained that she would never tell him about her abortion for fear that he would judge her for the abortion decision; she is ashamed.

That's not something I would bring up, I'm looking at my son right now, thinking, 'jeez', I won't be bringing it up to him 'cause they could easily think, 'my gosh, that could have been me'. I think in general a lot of people have a bad impression of people that have abortions; I think it boils down to shame.

Maria has avoided thinking about her abortion experience by blocking the abortion out of her mind. The abortion occurred with Maria's fourth pregnancy; during her subsequent pregnancies Maria thought about the child that might have been. She sometimes thinks about the abortion when looking at her children, "if I had another one there." "I feel bad about the abortion; I guess 'cause you just never know what could have been. I feel guilty, that was a baby. I still can't think about it."



To protect herself from judgement and condemnation, to insulate herself from the shame and guilt, Maria blocks out any and all information pertaining to abortion. She is unsure about the continued legality of abortion. She believes women should have more options and support for raising children. Maria does not vote; she avoids political and legal confrontation about abortion. She recalled hearing about abortion clinic violence on the news and in other places, but “blocked it out”.

I don't know how I really feel. I don't think abortion should really be legal, but that's a difficult question. There'd have to be another plan of action, more options for women that aren't able to get 'em, to have an abortion. They'd have to have more help for women that are pregnant, to make sure that the child doesn't get victimized. I don't think abortion should be a form of birth control; I don't even know what the laws are now about it. I really don't pay attention to any of that; I'm not a voter. I think it's great that they're at least trying to make it more difficult for women to obtain an abortion, but they need to give women more options, more information.

Maria seems to be referring to men, politicians, and lawmakers in ensuring that women who are not able to choose abortion, who are forced to continue unintended pregnancies, are provided with financial support and resources. Perhaps Maria wishes she had had support from somebody, anybody, back in 1994 when her unintended pregnancy occurred. She regrets her decision for abortion even though she felt she made the best decision she could at the time, given her life circumstances. It is possible that Maria wishes her life circumstances had been different so that she could have had the option of continuing the pregnancy; perhaps if she had been provided with more support and resources.

During our conversation, Maria offered advice to other women experiencing unintended pregnancy; she encouraged women to take time to consider all options. Maria confirmed her unintended pregnancy and had the abortion procedure within a week. She was

early in her pregnancy and did not understand fetal development; she thought she was terminating before the pregnancy developed into a child.

I would definitely want them to seek out all options that are possible and take time; take a lot of time to think about it 'cause I did not take the time to think about it. It was actually early in my pregnancy, that's probably why I did it so quickly. I was just thinking that, 'oh, it's only 8 weeks'; I was not informed, I did not know at that time, even though I'd had children, I didn't realize how much that child was already developed, I really didn't know even at that point.

Maria learned about fetal development by "paying more close attention to the pregnancies after" her abortion. She also learned more about fetal development from a chance encounter with a stranger at a restaurant. "I met this man and was talking to him, and he gave me these little tiny feet that were for a pin . . . he gave me a pamphlet on how kids develop in the first couple weeks."

Maria made the decision for abortion in 1994 based on her life circumstances at the time. For 30 years guilt, shame, and fear of judgement have been imposed on Maria by religion, private school, her parents, politics, and society rendering Maria silent about her abortion experience. She protects herself from criticism and condemnation by blocking out the abortion and by avoiding anything to do with abortion. She ignores political advertisements and pro-life messages; she does not vote or attend church; she is isolated from society to keep herself safe. Maria has been pregnant 6 times since her abortion; she never chose abortion again.

### **Lindsey**

Lindsey is a 31 year old Caucasian female of European descent. She does not associate with any particular religion. She and her boyfriend have been dating for 8 years. Lindsey has a Bachelor's of Science degree and works full time in marketing, earning about \$32,000 per year. She has been pregnant once. In 2008, at the age of 27, Lindsey

experienced an unintended pregnancy and had a surgical abortion procedure at a reproductive health clinic in a large Midwestern city. Lindsey and I met at her home for the interviews; we sat at her kitchen table and shared a cup of tea. She was friendly, inviting, and talkative; she seemed confident and pleased to share her abortion experiences.

Lindsey did not suspect that she was pregnant. She was working a lot of hours and feeling very tired, more tired than usual. One morning, after arriving at work, she was nauseated and vomited. She explained to a friend that she didn't know what was wrong; that she was feeling tired and had thrown up on several mornings; she thought she might have the stomach flu. Her girlfriend questioned Lindsey about the possibility of pregnancy, but Lindsey had not considered pregnancy because she was using birth control. After her friend's comment, Lindsey began to think about the possibility that she might be pregnant. A few days later her friend brought a pregnancy test to Lindsey at work during her lunch break. Lindsey went into the bathroom at work and took the test, which was positive, confirming the unintended pregnancy. Lindsey was in shock and did not absorb the information immediately. Later that afternoon, when she was talking with a customer, the reality of being unintentionally pregnant sank in and Lindsey left work.

I was working and feeling really tired, way more exhausted than normal. It was June so usually that's not a period where I'm a little more tired, so that was really strange and I couldn't explain that. And then one morning I got to work and got sick in the bathroom. I was like 'do I have the stomach flu?' and my girlfriend came in. 'I don't know what's wrong with me, I'm feeling like crap', she goes 'what do you mean?', 'I'm lethargic, I'm really tired, I have no energy'. There were actually a couple mornings where I got to work and had to go throw up and I told her that. She's like, 'is there any chance you could be pregnant?' And I went, 'as much chance as I ever have being on birth control'. And she goes 'alright, well, just give it a couple more days and see.' Of course that started my brain freaking out. A couple days later, I'd thrown up a couple more mornings. My friend came into work one day at lunch and said 'you're gonna take a pregnancy test' and I said 'okay'. So I went into the bathroom at work and took the pregnancy test and it came back

positive. I remember she left 'cause she had to go back to work, and she's like 'are you okay?', and I was like "yeah, I'm fine", 'cause it hadn't really sunk in yet. Then an older lady that I know came in and we were chit-chatting and I just crumpled and lost it. She's like 'are you okay?' and I'm like 'no', so I ended up going home from work.

Lindsey knew immediately that she did not want to continue the pregnancy. "As soon as my girlfriend asked me, 'what are you gonna do?', I said 'well I'm not keeping it', and she said 'okay'. I knew immediately." In the days following the positive pregnancy test, Lindsey talked with several friends, seeking support and acceptance for her decision. One of her friends is deeply spiritual and sensed that Lindsey was pregnant; Lindsey wondered why her friend had not said anything to her.

One of them is kind of spiritual. I'd told her I was feeling lethargic and then after the pregnancy test I called her and was freaking out. She's like, 'I knew it, I felt it', and then I'm like 'why in the hell didn't you tell me? I could've had this taken care of 6 weeks ago'. She's like, 'oh, I didn't think you wanted to know'; I was like, 'thanks'.

Another friend had experienced an unintended pregnancy when she was 15 years old. Lindsey thought she was helpful, but found her experience was different because she never had to make the decision for abortion, she had a miscarriage.

The other one, she had a miscarriage when she was about 15. She was probably the most help, but then not, because she didn't have to make the decision, it was just sort of was made for her.

Despite opposite views about politics and abortion, Lindsey felt supported by her best friend who agreed to help her with whatever decision she made.

There were lots of conversations with my girlfriend over the next few days of what to do. It's very odd; she and I are friends of different spectrums. She's very much a right wing republican, fairly religious. And I'm pretty far on the left and not very religious. She said, 'I'll do whatever I can do for you', and I said 'okay'.

Lindsey talked with several friends about the unintended pregnancy and her desire for abortion in an attempt to gain support and acceptance for her decision. “It all came about just me talking to them and freaking out about being pregnant and trying to find some sort of advice, solace from the people that I knew the best and that I trusted the most.”

Lindsey considered telling her boyfriend; she also considered telling the man involved with the unintended pregnancy. Events during this time period confirmed for Lindsey why she was choosing abortion and why she didn't want to tell the man who was the father. She ultimately decided not to tell her boyfriend or the man involved with the unintended pregnancy. She based her decision for abortion on her life circumstances; she had recently started a new job, a different career path and wanted to focus on work. Lindsey was not planning on having a child at the time, especially with the man involved.

I was debating on telling the guy that would have been the father and I believe that during that period time I had reconfirmation as to why I wasn't going to be keeping the baby and did not want to tell him he was the father. I love my boyfriend but he was oblivious so that one wasn't hard to not deal with. I guess for me it was never a question, I was having an abortion. I guess if the father had been my boyfriend I probably would have thought about it more, but at the same time I was 6 months into a new job, only making \$29,000 a year. I was trying to focus on work and didn't want to have a child at that time, and especially not with the man.

Lindsey considered the financial aspect of having an abortion compared with the costs associated with raising a child.

I thought a little bit about the financial aspect of abortion, because at the time I vaguely remember it being like \$600 or \$800. I didn't want to have my insurance cover it. I don't even know if my insurance would have covered it, but I just didn't want to. I just wanted to pay for it out of pocket and be done with it. I remember at the time being like, ‘wow, granted I'm only making \$29,000 a year, but imagine for someone making less money than me having to try and pay for this’. The reproductive health clinic has payment plans but, maybe that's the reason people decide to have babies because they can't afford to have an abortion; but then in the long run the kid's gonna cost you way more than the one time 6 or 8 hundred dollars. I don't know if people actually

think about that. The finances was never really a, it wasn't gonna make or break me, it was kind of a kid's gonna cost a lot more than this amount.

Lindsey did not suspect pregnancy because she was using a hormonal contraceptive vaginal ring to prevent ovulation and unintentional pregnancy. She occasionally would remove the vaginal ring during intercourse. Lindsey learned after the occurrence of the unintended pregnancy that the hormonal contraceptive vaginal ring should not be taken out for more than 3 hours. “I was on birth control at the time. I was on the hormonal vaginal ring and as I discovered, you can't leave it out for more than 3 hours because it leads to pregnancy.”

Lindsey went to a local clinic to confirm the unintended pregnancy and get a referral for the abortion. Her best friend could not accompany Lindsey, so she went by herself. During her clinic visit, Lindsey felt chastised by the nurse for the occurrence of the unintended pregnancy. She felt that the timing of the “use birth control” lecture was inappropriate; Lindsey needed the nurse to help her deal with the situation at hand, not lecture her about what should have happened.

One of the practitioners who I had a very brief run-in early on in the process started to give me a lecture and I went, ‘no, no, no, time out. That’s not what I’m here for right now. We need to just move on from this’ and she did quickly. There's a time and a place for the “you better make sure you use birth control every single time you have sex” lecture and the time for that lecture is not when somebody comes in and finds out that they're pregnant. At that point you just have to deal with the situation that's at hand, because at that point the ‘oh, shit’ has happened and now you have to come up with the solution of how to fix it. You can't change it; sure you can wish and hope and pray you have a miscarriage, but, yeah, you can't change it.

Lindsey was seeking knowledge and emotional support from the clinic staff during that initial visit and confirmation of the unintended pregnancy. She expected nurses to be kind, caring, and empathetic; Lindsey did not expect to get the “use birth control” lecture.

Receiving a lecture and feeling criticized was not helpful for Lindsey. She wanted matter-of-fact answers, reassurance, and a calming, human touch.

A medical professional can give you as much information as they know, the black and white factors and potentials, but there's still that emotional support. Having somebody, at least while you're there, not treating you like a criminal or a delinquent or lecturing you like a bad child, that definitely helps you, definitely. Somebody just being like, 'okay, this is what the situation is', 'this is how we gotta deal with it' and having somebody there to at least offer a reassuring hand on the shoulder, that human touch, at least calm some of the nerves.

The local clinic confirmed Lindsey's pregnancy and referred her to a reproductive health clinic in a larger city for the abortion. She waited about a week and a half for her first appointment at the abortion clinic; the waiting was "very stressful". During the waiting time, Lindsey learned that one of her coworkers wanted children but could not get pregnant. She wondered why she was pregnant and didn't want to be while someone else wanted to have a child and couldn't. Lindsey considered the option of adoption, but did not feel she could continue the unintended pregnancy and not parent herself.

I remember at the time one of my coworkers had just told me a story about how her daughter was an invitro baby and how long it had taken her and her husband to try and get pregnant and they didn't. I remember I was feeling sort of guilty, I don't know if guilty is the word, just remorseful. It's difficult. I was definitely having the conversation in my head of 'why am I pregnant and I don't want it and somebody else can't when they really do'. Briefly I was like, 'well, I could have it and then adopt it', and I just went, 'no, I can't do that'.

A friend accompanied Lindsey to the city for her first appointment at the reproductive health clinic. A nurse who drew Lindsey's blood to confirm the pregnancy was positive and cheerful. After the blood test, Lindsey had an ultrasound to determine the gestational age of the pregnancy. Lindsey could not see the screen during the ultrasound procedure; when the technician asked if she wanted to see pictures, Lindsey declined. She was curious, but felt it

best for her mental health if she did not view any fetal images. When Lindsey did sneak a peak, she could not see anything. The woman performing the ultrasound was not as cheerful as the woman who had drawn her blood; Lindsey rationalized that she must need to keep her personal feelings hidden to avoid influencing a client's decision about abortion. Lindsey reflected that making the decision for abortion is not a cheerful or upbeat experience for anyone.

The first time was for the test to make sure you're pregnant. I went with a friend of mine. The nurse that drew blood for the pregnancy confirmation was very upbeat. Then they did an ultrasound. The way that the tech had it set up, you couldn't see the screen. She asked me at one point if I wanted to see the results of the ultrasound and I said 'no'. Not that it would have changed my decision, but I had in my brain it's just abstract cells. I didn't want to see, but I did. When she turned around I did peek, but at that point I couldn't see anything, which was probably good and best for my mental health. The woman that was doing the ultrasound was cold, but I almost wonder to do that job if you could be any different. I would think personal feelings aside; you would probably be trying to not give the patient any personal inflection. Not that I want somebody to be really warm and fuzzy while I'm there; I mean abortion is not a fun decision for anybody.

After her initial appointment, Lindsey's abortion procedure was scheduled two weeks later. Her best friend accompanied her to the reproductive health clinic in the city on the day of the abortion. The abortion was scheduled on a Thursday, so Lindsey missed work on Thursday and Friday that week. She was relaxed about the abortion ahead of time. As they waited, Lindsey recalled that no one in the waiting room made eye contact; everyone looked down at the floor, not wanting anyone to recognize them or identify why they were at the clinic. She had been at the clinic in college for contraception. Lindsey felt a little nervous when they called her name and took her into a room. She felt okay as they reviewed the procedure with her and explained what to expect afterwards.

The second visit we went in and waited for awhile. I remember it was really interesting being in the reproductive health clinic waiting room because I



visited the reproductive health clinic when I was in college 'cause it was the inexpensive form of birth control. It's always like nobody makes eye contact 'cause nobody knows what anybody is there for, so everybody's just looking down. I was very fine and nonchalant about it beforehand and then got a little nervous going in. Beforehand they went over everything; that you might have spotting and whatnot, and I was okay.

The actual abortion procedure was not painful for Lindsey. She had some discomfort at one point and the nurse reassured her that the procedure was almost complete. Lindsey was surprised how quickly the abortion was over and glad the physician was skilled and professional.

The procedure itself didn't hurt, but I distinctly remember at one point just going 'ouch'. I think that was when they punctured the sac or whatever it is, and the nurse who was there said, 'okay, we're almost done' and I went, 'okay I can handle this then'. I was really surprised how fast it happened, which is probably thanks to the doctor who was very professional.

Lindsey found it curious that all of the clinic staff were female except the physician. She was comforted by the nurse who stood beside her during the abortion procedure. The woman held Lindsey's hand and talked to her about the progress of the procedure as she watched the physician. After the procedure, she stayed with Lindsey for awhile ensuring she was okay.

I did find it interesting that every person working at the reproductive health clinic, except for the doctor who performed the procedure, was female. And I didn't even see him; he wasn't even in the room until I was on my back, legs spread, prepped and ready to go. The woman, I don't know if she was a nurse, she stood next to me, held my hand and was keeping an eye on him to see where he was. She would say 'okay, it's almost over' or 'a few more minutes'. Afterwards she stood there for awhile for me and patted my hand and asked 'are you okay?', 'do you feel any pain?', 'is anything abnormal?' I remember being like, 'yeah, well, besides the fact that I just had something sucked out of me, oh, yeah, fine'. They said you can stay here as long as you need to, I don't remember sitting there for very long.

Lindsey's best friend was waiting for her after the procedure. She remembers the discharge instructions she received. She was panicked at the idea that she might have to

follow up for care at her local hospital. She was concerned that her abortion would be on her permanent medical record forever, making her private experience public knowledge.

My best friend was there when I came out. They told me to take some Advil or Tylenol if I needed it. They gave me a prescription, but I don't think I even got the prescription filled. I took Advil that day and possibly in the morning. I had a little bit of spotting the next day; they said if you continue to have spotting call us immediately and I remember thinking, 'oh, God please don't let me have spotting because I don't want to go to the local hospital and have them ask me what it's from, 'cause I'm sure it'll go on my record and I'll be ostracized forever'.

As Lindsey and her best friend left the clinic and walked to the car, Lindsey was enraged by a huge pro-life message on the fence around the clinic. The clinic's neighbor espoused that life begins at conception and that abortion is murder. Seeing the sign angered Lindsey while also strengthening her conviction that abortion was the best decision for her. Lindsey's best friend calmed her anger, ushered her into the car, and told her they were leaving.

I lost it in the parking lot. It was really hard because right outside they had a fence all the way around the reproductive health clinic and whoever the neighbor was had this big bulletin board, somethin' about baby's life starts so many days after conception and abortion is horrible. I actually remember looking at that thing and just thinking if I hadn't been so sure that the abortion was the best option for me that would have been a very difficult thing to look at. I remember feeling a lot of anger at that person and my friend is like, 'no, we're just gonna get in the car, we're gonna go, we're gonna leave'.

Being in the city, they had initially planned on going shopping after the abortion, but instead made the hour and a half drive home. Lindsey doesn't remember much about the evening afterwards; only that they had a few alcoholic beverages.

We had planned on going shopping afterwards 'cause we were in the city; she's like 'do you want to go?' I said, 'no, we're gonna go home'. And so we came home. I believe we started drinking, not as extensively as I would have thought we would have.

Lindsey's abortion occurred in the summer of 2008. By the fall, she and her best friend were living together; Lindsey had lost her job and her friend was getting divorced. Living together helped both of them; they were able to support and distract each other from their worries and troubles. When Lindsey would think about her abortion, her best friend would remind her how and why she made that decision.

She and I actually ended up moving in together that fall 'cause she was going through a divorce and I had lost my job. We moved in together which was very helpful; having someone who had been there with me, going through the whole process. If I came home, was having a bad day, and had been thinking about the abortion, which didn't happen a lot, we would talk about it. She was very good at reconfirming for me, 'Lindsey, you made the right choice for yourself, you've told me that this was the best decision for you, this was what you wanted to do'. And I was. I had told her "please reconfirm this for me when I'm 6 months down the road, when I'm having a hard time with it", and she said, 'okay, I will do that', and so she did that for me.

One of the most difficult aspects of Lindsey's abortion experience has been not having anyone with whom she can talk who has also experienced abortion and understand exactly what she has been through.

I think one of the most difficult parts of the whole thing for me was because I didn't want a lot of people to know about it. There are 5 people in the world besides myself that know about the abortion and to this day I am still best friends with all of them, well, except for the guy. None of those friends have gone through an abortion; some of them have been pregnant, one had a miscarriage and then my closet girlfriend had a miscarriage and then had a son. Another one had kids, but none of them have ever had an abortion. Not having someone to be like, 'so what's it feel like?' was a difficult situation. No one asked 'what happened? What did you do? What was the experience? What did you go through?'

Various events have prompted Lindsey to reflect upon her abortion experience. The weight gain from the unintended pregnancy was a constant reminder during the summer of 2008 that Lindsey had been pregnant and had had an abortion.

I think it was a difficult 3 months because I started gaining weight and then it took awhile for me to lose the weight even though it was summer. I was so

stressed out from work and the whole situation that it was difficult. I wasn't ready to be pregnant and have all the weight gain.

Lindsey would think about her decision for abortion when she would argue with the man involved with the unintended pregnancy. They continued to date on and off for about a year after the abortion. Lindsey referred to him as the “sperm donor”; their quarrels reaffirmed her decision for abortion.

When I would get into an argument with the father, I'm gonna call him the ‘sperm donor’, because he and I continued to see each other off and on for about a year afterwards. When I would get into arguments with the sperm donor it would reconfirm for me that I'd made the right decision. Even other times around him just confirmed for me that having an abortion was the right decision.

Anti-abortion commercials on television made Lindsey angry. She sometimes felt like writing letters; usually she changed the channel. Constantly hearing that abortion was wrong was difficult at times for Lindsey.

Occasionally I would see babies or commercials on TV, the ‘abortion is bad’ commercials, and I would get very, very angry. I don't think I ever wrote any nasty letters, but I used to change the channel. That would be very difficult to watch those.

Political advertisements also caused Lindsey to think about her abortion decision. Every time she learns that a political candidate does not support a woman’s reproductive right to choose abortion, Lindsey refuses to vote for that person. “Now, every time I learn of a political candidate who is not pro choice, ‘you're out’.”

An annual gynecological exam prompts Lindsey to think about her abortion. She sometimes wonders if she may still experience complications or problems from having an abortion.

I think about my abortion probably every time I go in for an annual exam. I wouldn't say I dwell on it, but there's sort of this in the back of my head, ‘oh, what if there are complications or what if something happened?’

Lindsey recently learned that two girlfriends cannot have children due to health concerns. Thinking about her friends' situation caused Lindsey to reflect on her own pregnancy and abortion experiences. She contemplated surrogacy for her friends that cannot achieve pregnancy, but want to have children.

I recently found out a girlfriend of mine has endometriosis. I don't know if it's that she can't have kids or that they recommend that she doesn't have kids. So thinking of that then brings up that I could have kids and this friend of mine can't.

Another girlfriend just got married again and her husband really wants to have kids of his own. She's had some health issues that make it risky for her to have another kid, and so the thought has popped up in my head, 'cause she's talked about surrogacy and in vitro and she's looking at all those options. I'm like, 'oh, could I be a surrogate?', and it was like, maybe after I have my own kids, so those kinds of things.

Seeing babies does not trigger thoughts and feelings about the unintended pregnancy and abortion for Lindsey; mostly she reflects on her own experiences when she is talking with friends about pregnancy and children. Her thoughts and feelings are transitory and short-lived, simply reminding Lindsey that she was once pregnant. She has no regrets about her decision for abortion.

I don't just think about the unintended pregnancy and abortion when I see babies on the street; but, when a good friend of mine, if we're talking about somebody trying to get pregnant or somebody just had a baby, it kinda crosses my head. Not so much like, 'oh, this could me, I could've had a baby', nah, no, it just sort of was a fleeting thought; it reminds me that I was once pregnant, more than it reminds me that I had an abortion. No regrets.

During the past 4 years, Lindsey has not talked about her abortion experience with many people. She continues to date her boyfriend of 8 years, but has not told him about the unintended pregnancy and abortion. Lindsey inadvertently told the male partner involved with the unintended pregnancy about a year after the abortion. He indicated that he felt the

decision was hers and Lindsey felt some retrospective support in that knowledge; however, she did not feel his input would have influenced her decision or her actions. Lindsey considered the time in the past that she was involved with him to have been a learning experience.

My boyfriend does not know about it. And the other man that I was sleeping with at the time, I didn't tell him for quite awhile. When I did finally slip, he was supportive I guess. He's like, 'well, it's your decision', 'I wish you'd told me', and I said 'well, what difference would it have made?' That was a dumb period of time.

Lindsey considered talking with her mother who is a retired nurse, but she does not feel comfortable revealing to her mother or father that she was sexually active with more than one man during the same time period.

My mother was a school nurse, retired. We have a very mother/daughter relationship; we get along, but we're not friends. She's my parent and I love her. That's not to say that if I had gone to her and told her, I would be able to trust her and she would help me through it. I was just not ready to deal with, and probably won't tell my mother, that I was sleeping with two different men, not really a conversation I want to have with my mother or my father.

Sometimes Lindsey wonders if she will ever feel comfortable in talking about her abortion experience. She views society as judgemental and condemning in unfair ways; especially of women who have had abortions. In recognition of the potential to be criticized by society, Lindsey is guarded about sharing her abortion story.

There are times when I just don't know if I would ever tell somebody that I had an abortion. I think it's one of those societal things because it's so divisive. I think abortion is something that people can throw back into your face pretty easily. God forbid we look down on somebody that gets their 4th DUI (Driving Under the Influence of alcohol), but people don't think twice about looking down on somebody who's had an abortion or made the choice that it was best for them to not be pregnant. We're a very hypocritical society, so in recognition of that I'm very careful about sharing that information.

One aspect of her abortion experience that has been frustrating for Lindsey is not being able to openly discuss her experience. A dialogue about her abortion experience only comes up if Lindsey initiates the conversation. This has been especially frustrating for Lindsey with her best friend, who shared in her abortion experience. Lindsey and her best friend refer to Lindsey's unintended pregnancy and abortion as "the alien invasion". Her friend will talk with her about the abortion experience once Lindsey opens the conversation to the topic. Despite their opposite political views, Lindsey feels supported by her best friend. Political commercials prompt Lindsey to reflect on her experiences of unintended pregnancy and abortion. She believes friendship transcends politics.

It's very frustrating for me. My girlfriend and I haven't really ever talked about the abortion. If I bring it up, I'll be like, 'oh, I was thinking about it the other day' - we call it the alien invasion, and I'll say something like, 'oh, I was thinking about the alien invasion', and she's like 'yeah, you alright?', 'yeah'. And she said 'what brought it on?' I said 'one of those commercials that your stupid political party brought up, paid for'. And she's like, 'yeah, I hate it when they do that'. And I'm like, 'yeah, me too'. For her it wasn't a political choice, for her it wasn't that I'm a liberal and she's a conservative. For her it was about 'my friend Lindsey needs to do what's best for her and I will help and stand by her through that'. I think it sort of transcends politics; it's just doing what's right for the individual.

Lindsey supports women's reproductive right to choose; she believes that each woman knows what choice is best for her and that women should trust their instincts.

I'm adamantly supportive of a woman being able to have the right to choose. 'Cause for some women they probably would have kept the child and it probably would have been a good decision for them. Some women would have terminated the unintended pregnancy. Other women would have gone through the pregnancy and adopted the child. It's so individual that it just reconfirms for me that the only person that knows what's right for you is you.

Lindsey believes abortion is a woman's decision that is not taken lightly. Women can make the decision for abortion and do not need to tell anyone else, they should trust their own feelings. Lindsey feels that abortion should be available to women as an option when an

unintended pregnancy occurs because people are not perfect. She does not believe in using abortion as birth control, but as a back up plan, a safeguard for the unexpected.

Every woman knows in her gut what's best for her and you don't have to tell anybody. It's your decision. I don't think it's something that should be as hidden and as secretive as it is, but at the same time women are given the privilege, right, choice to have children and I don't think that's something to take for granted, especially as I've seen friends who have struggled to get pregnant and then been disappointed time after time. Trust your gut. If there's the slightest inkling that the man isn't gonna be a good father or if you say 'oh shit' instead of 'yeah' when you get that positive pregnancy test, that's probably not the best situation. Not that I'm saying to be cavalier about using abortion as birth control, but just like we have oops safeguards, we have life insurance and we have car insurance for accidents that happen, we're human beings, accidents happen.

Lindsey believes that every woman needs to make her own decision when an unintended pregnancy occurs. For Lindsey the decision was straightforward; she imagines that the decision is not so easy for other women. As women, Lindsey believes that we need to retain our reproductive power and control by not letting politicians and men dictate our options. No one knows what is best for a woman except for that woman. Abortion is not bad; abortion is about keeping options available for women, about allowing women to follow their life plans. Having a child can affect your life plan too, but the choice should be for each woman to make, herself.

For some people it's not an easy choice. I don't envy the women who have to agonize over the decision; because I'm sure for some people who are more religious than I am it's not as black and white. I'm very glad and as women we need to exercise our strength by not letting politicians get involved with our choices. Nobody knows what's best for you except you. What's frustrating for me is people say abortion is bad. Well, it's not all about abortion, it's about keeping the option open and making it so that if the 'oh shit' does happen that somebody has an option to not screw up their life plan. People say babies screw up lives, well, not if you chose to have them. I think people have life plans.



Lindsey has been aware of the public controversy surrounding women's reproductive rights since she was young. Her mother was a school nurse and often shared nursing knowledge and stories with Lindsey. Lindsey remembered her mother talking about caring for young women who had experienced abortion when it was illegal; back alley, "coat hanger" abortions. Lindsey's mom talked about the physical and emotional trauma these girls suffered, along with the shame, guilt, and secrecy which shrouded their experiences. Lindsey was dismayed that such an atrocity could occur, especially in a liberal, western, coastal state. Lindsey could not imagine living any place where abortion is not legal, especially after listening to the horror stories her mother told about illegal abortion.

I have thought a lot about the legalities of abortion and my mom has told me some stories about when she was a nursing student or soon after. She had students come in when she was working at the schools. She said that there were a couple students who had had, she called it "coat hanger abortions" and the girls were infected. The pain and the trauma for them were terrible; the emotional distress that illegal abortion put those girls under was unbelievable. They couldn't tell their parents, they had to have an illegal abortion; and this was in a western coastal state which is fairly liberal. I can't imagine living somewhere where abortion is not legal, listening to her.

Lindsey's mom often talked about her experiences with pregnant adolescents as a school nurse, especially when it was just the two of them having a conversation. Lindsey and her mother didn't talk openly about unintended pregnancy over dinner because her father held conservative views about abortion; but, if the two of them were out shopping, they would talk freely about sexuality and women's reproductive rights. As Lindsey got older and went to college, she demonstrated her support for women's reproductive rights by attending protests and rallies. As she did so, her mom talked more openly about being a nurse and working with women. When her mom first graduated from nursing school she had wanted to

work at a reproductive health clinic, but she was living at home with her parents who forbid her from taking such a job.

My mom always has been very open about all kinds of anything medical. With my mother as a school nurse, she would come home with stories about how she had a pregnant kid at the school. It was never like a conversation we had at the dinner table, but if she and I were out somewhere shopping, 'cause my dad is fairly conservative, we would definitely talk about it. As I got more into college and started going to protests and pro choice rallies, she started to open up more. She talked about how when she graduated she had applied for a job to work for a reproductive health clinic, but she was living with her parents at the time and her parents strongly discouraged her from doing that, I think dissuaded her from doing that.

Lindsey recalled one heated conversation between her mother and father on the topic of abortion. Her mother explained the need for safe, accessible abortion as an option for her daughter and other women; her father could not refute the argument and was speechless. Lindsey speculated that the legality of abortion would never be an issue if women were in power in the world and the United States.

I remember that night we did actually talk about it at the dinner table. She and my dad very heatedly; my moms' like, 'I'm not in favor of killing anybody, I just want to make sure that my daughter can make a choice if she has to; that's what this is about'. And he's like, 'well . . .' and he couldn't come up with a good argument for not supporting abortion. The legality of abortion might be a different story if our society was run by women. I don't even know if we'd be having this conversation, having the legality conversation, if the world was, if the United States was run by women; abortion would be a non-issue.

Lindsey was very aware of the legality of abortion before her own experience with unintended pregnancy and abortion. She was living in Washington D.C. in 2003 during the 30<sup>th</sup> anniversary celebration of *Roe v. Wade*. Seeing the National Mall filled with people marching in support of women's reproductive rights was powerful for Lindsey.

I was living in Washington D.C. on the 30th anniversary of *Roe v. Wade* and there was like a 500,000 people march, they filled the National Mall; that was pretty powerful and pretty cool.

## **Amanda**

Amanda is an 18 year old Caucasian woman who works full time in the fast food industry. She earns \$700-\$800 per month. Amanda is a non-denominational Christian; she does not identify with any specific ethnicity. She and her boyfriend have been dating for about a year. Amanda described the relationship as loving and good; “the best boyfriend I’ve ever had”. Amanda completed the 11<sup>th</sup> grade and is working on finishing high school online. She has been pregnant once; Amanda had a surgical abortion in 2012, 2 months before our first interview. Amanda lives in an apartment in a large city in the western United States with her sister, her sister’s boyfriend, and their newborn.

Amanda was guarded when we began the first interview, then relaxed and opened up more after I explained the study and my support of women’s right to choose abortion. She provided limited verbal content. In fact, when we began the interview, I asked her to tell me about her abortion; she replied “it was sad and I was scared. I don’t know. That was pretty much it.” Amanda talked more with prompting and in response to specific questions. As we talked she described details of her abortion experience, including being candid about her feelings. During our conversations, Amanda only paused once; while she expressed sadness, I did not sense that she was crying. I believe she was waiting patiently for me to ask another question.

Amanda explained her first reactions to her pregnancy.

My boobs were hurting really, really bad, so I just told my boyfriend, ‘I don’t know what’s wrong with me’. I’d missed my period, too, and I was like, ‘uh-oh, I think I’m pregnant but I’m not sure’. So I took 3 pregnancy tests and they all said positive. Then I came to my mom’s house and I took one with her.

Initially Amanda's mother wanted Amanda to continue the unintended pregnancy and let her raise the child, but by the next day her mother had changed her mind.

My mom told me she wanted me to keep it, but it wasn't really up to her. She was really upset about me getting an abortion. At first she was saying, 'I would take the baby from you' and I was like, um, 'I would keep it if she wanted it' 'cause my first thought was to get an adoption, but my boyfriend's like 'if we're gonna get an adoption we might as well just keep it' and he's like 'we can't keep it'. He's like 'I don't want to give my baby away to someone else', and I was like, 'well if my mom wants my baby, I would happily give it to her 'cause she's divorced and she's all alone', but then she was kind of drunk, so the next day she's like 'no I can't do that'.

Amanda's mom did not support her decision for abortion in the beginning because she had helped Amanda's sister obtain an abortion when she was 16 years old. Amanda's sister made everyone view their mother in a negative way, so Amanda's mom did not want to be involved with Amanda's unintended pregnancy situation.

She had my sister get an abortion when she was 16 'cause she knew my sister wasn't ready; but, my sister made everyone look at my mom in a bad way 'cause my mom had her do it. So my mom didn't want to be involved with my unintended pregnancy and abortion. She was like 'I don't want people to drug me and hate me for helping you', but she ended up giving me \$300 to help me even though she didn't go with me to the clinic.

Amanda explained the pressure she felt from her boyfriend and her desire above everything to keep him in her life.

My boyfriend wasn't happy about the unintended pregnancy. I was kinda happy, but then I wasn't 'cause I really wish that I didn't get pregnant 'cause I didn't want to have to kill a child and I felt horrible about it. He kinda made me feel like I didn't really have a choice. Its like either get the abortion or lose the only person that's really cared about me like boyfriend wise; he's been like the best boyfriend to me.

Amanda may have acquiesced to her boyfriend's wishes, but she agreed with him that it would have been very difficult to raise a child at this point in their lives.

So, I felt I didn't have a choice. He didn't really support what I wanted, so I kinda just went with what he wanted; but, I knew why he did that, I

understood. I also know if I would have a baby right now I wouldn't be able to support the baby or anything and it would be a real big struggle. If I have a child I want my baby to have everything.

Amanda's boyfriend talked with his mother about the unintended pregnancy and their decision for abortion. His mother indicated that she would support whatever decision they made. Amanda was hopeful that her boyfriend's mother would be against the abortion; at the same she felt comforted knowing that his mother had also had an abortion.

He said, 'mom, I have bad news' or whatever, and she said 'what?', and he, 'ah, my girlfriend's pregnant', and she goes, 'oh, that's not bad news at all', and then he said, 'well, we're gonna get an abortion', and she's like 'oh, well, I understand that'. She's like 'I'll support anything you guys do' and that's how that went. I was kinda hoping she was gonna be against the abortion thing, but that didn't happen. But it kinda made me feel a little better knowing that she had had an abortion.

Amanda talked with her sisters and considered her boyfriend's feelings in making her decision for abortion.

Since I live with my sister, I would talk to her a lot. She was trying to get me not to have an abortion and that made my boyfriend mad. How I finally decided to want to have the abortion was because my boyfriend started telling me all the cons about having the baby right now. Then my other sister, she supported me getting it 'cause she's also had an abortion; I have 5 sisters. I just finally decided having an abortion was okay because he was gonna be upset if I had the baby. I wasn't worried about the financial problems . . . I knew that we would make it work if we had to, but it would be hard.

Amanda's sister helped her schedule the appointment for the abortion.

My sister went to this one clinic when she got her abortion when she was 16. She told me about the reproductive health clinic and then we scheduled the appointment for the 15<sup>th</sup>. We went around 11:00 o'clock in the morning.

The drive to the reproductive health clinic took 10 or 15 minutes, it was not far from Amanda's apartment. She only went to the clinic for one visit, the day the abortion procedure was scheduled. The abortion cost \$500; Amanda's mother paid \$300 and her

boyfriend paid \$200. Amanda's boyfriend and his mother accompanied her to the clinic on the day of the abortion. She really wished her mother had been willing to go with her.

I was scared to have his mom there because I don't really know her that well. I go with them sometimes to the store, but it was just weird for me. Having her there was a little awkward for me; I didn't feel like she was that supportive. I told her when we were at the store one time, I said 'I'm scared to get the abortion'; she just looked at me like I was a wimp or something. I wished that my mom could have been there 'cause it would have made me feel a lot more better.

Amanda is young and only recently had her abortion; she has not had years to reflect upon her abortion experience as many of the other participants have. She described the clinic and the abortion procedure in greater detail than other participants possibly because the experience was so new in her memory. Getting into the clinic was scary and uncomfortable for Amanda. She had heard about pro-life picketers that bomb abortion clinics and she was scared. Amanda had to use a doorbell to get inside the clinic; everything was locked up and the whole place seemed secure. She was aware of anti-abortion violence and was unnerved by tight security at the abortion clinic. There was a poster at the clinic that told the story of an abortion provider who was murdered by pro-life activists; that was very unsettling for Amanda.

I was scared. I've heard about picketers, people who go in there and bomb places. There was a picture at the clinic that said that the mob or the picketing people killed the doctor 'cause he gave abortions; that started creeping me out. You had to use a doorbell to get inside; everything was locked, it was all kind of scary. Overall the whole place looked secure, but it was a creepy place to be at; it was nice inside though.

Once she was inside the reproductive health clinic, Amanda felt more comfortable. There was a fish tank in the waiting room and everybody was friendly. Amanda did not feel like she was being judged; the woman who did the ultrasound was really nice to Amanda and made her feel comfortable. She gave her some medicine to help her relax.

Inside the clinic was really nice, the fish tank and everything seemed comfortable. I felt welcomed by everybody. And I didn't feel like I was being judged. I remember the one woman who did the ultrasound, she made me comfortable and she was really nice to me. She gave me a Valium or something to calm me down.

The physician who completed the abortion procedure was very nice to Amanda. She felt comforted when he talked her through the procedure and told her what to expect.

Amanda was able to assist with light sedation and use as much or as little as she needed to remain comfortable during the abortion. While she felt knowledgeable about the procedure and in control of her pain, she did not recall a lot of details.

Then the guy who did the abortion, he was really nice. He talked me through the procedure the whole time; he told me what he was doing every time. I had the laughing gas on and when I was getting too high from it, I would just take it off and breathe because I was the one who's controlling it. When I'd start feeling stuff then I'd put it back on; I controlled it the whole time. So I didn't hear him and I don't remember a lot.

Amanda recalled details about her discomfort after the abortion procedure and the help she received from the nurse.

As soon as I sat up I started crying, and the nurse said 'that's normal' or 'its okay', and had me get dressed. I had really bad pains in my stomach, so they had me go sit in this chair and they put a heating pad on. They take your blood pressure and stuff, but my cramps were like the way I was feeling was really bad, it felt like really intense for me, so I told them I get really bad period cramps, like really bad on my period, so 'is that making it worse for me?', she like, 'well yeah'. Then when she took my blood pressure she was like 'it's still a little high' so I sat there for 20 minutes.

Amanda did not recall a verbal exchange at the clinic going over discharge instructions or the availability of counseling.

I think the woman who did my blood pressure, the nurse, she handed me a bag. I don't really know if she talked to me actually, they just gave me this bag full of stuff like birth control, ibuprofen, and my infection medication. There were pamphlets in the bag about places that you can call, people you can talk to and stuff; they didn't really talk to me about my feelings or care after the abortion, just gave me pamphlets.

As she left the clinic, Amanda struggled. “It was really hard for me to walk to the car. I felt like my insides were falling out.” She took some ibuprofen when she got home but found that the medicine only helped a little. “My cramps are really strong, so it kind of toned it down, but it didn’t help really. I was in a lot of pain; I laid down the rest of the day.” Amanda missed one day of work. Her boyfriend and sister stayed with her during the days immediately after the abortion.

Amanda did not return to the clinic because she could not afford the additional fee.

They thought I could come back after 2 weeks, but I would have to pay like 50 or 150 dollars and I just didn’t have that around that time, so I didn’t end up going back for the follow-up appointment.

Amanda did take the antibiotics given to her, but did not start on the birth control pills because she thought they were an expensive brand from a foreign country. She is a cigarette smoker and was also worried about getting a blood clot. And one of her sisters told Amanda that this particular pill would cause her to gain weight. Amanda decided she would go to the local reproductive health clinic and get a birth control pill that was less expensive. At the time of our second interview she was not using any hormonal birth control method; Amanda and her boyfriend were using condoms during sexual intercourse.

The one that they prescribed me was Spanish or Mexican; I don’t know what it’s called. I smoke cigarettes, so I’m afraid to get blood clots. My sister said that stuff makes you gain weight and it was really expensive, so I didn’t even take it ‘cause I’m thinking about getting on a different one that’s cheaper. I like the local reproductive health clinic and get it for free. Right now I’m not on any birth control; we use condoms when we have sex which is about once a week.

At age 18, Amanda is the youngest participant in the study and the woman who has experienced abortion most recently. Amanda’s abortion occurred just 2 months before the



interviews. Her storytelling is concrete; she has had little time to reflect upon her abortion experience. In the first few weeks after her abortion Amanda felt sad, but that had eased.

For the first couple of weeks I was really upset and sad 'cause there's harm to human beings. I killed a baby and I didn't have a choice or a say in making the decision for abortion. I just kept thinking that in my head and I felt really bad. Then after 2 weeks went by I started to forget about the abortion and I wasn't really thinking about it that much. I felt okay with having had an abortion; I'm okay with it now, I'm fine; still really sad to me when I think about it sometimes though.

In the past month, the sister with whom Amanda lives had a baby. When Amanda sees her sister's baby she feels bad because she is reminded that she could have had a baby too. At the same time, seeing the challenges of caring for a baby has made Amanda feel better about having the abortion.

Seeing her beautiful baby, it made me feel really bad 'cause I wanted and I could have had that. I chose something different, so it just kind of made me upset. But now that I take care of the baby, sometimes I do see, though, taking care of the baby is hard. I see that my sister and her boyfriend are getting really tired and neither one of them, my sister's not working and her boyfriend barely even working and they're both exhausted and tired all the time. Thinkin' about them kind of made me feel a little better, 'well, at least you don't have to do all this'. I'm just trying to think of the bright side or the pros to not having a baby.

Amanda wished she had never gotten pregnant. She feels sad about having the abortion; at the same time, Amanda feels that she was not ready to care for a child.

I just wish I never got pregnant so I didn't have to go through any of that. I just feel sad, then I feel kinda okay about it at the same time because I see that it's hard and not something that I'm prepared to do right now. So it's a bittersweet thing.

In the three months since her abortion, Amanda has told one close friend about her experience. He did not condemn her actions or her decision. "I've known him ever since I was in 5<sup>th</sup> grade, so I pretty much tell him everything and I told him. He just looked at me; he didn't judge me or anything, he's like 'I understand'."

Amanda continues to have support from her boyfriend.

I can talk with him about the abortion whenever. If I do ever talk to him about it he's understanding and he doesn't get mad at me; he's very supportive of anything I have to say to him and he's there for me.

Amanda continues to live in the apartment with her sister and has also been able to talk with her about the abortion. Even though her sister tried to convince Amanda not to have the abortion, she is supportive of her decision now.

I talk to my sister about the abortion; she's supportive about it, too, now. She's upset that I got it, though, but she still feels at the same time like she can't really say anything 'cause she got one too. She thinks I shouldn't have had the abortion because she was pregnant and she couldn't see herself doing that anymore. So she's okay with the abortion now, she's supportive about it.

Amanda has not really ever thought about the legality of abortion; she believes that women should not have abortions because of feeling sad and upset. "I don't really think women should get abortions 'cause it's sad and what I went through, it's really upsetting. I don't think anyone should have to go through that, and everyone who has, I feel bad for them". Amanda believes women should "use birth control, and use condoms. If you're gonna have sex, make sure you're ready for a baby if you're not gonna use protection."

## Chapter 6: Findings and Interpretations, Across Case Analysis

In the previous chapter I presented women's narrative summaries and my interpretations and findings from the within case analysis. This chapter presents the identification of themes and provides a cross case analysis. Thematic analysis involves "finding common thematic elements across research participants and the events they report" (Riessman, 2003, p. 3). Themes identified by comparing and contrasting women's experiences of abortion in their narrative summaries were organized by research questions posed in the study.

### What are Women's Experiences of Abortion?

This research question sought to describe and better understand women's experiences of abortion; three themes were identified from women's narrative summaries. These themes encompassed feelings of disbelief at the occurrence of the unintended pregnancy, assessing physical, emotional, and financial support for continuing the pregnancy, and making the decision for abortion.

**"This (pregnancy) wasn't supposed to happen."** Women were shocked and dismayed when the unintended pregnancy was confirmed. No participant in this study planned on getting pregnant; they were genuinely surprised. Missing a menstrual cycle was the first sign that raised suspicion for these women, producing angst and distress. Eight of the ten participants immediately associated the missed period with the possibility of pregnancy. Lindsey did not suspect pregnancy; she initially attributed the lack of menstrual flow to normal side effects of her birth control method; however, as other symptoms of pregnancy (breast tenderness, nausea, vomiting) occurred in conjunction with the missed

period, Lindsey's friends began to suspect the possibility of pregnancy. Shirley was the other woman who did not realize she was pregnant.

Women validated their fears and confirmed the unintended pregnancy by doing a pregnancy test, either at home or at a clinic. Confirmation of the suspected and unintended pregnancy was distressing, provoking a whirlwind of thoughts and emotions. Women who had relied on birth control methods to prevent pregnancy were stunned; they never imagined they would be in a situation which required them to deal with an unintended pregnancy.

I had used a diaphragm, but not consistently. I didn't really give it a lot of thought until my period didn't show up. It was very upsetting, buying a pregnancy test, and then doing it, and finding it positive and then 'what am I gonna do?'

Barbara (P03)

I was on birth control pills, but I got pregnant. I missed my period and I got a pregnancy test; it came up positive. I remember feeling devastated. I was really caught up in 'oh, my god', 'what do I do?', 'what do we do?', 'what do I do about this?' and 'how's this gonna affect me?'

Elizabeth (P09)

Three participants, Donna, Kathleen, and Barbara, blamed themselves for the occurrence of the unintended pregnancy. They felt guilty about their inconsistent use of a reliable birth control method.

I was in high school and in my first relationship. I had girlfriends telling me what to use and what not to use. I was playing Russian roulette with birth control; I was just upset with myself.

Kathleen (P04)

Experiencing a second unintended pregnancy was especially difficult for Donna and Barbara. Both women were upset; they reflected on their behavior and knowledge with self-imposed judgment and criticism. Neither woman blamed the male partner involved with the unintended pregnancy as much as they blamed themselves. They were embarrassed and distressed.

I was really upset; really sad about the whole thing. I was very embarrassed about having gotten pregnant again. I felt so bad being in the same situation as I had previously; and just berating myself for making the same mistake again. I was more disappointed in myself; the first time I was really surprised and shocked. The second time it was just like, 'Oh god'.

Barbara (P03)

I don't know why I was so naïve; I know how babies get made, I've known it since I was a young girl. I wasn't using protection and we were in a relationship; well, I was using the old rhythm method. I was surprised. This wasn't supposed to happen.

Donna (P06)

After confirming the unintended pregnancy, women had to decide whether or not they were going to tell anyone else about their situation and if so, who they might tell. The male partner, friends, and family members comprised the repertoire of people from whom women chose to tell. Every participant told at least one person. Women talked with others about the unintended pregnancy in an effort to gain clarity and support around their decision making process and/or to seek help in obtaining the abortion.

**“I had no support (to continue the unintended pregnancy).”** Participants talked about support as they considered the trajectory of their lives and the potential future of a child. Women thought about the amount of physical, emotional, and financial support they and their child would receive from the father. Without a long term commitment from the male partner, women did not feel they had the option of continuing the pregnancy and parenting; they did not want to raise a child by themselves.

Rebecca and Lindsey recognized immediately that they could not rely on the male partner for any support. They did not want a lifelong connection with the male involved with the unintended pregnancy; severing ties with him meant not continuing the unintended pregnancy.

I wanted an abortion because I knew I didn't want to be with him. Things became clear to me at that point, when I found out I was pregnant; all of a sudden you realize where you are and what your relationship is and you see it more clearly. I just knew he wasn't a guy I wanted to be with long term; I didn't really want to be a part of his life or have him be a part of my life forever. I didn't feel like I could count on him.

Rebecca (P07)

For Donna, Kathleen, and Barbara, the male involved with the unintended pregnancy did not want a lifelong relationship with them. Donna spoke with her boyfriend on the telephone; as a young adult of 24 years, she recognized his lack of commitment.

I was in a relationship, I wanted that relationship. If I'd had support of the father, I'd probably kept that fetus and carried the pregnancy to term. So it was different, I mean it was sad 'cause I didn't want to terminate the pregnancy, but I didn't have a partner and I thought that was important. And the relationship was ending; he was like 'nope, I'm on my way to get my graduate degree and we're done'. So, I didn't feel like I could have a child alone.

Donna (P06)

Barbara continued to have contact with the male partner involved with her unintended pregnancy. She was also able to make a concrete assessment of the relationship and decided she could not continue the pregnancy and parent by herself.

At first I thought about, for about a week, I thought about 'well what if I . . . I don't really have to have the abortion, I could have a baby'. Having a baby just didn't seem like it was gonna be a realistic thing for me, 'cause there was only me. The person that got me pregnant wasn't really interested in getting married or even being fully committed to me as one person to one person. So, it didn't seem like I had a lot of options.

Barbara (P03)

At age 17, Kathleen was disillusioned and rejected when her first and only sexual partner wouldn't listen to her; he was already dating someone else and had moved on with his life. A senior in high school, Kathleen felt abandoned by her boyfriend. As an adolescent, she was still learning how her values and beliefs differed from those of her

parents; she was deathly afraid of her strict, pro-life parents finding out. Kathleen was alone in dealing with the situation; she felt she had no option to continue the unintended pregnancy.

I didn't want to have a baby and he was already dating somebody else. He didn't really break it off with me, he just started dating somebody else and I heard about it. I went to tell him and he basically laughed in my face and said 'you're just trying to get me back', and I said 'no, I'm serious'. He left me with the responsibility of it all; he left me in that situation. I didn't have a boyfriend, I didn't have a partner; I felt on my own. I didn't tell my mom or dad. I didn't want to ruin my life. I was planning on going to the university that next fall and I was signed up and ready to go. I just didn't want to upset my whole life plan.

Kathleen (P04)

Maria was also alone and isolated. By herself, in a new city, with limited resources, she never felt she had the option of continuing the unintended pregnancy. Maria only told a girl with whom she worked to gain assistance in finding a clinic.

I was going through a divorce actually; just gone through a separation. I had just moved to the city. I didn't have custody of my kids; I was going through a really ugly custody battle and I didn't even have my own children. I didn't have a place to provide for anything. I had nobody basically. I didn't have anything to offer anybody. I had a heavy alcohol history at that time. I talked to a girl that I worked with and she was telling me about a local reproductive health clinic.

Maria (P02)

Amanda thought about continuing the unintended pregnancy, but her boyfriend did not want to have a child. In contrast to Kathleen, Donna, and Barbara, Amanda's boyfriend wanted to continue the dating relationship. As a teenager, Amanda wanted to maintain the relationship more than anything else and keep him in her life. She came to understand his position to not continue the pregnancy.

My boyfriend wasn't happy about the unintended pregnancy. I was kinda happy, but then I wasn't. He made me feel like I didn't really have a choice. Its like either get the abortion or lose the only person that's really cared about me like boyfriend wise; he's been like the best boyfriend to me. He didn't really support what I wanted, so I just went with what he wanted; but, I knew why he did that, I understood.

## Amanda (P05)

Carolyn and Elizabeth were the only two women in this study who continued in a relationship with the male partner after the occurrence of the unintended pregnancy. In both cases, these women did not want a child at the time the unintended pregnancy occurred; they made their decision for abortion and then asked their partner to support them. Support meant agreeing with their decision, accompanying them to the clinic for the abortion procedure, and listening, talking, and crying with them. Both women married the man involved with the unintended pregnancy within two years.

Shirley was the only participant who was married when the unintended pregnancy occurred. She did not recall how she told her husband about the positive pregnancy test, only that she received no support from him. He refused to participate in the decision making process; she felt frustrated and alone. She considered the needs of their 3 year old son and the relationship with her husband in deciding that she could not continue the pregnancy.

I don't have any idea how I told my husband. I didn't feel like I had the support of my husband and he just indicated 'whatever you want to do is fine'. The real issue to me was, 'no, I want you to be a part of this decision', and he really put all of that on me. I remember being so angry with him about that and feeling so overwhelmed. I thought 'I can barely manage what I'm managing right now; I don't think I can manage anything else'. I remember going to the clinic and going through the counseling with my husband and him being so detached from it and saying, "whatever she wants I'll support, I'm just fine with it". And me trying to say, 'no, I want to hear what you think about it, don't just put this on me, this is an us kinda thing'. I was trying to engage him in the discussion of 'what are we going to do?' and that never happened so that was very frustrating. At the time I knew having another child was more than I could take; I knew I couldn't do it.

Shirley (P08)

All women considered the level of involvement of the male partner in their lives and the potential future life of a child in making their decision for abortion. Some women mulled over the possibility of continuing the unintended pregnancy and parenting. A male partner



who was absent, unsupportive, and/or unwilling to participate in raising a child influenced women's decision making processes; women did not want the sole responsibility for raising a child.

**“I did what I had to do.”** None of the women in the study made the decision for abortion thoughtlessly. Women considered how they would manage and what they had to offer a child physically, financially, and emotionally; they thought about the potential future of a child should they carry the pregnancy to term, as well as the future of their own lives. They evaluated their relationship with the male partner. Several women considered continuing the pregnancy and placing the child for adoption. The participants in the study did not see adoption as a viable option; none of them felt they could handle the emotional aspects of carrying a pregnancy to term and then relinquishing parental rights.

And giving it up was . . . I thought about it . . . it's hard to explain, but I didn't feel like I was capable of doing that. I just thought once I had the child I would feel like I couldn't let it go and so I didn't feel like I could emotionally handle having a child and then giving it to someone else; it didn't seem like an option to me, it seemed too hard.

Rebecca (P07)

Confirmation of the suspected and unintended pregnancy, evaluation of their relationships with the male partner, and consideration of adoption were elements of the decision making process for participants. These women evaluated their life circumstances as they considered their options. Women identified an imposed time period for making a decision for abortion based on the progression of the pregnancy; they wanted to make their decision and act on that decision as soon as possible. Women were pragmatic about their decision for abortion. Having an abortion was the right choice for them at that particular time of their lives.

Carolyn, Rebecca, and Lindsey knew immediately that they wanted an abortion.

I guess for me it was never a question, because I guess if the father had been my boyfriend I probably would have thought about it more, but at the same time I was starting a new job. I was 6 months into a new job, I had just switched careers; I was trying to focus on work and didn't want to have a child at that time, and especially not with the man. Briefly I was like, 'well, I could have it and then adopt it', and I just went, 'no, I can't do that'. For me, as soon as my girlfriend asked me, 'what are you gonna do?' I said 'well I'm not keeping it', and she said 'okay'. I knew immediately.

Lindsey (P10)

Elizabeth was also very certain of her decision for abortion. She discussed the choice with her boyfriend and made the decision together.

I knew pretty much right away this was not gonna be happy news for him. So we sat down in a quiet place together and I told him. He, of course, was upset and I was upset; he was trying to be there for me and supportive of me, but was very clear about not wanting a baby. We talked about it and it was an emotional discussion; then leaving it for awhile and then coming back the next day, coming back and talking about it again. We made the decision together.

Elizabeth (P09)

For Maria, Kathleen, Barbara, and Donna, the decision for abortion was more concrete. Similar to Amanda's initial sentiments, they felt they had no other options. These participants shared little details of their decision making process for abortion. They did what they felt they needed to do.

I was far from home, alone, and pretty much on my own. I just didn't think I could turn around and come home and say 'I'm home, I'm pregnant'. I just didn't think I could have a baby. It was like 'I can't have a baby', 'I don't know what to do' and 'I don't know how to do this' and 'this is not a good thing', so it was pretty clear to me. I firmly believe that I made the right choice.

Donna (P06)

Shirley, the only participant who was married at the time, and Barbara struggled with the decision for abortion. Shirley was overwhelmed and did not have support from her husband. During her first experience with an unintended pregnancy, Barbara felt she could not continue the pregnancy due to lack of support from the male partner. With the second

occurrence of an unintended pregnancy, she attended some counseling sessions to help her clarify her thoughts and feelings. With time, Barbara made a second decision for abortion.

That one too, I had toyed around with maybe carrying the pregnancy to term because I just thought, 'well maybe I can just do it on my own'. Having an abortion wasn't as quick a decision for me. I sort of went back and forth as to whether or not I was gonna have an abortion or not. I had a lot more discomfort about having a second abortion. I was really upset about just having to go through the whole thing again and I remember that I had some counseling sessions. I went to the clinic and they hooked me up with a counselor to make sure that having an abortion was what I wanted to do. And I remember the first time I went to actually have the procedure, I was crying so much that the doctor said 'we're gonna wait on this 'cause this doesn't feel good'; I was just too emotional about having the abortion. I continued to have these sessions with this woman and eventually I knew that having an abortion was what I wanted to do, but I was really grieving. I was really sad about the whole thing. So she told the doctor that I was probably gonna cry but that I had made my decision and that it was okay to proceed.

Barbara (P03)

Women addressed the unexpected positive pregnancy test result with self-evident intentions. They gathered up energy and sought to resolve the unanticipated situation of being pregnant. Women conducted a personal assessment of their life situation. They were thoughtful. They examined their own future and their aspirations; they thought about the potential future of a child. Women imagined what the world would be like for this child and themselves. In doing so, these women considered their relationships with the male partner, as well as relationships with family members and friends. They reflected on their living situation, employment opportunities, finances, and being able to provide for the needs and wellbeing of a child. As these women made their decision for abortion, they expressed that having an abortion was the right decision for them at the time.

Life circumstances varied greatly for the women in this study. Despite variations in age, education level, employment status, amount of income, presence and support of a male partner, existence and needs of other children, and living situations, the commonality for all

these women was that they could not continue the unintended pregnancy; they each made a decision for abortion. Women shared that they did what they had to do, what they needed to do. They expressed sadness, but affirmed their decision for abortion. Reflecting on their abortion experiences women voiced regret that their life circumstances were what they were at the time of the unintended pregnancy and that those circumstances did not allow them more options or to make a different decision. Women wished to be smarter, wiser, and more financially secure; they wanted male partners who would be emotionally, physically, and financially supportive and a stable, safe living environment.

**What women's narratives didn't say.** Equally important in analyzing the textual database was what was lacking in women's narrative summaries. In telling their stories, women spoke little about arranging for the abortion. Scheduling an appointment for the abortion was simply a matter of making a phone call to a local clinic. All of these participants were aware of the legality of abortion, had access to a clinic, and managed to come up with funds to pay for the abortion procedure. Only one participant, Carolyn, had insurance coverage for her abortion procedure in 1988.

One of my friends in school told me what to do and we went down to the city and went to the clinic.

Kathleen (P04)

I just called my medical provider and explained the situation and they made the appointment for me and I went in.

Carolyn (P01)

I just called 'em and I went in and that was it.

Maria (P02)

Women also talked little about the actual abortion procedure, especially if the abortion occurred some time ago. The use of medications for sedation and/or anesthesia may have influenced women's perceptions of the actual abortion procedure. Extraneous events

such as comments from a provider, counseling sessions, being sick and needing to reschedule, and the waiting room were more memorable for these participants than the actual abortion procedure. Women who experienced abortion more recently, Lindsey in 2008 and Amanda in 2012, recounted more details about the actual abortion procedure and, interestingly, the clinic waiting room. Since the majority of participants had experienced abortion in the 1980s, it may be that details of the actual procedure have been lost over time as other thoughts and feelings associated with the abortion experience have been committed to memory. Maria was the only participant to have an abortion in the 1990s; her lack of details about the abortion procedure may be due to the short time span of one week from when she made the decision and then had the procedure, ambivalence about her decision, or perhaps as her means of coping; she stated several times that she was drinking heavily at that time of her life and has simply blocked out the abortion experience.

Women didn't speak about the abortion much after the actual procedure. The ride home seemed to signify the end of the abortion experience for participants. Women discussed moving on with their lives and getting back to normal.

You just think, 'okay, that's done, I'm goin' back to my regular life and I'm putting this behind me'; that is exactly what you want to do because you don't want to think about the abortion too hard.

Elizabeth (P09)

Some women talked with friends and/or the male partner during the day of the abortion procedure, but the experience essentially ended at sundown. As the light faded away, women's voices about their abortion experiences fell silent.

I felt very relieved; I don't remember feeling anything else but relief. That the abortion was done and I did it and I had a lot of other things I had to deal with then; so whatever I was feeling, it just went underground.

Shirley (P08)

I didn't feel a huge sense of loss. I felt like I did what I needed to do and I wasn't gonna judge it. I think I compartmentalized the abortion pretty well.  
Rebecca (P07)

Women may have tried to go on with their lives, to get things back to normal, but sociopolitical events and issues intruded on women's secret world of being a woman who had an abortion.

### **What Historical Influence has Political and Social Events had on Women's Experiences of Abortion?**

This research question sought to explore and better understand the impact of social events and political issues on women's perceptions of their abortion experiences over time; three main themes were identified from women's narrative summaries; religion, politics, and telling. These themes encompassed the influence that religious and political issues had on women and their experiences of abortion, including the impact of these issues on the act of telling others about the abortion experience. Religious teachings incorporated parental values, childhood traditions, and negotiating spiritual beliefs. Political issues encompassed pro-life tactics (protestors, violence, commercials, billboards) and women's responses to these anti-abortion measures, the legality of abortion, and surviving the current anti-abortion political climate. Telling others about having an abortion covered talking with friends, family members, parents, partners, and children, with an emphasis on the personal nature of the abortion experience. Women spoke about theoretical conditions for sharing the abortion with others, as well as not telling.

**Religion.** Religious teachings, and especially a Catholic upbringing, influenced women's thoughts and feelings about abortion both at the time of the unintended pregnancy and in the time since. Parental values and childhood traditions impacted women's thoughts

about their decision for abortion and continued to invade their thoughts and feelings about the abortion after the actual procedure. Participants have negotiated the impact of religious teachings on their abortion experiences to varying degrees.

***“I understood that my parents thought abortion was wrong.”*** Maria identified with Christianity, but did not specify a Catholic upbringing; she was influenced by school, church, and her parents’ beliefs.

My family never talked about anything like pregnancies or sex so I was really naïve. It was my school and my church, ‘cause I went to a private school, that instilled in me that abortion was wrong. We never really talked about it with my parents; I understood that they thought abortion was wrong.

Maria (P02)

Kathleen, at age 17, felt she had no guidance during her childhood. She was deathly afraid of her strict parents. Like Maria, Kathleen understood that her parents thought abortion was wrong. Interestingly, Kathleen read the bible, searching for guidance in handling the unintended pregnancy situation by herself.

My parents weren’t involved in my life, they didn’t know what I was doing. They were involved in their own lives. It’s like ‘do what you’re told’ but then they don’t watch you. I was deathly afraid of my parents even knowing; my parents were very strict. I read the whole bible when I was going though that, trying to find the answer in the bible. ‘What should I do?’ I was so mixed up; 17 years old, with no going to church, no listening to sermons.

Kathleen (P04)

***“Getting an abortion is about the last thing that a good little Catholic girl would do.”*** Negotiating the decision for abortion involved reconciling religious beliefs from their upbringings with their personal life circumstances and their own evolving beliefs about life and the world. This was especially true for Donna and Elizabeth who were raised in strict Catholic households. They had to come to terms with their decision for abortion and their philosophical views of the world.

I had some shame. I was raised of Catholicism, from birth to senior in high school. I was an adamant pro-life group member in high school; I was an organizer, I went and did protests, and flip flop that to making the choices that I needed to make and then coming to terms with my philosophical shift was hard. I drank the 'kool-aid' of Catholicism that you do not have an abortion, you have a child. So it was very difficult for me to philosophically come to terms with my decision.

Donna (P06)

When you grow up Catholic and in a large Catholic family, guilt and shame is a huge part of your upbringing. You're raised as a group and there's something about 'towing the line' that's part of your upbringing as well. And towing the line means being a good little Catholic girl. And getting an abortion is about the last thing that a good little Catholic girl would do. I was 19 years old; I was scared; I couldn't tell anyone in my family. I felt like I would have been ostracized from my family if they would have known.

Elizabeth (P09)

At the time of the unintended pregnancy, Elizabeth had been questioning her own values and beliefs against those of her upbringing. She had been exposed to different religious ideas by attending a public high school.

I was so entrenched in this huge Catholic family that lived in this big Catholic parish and we were taught that we only played with Catholic children. As I got older I did have friends that were not Catholic, when I got into high school, I was at a public high school. That was a big change; all of my older brothers and sisters had gone to Catholic high schools, but the bottom 6 did not, we went to public. I came into the public system younger, so my world opened a little bit more.

Elizabeth (P09)

Elizabeth continued to question the beliefs of her Catholic upbringing when she took a course about religion during her first year of college, before she had the abortion.

One of the first classes I had when I got to college was an Introduction to Religion and I learned about all these other religions that were out there; blew my mind. Talking about Buddhism and Hinduism started me down a path that is this interest in all religions - what do they have in common, what's different about them, and what makes sense and what doesn't. I have a strong spiritual life; I believe in a higher power, in something greater than myself. I have a lot of negative feelings about our religious organizations that were created by men that we have on this earth, particularly in the United States. I moved



away from the Catholic Church in college and I started visiting different religions.

Elizabeth (P09)

Being at a public high school and taking a course on religion in college seemed to prompt Elizabeth to question her religious upbringing. Perhaps the questioning of her childhood beliefs prompted her to take the class in college, which helped her with the decision for abortion. It is unclear what prompts some women to reflect on their own values and religious beliefs, while others attempt to negotiate their decision for abortion within their childhood church teachings. Elizabeth was able to articulate her spiritual journey around and in response to her decision for abortion. Other women seem to have never questioned the religious beliefs with which they were raised or have questioned them very little. Some women have attempted to negotiate their decision for abortion within their childhood religious teachings, sometimes with emotional distress resulting from contradictory beliefs.

*“You don’t grow up steeped in Catholicism for 18 years and be able to just throw that off.”* Participants made their decision for abortion based on their life circumstances at the time the unintended pregnancy occurred. Having an abortion, which is what each of these women decided they needed to do at the time, caused women to reflect on their own religious beliefs. As a result of having an abortion, several women began to compare and contrast their religious upbringing with their adult beliefs and philosophies. Negotiating childhood dogma learned through parental belief systems happened in varying degrees over different amounts of time for participants. Donna and Elizabeth have been negotiating the influence of childhood religious teachings on their own philosophical views throughout their adult lives.

I firmly believe that I made the right choice and I have the right. But coming to terms with teachings and the poisoning that is anti-choice philosophy was

really hard. It's taken a long time to have compassion for myself that I needed to make those decisions for abortion.

Donna (P06)

I've never talked to anybody else who has had an abortion. Do you ever think, 'oh, my gosh, that was a terrible thing that I did there and maybe I shouldn't have done it?' I wonder . . . there's always a little bit of that maybe. I think it comes from religion. I think that what's out there in public is coming from religion. It comes from basically growing up in a religious culture; you don't kill other life or you go to hell basically and you're punished by God. You don't grow up steeped in that for 18 years and be able to just throw that off.

Elizabeth (P09)

Over time, Donna and Elizabeth have gained knowledge and understanding of their own spirituality; they have navigated the religious beliefs of their childhood and assessed their own beliefs, especially with regards to their abortion decision. It is possible that having an abortion prompted a self-examination of beliefs; it is also possible that exploring religious teaching from their upbringing helped them negotiate the decision for abortion. Most women in the study have entertained thoughts about religion and abortion, but many did not articulate the details of their experiences the way Donna and Elizabeth were able to do. Perhaps the details reflect their comfort level with their own spiritual journey and the place where abortion fits.

*“You can't belong because of their beliefs.”* In contrast, Kathleen struggles with religion and her abortion experience; she continues to feel conflicted and emotional about her abortion. No matter where women were on their personal spiritual journey, rejecting the ideals of traditional religious teaching that abortion is wrong was necessary to make the decision for abortion. After having the abortion, women were left feeling excluded from religious organizations.

When you have an abortion, you don't feel like you belong to this religion where certain things are expected of you and you're expected to be this certain kind of person when you know inside that you're not. The Catholic Church

doesn't believe in birth control; I had my own ideas of what made sense and they didn't line up with the Catholic Church.

Elizabeth (P09)

They're one sided about abortion. If you're Christian you should be accepting and they're not accepting. So that gets you sad. It's like you can't belong to anything; you can't belong to a church because of their beliefs and you can't belong to a group because of their beliefs.

Kathleen (P04)

***"I don't really understand that abortion was a horrible thing."*** Some women have struggled with Christian principles since having the abortion. For women who did not identify difficulty in making the decision for abortion based on religious views, with time, even some of them came to question whether or not they needed to ask god for forgiveness.

I think later on in my life I may have wondered if I did the right thing, but not to the point of wishing I hadn't had the abortion. I mean praying about it and asking God for forgiveness, if abortion was a horrible thing, then I apologize. I don't really understand that abortion was a horrible thing, but if it was, I guess in that respect I probably sought some kind of forgiveness.

Rebecca (P07)

***"I felt bad."*** Maria's Christian beliefs have imposed guilt and shame on her for having an abortion; "I still have guilt about it. It just went against my Christian beliefs."

Kathleen is still emotional and conflicted about her decision for abortion.

I'm listening to the Christian radio and they start saying abortion's murder and it makes you feel bad, 'cause I am Christian, but you also have a choice, you do. On the Christian radio they talk about abortion; they don't know my decision; they don't know my feelings about my abortion. They're saying that they're against abortion; all they talk about is how bad it is to have an abortion. I was listening to that radio station thinking 'really?'

Kathleen (P04)

Barbara has struggled with guilt about her abortions for years. In an attempt to resolve her feelings she once attended an abortion survivor's group at a Catholic Church. She did not find comfort in religious teachings, but rather from the knowledge that she was not the only woman in the world who had terminated more than one unintended pregnancy.

I struggled with the issue for a number of years, into my mid 30s. I had a lot of guilt. I went to some sort of Catholic abortion survivor's group. I don't remember too much about it. I do remember there was this one woman who looked like she was maybe in her early 20s and by that time I was in my mid 30s. She had had 5 abortions, so I was like, 'wow'; I didn't feel so bad because I'd had 2. It wasn't really a very nice thing to think maybe, but I didn't feel so much alone 'cause other people had had abortions too, more abortions than me. She didn't see it as much of a problem; it didn't appear that she felt very guilty about it at all.

Barbara (P03)

Some women have come to terms with the difference between their action of having an abortion and their beliefs about religious and church teachings. Other women continue to grapple with the discrepancy; their religious upbringings and personal spiritual beliefs impose guilt and shame. They find it difficult to associate with religious organizations that do not allow for forgiveness or acceptance as human beings who made the best, and possibly only, decision they could when the unintended pregnancy occurred.

Religion is intertwined with the current political climate in the United States. Since the mid-1980's, abortion and religion have been associated along party lines. Democrats are now seen as liberal, supportive of women's reproductive right to choose abortion and freedom of religion. On the opposite end of the continuum, Republicans are viewed as conservatives who espouse Christian ideals of heterosexuality and support male control over female reproduction; they believe abortion is murder. Most of these participants (7/10) had their abortions during the 1980's when these political changes were occurring; over the past 30 years, they have reflected on how these political changes have influenced their perceptions of their abortion experiences.

**Politics.** The political climate influenced women's experiences of abortion before, during, and after the abortion procedure. Even the youngest of participants and the women who had the most recent abortions encountered anti-abortion tactics and language during

their abortion experiences. Women were aware of pro-life messages which equated abortion with murder; they were frightened by protestors, stories of clinic bombings and murdered abortionists; they were distraught at being called “baby killers”. While making their decision for abortion and throughout their abortion experiences, women negotiated and were angered by anti-abortion messages. Kathleen and Barbara were especially angry about gender inequalities. Participants were aware of the legality of abortion and concerned about a return to the “dark days” if *Roe v. Wade* is ever overturned in the courts. Women negotiated the current anti-abortion political climate by rationalizing their decision for abortion and protecting themselves from judgement in the face of anti-abortion measures.

***“I didn’t feel like I was killing my child.”*** Since Kathleen was under 18 years of age at the time of her abortion, she was required by law to tell her parents or seek judicial bypass. Deathly afraid of her strict, pro-life parents, Kathleen chose judicial bypass, the process by which she obtained permission for an abortion from a judge, without her parents’ knowledge. On her way to the court house, she was exposed to anti-abortion voices equating abortion with murder.

A judge had to okay the abortion. I remember walking down the road and I heard people saying ‘baby killer’ and this lady said ‘just ignore it, just keep going’; I didn’t see any people around.

Kathleen (P04)

Amanda, who had her abortion 2 months prior to our first interview in 2012, was aware of anti-abortion violence which induced fear, especially when she went to the reproductive health clinic on the day of the abortion procedure. She was unnerved by the extensive security, but felt safe once she was inside.

I was scared. I’ve heard about picketers, people who go in there and bomb places. There was a picture at the clinic that said that the mob or the picketing people killed the doctor ‘cause he gave abortions; that started creeping me out.

You had to use a doorbell to get inside; everything was locked, it was all kind of scary. Overall the whole place looked secure, but it was a creepy place to be at; it was nice inside though.

Amanda (P05)

Women's experiences of abortion were not only impacted by anti-abortion language during the abortion process, but immediately afterwards. Lindsey was caught off guard emotionally by a billboard in a neighbor's yard next to the abortion clinic.

I lost it in the parking lot. It was really hard because right outside they had a fence all the way around the reproductive health clinic and whoever the neighbor was had this big bulletin board, somethin' about a baby's life starts so many days after conception and abortion is horrible. I actually remember looking at that thing and just thinking if I hadn't been so sure that the abortion was the best option for me that would have been a very difficult thing to look at. I remember feeling a lot of anger at that person and my friend is like, 'no, we're just gonna get in the car, we're gonna go, we're gonna leave'.

Lindsey (P10)

Anti-abortion language and tactics affected women on the way to the abortion, during the abortion, and immediately afterwards. Maria and Kathleen were forced to think about their unintended pregnancy as a baby when given pamphlets on fetal development just a few weeks after their abortion procedures. Maria met a stranger at a restaurant; "he gave me these little tiny feet that were for a pin and he gave me a pamphlet on how kids develop in the first couple weeks".

I didn't realize how much that child was already developed, I really didn't know even at that point. I was at a restaurant one time and I met this man and was talking to him. He gave me these little tiny feet that were for a pin . . . he gave me a pamphlet on how kids develop in the first couple weeks. (Maria)

Kathleen was given a pamphlet on fetal development by a class mate in high school.

In school somebody must have told somebody and then one of the girls gave me a pamphlet of what a baby looked like. They didn't give me those things; they didn't talk about those things when I was pregnant, at the reproductive health clinic. You see a baby grow in your stomach at 7 weeks old and it's almost fully formed. The pictures made me think, 'what did I just do?'

Kathleen (P04)

Tiny feet and fetal development pamphlets imposed guilt on women, emphasizing that the unintended pregnancy was a baby with no regard for women's own beliefs about life. Even years after the abortion procedure, women were forced to think about their abortion experience when faced with politically motivated references to abortion as murder. Comments from a fellow nurse inflicted emotional distress on Barbara in the months following her second abortion.

I remember at the clinic where I worked, one of the nurses said 'yeah, we do all our baby killing on Friday' 'cause they had an abortion service at the student health service on Fridays. That was always like, 'wow'; that was a comment that's stuck with me; it was a difficult time.

Barbara (P03)

Shirley did not think of her abortion as killing in 1986, but has come to question those thoughts in the past two decades as abortion opponents have continually referred to abortion as murder.

Socially abortion is shameful, it's killing. I didn't feel like I was killing my child, that's such a strong word, but I didn't feel that. I don't feel that now, although with all the current political things going on, that is in my face a lot. I understand how people, how women, begin to think that abortion is killing. It isn't that I haven't had that thought go through my mind either; I have, actually, I have.

Shirley (P08)

Amanda, the youngest participant at age 18, and the woman with the most recent abortion experience, 2 months before her participation in the study, does not seem to question that abortion is murder; she seems to have integrated anti-abortion language into her own vocabulary without any questioning.

I really wish that I didn't get pregnant 'cause I didn't want to have to kill a child and I felt horrible about it. For the first couple of weeks I was really upset and sad 'cause there's harm to human beings; I killed a baby.

Amanda (P05)

Women have been made to feel and think that abortion is synonymous with murder through pro-life language and political tactics. They are constantly bombarded with the idea that abortion is killing; an idea that has taken hold politically since the mid-1980's when abortion opponents were unsuccessful in passing a Human Life Amendment. Pro-life tactics make women and others think of women who've had abortions as "baby murderers". In addition, abortion opponents have pushed the courts to define "life" as beginning at conception.

*"Is that life?"* The question of when does life begin has filtered through participants' thoughts and feelings over time.

I felt like it was such an early abortion - is that life? I think the whole discussion about when does life begin, is there an answer to that yet? I'm not sure. I would say that that question's still hanging. Did we just take out a mass of cells that were developing? Or could you say that was a human life? I don't know; I'm not sure. How much of it is blown way up to get people to believe so that they won't have an abortion? So that they'll see abortion as bad and immoral? In some religions, God will punish you. Everyone has to go through their own faith journey about what's right in their life and what's not right, and yet you're not doing that in a bubble. So all of that noise and commotion going on around you absolutely makes you think, look back at that experience and think, 'what was that really?' and 'what does it mean to me?'

Elizabeth (P09)

I don't think having an abortion is something to be ashamed of. I think it's a cultural thing where people want to shame you because they want you to do what they think is right. I think people have the right to believe whatever they want to believe about when life begins, but I don't think they have the right to legislate their religious beliefs on others. That's why we have freedom of religion and our Constitution. I think it's a wonderful thing because it allows everybody to practice their own religion, but to not force that on others. I didn't run into judgmental attitudes and I'm thankful for that 'cause it would have made it a lot harder, more emotional for me. I felt like I was doing the right thing. I wish things were different in our culture so that people could speak out a little bit more about these kinds of things.

Rebecca (P07)



Rebecca learned about the number of spontaneous abortions that occur naturally; for her, this information challenged the idea that life begins at conception.

I've taken classes in child development and I learned that it's about 50 percent of pregnancies are spontaneously aborted, most of the time even before a woman knows that she's pregnant. For me that kind of dissolved the idea that life begins at conception. I believe that life and a soul come in at a later date. I don't know when, maybe it's during birth. I don't know when life begins exactly, but to me that whole idea gave me some comfort that life doesn't begin at conception.

Rebecca (P07)

Anti-abortion language, heavily influenced by religion and conservative Christians imposed fear, shame, and guilt on women, years after the abortion. Changes in the political climate caused women to reevaluate their abortion experiences from a different perspective.

***“I was very angry.”*** Women were angered by anti-abortion tactics that imposed pro-life views about abortion on them and other women with no regard for individual circumstances, choice, and rights.

Occasionally I would see babies or commercials on television, the ‘abortion is bad’ commercials, and I would get very, very angry. That would be very difficult to watch those.

Lindsey (P10)

I remember seeing protestors on the street with picket signs with pictures of fetuses and I just don't understand those people. They call themselves pro-life, anti-abortion people, but to me it's their choice. If you get pregnant and you don't believe in abortion, then that's fine, that's your decision, but you shouldn't be forcing your beliefs on other people. It just seems common sense, talk about freedom, freedom, freedom; everyone should have the freedom to do what they want with their own bodies at least.

Barbara (P03)

Carolyn was angered that a lack of resources could interfere with a woman's ability to choose abortion, especially if women do not have the means of paying for the abortion procedure. As discussed in Chapter 2, health insurance with no coverage for abortion and

lack of federal funding for abortion services have been two anti-abortion tactics employed to discourage women from having abortions.

I think about myself and my ability; I had the money, I had the insurance, I didn't have to pay anything, I had the emotional support, I'm a therapist, I had myself, I had resources, I had everything. I think about women who have to scrounge for money to be able to have an abortion; it infuriates me that women who make a choice 'I don't want to give birth' are in the situation where they have felt forced to go through with their pregnancies.

Carolyn (P01)

Shirley experienced anti-abortion violence first hand while working as a counselor at a reproductive health clinic. She was shocked that people felt so negatively about abortion.

I did some part time work at an abortion clinic around 1991. I was doing work with helping young women decide what they wanted to do, which direction they wanted to go, or what options they had, and helping them in that process. I actually liked working with those young women; some went one way, some went the other, and that always felt really good to me that they really were able to make up their own mind about it. It was just at the beginning of when people were really starting to be negative about abortion. At one point the clinic has a couple of picketers and then someone threw a rock through the window; I remember being so surprised that people felt that way about abortion.

Shirley (P08)

Many participants believed the negativity surrounding abortion in the current political climate was worrisome; several women voiced concern about the continued legality of abortion in the United States.

***"I can't imagine living somewhere where abortion is not legal."*** Many participants were thankful for access to safe, clean, abortions by trained, competent providers. In discussing the legality of abortion, many women reflected on the "very dark period" when women endured horrible conditions and died from illegal abortions performed by unskilled persons under clandestine conditions. Women voiced concern about the continued legality of

abortion in the United States and their anger at men for trying to control women's reproductive rights.

I remember feeling so grateful that the reproductive health clinic was there for me because you hear stories of women havin' to go into these dirty, icky places and die from having abortions. 'Thank God the reproductive health clinic is here and they do it in a clean, sterile, safe way'.

Elizabeth (P09)

I have thought a lot about the legalities of abortion and my mom has told me some stories about when she was a nursing student or soon after. She had students come in when she was working at the schools. She said that there were a couple students who had had, she called it "coat hanger abortions" and the girls were infected. The pain and the trauma for them were terrible; the emotional distress that illegal abortion put those girls under was unbelievable. They couldn't tell their parents, they had to have an illegal abortion; and this was in a western coastal state which is fairly liberal. I can't imagine living somewhere where abortion is not legal after listening to my mom.

Lindsey (P10)

With the political tenor in the country there's political division regarding the right to abortion; times are threatening, the possibility exists to make abortion illegal or difficult. There is so much judgement about women's sexuality, like the Senator who believes that if a woman is raped, she wouldn't conceive because her body would miraculously stop pregnancy. These huge, malicious, scientific untruths are setting a tone that blames a woman for her ability to conceive, as if it is a horrible thing, monstrous.

Donna (P06)

For Barbara and her daughter, the reality of abortion being illegal came true during the summer of 2012. In the Midwestern state in which they live, the Governor effectively outlawed medical abortion, forcing them to travel to a neighboring state to obtain the safest, most natural method of abortion.

My 16 year old daughter wanted a chemical abortion and she couldn't get it here in our state, so she went to a neighboring Midwestern state, to a reproductive health clinic in a large urban city. I was worried about her and tried to help her.

Barbara (P03)

Their state is not the only one in the United States with limitations on abortion methods or providers. As participants spoke about the legality of abortion they also talked about their beliefs in women's reproductive rights.

***“Every woman has the right to choose.”*** Participants affirmed women's right to choose abortion. For some women, having an abortion has made their convictions about the legality of abortion even stronger.

Having an abortion has meant that I'm stronger in my position that women should have a choice to do what they need to do. I don't believe in ever changing the right for that freedom; every woman has the right to choose.

Donna (P06)

Kathleen and Barbara have experienced emotional conflict and turmoil as a result of their abortions, but still support and believe in women's reproductive rights.

I was very glad that the services were there. I'm very much a pro-choice person. I think absolutely there should be things in place for women to get abortions, absolutely, but at the same time, for me, having an abortion was a difficult thing; it was very traumatic to me for a lot of years, I carried the guilt for many, many years after the abortions.

Barbara (P03)

Maria was the only participant who was unsure about the continued legality of abortion. Perhaps she is so overcome with guilt and shame imposed by sociopolitical issues, that she protects herself from judgement by avoiding social and religious places like attending church; she does not even vote anymore. She seems to wish that she would have had more resources at the time of her unintended pregnancy so that she could have made a different decision.

I don't know how I really feel. I don't think abortion should really be legal, but that's a difficult question. There'd have to be another plan of action, more options for women that aren't able to have an abortion. They'd have to have more help for women that are pregnant, to make sure that the child doesn't get victimized. I don't even know what the laws are now about it. I really don't pay attention to any of that; I'm not a voter.

Maria (P02)

Some women felt so strongly about the right of reproductive choice that they will only vote pro-choice at the polls.

I think it's a pretty important right (reproductive choice) for women to have and I'm glad that I had that right. I think it would have been a lot more devastating to me not to have the right and to be forced to carry that child to term that I did not want, and then have to deal with whether I was gonna raise that child or give it away. I think that is a lot crueller. I feel that we have the right to make those choices for ourselves and I'm glad that I could do that, I think it's a basic human right to control my own destiny. We can't control everything in our lives but I do think that is something that we have the right to control, whether we have children or not. I think women are at a huge disadvantage because men don't have to make this choice, they don't have the same consequences that we do. It's important to me to keep that freedom; I do give money to organizations supporting reproductive health services and I do vote for choice at the polls. I think it would be awful if we went back to abortion not being legal; that's gonna be a horrible situation, a horrible mess if that right is taken away.

Rebecca (P07)

Other women are conflicted about choosing a political candidate and voting based on only the issue of abortion.

It's like the politics too. One doesn't want abortion, one's pro-choice and you pick because of that? You're picking a candidate because of their opinion, and sometimes you have to go against your opinion 'cause you like other qualities about them, so it's hard. It is a lot, trying to decide who you're gonna vote for because you might be ostracized because of one thing you did.

Kathleen (P04)

Women were angered at men's political involvement in women's reproductive rights. Many participants felt that Congress, senators and representatives, should not have any input into women's reproductive rights about if, when, or where a woman has access to abortion.

As women we need to exercise our strength by not letting politicians get involved with our choices. Nobody knows what's best for you except you. It's not all about abortion, it's about keeping the option open and making it so that if the 'oh shit' does happen that somebody has an option to not screw up their life plan. We have oops safeguards; we have life insurance and we have

car insurance for accidents that happen, we're human beings, accidents happen.

Lindsey (P10)

They should mind their own frickin' business. If they don't want to allow abortion then they should give a vasectomy to every father of every baby 'cause that person isn't responsible. Or they should fine them; hunt them down and make them pay. Abortion is just none of their business.

Barbara (P03)

***“He left me with the responsibility of it all.”*** Two participants, Barbara and Kathleen, expressed anger about gender inequity both at the time of the abortion and in the years since. Kathleen was 17 years old when she experienced the unintended pregnancy and abortion. She was afraid of her strict, pro-life parents and felt abandoned by her adolescent boyfriend. He accepted no accountability for the consequences of his sexual activity.

He was already dating somebody else. He didn't really break it off with me, he just started dating somebody else and I heard about it. I went to tell him I was pregnant and he basically laughed in my face. He said 'you're just trying to get me back', and I said 'no, I'm serious'. He left me with the responsibility of it all; he left me in that situation.

Kathleen (P04)

Kathleen's first relationship and experience of sexual activity ended with her making a decision on her own for abortion. Her boyfriend did not accept any responsibility for his role in the unintended pregnancy; he was not committed to her as a person in a relationship, he shirked his duty to help in dealing with the situation and offered no support for Kathleen financially, emotionally, or physically.

After attending college for a few years, Kathleen returned to her home town, where she continued to have connections with the man who had abandoned her to deal with the unintended pregnancy alone. Kathleen was angry when his sister told her about other girls who had also been impregnated by her brother.

I found out later from his sister who worked with me, this is her brother that I had the abortion with; he had done it to 5 other girls, so how many did he do after me or before? I was really mad. I was mad at the 5 other girls that got raped, or raped like that and murdered a baby, it's just sick.

Kathleen (P04)

Awareness of his presence around town angered and sickened Kathleen that he could evade all responsibility and acknowledgement of what she had been through with the abortion. When given the opportunity, Kathleen moved away from her family and friends.

I moved because I'd see his picture all over the place; he was in real estate. He's doing well; his business and he was married and had 3 boys and he lived next door to one of my friends. I heard about stuff that he did and I just don't want to hear it anymore. My husband got an opportunity; I moved from my hometown because I just did not want to be around him anymore. Every time you see his picture on the billboard or on the bus stop or wherever, I, 'oohh', see him in the parade, I'm like, 'oohh' . . . hurts . . . you shudder, you just don't want to be around somebody that didn't care.

Kathleen (P04)

Kathleen has two children with her ex-husband and a son with her ex-boyfriend. She continues to be irritated and annoyed with the men in her life who have been irresponsible in supporting her in the care for their children. Her anger at gender inequities is aimed at her first boyfriend too.

Through the court system I fight with my husband and ex-boyfriend now for support. So it's just a constant battle with the court systems. So the men just don't work; they don't work so they don't have to pay child support, it's pretty sad. I would have been fightin' for 18 years with the guy to get any support.

Kathleen (P04)

News stories and internet articles cause Kathleen to feel irate and livid when women are blamed and punished for the occurrence of an unintended pregnancy when men are not held answerable.

What did I see on the news or on the internet? Some girl can't go to school because she's pregnant. They were gonna kick her out, why don't they kick the guy out too? It's always the responsibility on the woman; that makes me

angry. If they're gonna come at the woman for getting pregnant, they should go after the guys for having sex with girls. It's not just the woman's problem; it's also the man's. The boys need to be aware, care about these women that do get pregnant. It's not just the woman that has to deal with it. I think they should have said 'who's the guy?' and drag him in there. It's not just girls having babies, it's the boys doing the stuff that they're doing and they think it's okay.

Kathleen (P04)

Like Kathleen, Barbara expressed anger at gender inequity too. While Barbara accepted full responsibility for the unintended pregnancies and abortions, she is angry when men evade their accountability for their part in sexual activity and child rearing.

I was scared 'cause I thought he would blame me for getting pregnant, because I shouldn't have gotten pregnant. I thought he would be very upset and angry. I ended up, again, not telling the person. I was very embarrassed about having gotten pregnant again. I felt so bad. I don't know what those other people would have done really; I don't know what real help they could have given me. It was still gonna come down to my decision, and it was my responsibility basically.

Barbara (P03)

If men were carrying children maybe it would be different, but they shouldn't have any right to say what a woman does because they weren't responsible; they got the woman pregnant and they act like it's all the woman's fault. You have to have both people involved for the pregnancy to occur and there's no talk about any sort of retribution or punishment for the other half of the event. Generally the men aren't around or they don't want to be around, so it's all on the woman. Women aren't supported with child care and they don't get the stuff that they need to successfully raise children.

Barbara (P03)

In the summer of 2012 when Barbara's 17 year old daughter experienced an unintended pregnancy and medical abortion, Barbara was upset and very angry with the adolescent boy who assumed no responsibility.

I don't know inwardly what my daughter thinks, but I was angry. I read the riot act to the young man that was involved. I told him 'you have to take responsibility' and 'you're gonna have to pay for half of this'; I was like momma tiger. I haven't gotten a dime from him, but he's a young kid too.

Barbara (P03)



**“Did I really do something terribly wrong?”** With all the negative social and political messages surrounding the issue of abortion, women who have had an abortion can't help but question their actions as perceptions of abortion shift. Women have needed to negotiate the information and process their thoughts, feelings, and reactions in response to anti-abortion messages.

I think about the noise and commotion of all of the talk about abortion. I don't think that back in 1980 abortion was something that was as political as it is now. Every time abortion is brought up, I mean, you can't help but think back; any time abortion is brought up politically, and it's often, every time I go by a truck that has the picture of a fully formed child and some pro life message. A lot of times I can look at those messages and think 'they're putting misinformation out there to try and hook people emotionally', so that they won't get abortions. So much of the facts, of the science, of the biology of unintended pregnancy get lost in all of the politics of abortion. Logically, I see that and I know that, but when you hear all of that you can't help but think, 'gosh, did I do something really terribly wrong here?'

Elizabeth (P09)

In the current political climate, women constantly negotiated pro-life messages and religious persecution for having an abortion. Religion and politics have imposed guilt and shame on women; fear of judgement and condemnation has silenced women from talking about their abortion experiences. Despite the silence and secrecy now imposed on women who have experienced abortion, some women have told others about their decision for abortion.

**Telling.** Telling others about having an abortion encompassed talking with friends, family members, partners, and children, with an emphasis on the personal nature of the abortion experience. Women spoke of conditions for sharing the abortion with others, as well as not telling.

**“She was very understanding.”** Women told others about the unintended pregnancy to gain acceptance for their decision for abortion and for emotional, physical, and spiritual

support. After the abortion, women also turned to others for the same reasons; they found comfort from others in sharing that they had had an abortion. Initially women seemed to confide in close female friends and/or sisters.

Shortly after it happened I talked to my closest friend who is also my older brother's wife. She came into my life when I was in 7th grade; she and I have always been very close. After I had the abortion I was struggling with depression. I went to her first and told her all about it. She was wonderful; she listened and cried. She's always been there for me in that way, where she listens and cries with me and takes care of me emotionally. So I told her.  
Elizabeth (P09)

My sister is a very non-judgmental person and she believes in abortion rights. She was very understanding of my situation, that I was unmarried and I didn't want this relationship; she wasn't judgmental at all. I would not have told her if I thought there was any judgment in her heart towards me. She's been great; she's never said a word to anybody.  
Rebecca (P07)

***“I just felt compelled to tell him.”*** Women felt a need to tell male partners when dating was serious and a long term relationship seemed likely. Disclosure of the abortion history to a new male partner seemed to test the relationship and establish acceptance of the woman as a valuable human being, worthy of love. Carolyn conveyed this same sentiment when she told her then boyfriend, now husband, about the unintended pregnancy; she said “acceptance just cemented us, it was good”. Telling male partners who were not involved with the unintended pregnancy and abortion was a turning point in the relationship for several women.

I told my husband when we were dating and getting serious, because I probably met him like 2 years later. I told him about the abortion and he was very non-judgmental about it and compassionate; I didn't feel judged at all. That was a good thing for us.  
Rebecca (P07)

We were sitting in a bar and I think we were sitting at the bar. I mean, how much more public can you get? People are everywhere, it's not even like it was a private place. We'd been together for a long time and we were talking

about the issue of abortion. I don't know if it was on the news or why it came up in our conversation. We were talking about abortion in a general sense and then I just felt compelled to tell him; it felt like the right time to tell him. I just casually said, 'well, I had an abortion when I was in college' and he was shocked. At that point he knew my family very well and because of the strict Catholic family that I came from, he was taken off balance there for a minute. I told him the story and he listened and he said, 'wow, that must have been tough.' I remember feeling sad about it and feeling like, 'yeah, that was really hard'. And then we just kinda went on.

Elizabeth (P09)

***“I would consider telling my children if they experienced an unintended pregnancy.”*** Eight of the ten participants in the study have children; more than half of them have talked with their children about the abortion. Carolyn, Shirley, Donna, Barbara, and Kathleen have spoken with their children about their abortion experiences; however, in all cases, telling was not a planned event and only occurred as an isolated incident when women felt compelled to tell based on circumstances. Carolyn is sure that both her son and daughter know about her abortion, but does not recall specific conversations; she does not believe telling them was a dramatic event.

I'm pretty sure I didn't tell my son at the time that I had the abortion because he had just graduated from high school and was going on to college. I don't specifically remember telling him, but I feel pretty certain that he knows; it wasn't some big disclosure.

Carolyn (P01)

I think I've told my daughter. We certainly had the, 'if you're gonna be sexually active, make sure you're on birth control pills' talk. I don't think I would have told her right out then 'I did get pregnant'. If she had asked, I would have answered truthfully. I would not have lied. So my instinct is that I must have told her at some time, it must have come up in the conversation. She's never been pregnant; she is on birth control pills now. I'm pretty open with her, I just don't remember. The abortion is about one of my most secret things, if you say secret things, but it doesn't feel like telling her about my abortion was a big dramatic thing, that I'm sharing this big, deep, dark secret.

Carolyn (P01)

Like Carolyn, Shirley does not recall the specific circumstances surrounding the occasion when she told her son about her abortion.

I did tell my son; he was probably in his early 20's. I can't quite remember why I thought this is important for him to know and I'm not quite sure of the circumstances that came up. We didn't discuss it much, but I remember telling him because I thought it was important for him to know. It was pretty short. I didn't know what else to say and I think that was probably something for him to digest. I wasn't sure if he already knew, if his dad had mentioned that or not to him, but my guess was that he hadn't. He didn't say very much.

Shirley (P08)

Donna told her daughter about her abortions on a single occasion when her daughter came to her for help with obtaining Plan B, a birth control pill which prevents a fertilized egg from implanting in the uterine lining after unprotected intercourse. Donna wanted to educate her daughter about the choice of abortion in the event of an unintended pregnancy.

Disclosure of her abortions was more difficult for Donna in her 50's than for her daughter in her 20's.

It's my generation that has trouble, it's more our concept that's hard and our perceptions than for the young people 'cause we grew up before *Roe v. Wade*, during *Roe v. Wade* and out of a very constrictive time. It's not as horrible as we think, and actually it's a very good thing to do because you're saying 'somethin' could happen to you too' and 'I want you to be able to come to me'. Our girls could possibly need to make these decisions too, so be there for younger girls. For us to talk to our daughters about our experiences is power and connection. It's kind of like coming out of the closet. I'm not gay so I don't know what that is like, but this is a big thing. It's a very large personal experience.

Donna (P06)

Barbara did not intend to tell her daughters; however, her youngest daughter's unintended pregnancy and medical abortion last summer prompted her to mention her own abortion experiences with the hope that her daughter will not have to experience abortion a second time.

I don't think I've told my daughters 'cause it's still something I'm not proud of. I've pushed my abortion experiences away; it was a very difficult time. I think abortion is very necessary and should be legal and easily accessible, but it's still an emotional nightmare.

Barbara (P03)

My daughter told her sister and me, she was fairly open about the unintended pregnancy and abortion. I don't think we had a real heart-to-heart talk about it, but I did think I mentioned my abortion experiences 'cause I don't want her to have another one. I don't want her to have to do it again.

Barbara (P03)

Like Barbara, Kathleen really did not intend to ever tell her children. However, she was forced to talk with her children about her abortion when her abortion history was disclosed to her children by her ex-husband.

I didn't tell my daughter about my personal abortion, I think it's a choice, and I didn't want to talk about it. Her sexual activity is what I worry about. I don't like to bring the abortion up 'cause it brings up problems and then she starts thinking negative things and I just want to try to do positive things with her. She lives with her dad; she chose that about 2 years ago. It's been a war with him over who's the better parent, and who can give 'em more, it's just a contest all the time.

Kathleen (P04)

Two weeks prior to me meeting you I found out my kids found out about the abortion through my ex-husband. He told 'em. My daughter was mad at me; she's 18 years old and she calls me a cunt whore, she was just really nasty. I called my older son who's 21; he goes 'yeah, dad told us'. It really hurt me, I was so angry. He's probably doing it out of anger and being mean to me. That's the vilest thing I've ever heard anybody do to anybody. It's my private life, and that was my private decision and everybody has a choice; it makes me mad. I wasn't ready to tell 'em I guess, and maybe when my husband told 'em they needed to hear it, but I don't think they needed to hear it as an evil thing, like 'mom's bad, she had that done'.

Kathleen (P04)

While Carolyn and Shirley did not recall specific circumstances for telling their children about the abortions, Donna, Barbara, and Kathleen were compelled to tell as situations beyond their control unfolded with their children. Telling children about the history of abortion was not a conversation or a mutual exchange of ideas. Telling children

about having had an abortion was a disclosure, a confession, a lesson of what might happen. Disclosure was strictly for the purpose of educating children; as a means of saying “abortion is an option when an unintended pregnancy occurs”.

Maria, Elizabeth, and Rebecca have not told their children about their abortions; perhaps because circumstances have not yet forced them to do so.

My abortion is not something I would bring up, I'm looking at my son right now, thinking, 'jeez', I won't be bringing it up to him 'cause he could easily think, 'my gosh, that could have been me'. I think in general a lot of people have a bad impression of people that have abortions; I think it boils down to shame.

Maria (P02)

Elizabeth has talked with her children about sexuality, but has never told them about her abortion and has no plans to do so.

When I had my own kids I started with a couple of books that you read with your kids about human sexuality; about homosexuality and heterosexuality, they're fact based, 'this is what sexuality is'. And then when they got older and started to have girlfriends, when they got into high school and the girlfriends would be around for a little while, then we would talk about, 'are you having sex?' They understood completely that if they were gonna take that step, they had to have birth control and they had to be talking about that with their girlfriend. I recommended that the girl be on the pill and they use condoms. I never told them why, but I was always, 'you just want to be so safe' and 'you do not want an unintended pregnancy because you have no good options at that point'; 'you don't want to have to be in that position to make those choices.' I think I probably talked with them about it a lot more than other moms and maybe to a point where my husband would get a little bit uncomfortable with it.

Elizabeth (P09)

Like Elizabeth, Rebecca has talked with her children about sexual activity, but has not disclosed her own experiences with unintended pregnancy and abortion. She has talked about the decision for abortion in a broad, general sense, but not as a personal experience.

I've had the talk with my kids that I want them to use birth control if they're even thinking of having sex. I told them that I didn't think that abortion is murder, but I do think it's not a situation I would want anyone to have to be in

to choose whether to have to have an abortion or to have a baby or to give one away. I said those are really, really difficult decisions and I wouldn't wish that on anyone. I wanted them to be intentional about when to have sex and having kids. I wanted them to protect themselves and I wanted them to know that I didn't think abortion was an evil thing.

Rebecca (P07)

Rebecca is hesitant to tell her children for fear they will be judged by others and for fear that she will be judged by them and other community members if her secret is revealed.

I haven't told my children primarily because we live in a community that is pretty conservative and religious. I feel that it would have been a burden for them to know because I think that there are a lot of pro-life people here that wouldn't be accepting of that or that they would be judgmental and I wouldn't want them to feel judged. It's more the fear of them being judged or them being hurt by it. And I guess if I told them it might not, no one else might ever know, but I wouldn't want to give them that burden to keep my abortion secret either.

Rebecca (P07)

Rebecca would consider telling her children about her abortion if either one of them was in a situation where an unintended pregnancy occurred; however, she is still concerned about judgement from them for her decision for abortion.

I would probably consider telling my daughter if she had gotten pregnant or if she would get pregnant. She's the kind of person . . . she's fairly non-judgmental. I don't think she has any real negative opinions or beliefs about abortion so I feel like it's something we could discuss; I feel like I could tell her and confide in her. Certainly if she was in that position I would share probably with her my experience and support her through it.

Rebecca (P07)

My son is a little young. He's 18, but I don't think he'd be ready for this information. He's a kid that is more religious, he's more attuned to the rules of religion, and so I wouldn't maybe tell him just because I don't want to be judged by him. I'm not sure if he would judge me, but he might. So I probably wouldn't tell him, unless he was in a similar situation. I guess if he got into an unintended pregnancy situation, my abortion could become part of the conversation. I'm pretty honest with my kids; I'm quite open with them normally, but I guess I'd have to think about that.

Rebecca (P07)

***“I didn’t want to tell my parents.”*** “Not telling children” weren’t the only stories women told about not talking about the abortion. Barbara and Amanda were the only participants who mentioned telling their mothers when the unintended pregnancy occurred. Most women were uncomfortable with telling their parents.

My family never knew about the abortion, partially because they were Catholic. My parents were pro-life and I was nervous that they might disown me if they knew.

Rebecca (P07)

At age 17, Kathleen was deathly afraid of her strict, pro-life parents. Now that her abortion history has been disclosed by her ex-husband to her children, she worries that her parents will find out about her abortion 30 years ago.

I haven’t even told my mom or dad about the abortion. Should I tell them now that I know my kids know? It’s gonna come out some day.

Kathleen (P04)

Lindsey and her mother, a retired school nurse, would talk about women’s reproductive rights, especially once Lindsey was in college. Despite some level of communication between the two of them, Lindsey did not feel comfortable telling her mom about the unintended pregnancy and her decision for abortion.

We have a very mother/daughter relationship; we get along, but we’re not friends. She’s my parent and I love her. That’s not to say that if I had gone to her and told her, I would’ve been able to trust her and she would’ve helped me through it. I was just not ready to deal with, and probably won’t tell my mother, that I was sleeping with two different men. Not really a conversation I want to have with my mother or my father.

Lindsey (P10)

While many women indicated that they might never tell their parents, Donna especially would have liked to have been able to talk with her mom both at the time of the unintended pregnancies and abortions and even now.



I wish my mom had been there for me, but it was taboo. My mother doesn't know about my abortions and that's hard. I wish I could talk to her about it. I wish I could. I think that would be really good for me. It would be terribly difficult, more difficult than me talking to my daughter. Well, it is. I haven't done it and I really haven't made a plan to.

Donna (P06)

It's possible that women didn't tell their children and their parents about their abortion experiences out of fear of judgement and rejection. I suspect that other women are similar to Donna and long for a deeper, more intimate connection with their mothers. However, fear of judgement and condemnation imposed by religion, politics, and perhaps the dynamics of the parent/child relationship prohibit disclosure. By telling their parents and children about their abortions, women risk loss of love in the relationship, rejection as a person, and lack of understanding and acceptance for their situations and decisions. Perhaps women would feel safe in talking with their children and their parents if they knew ahead of time that those family members would be kind, gentle, and accepting of them as daughters and mothers. Not being able to talk about their abortion experiences has kept women closed off from their parents, both at the time of the abortion and decades later.

***“My abortion is private; it's a deeply personal matter.”*** Women indicated that talking about their abortion experiences was private, a deeply personal matter.

My abortions are very personal but yet very deep. It's emotional. I don't know why I get so emotional, but I do. I don't know if it's guilt or shame, or embarrassment. I'm smart, why did I have this happen, I know better. I don't know if others have judgment or if I feel judgment, but it's a tricky situation for me. I don't run around saying, 'oh yes, I had two unintended pregnancies' and I'm not sure why. I think it's complicated.

Donna (P06)

It's private. Abortion is a hard subject to talk about 'cause it's a controversial thing. Some people like it, some people think its okay, and some people don't. And you don't know who to trust. When you start telling everybody about it you don't know who you told, it's like a lie. You don't know who you told and who you didn't, so then you just assume everybody knows. I

think it's private; abortion is something that you can decide to tell people or you don't have to.

Kathleen (P04)

You have to be in a place that's safe emotionally. The abortion is not something that you're proud of. There's so much in the way of moral judgment. I grew up in a very traditional Catholic family and I'm the 11th of 13 children; although the whole family isn't Catholic anymore. My parents who are in their late 80s, early 90s, are very Catholic. My brothers and sisters are either Catholic, Lutheran, or born again Christians; very conservative Christian people. I could never share this with any of them, that's just not a safe place. It has to be a place that feels safe and where there are not going to be any ramifications on my kids, my husband, or my job.

Elizabeth (P09)

Judgement, controversy, individual choice, and my own experience were words participants used in describing the personal nature of telling others about their abortion.

Abortion was equated with a lie or a secret; women don't know who else knows and don't want to be caught in the middle trying to explain their decision. It is safer to tell no one.

There are times when I just don't know if I would ever tell somebody that I had an abortion. I think it's one of those societal things because it's so divisive. I think abortion is something that people can throw back into your face pretty easily. God forbid we look down on somebody that gets their 4th DUI (Driving Under the Influence of alcohol), but people don't think twice about looking down on somebody who's had an abortion or made the choice that it was best for them to not be pregnant. We're a very hypocritical society, so in recognition of that I'm very careful about sharing that information.

Lindsey (P10)

While protecting themselves from judgement and ridicule by not telling others about their abortions, women also indicated that there were certain conditions that, if present, would make disclosure of the abortion more likely.

***“If somebody asked me about the abortion or was struggling with the same decision.”*** While rationalizing whether or not to tell, women indicated that there were some circumstances under which they might disclose their abortion experiences. In explaining if, when, and to whom women would tell their abortion stories, these participants identified

potential situations for telling and circumstances that might prompt them to reveal their history of abortion. Hypothetically, women were willing to talk about their abortion experiences if the topic came up in the conversation or to help another woman who was considering abortion as an option in response to an unintended pregnancy.

I don't feel a need to talk about my abortion. It's not something I'm . . . of course you wouldn't be proud of it, but it's embarrassing to me . . . and people that I would know, especially family. If somebody brought it up or asked me a question about it, I wouldn't lie to them. I'd have to feel comfortable with that person . . . if they were looking for help or some kind of guidance or some sort of information, I wouldn't deny my experience to anybody that had questions. That's a pretty private topic for someone to bring up, so obviously you'd have to think that someone would feel comfortable with you by even bringing it up.

Maria (P02)

I'm sure I have told some people as it might have come up in conversation. My abortion doesn't feel like anything that I would keep secret or that it was a deeply painful thing. I never felt that 'I have to tell this', because it does seem like a deeply personal matter, but, as appropriate, I would certainly. If somebody was struggling, certainly a friend or a relative who was struggling with making that decision, I'd feel free to share as something to ease them or to help them, just to say 'I had an abortion'. I wouldn't hesitate to say I made the decision for abortion and it was a really good one for me. My abortion is not anything that I'm ashamed of. If they're thinking, 'oh, gosh, what would people think of me?', I'd tell them you don't have an 'A' on your forehead when you have an abortion; people don't know, your abortion experience is something you carry inside you and you can decide to tell people or not. I guess part of what makes it easier is if you know, if you strongly suspect what people's feelings are on abortion, it makes it easier to share. It's a little harder if you don't know. I wouldn't tell, for instance, my mother-in-law; my husband's folks come from a Catholic background and somehow I have felt that there might have been some judgmental thing about my having an abortion.

Carolyn (P01)

***“None of us had ever talked about the abortion.”*** Fear of judgement, embarrassment, shame, and guilt keep women from talking about their abortion experiences, yet several participants said they would like very much to talk with other women about their

abortion experiences, in a safe place. An emotionally safe place seemed to mean a situation that contained an absence of judgement and an opportunity for acceptance and understanding.

I wish there was a place to come together and talk with other women about our experiences. Abortion is not something you're gonna shout from the rooftop, but why not? I would talk about a knee surgery or lots of things, but why is abortion a hush-hush kind of a thing? I think there needs to be a forum or a discussion group offered for women to come in a safe place and share whatever it is that they need to share.

Donna (P06)

It's very frustrating for me. My girlfriend and I haven't really ever talked about the abortion unless I bring it up. I think one of the most difficult parts of the whole thing for me was that none of the friends I told have gone through an abortion. Not having someone to be like, 'so what's it feel like?' was a difficult situation. No one asked 'what happened? What did you do? What was the experience? What did you go through?'

Lindsey (P10)

Participating in the study prompted women to disclose their abortion experiences to long time friends; study participation was a way to open a conversation about abortion.

So it's just my sister and my husband that knew about my abortion for 30 years. But then I told 2 friends at lunch last week that I was gonna be interviewing with you and that I'd had an abortion. I trust them both immensely and I knew I was safe with them. I said you're the only 2 people that know, besides my husband and my sister, and they laughed. And then my girlfriend said, 'well I had one too'. And it was like, 'wow'. None of us had ever talked about this before.

Rebecca (P07)

Those two people are the only people I've ever told (husband, sister-in-law). Well, until I was at lunch with my friend. She talked about you (researcher) and told me how she'd had an abortion in college. Honestly, that is the first person that has ever just openly admitted that they'd had an abortion. I was just kind of in shock at first; then she talked about how important it is that abortion is something that we all hide. And she said that since she's been talking about her abortion, she's amazed at how many other women also had abortions in college. So then I just felt compelled to say, 'well so did I'. We talked about how important it is to help those coming behind us and why, she talked like it was important to be part of the study and so then I got your name and number, so that's three people that I've told.

Elizabeth (P09)

Talking with other women about the abortion experience and participating in the study raised consciousness and was empowering for several women.

I was struck by just how young you are at 19 years old and how hard I was working to get that degree; working 3 jobs and going to college. I was determinedly on this path of wanting self-sufficiency in my life and wanting to be a teacher. The insight was I was young, I was working so hard, and then the unintended pregnancy happened; how difficult that is for such a young person; I haven't really thought about how that abortion experience impacted my life. I thought, 'oh my gosh that was the best decision'; maybe one of the best decisions I've made in my whole life actually. I mean my life path would have changed so drastically. It was really helpful for me to share my abortion story; I didn't even realize how helpful it would be.

Elizabeth (P09)

***"I wish I'd talked with her."*** Despite a desire and an innate need to talk with other women about the abortion, participants still identified situations and opportunities for talking about their abortion experiences in which they remained silent.

At my church, people were just hanging in the kitchen where lots of conversations take place. An older lady who I knew quite well, like my mother's generation, she would have been late 70's, early 80's, and we were standing together talking about something and she said 'oh, yes, we didn't have the money back in the 40's and I had to terminate 2 pregnancies 'cause we couldn't afford to have more kids'. And I thought, 'wow that was amazing', just jabber, standing next to me and openly say that. It was just like a big wash coming over me. It's very wonderful to share that in a way just like, 'well we just couldn't do it and I had to terminate those pregnancies'. I wish I'd talked to her about that and I didn't. I'd like to know other people's stories, I'd like to know all women's stories and I'd like to share in that way, it'd be healing for me.

Donna (P06)

Abortion is not a topic fit for everyday conversation. Women are not free to ever respond when abortion is spoken about in a matter of fact way. Shirley was taken aback when she spontaneously disclosed her history of abortion while working as a counselor.

I think sometimes in doing therapy it was difficult when women were talking about abortion. Not the young women that were going through the experience

of trying to decide, but women that had talked about abortion in some other way. I remember one woman I was seeing for something and it just came up that she found out she was pregnant. Her life circumstances were such that continuing the pregnancy wasn't gonna work for her. She was pretty clear she was gonna have an abortion. At one point I was so engaged with the conversation, she asked me if I'd had an abortion and I told her 'yes', which wasn't a very good thing for me to do probably given the relationship, but at the time it felt right. It felt like it was appropriate to share that information with her so she didn't feel so alone. I remember trying to support her in the decision she had made.

Shirley (P08)

Disclosure that she had had an abortion did not entail sharing her abortion story; telling was more of a big announcement. Afterwards Shirley doubted herself for sharing and questioned her judgement as a professional.

*“I stopped talking about the abortion.”* At times, women longed to share their abortion stories, but discomfort and feelings of fear seemed to overtake their desire to share. With increased social and political criticism and judgement of women who have had abortions, women's voices have fallen silent and abortion has become a hidden life experience. Shirley, who experienced abortion in 1986, like most of the participants in the study, described this phenomenon when she identified that she no longer talks about her abortion experience.

At that time I was very open about it. I talked to friends about the abortion and I talked to my sisters. I was very open about the unintended pregnancy and abortion; I talked to people on the phone about it, friends that weren't close by. I didn't feel like I'd done anything wrong or shameful at that time. We were very open about it. We were both professional people in a very small community and I don't remember getting any negative feedback about the abortion.

Shirley (P08)

My husband and I separated and then got back together, and then divorced, but our relationship didn't make it through the abortion. I was never able to talk with him, to really resolve that with him. And then it became very shameful publicly to even mention that you've had an abortion. I stopped

telling anybody about it. I have no idea how that came about; I don't remember any specific event, but I stopped talking about it.

Shirley (P08)

Not talking about the abortion experience has left Shirley feeling isolated and alone in her own community, a feeling echoed by other participants. Decades after the abortion procedure, women are robbed of intimacy in relationships with other women, close friends, mothers and children by the silence of abortion. Abortion has become a hidden life experience for women; Barbara's experience of unexpected disclosure demonstrates how encompassing the closet has become.

When I went to have my older daughter at the hospital, and the nurse was admitting me, she wanted to know my pregnancy history, and my husband was sitting there with me and I hadn't told him. So then it came out that I'd had these 2 abortions right at the time I was giving birth, that was kind of weird.

Barbara (P03)

## Summary

This chapter has provided an across case analysis with interpretation of the textual data in women's narrative summaries. Three main themes and several subthemes were identified for each research question posed in the study. Women's experiences of abortion involved three main themes that encompassed feelings of disbelief at the occurrence of the unintended pregnancy (This wasn't supposed to happen.), assessing physical, emotional, and financial support for continuing the pregnancy (I had no support.), and making the decision for abortion (I did what I needed to do.).

The historical influence of sociopolitical factors on women's perceptions of their abortion experiences included themes around religion, politics, and telling. These themes encompassed the influence that religious and political issues had on women and their experiences of abortion, including the impact of these issues on the act of telling others about

the abortion experience. Religious teachings incorporated parental values, childhood traditions, and negotiating spiritual beliefs. Political issues encompassed pro-life tactics (protestors, violence, commercials, billboards) and women's responses to these anti-abortion measures, the legality of abortion, and surviving the current anti-abortion political climate. Telling others about having an abortion covered talking with friends, family members, parents, partners, and children, with an emphasis on the personal nature of the abortion experience. Women spoke about theoretical conditions for sharing the abortion with others, as well as not telling.



## Chapter 7: Discussion

The purposes of this study were to better understand women's experiences of abortion and the historical influence of society and politics on women's perceptions of their abortion experiences. In this chapter I will briefly summarize my findings for each research question posed and discuss my conclusions. I'll compare and contrast these findings with extant literature, identify limitations of the study, and conclude by highlighting this study's implications for future research, policy, and nursing practice.

### Summary of Results

**What are women's experiences of abortion?** With slight trepidation and much optimism, the women in this study told stories of their abortion experiences. All of these participants experienced unintended pregnancies; many of them were using contraception and none of them planned on pregnancy occurring. Women were genuinely surprised when they missed their menstrual cycle and began experiencing early pregnancy symptoms. Breast tenderness, fatigue, nausea, and vomiting, along with the missed period, aroused suspicion of pregnancy and triggered feelings of distress. Women spoke of managing their life circumstances; they were thoughtful in making their decision for abortion. They considered their future and what they could offer a child financially, emotionally, and physically. Several participants thought about continuing the unintended pregnancy and parenting or placing the child for adoption. Women evaluated the relationship with the male partner for support and long-term commitment to both themselves and the child. They told a few select others about the unintended pregnancy situation to gain understanding for their decision making process and for help with following through on their decision for abortion. Women made their decision in a timely fashion, aware of the need to avoid delay thus allowing the

pregnancy to advance. Once the decision for abortion was made, women acted on that decision. They took steps to contact reproductive health clinics and made arrangements to obtain the abortion procedure. These participants were honest and realistic in examining their life circumstances when the unintended pregnancy occurred. They imagined their future, attended to feelings, and acted on what they knew to be right. Women did what they had to do, what they felt they needed to do. Immediately after the abortion procedure they felt relieved. Some women expressed sadness while affirming their decision for abortion.

**What historical influence has political and social events had on women's experiences of abortion?** Without delay, women returned to the routine of their lives seeking normalcy. The abortion experience became a thing in their past and for most women was compartmentalized or pushed underground; it was as if the abortion had never happened. If and when women wanted to talk about the abortion experience, they generally had to bring up the topic of abortion in a conversation. They could discuss the experience with the male partner and/or friends in whom they had confided at the time of the unintended pregnancy; however, most women told no one new about the abortion and they rarely spoke about the abortion with those who did know.

Barbara and Amanda were the only two participants who talked with their mothers about having an abortion. Most women did not tell their parents when the unintended pregnancy occurred; some wanted to be able to talk with family members, but many participants understood that their parents thought abortion was wrong. Women feared rejection and abandonment by their closest family members; they feared the loss of a love relationship. Rather than risk being ostracized and disowned, women remained silent about

their abortions to ensure continued connections with family members. Their place within their family network was secure so long as their abortion remained a secret.

In making their decision for abortion, women negotiated religious teachings, childhood traditions, and parental belief systems. After the abortion, women continued to examine, to varying degrees, their spiritual beliefs and personal life philosophies. Religion imposed judgement and condemnation on women through their upbringing, church, and school. Women compared and contrasted their beliefs about life and abortion with those of religious organizations, family members, friends, and even strangers. Over time, most participants withdrew from mainstream religious organizations and traditional Catholic churches. Women wanted acceptance by spiritual leaders and understanding from church and community members; they wanted to feel like they could belong. When acceptance and understanding was not available, women protected themselves from further judgement and condemnation for their abortion decision by avoiding church and religious groups.

As time passed women needed and wanted to share their abortion stories. In order to talk about their abortions, women needed to feel safe; participants identified that feeling safe meant that they needed to know they would not be judged by the other person, that their decision for abortion would be understood and that they would be accepted and loved as the human beings that they were. Most women risked judgement and rejection as they shared their abortion secret with at least one other person in the year following the abortion procedure. Once disclosed, the abortion experience was tucked away like a quilt in a hope chest; safely stored away for some unknown future date. Women's voices fell silent.

As women's lives moved forward, they entered into new relationships. Some women felt compelled to disclose their abortion history to their new partners, others did not. Telling

the new male partner about the abortion was a test of his understanding and acceptance of the woman for her abortion decision. Confiding in the male partner was a turning point in the relationship for some women; receiving acceptance made women feel worthy of love and cemented the connection with the partner, allowing women to achieve a deeper level of intimacy in a significant relationship.

The majority of women in this study experienced abortion 20 or more years ago. As their lives progressed, they entered into long term relationships, became parents and raised children, maintained connections with their extended families, developed friendships, and advanced in their careers. As women lived their lives, their experiences of abortion remained hidden, like the root of a tree, buried deep and protected. Safe beneath the surface, no one had to know about the abortion; but women knew and their lives were impacted by their experiences of abortion.

Through the decades, as women lived their lives, the public side of abortion became more pro-life. Anti-abortion activists and conservative Christians joined with the Republican Party in the mid-1980s. Unable to make abortion illegal through the U.S. judicial system, anti-abortionists launched new tactics aimed at women. Pro-life politicians and judges have successfully limited women's access to abortion by imposing barriers such as a mandatory waiting period, parental notification, biased counseling and consent requirements, and lack of funding and insurance coverage for abortion. Pro-life lawmakers have attempted to pass a Human Life Amendment which would define the beginning of life as occurring at the moment of conception and make abortion murder and therefore, by extension, illegal. At the same time, pro-life activists have sought to impose guilt and shame on women by implying that any woman choosing abortion is a murderer. Women in this study were exposed to pro-

life tactics that included protestors, picketers with fetal images, abortion clinic violence, television commercials, campaign advertisements, fence signs and billboards, tiny feet pins, fetal development pamphlets, and hearing abortion referred to as “baby killing”. They felt attacked; they were unnerved and they were angry. Some participants fought back by participating in pro-choice rallies, working or volunteering at abortion clinics, counseling women about options, accompanying adolescents to court and assisting them through the judicial bypass process, and by sharing their own abortion histories to help and comfort others dealing with an unintended pregnancy. For some women, the only way to manage the shame and guilt imposed upon them by religion and politics was to retreat from society and protect themselves in a cloak of silence; their abortion roots were buried deep and protected from the outside environment.

Occasionally an opportunity to disclose their abortion history would present itself and women would venture to speak with others. Most participants disclosed their abortion to help others with obtaining an abortion or so another woman making the decision for abortion would not feel so alone. Much like a tree root grows towards the surface, women’s abortion stories could gently and safely be revealed. In contrast, both Barbara and Kathleen had their abortion experiences abruptly and unexpectedly exposed. For Barbara at the hospital and Kathleen with her ex-husband telling their adolescent children, abortions were thrust out into the open like the sharp, whirling blade of a lawn mower slicing open a root hidden by the grass. The loud thud, followed by the whining sound of metal ripping into the unseen, undetected root must resemble the swirling thoughts and feelings of women’s hearts and minds as their abortion is made public. Just as the gardener stops suddenly to examine the

damage to the root, so are women left in a world suddenly silent, waiting for their reaction and response.

Women told their children about their history of abortion only when circumstances forced them to do so. Unprotected sexual activity, the need for emergency contraception, and the occurrence of an unintended pregnancy found women in situations of needing to help their adolescent daughters. Disclosure of their abortion histories was brief and meant to convey to young women the option of abortion; to teach them a lesson about what can occur and the options available. Telling sons about the abortion history was nondescript and participants did not recall specific details or circumstances surrounding those conversations. Women identified the need to educate young people about birth control to prevent unintended pregnancies. They voiced the need to tell about their abortions to support young people, but didn't know quite how that could occur except by chance. Women understood the power of telling, the deeper connection they could potentially have with their children, yet shame, guilt, and fear of judgement from their children kept women silent about their abortion experiences. Donna's words illustrate the controversy in telling children.

I'd like women to be able to talk with their daughters, but how? When a girl's a little more mature? Or if she gets pregnant? Me talking with my daughter just happened, she needed Plan B. It's my generation that has trouble 'cause we grew up before and during *Roe v. Wade*, out of a very constrictive time. It's not as horrible as we think, and actually it's a very good thing to do because you're saying 'somethin' could happen to you too' and 'I want you to be able to come to me'. Our girls could possibly need to make these decisions too, so be there for younger girls. For us to talk to our daughters about our experiences is power and connection. It's kind of like coming out of the closet. I'm not gay so I don't know what that is like, but this is a big thing.  
Donna (P06)

With the passing of time, women identified a need to talk about the abortion with others. They wanted understanding and acceptance for their abortion decision and talking

offered women an opportunity to process their abortion experiences within the context of their lives. The problem was who to tell and how to bring up the topic of abortion. The sociopolitical climate imposed fear, guilt, and shame. Women protected themselves from the judgement of religious organization, churches, and other social groups by avoiding being members. They sheltered themselves from being ostracized and denounced by friends and family members by never revealing their abortion experiences. In shielding themselves, women remained silent; as a result, they became isolated and alone in their experiences of abortion.

The consequences of imposed silence about abortion are that abortion is a secret that has become a personal matter and there is really no way for women to talk about their experiences. Abortion has become an unspeakable topic. Women are unable to connect with others, to share their abortion experiences in conversations, to validate their decisions for abortion with others, and to gain acceptance and understanding for their life experiences. The silence leaves women more susceptible to religious and political messages that are in the public domain; messages that equate abortion with murder, label women who choose abortion as “baby killers”, and make women feel bad. Participants felt unable to belong to churches and other social groups; they became socially isolated. Women struggled to vote for candidates who did not support women’s reproductive rights, even when they agreed with other issues the candidate supported. The silencing of abortion cut women off from family members and friends, robbing them of opportunities for deeper intimacy in significant relationships.

Identifying the desire and need to talk about their abortions, these participants voiced a need for support groups with other women. They longed to talk openly and share their

abortion experiences. Women were angered and frustrated that the political climate is judgemental, dichotomous, and allowed to continue with no acknowledgement of their life circumstances or reflection on their individual abortion experiences. Talking about abortion should not be a big announcement; it should not feel like a confession. Women dared to imagine a world where telling others about their abortion experiences was not simply a disclosure or a lesson, but could be a real conversation with sharing. They want to tell their abortion stories, hear other women's stories, and communicate together about this common life experience. Participating in this study allowed women an opportunity to talk about their abortion experiences. Sharing their abortion stories was empowering for women and raised consciousness for them. Talking about abortion openly and honestly has the potential to raise consciousness for others and politically mobilize people in support of women's reproductive rights.

These participants' stories provided insight into women's experiences of abortion and demonstrated the silencing effects which have resulted from the influence of social events and political issues on women's perceptions of their abortions over time. The words of these participants inform health care providers, policymakers, and society about the needs of women experiencing abortion, both at the time of the procedure and years later.

### **Congruency with Extant Literature**

Much of the literature reviewed described key chronological events in women's experiences of abortion (Andrews & Boyle, 2003; Andrist et al., 2006; Elul et al., 2000; Faria, Barrett, & Goodman, 1978; Fielding et al., 2002; Fielding & Schaff, 2004; Freedman, 1978; Schaff et al., 1997; Simmonds et al., 1998; Smith, 1973; Winikoff et al., 1998; Zimmerman 1977). These events included suspecting and confirming the unintended



pregnancy, telling others, making the decision for abortion, arranging for and having the abortion procedure, and thoughts and feelings immediately after the abortion. While women in this study mentioned these chronological elements in their experiences of abortion, most did not tell stories specific to confirming the unintended pregnancy, arranging for the abortion, and having the abortion procedure. The emphasis of women's stories focused primarily on telling others about the unintended pregnancy and the process of making the decision for abortion.

Several researchers have categorized women's experiences of abortion based on women's feelings years after the abortion (Avalos 1999, 2003; Hess, 2004; Trybulski 2005, 2008). While women reflected on their abortion experiences with varying thoughts and emotions, labeling women's experiences based on these sentiments would not have done justice to their stories or the complexity of their experiences. Analyzing women's narratives as a whole revealed that each woman based her decision for abortion in the particular circumstances of her life at the time the unintended pregnancy occurred. The sociopolitical climate imposed guilt, shame, and fear of condemnation.

The conclusion from this study that women made their decision for abortion in the context of their life circumstances when the unintended pregnancy occurred is consistent with the findings of other studies. Life circumstances varied greatly for the women in this study. Despite variations in age, education level, employment status, amount of income, presence and support of a male partner, existence and needs of other children, and living situations, the commonality for all these women was that they thoughtfully examined their life circumstances and made a decision for abortion. Women shared that they did what they had to do, what they needed to do. They expressed sadness, but affirmed their decision for

abortion. Reflecting on their abortion experiences women voiced regret that their life circumstances were what they were at the time of the unintended pregnancy and that those circumstances did not allow them more options or to make a different decision. Labeling women's abortion experiences as conflicted, emotional, or remorseful does not acknowledge the well thought out decision women made at the time the unintended pregnancy occurred. Perhaps women would not feel regret and remorse if the sociopolitical climate did not impose shame, guilt, and judgement. Women dared to imagine a world where they would be honored for the wisdom of their decision, not the target of political tactics on either side of the abortion debate.

### **Implications for Research**

**Limitations and strengths of this study.** The results of this study apply to the women who participated and may be transferable to other women who have also experienced abortion. The sample size in this study (N = 10) allowed for in-depth detail about women's experiences of abortion; however the small sample size also limits the generalizability of the data. All of the participants experienced surgical abortion procedures; these results may not apply to women who have experienced medical abortion. All of the women who volunteered to participate were Caucasian, primarily of European descent; one woman was part Hispanic. These women's stories of abortion cannot be taken to represent the abortion experiences of women of color.

Women who have experienced abortion are truly a hidden population making recruitment challenging at best. The current anti-abortion sociopolitical climate contributed to my difficulty in finding volunteers for participation in the study. Nurses working in community clinics, at clinics serving low income women, and public health departments

were all leery of posting flyers. Nurses working with free or low income clinics feared retributions from religious organizations providing funds and buildings for their clinics. Public health nurses feared retaliation from the state government for involvement with anything to do with the topic of abortion. Nurses protected the clients they served and feared the precarious survival of their own clinics and their ability to provide care to those they identified needed the most assistance in our society. When visiting the one clinic that allowed me to post recruitment flyers, I could see that some of my contact information had been torn off the poster, presumably by women potentially interested in participating in the study. Perhaps women felt able to take my contact information in the safety of an exam room, with a provider who supported recruitment. However, it seems likely that these women, once outside the safety of the private exam room, also feared judgement and condemnation if others should find out about their abortion history. The missing tabs of paper instilled hope that some women would volunteer to participate in the study, yet no women from this clinic ever contacted me.

Women's experiences of abortion occurred primarily in the 1980's and have been influenced by changes in the social and political contexts since that time. An inability to recruit women from a broad range of time periods limits the comparisons that can be made about specific historical time periods and the influence of those events on women's experiences of abortion.

Despite variations in socioeconomic status, all women in the study were able to obtain the necessary funds to pay for the abortion procedure. Amanda was the only participant who did not keep a follow-up appointment at the abortion clinic due to the cost of the visit. All women were able to access abortion services through a variety of means;

Shirley, Kathleen, and Lindsey traveled over an hour's drive to an abortion clinic with the assistance of others. Lack of details in women's narratives about arranging for and having the abortion procedure make drawing conclusions about the impact of barriers on obtaining abortion limited.

My limited experience as a researcher, especially with qualitative methodology and interviewing skills, may have influenced the data collection and analysis. Flexibility in conducting interviews via phone or in person allowed participants to choose the method that worked best for them and allowed me to interview women across the United States. Conducting a second interview with each woman allowed women to evaluate the content and meaning of their abortion stories and reflect upon historical and social issues and events. Repeated interactions with women allowed me to develop rapport with participants, establish an environment of trust, safety, and comfort in sharing. My willingness to travel to meet with women also enhanced their ability and willingness to participate in the study.

**Research design.** By using a feminist philosophical foundation and a qualitative narrative design, this study began by valuing women and their experiences of abortion. The results of this research are grounded in the lived experiences of women and this methodology has offered me the opportunity to describe and explore women's experiences from their perspectives, to recognize systematic conditions that oppress women, and reach toward transformations that create a better world for women (Hall & Stevens, 1991; Chinn, 2003). This study enhanced nursing's knowledge of women's experiences of abortion by using an approach to studying this phenomenon that allowed women's voices to be heard without assumptions or labeling.

**Directions for future research.** Additional research should include women whose abortion experiences have occurred across a broader historical context. More participants with abortion experiences from different time periods could allow for a comparison of the historical influence of society and politics on women's experiences of abortion. Another method of evaluating political and social events and issues on women's experiences of abortion would be to identify significant moments in history such as the re-criminalization of medical abortion in a particular state and then determine the impact of these changes on women's experiences of abortion, such as Barbara's daughter who had to travel to another state to obtain a medical abortion.

Extending the current study to include interviews with the same participants over a great period of time or employing a longitudinal design with women could also add to knowledge about women's experiences of abortion. Following up with women every 5 years for another 20 years could explore the impact of social and political issues on women's experiences of abortion over time and allow for a comparison of their abortion experiences across both the sociopolitical climate and women's life stages.

Women in this study talked about the possibility of getting together with other women to talk about their abortion experiences. A research design which incorporates focus groups in which women could share and compare their abortion experiences with other women could meet women's needs to talk about their personal life experiences in a safe, comfortable place while adding to what is known about this phenomenon.

One participant, Donna, experienced an illegal abortion and then a legal abortion. Future research should include more women with these dual abortion experiences. Illegal and legal abortion experiences could be compared and contrasted for the same woman and

across participants to more fully understand the impact of legality on women's experiences of abortion.

### **Implications for Nursing Practice**

Women's narratives provided insight into women's experiences of abortion and revealed several implications for nursing practice. Women seeking confirmation of the suspected and unintended pregnancy were distressed; they did not plan on being in this situation. Lecturing women about contraception use is inappropriate and unhelpful once the unintended pregnancy is confirmed. Women want and need help with the current problem, the unintended pregnancy. Lindsey specifically encountered this response from nurses at a local clinic; while she could understand a re-emphasis on the correct use of contraception if the pregnancy test was negative, she could not justify hearing about birth control when she was already unintentionally pregnant.

Most participants confirmed the unintended pregnancy with a home pregnancy test, especially women with more recent experiences. After confirmed the unintended pregnancy, women thoughtfully examined their life circumstances and made their decision for abortion, before they ever contacted a reproductive health clinic. While politicians, religious organizations, and pro-life proponents insist that women need options counseling and a mandatory waiting period to consider their options, these participants gave no indications of needing either of these things. Their decision was not based on moral, religious, or political beliefs, but on the concrete circumstances of their lives when the unintended pregnancy occurred.

Once the decision for abortion had been made, women wanted to act on that decision and have the abortion performed quickly. Carolyn, Barbara, and Lindsey expressed

discomfort over the waiting time between arranging for the abortion and actually having the procedure.

It was a difficult period between when I decided I wasn't going to have the baby and the actual abortion. I think that was the most difficult part because I was a nurse and I had a baby inside, but I didn't want to tell anybody I was pregnant so I didn't really want to tell people 'I can't take care of that patient or this patient or whatever'. I remember going to work . . . I worked at 7:00am . . . and just being really nauseated; I had morning sickness and I'd vomit on the sidewalk. That period between having the appointment and really having the abortion, that time was really the hardest, the secrecy about it. I was really fatigued. I would come home and go directly to bed and I'd sleep until the next day when I had to get up. It was a difficult waiting period; I just kind of took care of myself.

Barbara (P03)

Nurses working in abortion and reproductive health clinics need to understand women's restlessness while waiting for the abortion procedure. It is important for health care providers to recognize that this time period may be stressful for women. Nurses should share knowledge about the timing of abortion procedures and help women understand the reasons for any delays. Delays in terminating pregnancies should be avoided to reduce women's anxiety and increased risks associated with advanced gestational terminations.

Women were sure of their decision for abortion, yet still felt apprehensive about going to the clinic on the day of the abortion procedure. They were nervous, anxious, and scared. They worried about long term side effects of having an abortion. Women's fears increased on the way to the abortion procedure when they encountered picketers, saw billboards and fences with pro-life messages, navigated advanced security systems, read posters about murdered abortionists, and heard people calling them "baby killers". Nurses working in abortion clinics need to be cognizant of women's concerns. Women are mature, responsible adults who have already made their decision for abortion yet they are human

beings who are frightened and in need of kindness, caring words, compassion, and reassurance about their safety.

Women in this study recounted the positive influence of health care providers and nurses who were kind, caring, compassionate, non-judgmental, and good listeners. Women greatly appreciated being talked through procedures and given information about what to expect. These interventions decreased their anxiety and enhanced their control over the unfamiliar and scary experience of having an abortion. Participants also recounted stories of inappropriate behaviors by nurses and those providing abortion services. Unsuitable comments and badly chosen jokes reflected unprofessionally on nurses. While working in an abortion clinic may become routine for providers, there is nothing ordinary for women about having an abortion. They need and want competent professionals who are skilled and proficient in providing safe, quality care; they want reassurance, not lackadaisical circumstances.

Fielding and Schaff (2004) studied the impact of the social context on women's experiences of abortion, exploring women's emotional responses based on the manner in which women defined the unintended pregnancy. These researchers identified that women who defined the pregnancy as a baby experienced more emotional conflict than women who considered the pregnancy a fetus or a potential baby. Some of the women in this study defined their pregnancy as a baby, others did not. Nurses need to understand that some women define the unintended pregnancy as a baby while others consider it a fetus or a potential child. Healthcare professionals need to be aware of the ways in which women characterize their pregnancy and avoid imposing their own views. During the counseling



session for her second abortion, Barbara felt awkward when the clinic staff attempted to minimize the impact of having an abortion.

I do remember from the second one that in the pre-procedure phase I had a counselor and she was showing me pictures of how a human fetus looks like this and it's not really too much different from a cow fetus and a sheep fetus. I always remember that as being kind of bizarre. I think it was so I would think of this as not really a baby, you know, it was a fetus just like any other kind of animal. I think she was trying to minimize the impact of it, but I felt it was a baby.

Barbara (P03)

Nurses and counselors need to avoid trying to minimize or change a woman's definition of the unintended pregnancy. Instead attempt to address the needs of women by acknowledging and validating their views and beliefs. Additionally, consider talking with the women who define the pregnancy as a baby about mental health counseling after the abortion and ensure they are given resources and referrals as needed.

### **Implications for Policy**

Women in this study believed that abortion should be legal, safe, and accessible even if they didn't think they would choose abortion again. They want politicians and lawmakers to keep abortion out of the political arena and leave abortion as a reproductive health issue between a woman and her healthcare provider. These participants wanted to elect representatives, congressmen, senators, and presidents based on issues other than abortion. Overall they felt that men, lawmakers, politicians, and judges should not be allowed to determine women's reproductive rights. Women want to make their own decisions about reproductive health; they want men to support the decisions they've made. Men need to think about their wives, daughters, mothers, and sisters when making judgemental, condemning, and ostracizing comments about abortion. Women want others to be accepting, understanding, kind, and compassionate towards them about the abortion decision; they want

others, including their own family members, to realize that they made the most pragmatic decision they could at the time.

Women's stories told of their frustration with pro-life and pro-choice politics. Women don't want their abortion experiences to be used to support either side of the abortion debate as this approach dichotomizes women's lived experiences and negates the complexity of women's circumstances and their individualized decision making processes.

I've read a lot about other people's abortion stories and sometimes I think a lot of it's politically motivated actually; that these women have this terrible grieving and loss and they regret it forever. I never felt like that and I'm glad I didn't.

Rebecca (P07)

Advanced practice nurses such as Nurse Practitioners (NPs) and Certified Nurse Midwives (CNMs) are in a great position to provide both surgical and medical abortion to women in a kind, caring, and compassionate manner. Legislation and nursing organizations need to support the provision of abortion services by NPs and CNMs. Much recent research has focused on the provision of abortion care by nurses (citations).

### **Final Reflections**

I am so very grateful to the women who volunteered to share with me their stories of abortion. I am honored to have had the opportunity to listen to their personal experiences as only they could tell. They taught me to be a nurse researcher with kindness and compassion. They voiced a need for their stories to be told and heard. These women encouraged me to move their issues out of the cloak of darkness and secrecy into the light of reality. I am grateful as a nurse to better understand abortion through their experiences. Women generously shared of their time and stories, which helped me understand even more that women's experiences of abortion are varied, but they all made the decision for abortion

based on their life situation when the unintended pregnancy occurred. My hope is that nurses, providers, researchers, politicians, and family members will avoid the political dichotomy of categorizing women's experiences of abortion as right or wrong, good or evil. Instead of labeling and judging women for their decision to have an abortion, accept them as people who have made thoughtful, wise decisions based on their particular life circumstances. People who truly care about women and their reproductive health will recognize that society and politics have imposed shame, guilt, and fear on women who have experienced abortion and will put an end to a dichotomized view of abortion, which is not consistent with what women have to say about the reality of their lives.

## References

- Adler, N. (1976). Sample attrition in studies of psychosocial sequelae of abortion: How great a problem? *Journal of Applied Social Psychology*, 6 (3), 240-259.
- Adler, N. (1979). Abortion: a social-psychological perspective. *Journal of Social Issues*, 33, 100-119.
- Adler, N.E., David, H. P., Major, B. N., Roth, S. H., Russo, N. F., & Wyatt, G. E. (1990). Psychological responses after abortion. *Science*, 248, 41-44.
- Almeling, R., Tews, L., & Dudley, S. (2000). Abortion training in U.S. obstetrics and gynecology residency programs, 1998. *Family Planning Perspectives*, 32(6), 268-271, 320.
- American College of Obstetricians and Gynecologists (ACOG). (2007). *Statement on the U.S. Supreme Court decision upholding the Partial Birth Abortion Ban Act of 2003*. Retrieved from [http://www.acog.org/from\\_home/publications/press\\_releases/nr04-18-07.cfm](http://www.acog.org/from_home/publications/press_releases/nr04-18-07.cfm)
- Andrews, J. & Boyle, J. (2003). African American adolescents' experiences with unplanned pregnancy and elective abortion. *Health Care for Women International*, 24, 414-433.
- Andrist, L. C., Simmonds, K., Liebermann, E., & Healey, K. (2006). Women's experiences of medical abortion. *The American Journal of Nurse Practitioners*, 10, 59-65.
- Aubény, E., Peyron, R., Turpin, C., Renault, M., Targosz, V., Silvestre, L., Ulmann, A., and Baulieu, EE. (1995). Termination of early pregnancy (up to 63 days of amenorrhea) with mifepristone and increasing doses of misoprostol. *International Journal of Fertility and Menopausal Studies*, 40(suppl 2), 85-91.

- Avalos, L. (1999). Hindsight and the abortion experience: what abortion means to women years later. *Gender Issues, Spring 1999*, 35-57.
- Baehr, N. (1990). *Abortion without Apology: A Radical History for the 1990s*. Boston, MA: South End Press.
- Beckman, L. J. & Harvey, S. M. (1997). Experience and acceptability of medical abortion with Mifepristone and Misoprostol among U.S. women. *Women's Health Issues, 7* (4), 253-262.
- Bell, S. E. (1988). Becoming a political woman: The reconstruction and interpretation of experience through stories. In A. D. Todd and S. Fisher (Eds.), *Gender and discourse: The power of talk* (pp. 97-123). Norwood, NJ: Ablex.
- Bennett, I., Johnson, M., Wu, J., Kalkstein, K., Wolff, E., Bellamy, S., & Fleischman, J. (2007). A family medicine training collaborative in early abortion. *Journal of Family Medicine, 39*(3), 164-166.
- Berer, M. (2009). Provision of abortion by mid-level providers: international policy, practice, and perspectives. *Bulletin of the World Health Organization, 87*, 58-63.
- Blumberg, B. D., & Golbus, M. S. (1975). Psychological sequelae of elective abortion. *Western Journal of Medicine, 123* (3), 188-193.
- Blumenthal, S. J. (1991). Psychiatric consequences of abortion: an overview of research findings. In N. L. Stotland (Ed.) *Psychiatric Aspects of Abortion* (pp.17-37). Washington, DC: American Psychiatric Press.
- Bonavoglia, A. (2001). *The choices we made*. New York, NY: Four Walls Eight Windows.
- Boonin, D. (2003). *A defense of abortion*. New York, NY: Cambridge University.

- Boonstra, H. D., Gold, R. B., Richards, C. L., & Finer, L. B. (2006). *Abortion in Women's Lives*. New York, NY: Guttmacher Institute. Retrieved from <http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf>
- Boyle, M. & McEvoy, J. (1998). Putting abortion in its social context: Northern Irish women's experiences of abortion in England. *Health*, 2(3), 283-304.
- Bracken, M. B., Hachamovitch, M., & Grossman, G. (1974). The decision to abort and psychological sequelae. *The Journal of Nervous and Mental Disease*, 158 (2), 154-162.
- Briggs, C. L. (1986). *Learning how to ask: A socio-linguistic appraisal of the role of the interview in social science research*. Cambridge, MA: MIT Press.
- Burns, N. & Grove, S. (2001). *The practice of nursing research: conduct, critique, & utilization*. Philadelphia, PA: W.B. Saunders.
- Burns, G. (2005). *The moral veto: framing contraception, abortion, and cultural pluralism in the United States*. Cambridge, MA: University Press.
- Buseh, A. G. & Stevens, P. E. (2006). Constrained but not determined by stigma: resistance by African American women living with HIV. *Women and Health*, 44 (3), 1-18. doi: 10.1300/J013v44n03\_01
- Bydeman, M. & Swahn, M. L. (1985). Progesterone receptor blockage; effect on uterine contractility and early pregnancy. *Contraception*, 32, 45-51.
- Centers for Disease Control and Prevention (CDC). (2011). Abortion Surveillance Report, 2007. *Mortality and Morbidity Weekly*, 60 (1), pp. 1-12. Retrieved from <http://www.cdc.gov/mmwr/pdf/ss/ss6001.pdf>

- Chalker, R. & Downer, C. (1992). *A Woman's Book of Choices, Abortion, Menstrual Extraction, RU-486*. New York, NY: Four Walls Eight Windows.
- Chinn, P. L. (2003). Feminist approaches. In Clare, J. and Hamilton, H. (Eds.) *Writing Research: Transforming data into text*, Chapter 5, pp. 61-84, Churchill Livingstone: New York.
- Clinicians for Choice (CFC). (2007). *Certified nurse-midwives, nurse practitioners, and physician assistants as abortion providers*. Retrieved from [http://www.prochoice.org/pubs\\_research/publications/downloads/cfc/CNM\\_NP\\_PA\\_org\\_statements.pdf](http://www.prochoice.org/pubs_research/publications/downloads/cfc/CNM_NP_PA_org_statements.pdf)
- Clinicians for Choice (CFC). (2009). *Timeline, state by state: expanding CNM, NP, and PA provision of abortion care*. Retrieved from [http://www.prochoice.org/pubs\\_research/publications/downloads/cfc/cfc\\_states\\_timeline.pdf](http://www.prochoice.org/pubs_research/publications/downloads/cfc/cfc_states_timeline.pdf)
- Cohen, S. A. (2008). Abortion and women of color: the bigger picture. *Guttmacher Policy Review*, 11(3):2-5. Retrieved from <http://www.guttmacher.org/pubs/gpr/11/3/gpr110302.html>
- Coleman, P. K., Reardon, D. C., Strahan, T., & Cogle, J. R. (2005). The psychology of abortion: A review and suggestions for future research. *Psychology and Health*, 20(2), 237-271.
- Collins, P. H. (1986). Learning from the outsider within: The sociological significance of black feminist thought. In S. G. Harding (2004) (Ed.), *The feminist standpoint reader* (pp. 103-126). New York, NY: Routledge.

- Collins, P. H. (1991). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. New York, NY: Routledge, Chapman, & Hall.
- Creinen, M. D. (2000). Medical abortion regimens: historical context and overview. *American Journal of Obstetrics and Gynecology*, 183, S3-S9.
- Dagg, P. K. B. (1991). The psychological sequelae of therapeutic abortion – denied and completed. *American Journal of Psychiatry*, 148, 578-585.
- David, H. P. (1972). Abortion in psychological perspective. *American Journal of Orthopsychiatry*, 42 (1), 61-68.
- Davis, T. (2005). *Sacred work: Planned Parenthood and its clergy alliances*. New Brunswick, NJ: Rutgers University.
- Dehlendorf, C., Brahmi, D., Engel, D., Grumbach, K., Joffe, C., & Gold, M. (2007). Integrating abortion training into family medicine residency programs. *Journal of Family Medicine*, 39(5), 337-342.
- Dehlendorf, C., & Grumbach, K. (2008). Medical liability insurance as a barrier to the provision of abortion services in family medicine. *American Journal of Public Health*, 98, 1770–1774. doi: 10.2105/AJPH.2008.136325.
- Dehlendorf, D., & Weitz, T. (2011). Access to abortion services: a neglected health disparity. *Journal of Health Care for the Poor and Underserved*, 22, 415-421.
- Dennis, A., Henshaw, S. K., Joyce, T. J., Finer, L. B., & Blanchard, K. (2009). *The impact of laws requiring parental involvement for abortion: a literature review*. New York, NY: Guttmacher Institute. Retrieved from <http://www.guttmacher.org/pubs/ParentalInvolvementLaws.pdf>



- Denzin, N. K. & Lincoln, Y. S. (2000). Introduction: The Discipline and Practice of Qualitative Research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 1-29). Thousand Oaks, CA: Sage.
- Ehrlich, J. S. (2003). Choosing abortion: Teens who make the decision without parental involvement. *Gender Issues*, Spring, 3-39.
- Elul, B., Pearlman, E., Sorhaindo, A., Simonds, W., & Westhoff, C. (2000). In-depth interviews with medical abortion clients: Thoughts on the method and home administration of Misoprostol. *Journal of the American Women's Medical Association*, 55, 169-172.
- Faria, G., Barrett, E., & Goodman, L. (1986). Women and abortion: attitudes, social networks, decision-making. *Social Work in Health Care*, 11 (1), 85-99.
- Feldt, G. (2002). *Behind every choice is a story*. University of North Texas Press: Denton.
- Fielding, S. L., Edmunds, E., & Schaff, E. A. (2002). Having an abortion using Mifepristone and home Misoprostol: A qualitative analysis of women's experiences. *Perspectives on Sexual and Reproductive Health*, 34 (1), 34-40.
- Fielding, S. L., & Schaff, E. A. (2004). Social context and the experience of a sample of U.S. women taking RU 486 (mifepristone) for early abortion. *Qualitative Health Research*, 14, 612-627.
- Finer, L. B., & Wei, J. (2009). Effect of mifepristone on abortion access in the United States. *Obstetrics and Gynecology*, 114, 623-630.
- Finer, L. B., & Zolna, M. R. (2011). Unintended pregnancy in the United States: incidence and disparities, 2006. Retrieved from <http://www.guttmacher.org/pubs/journals/j.contraception.2011.07.13.pdf>

- doi: 10.1016/j.contraception.2011.07.013
- Freeman, E. W. (1978). Abortion: Subjective attitudes and feelings. *Family Planning Perspectives, 10* (3), 150-155.
- Free Clinics in Wisconsin (2011). Retrieved from [www.dhs.wisconsin.gov/forwardhealth/pdf/free.pdf](http://www.dhs.wisconsin.gov/forwardhealth/pdf/free.pdf)
- Freedman, L., Landy, U., Darney, P., & Steinauer, J. (2010). Obstacles to the integration of abortion into obstetrics and gynecology practice. *Perspectives on Sexual and Reproductive Health, 42*(3), 146-151; doi: 10.1361/4214610
- Freedman, M. A., Jillson, D. A., Coffin, R. R., & Novick, L. F. (1986). Comparison of complication rates in first trimester abortions performed by physician assistants and physicians. *American Journal of Public Health, 76* (5), 550-554.
- Fried, M. G. (1998). Abortion in the United States – legal but inaccessible. In R. Solinger (Ed.) *Abortion wars: a half century of struggles, 1950-2000* (pp. 208-226). Berkeley, CA: University of California.
- Ginsburg, F. D. (1998). *Contested lives: the abortion debate in an American community*. Berkeley, CA: University of California Press.
- Goldman, M. B., Occhiuto, J. S., Peterson, L. E., Zapka, J. G., & Palmer, R. H. (2004). Physician assistants as providers of surgically induced abortion services. *American Journal of Public Health, 94*, 1352-1357.
- Gordon, L. (1974). *Woman's body, woman's right*. New York, NY: Penguin Books.
- Gorney, C. (1998). *Articles of Faith: a frontline history of the abortion wars*. New York, NY: Simon & Schuster.

- Griffin-Carlson, M. S., & Mackin, K. J. (1993). Parental consent: factors influencing adolescent disclosure regarding abortion. *Adolescence*, 28 (109), 1-12.
- Grossman, D., Holt, K., Peña, M., Lara, D., Veatch, M., Córdova, M., Winikoff, B., & Blanchard, K. (2010). Self-induction of abortion among women in the United States. *Reproductive Health Matters*, 18(36), 136-146. pii: S0968-8080(10)36534-7
- Guttmacher Institute. (2008). *An overview of abortion in the United States*. Retrieved from <http://www.guttmacher.org/media/presskits/2008/01/12/abortionoverview.html>
- Guttmacher Institute. (2011). *Facts on induced abortion in the United States*. Retrieved from [http://www.guttmacher.org/pubs/fb\\_induced\\_abortion.pdf](http://www.guttmacher.org/pubs/fb_induced_abortion.pdf)
- Guttmacher Institute. (2011). *State policies in brief: An overview of abortion laws*. Retrieved from [http://www.guttmacher.org/statecenter/spibs/spib\\_OAL.pdf](http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf)
- Guttmacher Institute. (2011). *State policies in brief: Parental involvement in minors' abortions*. Retrieved from [http://www.guttmacher.org/statecenter/spibs/spib\\_PIMA.pdf](http://www.guttmacher.org/statecenter/spibs/spib_PIMA.pdf)
- Guttmacher Institute. (2011). *State policies in brief: Counseling and waiting periods for abortion*. Retrieved from [http://www.guttmacher.org/statecenter/spibs/spib\\_MWPA.pdf](http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf)
- Guttmacher Institute. (2011). *State policies in brief: State funding of abortion under Medicaid*. Retrieved from [http://www.guttmacher.org/statecenter/spibs/spib\\_SFAM.pdf](http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf)
- Guttmacher Institute. (2011). *State policies in brief: Restricting insurance coverage of abortion*. Retrieved from [http://www.guttmacher.org/statecenter/spibs/spib\\_RICA.pdf](http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf)

- Hall, J. M., & Stevens, P. E. (1991). Rigor in feminist research. *Advances in Nursing Science, 13*, 16-29.
- Halldén, B. M., Christensson, K., & Olsson, P. (2005). Meanings of being pregnant and having decided on abortion: young Swedish women's experiences. *Health Care for Women International, 26*, 788-806.
- Haraway, D. J. (1988). Situated Knowledges: The science questions in feminism and the privilege of partial perspective. *Feminist Studies, 14* (3), 575-599.
- Harden, A., & Ogden, J. (1999). Young women's experiences of arranging and having abortions. *Sociology of Health and Illness, 21*(4), 426-444.
- Harding, S. G. & Hintikka, M. B. (1983), (Eds.). *Discovering reality: feminist perspectives on epistemology, metaphysics, methodology, and philosophy of science*. London, UK: Springer.
- Harding, S. G. (1986). *The science question in feminism*. Ithaca, NY: Cornell University.
- Harding, S. G. (Ed.). (1987a). *Sex and inquiry*. Chicago, IL: University of Chicago.
- Harding, S. G. (Ed.). (1987b). *Feminism & methodology: Social science issues*. Bloomington, IN: Indiana University.
- Harding, S. G. (1987c). The method question. *Hypatia, 2* (3), 19-35.
- Harding, S. G. (1989). Women as creators of knowledge. *The American Behaviorist Scientist, 32* (6), 700-706.
- Harding, S. G. (1990). Feminism and theories of scientific knowledge. *Women, 1* (1), 87-98.
- Harding, S. G. (1991). *Whose Science? Whose Knowledge: Thinking from women's lives*. Ithaca, NY: Cornell University Press.

- Harding, S. G. (1993). *Rethinking standpoint epistemology: What is "strong objectivity"?* In L. Alcoff & E. Porter (Eds.), *Feminist epistemologies* (pp. 49-82). New York, NY: Routledge.
- Harding, S. G. (2003). *How standpoint methodology informs philosophy of social science*. In *The Blackwell Guide to the Philosophy of Science* (pp. 291-310). Malden, MA: Blackwell.
- Harding, S.G. (Ed.). (2004a). *The feminist standpoint theory reader: intellectual and political controversies*. New York, NY: Routledge.
- Harding, S. G. (2004b). A socially relevant philosophy of science? Resources from standpoint theory's controversiality. *Hypatia*, 19 (1), 25-47.
- Harding, S. G. (2007). *Feminist Standpoints*. In S. N. Hesse-Biber (Ed.), *Handbook of feminist research: theory and praxis*, (pp. 45-69). Thousand Oaks, CA: Sage.
- Harper, C. C., Henderson, J. T., & Darney, P. D. (2005). Abortion in the United States. *Annual Review of Public Health*, 26, 501-512.
- Hartsock, N. C. M. (1975). Fundamental feminism: process and perspective. *Quest: A Feminist Quarterly* 2, 2.
- Hartsock, N. C. M. (1983). The feminist standpoint: Developing the ground for a specifically feminist historical materialism. In S. Harding & M. B. Hintikka (Eds.), *Discovering Reality* (pp. 283-310). Boston, MA: Kluwer.
- Hartsock, N. C. M. (1985). *Money, sex, and power: Towards a feminist historical materialism*. Boston, MA: Northeastern University Press.

- Hartsock, N. C. M. (1997). Standpoint theories for the next century. In S. J. Kenney & H. Kinsella (Eds.), *Politics and feminist standpoint theories* (pp. 93-101). New York, NY: Haworth.
- Hartsock, N. C. M. (1998). *The feminist standpoint revisited and other essays*. Boulder, CO: Westview.
- Henshaw, S. K., & Finer, L. B. (2006). Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspectives on Sexual and Reproductive Health*, 38(2), 90–96. Retrieved from <http://www.guttmacher.org/pubs/journals/3809006.pdf>
- Henshaw, S. K., Joyce, T. J., Dennis, A., Finer, L. B., & Blanchard, K. (2009). *Restrictions on Medicaid funding for abortions: A literature review*. New York, NY: Guttmacher Institute. Retrieved from <http://www.guttmacher.org/pubs/MedicaidLitReview.pdf>
- Henshaw, S. K., & Kost, K. (1992). Parental involvement in minors' abortion decision. *Family Planning Perspectives*, 24 (5), 196-207, 213.
- Hess, R. (2004). Dimensions of women's long-term postabortion experience. *American Journal of Maternal/Child Nursing*, 29, 193-198.
- hooks, b. (1984). *Feminist theory: from margin to center*. Boston, MA: South End.
- hooks, b. (1990). The politics of radical black subjectivity. In b. hooks (Ed.), *Yearning: race, gender, and cultural politics* (pp. 15-22). Boston, MA: South End.
- hooks, b. (2000). *Feminism is for everybody: passionate politics*. Cambridge, MA: South End.
- Jackson, C. B. (2011). Expanding the pool of abortion providers: nurse-midwives, nurse practitioners, and physician assistants. *Women's Health Issues*, 21 (3S), S42-S43. doi: 10.1016/j.whi.2011.01.010

- Jaggar, A. M. (1983). Feminist politics and epistemology: the standpoint of women. In S. G. Harding (2004) (Ed.), *The feminist standpoint reader* (pp. 55-66). New York, NY: Routledge.
- Joffe, C. (1999). Abortion in historical perspective. In M. Paul, E. S. Lichtenberg, L. Borgatta, D. A. Grimes, & P. G. Stubblefield (Eds.), *A clinical guide to medical and surgical abortion*. Philadelphia, PA: Churchill Livingstone. Retrieved from [http://www.prochoice.org/education/resources/surg\\_history\\_overview.html](http://www.prochoice.org/education/resources/surg_history_overview.html)
- Joffe, C., & Yanow, S. (2004). Advanced practice clinicians as abortion providers: current developments in the United States. *Reproductive Health Matters*, 12 (24 supplement), 198-206.
- Jones, R. K., Singh, S., Finer, L. B., & Frohworth, L. F. (2006). Repeat abortion in the United States. *Occasional Report No. 29*. New York, NY: Guttmacher Institute. Retrieved from <http://www.guttmacher.org/pubs/2006/11/21/or29.pdf>
- Jones, R. K., Finer, L. B., & Singh, S. (2010). *Characteristics of U.S. abortion patients, 2008*. New York, NY: Guttmacher Institute. Retrieved from <http://www.guttmacher.org/pubs/US-Abortion-Patients.pdf>
- Jones, R. K., & Kavanaugh, M. L. (2011). Changes in abortion rates between 2000 and 2008 and lifetime incidence of abortion. *Obstetrics and Gynecology*, 117 (6), 1358-1366.
- Jones, R. K., & Kooistra, K. (2011). Abortion incidence and access to services in the United States, 2008. *Perspectives on Sexual and Reproductive Health*, 43(1), 41-50. doi: 10.1363/430411.

- Jones, R. K., Zolna, M. R. S., Henshaw, S. K., & Finer, L. B. (2008). Abortion in the United States: incidence and access to services, 2005. *Perspectives on Sexual and Reproductive Health*, 40(1), 6-16.
- Joyce, T. J., Henshaw, S. K., Dennis, A., Finer, L. B., & Blanchard, K. (2009). *The impact of state mandatory counseling and waiting period laws on abortion: a literature review*. New York, NY: Guttmacher Institute. Retrieved from <http://www.guttmacher.org/pubs/MandatoryCounseling.pdf>
- Kahn, J. G., Becker, B. J., MacIsaac, L., Amory, J. K., Neuhaus, J., Olkin, I. & Creinin, M. D. (2000). The efficacy of medical abortion: a meta-analysis. *Contraception*, 61, 29-40. pii S0010-7824(99)00115-8
- Kaplan, L. (1995). *The story of Jane: the legendary underground feminist abortion service*. New York, NY: Pantheon Books.
- Kapparis, K. (2002). *Abortion in the ancient world*. London, UK: Duckworth.
- Keasling, G. & Davis, J. (1975). Therapeutic abortion: a selective review of the literature. *The Nebraska Medical Journal*, 60, 388-392.
- Koopersmith, T. B. & Mishell, D. R. (1996). The use of misoprostol for termination of early pregnancy. *Contraception*, 53, 238-242.
- Kruse, B., Poppema, S., Creinin, M., & Paul, M. (2000). Management of side effects and complications in medical abortion. *American Journal of Obstetrics and Gynecology*, 183, S65-S75.
- Kumar, V., Herbitter, C., Karasz, A., & Gold, M. (2010). Being in the room: reflections on pregnancy options counseling during abortion training. *Journal of Family Medicine*, 42(1), 41-46.



- Labov, W. and Waletzky, J. (1967). Narrative analysis: oral versions of personal experience. In J. Helm (Ed.), *Essays on the verbal and visual arts: proceedings of the 1966 annual spring meeting of the American Ethnological Society* (pp. 12-44). Seattle, WA: University of Washington.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 163-188). Thousand Oaks, CA: Sage.
- Maforah, F., Wood, K., & Jewkes, R. (1997). Backstreet abortion: women's experiences. *Curationis*, 20(2), 79-82.
- Major, B., Appelbaum, M., Beckman, L., Dutton, M. A., Russo, N. F., & West, C. (2009). Abortion and mental health. *American Psychologist*, 64 (9), 863-890. doi: 10.1037/a0017497
- McIntyre, M. (2005). Commentary by McIntyre. *Western Journal of Nursing Research*, 27(5), 577-579. doi: 10.1177/0193945905275937
- McLaughlin, J. (2003). *Feminist social and political theory: contemporary debates and dialogues*. Hampshire, UK: MacMillan.
- Mishler, E. G. (1986). *Research interviewing: context and narrative*. Cambridge, MA: Harvard University.
- Mohr, J. (1978). *Abortion in America: the origins and evolution of national policy, 1800-1900*. New York, NY: Oxford University.
- Morse, J. M. (1994). (Ed.). *Critical issues in qualitative research methods*. Thousand Oaks, CA: Sage.

Morse, J. M., & Richards, L. (2002). *Read me first for a user's guide to qualitative methods*.

Thousand Oaks, CA: Sage.

Mudd, E. H. (1973). Thoughts on the sociological and psychological aspects of abortion. In J.

D. Osofsky, & H. J. Osofsky (Eds.), *The abortion experience: psychological and medical impact* (pp. 554-561). New York, NY: Harper & Row.

National Abortion Federation (NAF). (2003a). *Access to abortion*. Retrieved from

[http://www.prochoice.org/pubs\\_research/publications/downloads/about\\_abortion/access\\_abortion.pdf](http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/access_abortion.pdf)

National Abortion Federation (NAF). (2003b). *Teenage women, abortion, and the law*.

Retrieved from

[http://www.prochoice.org/pubs\\_research/publications/downloads/about\\_abortion/teenage\\_women.pdf](http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/teenage_women.pdf)

National Abortion Federation (NAF). (2006). *Public funding for abortion: Medicaid and the Hyde amendment*. Retrieved from

[http://www.prochoice.org/pubs\\_research/publications/downloads/about\\_abortion/public\\_funding.pdf](http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/public_funding.pdf)

National Abortion Federation (NAF). (2008a). *Facts about Mifepristone (RU 486)*. Retrieved from

[http://www.prochoice.org/pubs\\_research/publications/downloads/about\\_abortion/facts\\_about\\_mifepristone.pdf](http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/facts_about_mifepristone.pdf)

National Abortion Federation (NAF). (2008b). *What is medical abortion?* Retrieved from

[http://www.prochoice.org/pubs\\_research/publications/downloads/about\\_abortion/medical\\_abortion.pdf](http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/medical_abortion.pdf)

National Abortion Federation (NAF). (2010). *Medical abortion/history and overview*.

Retrieved from

[http://www.prochoice.org/education/resources/med\\_history\\_overview.html](http://www.prochoice.org/education/resources/med_history_overview.html)

National Abortion Federation (NAF). (2011). *NAF violence and disruption statistics:*

*incidents of violence & disruption against abortion providers in the U.S. & Canada.*

Retrieved from

[http://www.prochoice.org/pubs\\_research/publications/downloads/about\\_abortion/stats\\_table2010.pdf](http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/stats_table2010.pdf)

Olesen, V. L. (1994). Feminisms and models of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 158-174). Thousand Oaks, CA: Sage.

Olesen, V. L. (2000). Feminisms and qualitative research at and into the millennium. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 215-256). Thousand Oaks, CA: Sage.

Olesen, V. L. (2005). Early millennial feminist qualitative research – challenges and contours. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage Handbook of Qualitative Research* (pp. 235-278). Thousand Oaks, CA: Sage.

Osofsky, J. D., Osofsky, H. J., Rajan, R., & Fox, M. R. (1971). Psychologic effects of legal abortion. *Clinical Obstetrics and Gynecology*, 14(1), 215-234.

Palmer, L. J. (2002). *Encyclopedia of abortion in the United States*. Jefferson, NC: McFarland & Company.

- Paul, M., Nobel, K., Goodman, S., Lossy, P., Moschella, J., & Hammer, H. (2007). Abortion training in three family medicine programs: resident and patient outcomes. *Journal of Family Medicine*, 39(3), 184-189.
- Petchesky, R. P. (1990). *Abortion and woman's choice: the state, sexuality, and reproductive freedom*. Boston, MA: Northeastern University Press.
- Peyron, R., Aubény, E., Targosz, V., Silvestre, L., Renault, M., Elkik, F., Leclerc, P., Ulmann, A., & Baulieu, E. (1993). Early termination of pregnancy with mifepristone (RU 486) and the orally active prostaglandin misoprostol. *New England Journal of Medicine*, 328 (21), 1509-1513.
- Plach, S. K., Stevens, P. E., & Keigher, S. (2005). Self-care of women growing older with HIV and/or AIDS. *Western Journal of Nursing Research*, 27 (5), 534-553. doi: 10.1177/0193945905275973
- Planned Parenthood Clinics in Wisconsin. (2011). Retrieved from <http://www.plannedparenthood.org/health-center/findCenter.asp>
- Polanyi, L. (1985). *Telling the American story: a structural and cultural analysis of conversational storytelling*. Norwood, NJ: Ablex.
- Polit, D. F., & Beck, C. T. (2004). Qualitative research design and approaches. In *Nursing Research: Principles and Methods* (pp. 245-272). Philadelphia, PA: Lippincott, Williams, & Wilkins.
- Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: beyond attitudes and behaviors*. Beverly Hills, CA: Sage.
- Pymar, H. C., & Creinin, M. D. (2000). Alternative to mifepristone for termination of early pregnancy. *American Journal of Obstetrics and Gynecology*, 183, s54-s64.

- Reagan, L. (1997). *When abortion was a crime*. Berkeley, CA: University of California Press.
- Reagan, L. (2000). Crossing the border for abortions: California activists, Mexican clinics, and the creation of a feminist health agency in the 1960s. *Feminist Studies*, 26 (2), 323-348.
- Remeikis, G. V. (2001). A review of the psychoanalytic literature on abortion. *Journal of the American Academy of Psychoanalysis*, 29(2), 231-244.
- Remennick, L., & Segal, R. (2001). Socio-cultural context and women's experiences of abortion: Israeli women and Russian immigrants compared. *Culture, Health, & Sexuality*, 3(1), 49-66.
- Richardson, L. (1988). The collective story: postmodernism and the writing of sociology. *Sociological Focus*, 21(3), 199-208.
- Riessman, C. K. (1987). When gender is not enough: women interviewing women. *Gender and Society*, 1 (2), 172-207.
- Riessman, C. K. (1993). *Narrative analysis: qualitative research methods*. Newbury Park, CA: Sage.
- Riessman, C. K. (2003). *Narrative analysis*. Retrieved from <http://cmsu2.ucmo.edu/public/classes/Baker%20COMM%205820/narrative%20analysis.riessman.pdf>
- Rogers, J. L., Stoms, G. B., & Phifer, J. L. (1989). Psychological impact of abortion: methodological and outcomes summary of empirical research between 1966 and 1988. *Health Care for Women International*, 10, 347-376.

- Rose, H. (1983). Hand, brain, and heart: a feminist epistemology for the natural sciences. *Signs*, 9(1), 73- 90.
- Rowland, D. (2004). *The boundaries of her body: the troubling history of women's rights in America*. Naperville, IL: Sphinx.
- Samora, J. B., & Leslie, N. (2007). The role of advanced practice clinicians in the availability of abortion services in the United States. *Journal of Obstetric, Gynecologic, and Neonatal Nurses*, 36 (5), 471-476. doi: 10.1111/J.1552-6909.2007.00169.x
- Sandelowski, M. (1995). Focus on qualitative methods: sample size in qualitative research. *Research in Nursing and Health*, 18, 179-183.
- Sauer, R. (1974). Attitudes to abortion in America, 1800-1973. *Population Studies*, 28(1), 53-67.
- Schaff, E. A., Stadalius, L. S., Eisinger, S. H., & Franks, P. (1997). Vaginal misoprostol administered at home after mifepristone (RU 486) for abortion. *Journal of Family Practice*, 44, 353-360.
- Schoen, J. (2005). *Choice & coercion: birth control, sterilization, and abortion in public health and welfare*. Chapel Hill, NC: University of North Carolina.
- Sethna, C., & Doull, M. (2007). Far from home? A pilot study tracking women's journeys to a Canadian abortion clinic. *Journal of Obstetrics and Gynaecology Canada*, 27(8), 640-647.
- Shusterman, L. (1976). The psychological factors of the abortion experience: a critical review. *Psychology of Women Quarterly*, 1, 79-106.
- Simon, N. M., & Senturia, A. G. (1966). Psychiatric sequelae of abortion: review of the literature, 1935-1964. *Archives of General Psychiatry*, 15, 378-389.

- Simonds, W., Ellertson, C., Springer, K., & Winikoff, B. (1998). Abortion, revised: participants in the U.S. clinical trials evaluate mifepristone. *Social Science Medicine*, 46, 1313-1323.
- Smith, E. M. (1973). A follow-up study of women who request abortion. *American Journal of Orthopsychiatry*, 43(4), 574-585.
- Smith, D. E. (1974). Women's perspective as a radical critique of sociology. *Sociological Inquiry*, 44, 1-13.
- Smith, D. E. (1987). *The everyday world as problematic, a feminist sociology*. Boston, MA: Northeastern University.
- Smith, D. E. (1991). Writing women's experience into social science. *Feminism & Psychology*, 1, 155-169.
- Smith, D. E. (1997). From the margins: women's standpoint as a method of inquiry in the social sciences. *Gender, Technology and Development*, 1, 113-135.
- Solinger, R. (1998). *Abortion Wars: a half century of struggle, 1950-2000*. Berkeley, CA: University of California.
- Solinger, R. (2005). *Pregnancy and power: a short history of reproductive politics in America*. New York, NY: New York University.
- Spitz, I. M., Bardin, C. W., Benton, L., & Robbins, A. (1998). Early pregnancy termination with mifepristone and misoprostol in the United States. *New England Journal of Medicine*, 338, 1241-1247.
- Stein, R. & Shear, M. (2009, January 24). Funding restored to groups that perform abortions, other care. *The Washington Post*, Section A03.

- Steinauer, J., Landy, U., Filippone, H., Douglas, L., Darney, P. D., & Jackson, R. A. (2008). Predictors of abortion provision among practicing obstetrician-gynecologists: a national survey. *American Journal of Obstetrics and Gynecology*, 198(1), 39.e1-6.
- Stevens, P. E. (1993). Marginalized women's access to health care: a feminist narrative analysis. *Advances in Nursing Science*, 16 (2), 39-56.
- Stevens, P. E. (1994). Lesbians' health-related experiences of care and noncare. *Western Journal of Nursing Research*, 16 (6), 639-659.
- Stevens, P. E. (1996a). Lesbians and doctors: experiences of solidarity and domination in health care settings. *Gender and Society*, 10(1), 24-41.
- Stevens, P. E. (1996b). Struggles with symptoms: women's narratives of managing HIV illness. *Journal of Holistic Nursing*, 14(2), 142-161.
- Stevens, P. E. (1998). The experiences of lesbians of color in health care encounters: narrative insights for improving access and quality. *Gateways to Improving Lesbian Health and Health Care* (pp. 77-94). New York, NY: Haworth.
- Stevens, P. E., & Doerr, T. (1997). Trauma of discovery: women's narratives of being informed they are HIV-infected. *AIDS Care*, 9 (5), 523-538.
- Swahn, M. L., Cekan, S., Wang, G., Lujndstron, V., & Bygdeman, M. (1985). Pharmacokinetics and clinical studies of RU 486 for fertility regulations. In E. E. Baulieu & S. Siegel (Eds.), *The antiprogestin steroid RU 486 and human fertility control* (pp. 249-258). New York, NY: Plenum.
- Taylor, D., Safriet, B., & Weitz, T. (2009). When politics trumps evidence: legislative or regulatory exclusion of abortion from advanced practice clinician scope of practice. *Journal of Midwifery and Women's Health*, 54(1), 4-7.



- Trybulski, J. (2005). The long-term phenomena of women's postabortion experiences. *Western Journal of Nursing Research, 27*, 559-576.
- Turell, S. C., Armsworth, M. W., & Gaa, J. P. (1990). Emotional response to abortion: a critical review of the literature. *Women & Therapy, 9* (4), 49-68.
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. (2008). *Health centers: America's primary care safety net, reflections on success, 2002-2007*. Retrieved from [ftp://ftp.hrsa.gov/bphc/HRSA\\_HealthCenterProgramReport.pdf](ftp://ftp.hrsa.gov/bphc/HRSA_HealthCenterProgramReport.pdf).
- Walter, G. S. (1970). Psychologic and emotional consequences of elective abortion: a review. *Obstetrics and Gynecology, 36* (3), 482-491.
- Watters, J. K., & Biernacki, P. (1989). Targeted sampling: options for the study of hidden populations. *Social Problems, 36* (4), 416-430.
- White, R. B. (1966). Induced abortions: a survey of their psychiatric implications, complications and indications. *Texas Reports on Biology and Medicine, 24* (4), 531-558.
- Wilder, M. J. (1998). The rule of law, the rise of violence, and the role of morality; reframing America's abortion debate. In R. Solinger (Ed.), *Abortion wars: a half century of struggles, 1950-2000* (pp. 73-94). Berkeley, CA: University of California.
- Winikoff, B., Ellertson, C., Elul, B., & Sivin, I. (1998). Acceptability and feasibility of early pregnancy termination by mifepristone-misoprostol. *Archives of Family Medicine, 7*, 360-366.
- Yarnall, J., Swica, Y., & Winikoff, B. (2009). Non-physician clinicians can safely provide first trimester medical abortion. *Reproductive Health Matters, 17* (33), 61-69.

Zimmerman, M. K. (1977). *Passage through abortion: the personal and social reality of women's experiences*. New York, NY: Praeger Publishers.

## Appendices

## **Appendix A: Definition of Terms and Abortion Terminology**

For clarification and consistent use of terminology throughout this dissertation, terms were defined as follows:

### **Abortion**

An abortion is a procedure or technique to end a pregnancy. The procedure may include the use of herbs, medications, mechanical means and/or instruments to remove the embryo or fetus, placenta, and membranes from the uterus.

### **Abortion Methods**

The methods used to terminate pregnancy vary according to socioeconomic status, access to health care, legality, ethnicity, politics, and religiosity. Abortion methods are influenced by gestational age, the indication for termination, and medical and surgical considerations relevant to the woman. Abortion can be accomplished through a variety of methods including: Abortifacients, Mechanical Means, Medical Abortion, Menstrual Extraction (ME), Vacuum Aspiration (VA), Dilatation and Evacuation (D&E), Dilatation and Curettage (D&C), Intact Dilatation and Extraction (D&X), Hysterotomy, and Instillation.

### **Abortifacients.**

“An abortifacient is an agent that terminates pregnancy; in modern medicine the agents producing this action are called ecbolics, oxytocics, and emmenagogues” (Riddle, 1991, p. 9-10). Abortifacients can be oral preparations, pessaries, or ointments and are often used in conjunction with mechanical, surgical, and other abortion techniques.

Historically, abortifacients have been derived from plants and herbs. The most common include: Angelica, Birthwort, Black Cohosh, Blue Cohosh, Celery, Clover, Cotton (seed or root), Edderwort, Ergot, Ginger, Horseradish, Mistletoe, Motherwort, Mountain Rue,

Parsley, Pennyroyal, Peruvian bark, Queen Anne's Lace, Savin (juniper), Shepard's purse, Silphion (ferula), Squirting cucumber, and Tansy. Pharmaceutical preparations frequently used today include Pitocin (oxytocin), Mifepristone (RU-486), misoprostol, and methotrexate.

### **Mechanical methods.**

Abortion is sometimes attempted by causing trauma to the abdomen. External mechanical means of inducing an abortion include jumping off tables, rolling on the floor, massaging the stomach, strenuous physical exertions, leaping (kick up her heels so as to strike her buttocks as she jumped), walking energetically, jumping vigorously, tightening a girdle or corset, carrying heavy objects, riding animals or being shaken about on carriages, and/or throwing oneself down a flight of stairs. External mechanical methods usually do not result in termination of a pregnancy, yet in attempting abortion in this manner, women might experience trauma to other internal organs or broken bones, either of which could be life threatening.

When external means fail to produce an end to a pregnancy, an abortion may be attempted by inserting a catheter or other object into the vaginal and through the cervix into the uterus. Objects used include blunt instruments such as a stick with cotton attached to the end, a thin candle, a flexible plastic or rubber catheter, or a pessary. Rigid objects include coat hangers, knitting needles, crochet hooks, pieces of bone or wood, or metal catheters. Often an internal mechanical method is used in combination with an abortifacient.

Bleeding, hot baths, a restricted diet, inducing pain, severe indigestion, intense fright, violence, or a strong emotional shock are some other techniques attempted to induce an abortion.

### **Menstrual extraction.**

In 1971, Lorraine Rothman and Carol Downer, founding members of the feminist self-help movement in Los Angeles developed a technique to assist women in gaining and maintaining control over their menstrual cycles and reproductive lives. They invented the Del-EM™; a safe, inexpensive suction device that can be used as a simple way to remove menstrual blood or as a method of very early pregnancy termination. The Del EM™ made it possible for people with minimal training to perform early abortions called menstrual extractions. These early abortions were performed safely at home by a group of women with little or no formal medical training (Chalker and Downer, 1992).

### **Menstrual regulation.**

Menstrual regulation (MR) is a procedure performed by an individual health care provider using a commercially produced kit. With this kit, the contents of the uterus are sucked directly into the syringe, similar to ME. In the United States, menstrual regulation is used as a method of fertility regulation and a means of hygiene. MR often takes place without a technical verification of pregnancy.

### **Medical abortion.**

A medical abortion is accomplished with a variety of medications taken singly or in succession. Medications are taken orally and/or vaginally and are generally used early in pregnancy, prior to 9 weeks gestation. Drugs used in medical abortion include mifepristone (RU-486), methotrexate, and Misoprostol.

### **Surgical abortion.**

The use of procedures and instruments to end a pregnancy; includes opening or dilation of the cervix and removal of the products of conception by suction aspiration, curettage, or extraction. Surgical abortion methods also include Hysterotomy and Instillation.

*Vacuum aspiration.*

In the first 12 weeks of a pregnancy, suction aspiration or vacuum abortion is the most common method. Manual vacuum aspiration (MVA) abortion consists of removing the products of conception (fetus or embryo, placenta, and membranes) by using a manual syringe to provide the suction. Electric vacuum aspiration (EVA) abortion uses an electric pump to apply suction. Regardless of the means of suction, vacuum aspiration generally requires dilation of the cervix under local anesthesia. For efficiency and ease of inserting a larger cannula, a tenaculum may be used to grasp the cervix to hold it steady while the cannula is being rotated and moved back and forth. The teeth of the tenaculum may cause a break in the cervix and some pain. These procedures are performed on a woman by a skilled and experienced provider in a clinic or hospital setting and generally take less than 15 minutes.

Prior to MVA/EVA, it is necessary to determine if the woman is pregnant, or at least to find out if she has some medical problem that could lead to a late menstrual period. This requires taking a medical history, performing a pregnancy test, and perhaps even an ultrasound. Also, it is necessary to ensure that all the contents of the uterus are removed, the products of conception must be examined and the woman may need medications in case of a possible incomplete abortion or infection.

When used for uterine evacuation, vacuum aspiration is 98% effective in removing all uterine contents (Baird & Flinn, 2001). Retained products of conception require a second

aspiration procedure. This is more common when the procedure is performed very early in pregnancy, before 6 weeks gestational age (Keder, 2003). Other complications occur at a rate of less than 1 per 100 procedures and include excessive blood loss, infection, injury to the cervix or uterus, and uterine adhesions (Baird & Flinn, 2001; Keder, 2003).

*Dilatation and curettage.*

Dilatation and curettage (D&C) literally refers to the opening of the cervix and the surgical removal of the contents of the uterus with a sharp, slightly curved instrument. Once the standard of care in abortions during the 1970s, D&C is now considered a therapeutic gynecological procedure used for dysfunctional or abnormal uterine bleeding, incomplete abortions or miscarriages, retained placentas, or to remove excess uterine lining in women with hormonal imbalances.

The first step in a D&C is to dilate the cervix, which is usually done a few hours before the surgery with a laminaria or gel. The woman is usually put under general anesthesia before the procedure begins. The curette, a metal rod with a handle on one end and a sharp loop on the other, is inserted into the uterus through the dilated cervix. The curette is used to gently scrape the lining of the uterus and remove the tissue in the uterus. This tissue is examined for completeness (in the case of abortion or miscarriage treatment) or pathologically for abnormalities (in the case of treatment for abnormal bleeding) (Paul, 1999).

One risk of sharp curettage is uterine perforation. Although normally no treatment is required for uterine perforation, a laparoscopy may need to be done to verify that bleeding has stopped on its own. Infection of the uterus or fallopian tubes is also a possible complication, especially if the woman has an untreated sexually transmitted infection.



Another risk is intrauterine adhesions, or Asherman's syndrome. Trauma from the curettage can cause fibrosis or scarring within the uterine cavity. This may result in menstrual irregularities, pelvic pain, and/or infertility.

*Dilatation and evacuation.*

Dilatation and evacuation (D&E) is a second trimester abortion procedure, generally used between 15 to 26 weeks gestation. The second trimester has been defined to begin at 13 weeks gestation and at sometime during the second trimester it becomes necessary to use instruments to help remove the fetus. This instrumental procedure is normally what is meant when the term *dilatation and evacuation* is used. However, D&E has various names, including: D&E (Dilation and evacuation), ERPOC (Evacuation of Retained Products of Conception), and TOP or STOP ((Surgical) Termination Of Pregnancy). In 2005, there was an estimated 70,000 second-trimester abortions performed in the United States, approximating 8% of all abortions (CDC, 2008).

The first step in a D&E is to dilate the cervix. This is often begun about a day before the surgical procedure. Enlarging the opening of the cervix enables surgical instruments such as a curettage or forceps to be inserted through the cervix into the uterus. The second step is to remove the fetus. The woman is usually put under general anesthesia before the procedure begins. Forceps are inserted into the uterus through the vagina and used to separate the fetus into pieces, which are removed one at a time. The third step is to use vacuum aspiration (VA) to remove all tissue (fetal, membranes, or placenta) from the uterus. The final step involves an examination of the contents to ensure that the entire fetus, placenta, and membranes were removed.

Feticide may be performed prior to the surgical procedure. The intentional destruction of the fetus prior to the procedure allows the tissues to soften, making dismemberment easier. The standard D&E procedure is difficult after 20 weeks gestation due to the toughness of the fetal tissues (Haskell, 1992). If the fetus is removed intact, the procedure is referred to as intact dilation and extraction by the American Medical Association (AMA) and referred to as intact dilation and evacuation by the American College of Obstetricians and Gynecologists (ACOG).

*Intact dilatation and extraction.*

Intact dilatation and extraction (IDX or intact D&X), also known as intact dilation and evacuation (intact D&E), dilation and extraction (D&X), or intrauterine cranial decompression is a surgical abortion wherein an intact fetus is removed from the uterus via the cervix. The procedure is also used to remove a deceased fetus that is developed enough to require dilation of the cervix for its extraction. The term dilation and extraction, or D&X, was coined by Cincinnati physician W. Martin Haskell in a monograph that was distributed by the National Abortion Federation in September 1992. Haskell's term was a variation on intact dilation and evacuation (intact D&E).

Preliminary procedures are often performed over several days to gradually open the cervix using laminaria (sticks of seaweed which absorb fluid and swell). Sometimes drugs such as pitocin, a synthetic form of oxytocin, are used to induce labor. Once the cervix is sufficiently dilated, the physician uses a forceps, guided by ultrasound to grasp the legs of the fetus, turning the fetus into a breech or butt first position. If necessary, the physician pulls one or both legs out of the birth canal, causing what is referred to by some people in the United States as the 'partial birth' of the fetus. The physician subsequently extracts the rest of

the fetus, usually without the aid of forceps, leaving only the head still inside the birth canal. An incision is made at the base of the skull, a blunt dissector (such as a Kelly clamp) is inserted into the incision and opened to widen the opening, and then a suction catheter is inserted into the opening. The brain of the fetus is suctioned out, which causes the skull to collapse and allows the fetus to pass more easily through the birth canal. The placenta is removed and vacuum aspiration of the uterus is done using a cannula to ensure that all products of conception have been removed.

IDX, along with dilation and evacuation (D&E), early induction of labor, and rare procedures such as saline abortion, are only used in the late stages of pregnancy, generally after 20 weeks gestation. Late-term abortions at 21 weeks or later accounted for 1.4% of all abortions in the USA in 2005 (CDC, 2008). Intact D&X procedures were used in approximately 15% (2,500 – 3,000) of all late-term abortion cases in 2000 (AGI, 2000). This procedure was typically done between 20 and 24 weeks gestation when changes in fetal tissues necessitated the change in method. Though the procedure had a low rate of usage, it developed into a focal point of the abortion debate. In the United States, intact dilation and extraction was made illegal in most circumstances by the Partial-Birth Abortion Ban Act of 2003.

#### *Hysterotomy.*

Hysterotomy abortion is a procedure in which the uterus is opened through an abdominal incision and the fetus is removed, similar to a caesarean section but requiring a smaller incision. As major abdominal surgery, hysterotomy is performed under general or regional anesthesia and is only used in rare situations where less invasive procedures have failed or are medically inadvisable, such as in the case of placenta accrete. Hysterotomy is

used between 12 and 24 weeks gestation and, according to Roche (2006), has the greatest risk of complications out of all the abortion procedures.

#### *Instillation.*

Instillation abortion is a rarely-used method of induced abortion, performed in the second trimester, by injecting a solution into the uterus to cause uterine contractions.

Instillation abortion is performed by injecting a chemical solution consisting of either saline, urea, or prostaglandin through the abdomen and into the amniotic sac. The cervix is dilated prior to the injection and the chemical solution induces uterine contractions which expel the fetus. Sometimes a D&C procedure is necessary to remove any remaining tissue.

Instillation methods can require hospitalization for several days. Developed in 1934 by Eugen Aburel, the method of instillation abortion is most frequently used between 16 and 24 weeks gestation. Intrauterine instillation accounted for 0.1% of the total incidence of induced abortion in the United States during 2005 (CDC, 2008). Once in common practice, abortion by intrauterine instillation has fallen out of favor, due to its association with serious adverse effects for the woman and its replacement by procedures which require less time and result in less physical discomfort (Trupin, 2006).

#### *Perforation.*

Perforation means the instrument has punctured a hole through the uterine muscle, risking excessive bleeding, severe infection, and/or trauma to other internal organs such as the bowel and bladder. The woman may need additional abdominal surgery such as a laparoscopy or laparotomy to ascertain the amount of bleeding. She may need no treatment except close monitoring and antibiotics.

### **Abortion Terminology**

**Elective abortion (nonrestrictive abortion, on-demand abortion).**

The ability to end a pregnancy by choice; permission. An abortion is referred to as elective when it is performed at the request of the woman.

**Eugenic abortion.**

The termination of a pregnancy for “the production of good offspring” (Merriam-Webster, 2009).

**Illegal abortion.**

Ending a pregnancy not according to or authorized by law; not sanctioned by official rules or regulations.

**Legal abortion.**

Permission to end a pregnancy by law or established rules; recognized or made effective by a court of law.

**Missed abortion.**

An intrauterine death of an embryo or fetus that is not followed by its immediate expulsion.

**Spontaneous abortion.**

The spontaneous expulsion of the embryo or fetus before viability; synonymous with miscarriage.

**Therapeutic abortion.**

Therapeutic abortion is defined as the termination of pregnancy before fetal viability in order to preserve maternal health. In its broadest definition, therapeutic abortion can be performed to (1) save the life of the mother, (2) preserve the health of the mother, (3) terminate a pregnancy that would result in the birth of a child with defects incompatible with

life or associated with significant morbidity, (4) terminate a nonviable pregnancy, or (5) selectively reduce a multifetal pregnancy. The vast majority of abortions performed in the United States are elective. According to James and Roche (2006), pregnancy-related conditions that threaten maternal life are rare and difficult to define precisely.

### **Stillbirth.**

The birth of a dead fetus.

### **Trimesters**

The duration of a human pregnancy is divided into three time periods; the first trimester (< 13 weeks), the second trimester (13-24 weeks), and the third trimester (24-42 weeks). Pregnancy has been delineated into trimesters as a means to understand and describe fetal development inside the uterus. The concept of trimesters representing discrete time periods has been challenged as medical technology advances the ability of medicine to (artificially) sustain life in premature infants outside the uterus.

### **Unintended Pregnancy**

A pregnancy that occurred inadvertently, involuntarily; a pregnancy that was not planned or anticipated; there was no thought or planning of pregnancy.

### **Unplanned Pregnancy**

A pregnancy that occurred at a time when a woman was not expecting that she would conceive; she may have been anticipating conception at a different time.

### **Pregnancy Test**

A blood or urine analysis that determines the level of human chorionic gonadotropin hormone (HCG) in a woman's body. The presence of HCG is chemical evidence of a pregnancy.

**Quickening**

The first perception of fetal movement by the pregnant woman; generally occurs around 20 weeks or 5 months gestation in first pregnancies, may be noticed sooner, around 16 weeks in subsequent pregnancies. Quickening is often associated with the mid-point of a pregnancy. Quickening comprised the key element of the legal definition of pregnancy under British and early American Common Law when no other means of identifying or confirming a pregnancy were available.

**Irregular Practitioners/Physicians**

Providers in the 1800s who had no formal training or education; they obtained their medical knowledge through hands on experience and oral history.

**Regular Physicians**

Physicians in the 1800s who had formal training and education in the field of medicine; organized in the mid-1800s to form the American Medical Association (AMA) and control all aspects of medicine in the United States. Known now simply as physicians.

## Appendix B: Studies about Women's Experiences of Surgical Abortion

Study/Perspective	Focus	Sample	Methods	Findings
Smith (1973) Psychiatry, Social Work	Psychological effects of abortion; characteristics of women who request abortion	Missouri; convenience; 80 women; induced abortion; mean age 21, range 14 - 42; 97% first pregnancy; 99% first abortion; 46% used contraception when pregnancy occurred; 92% white; 81% single; 58% in school; 46% Protestant, 27% Catholic	Questionnaire; pre-abortion counseling and 1 to 2 years after abortion	<p>Psychological adjustment: Felt desperate when pregnant; crisis ended with abortion 78% reported no negative psychological reactions immediately after abortion; 90% at follow-up; many reported feelings of relief and satisfaction Few experienced depression, remorse, or guilt; self-limiting, did not impair functioning or require professional help More difficult for unmarried, teenagers, concerned for fertility, fond of children, lacked support, discontinued relationship with male partner; religion not an influence 94% satisfied with decision, no regret; 3% who regretted the abortion were influenced by others Majority had no history of psychiatric problems; 2 of 15 women with a psychiatric diagnosis required professional help</p> <p>Reasons for abortion: Single – lack of marriage, continue education Married – finances, desired no further children</p> <p>Effect: 47% none, 40% positive, 2% negative; remain in school, continue job, time with family; viewed as growth producing or maturing process</p>



Study/Perspective	Focus	Sample	Methods	Findings
				Most had emotional, financial support from male partner at time of abortion; 44% single discontinued contact with male partner Increase in number using contraception, more reliability, consistent 86% found counseling helpful; most valuable for younger, lacked confidant

*Implications: Majority of women do not experience negative psychological reactions to abortion. Many women are relieved, satisfied with decision; experienced personal growth, maturation; women who experienced regret often reported feeling influenced by others in the abortion decision; women who are younger and lack social support benefit the most from pre-abortion counseling.*

Zimmerman (1977)  Sociology, Psychology	Identify the patterns by which women move through phases of the abortion process.  Describe the impact of the social context on the experience of abortion.	Large city in Midwestern United States; purposive; 40 women; surgical abortion < 17 weeks; Age range 14 to 39; majority between 18 and 22 years; 100% first abortion; 65% with no children; 80% careless users of	Qualitative  Interview; 6-10 weeks after the abortion	A description of the pre-pregnancy context (2 to 3 months before the abortion) of the women's lives and attitudes about abortion prior to becoming pregnant.  Two groups according to social integration: <ul style="list-style-type: none"> <li>Affiliated (securely rooted or enmeshed in social life, n=21)</li> <li>Disaffiliated (detached or loosely tied in to social life, n=19).</li> </ul> Four phases of the abortion experience: <ol style="list-style-type: none"> <li>becoming pregnant</li> <li>making a decision to abort</li> <li>having the abortion</li> <li>moving on</li> </ol>
---	---	---	---	--

Study/Perspective	Focus	Sample	Methods	Findings
		contraception; 88% white; 85% not married; 67% high school graduates or more 55% Blue collar; 45% White collar		Affiliated women – reacted pragmatically, certain of decision, told few others, and received no negative reactions from others; experienced relief, positive relationship changes.  Disaffiliated women – reacted emotionally, distressed, confused about decision, told many others and received hostile reactions from others; experienced guilt, regret, sadness, and disruption in relationships.

*Implications: Some women have a smoother passage through abortion than others. The way abortion is experienced by women depends largely on each woman's particular roles in her social world, the reactions of others to her abortion, and her perceptions of the medical facility where the abortion was performed. Whether a woman experiences abortion as a "crisis" is heavily dependent upon the quality and integrity of her relationships, social interactions, and social activities.*

Freeman (1978)  Public Health, Women's Studies	Women's attitudes about abortion; contraceptive behaviors before and after abortion	Philadelphia; convenience 329 women; first-trimester abortions; age range 15-40 with 65% between 15-24; # pregnancy NP; 80% first abortion; 59% used contraception when pregnancy occurred;	Questionnaire; immediately and 4 months after the abortion	Attitudes toward abortion: 37% certain they would never have an abortion; 28% expected to have an abortion; 13% undecided; 2% unaware of abortion; 20% had previous abortions  Emotions - relief, depression, indifference, anger, disappointment, nervousness, ambivalence Anxiety and Depression: Prior to pregnancy – 31%; 17% Between pregnancy & abortion – 68%; 48% 4 months after abortion – 14%; 13%
---	---	---	---	--

Study/Perspective	Focus	Sample	Methods	Findings
		77% white; 81% unmarried; education NP; religion NP		<p>Hardest part of the experience: 24% contending with feelings of loss of a child 14% making the decision 13% waiting for the abortion to be performed 11% loneliness 7% self-acceptance</p> <p>60% resolved feelings; 40% continued to be troubled Associated with personality attributes, relationship with male partner; not related to decision, use of contraception, or wantedness of pregnancy</p> <p>58% increased self-management; felt stronger, in control, learned could make own decisions, withstand social pressures</p> <p>Contraceptive Behaviors: 78% tried to prevent pregnancy by limiting intercourse to the “safe” period; many mistaken in their knowledge 93% used contraception following the abortion; increase in consistency, reliability of methods</p>

*Implications: Attitudes toward abortion do not predict women’s behavior. Many women experienced anxiety, depression, and ambivalence; mostly relief. Resolution of negative feelings not related to emotional distress prior to the abortion, but appears to be related to the ability to cope with emotions, personality attributes, and the relationship with the male partner.*

Study/Perspective	Focus	Sample	Methods	Findings
Faria, Barrett, & Goodman (1986)  Social Work	Counseling women with an unwanted pregnancy; increased understanding of attitudes about abortion, help-seeking behaviors, and reasons for decision	Kansas; convenience; 517 women; 56% 2-3 months, 32% < 2 months, 10% > 3 months; mean age 22, range 13 to 45; 47% first pregnancy; 75% first abortion; 51% used no birth control in the 6 months prior to the abortion; 81% White; 13% Black, 3% Hispanic, 2% Asian; 59% single, 19% married, 20% divorced or separated, 2% engaged; 25% not completed high school, 63% high school or some college, 8%	Questionnaire  With the clinic paperwork, just before the abortion procedure	Attitudes about abortion – positive White, Protestant, older, some college, higher income, used contraception associated with more positive general attitudes Positive about decision for abortion; nonwhite more positive about decision than white women  Help-seeking pattern – 72% sought help from someone 41% partner 29% friends 21% physician 15% mothers 10% others  Reasons and Decision-Making: 16 categories; women gave more than one, no one reason 33% parenting readiness 26% lack of financial resources 15% no partner 14% unable to care for more children 13% age 11% interference with career, education 6% inadequate emotional resources 6% interference with personal plans 6% physical problems 5% relationship problems 3% extramarital affair 2% difficulties with family of origin 1% fears about pregnancy

Study/Perspective	Focus	Sample	Methods	Findings
		completed college, 3% graduate or professional degree; 53% Protestant 19% Catholic 9% Other 14% None		1% contraceptive failure 1% rape <1% partner objects  Comparison of women who did and did not seek counseling – counseling group sought help more often, including from a physician and noted difficulties with their family of origin as a reason for the abortion

*Implications: General attitudes about abortion are not necessarily good predictors of how a woman may feel about her decision to have an abortion. Most women utilize their social networks in the process of making a decision about an unwanted pregnancy. Women arrive at the decision to have an abortion for a variety of reasons; each woman's circumstances are unique. For some women the decision-making process is more problematic: non-white, non-Protestant, younger, less educated, with less income, non-contraceptive users, or lacking a supportive social network.*

Note. NP = Not provided.

## Appendix C: Studies about Women's Experiences of Medical Abortion

Study/Perspective	Focus	Sample	Methods	Findings
Beckman & Harvey (1997)  Medical, Psychology, Public Health, Women's Studies  Population Council; Mifepristone Clinical Trials Group	To examine the experience with and acceptance of medical abortion; reasons for choice, expectations, satisfaction.  Mifepristone and Misoprostol	National; convenience; 262 women; < 63 days amenorrheic, EGA 49.5 days; mean age 27, range 18-44; 72% previous pregnancy; 51% previous abortion; contraceptive use NP; 83% White, 5% Asian American, 4% Hispanic Latina, 2% African American, 6% Other; marital status NP; 10% < high school, 24% high school, 39% some	Quantitative  Pretested, self-administered questionnaires  Completed twice: First visit (262) and 2 weeks later at the follow up visit (240)  Data abstracted from medical charts	Reasons for choosing medical abortion: 63% avoid surgery 56% safer 41% more natural 35% lower risk of infection or damage 27% use earlier  Other aspects of the abortion experience: 67% made the decision alone; Influenced by others – 16% sexual partner, 13% health professional, 8% friend, 6% family member 50% preferred to wait with a partner, friend, or family member for the abortion to occur; comfort and wanting to share the experience with someone else 31% preferred to be by themselves; need for privacy 18% preferred to wait with other women; importance of sharing the experience  Expectations versus Actual Experience: Expected more discomfort than they actually experienced Underestimated the length of time they would bleed, actual days of bleeding > expected  Satisfaction with Medical Abortion:

Study/Perspective	Focus	Sample	Methods	Findings
		college, 27% college graduate; religion NP		73% very satisfied 16% somewhat satisfied 94% would recommend to a friend 87% would choose again Less satisfied group - higher levels of discomfort, anxiety Level of satisfaction varied with experience with the abortion procedure; did not differ by demographic characteristics or prior abortion status

*Implications: Women choose medical abortion for its naturalness, privacy and noninvasive characteristics; prefer to experience abortion alone or share only with their partner, close family member or friend; most are very satisfied and find medical abortion acceptable.*

Elul, Pearlman, Sorhaindo, Simonds, & Westhoff (2000)	To document women's experiences with a home- use mifepristone- misoprostol medical abortion regime	New York; convenience; 22 women; successful medical abortion, took misoprostol at home; demographics published elsewhere	Qualitative  Interview	Majority found the home-use regimen acceptable; would not have preferred to return to the clinic for misoprostol.  Described the medical procedure as "natural", private, and noninvasive.  Physical experiences of cramping, bleeding more tolerable in the comfort of their homes with someone familiar nearby for support.  Felt prepared for the experience and competent in assessing any problems that arose.
--	---	---	------------------------------	---

*Implications: Home use of misoprostol affords women more flexibility, privacy, and control in their abortions, ultimately*

Study/Perspective	Focus	Sample	Methods	Findings
<i>allowing them to seek their own comfort level.</i>				
Fielding, Edmunds, & Schaff (2002)  Medicine, Sociology, Nursing	To determine whether previous experience with a surgical abortion influenced women's perceptions of medical abortions.  Mifepristone and home Misoprostol	New York; convenience; 43 women; 22 who had previously had a surgical abortion; 21 who had never had an abortion before; mean age 26; mean education 14 years; 77% White; 75% single; most worked full time	Qualitative  Questionnaire; two open-ended questions  Twice, prior to abortion counseling and at follow-up visit  30 interviews by phone or in person, 1-6 weeks after the abortion	93% acceptability of mifepristone abortion; no differences between women with prior surgical abortions and those who had never had an abortion  <u>The First Visit</u> – Already decided on abortion; difficult for many Pragmatic focus Avoid surgery meant maintaining control, avoiding pain and physical trauma, reducing the vulnerability to judgemental clinic staff, and minimized guilt Control had two dimensions; medical procedure and impact of abortion on their lives  <u>The Follow-Up Visit</u> – Relief, guilt, uncertainty and reassurance that the abortion was complete, concern about long term health effects, control over their lives  <u>In-Depth Interview</u> – returned to daily lives, positive feelings, focus on career; continued concern about long-term health effects; guilt, loss, no regret; importance of continuing school, devoting resources to current families, and avoiding surgery

*Implications: This study confirms past findings that some women choose medical abortion for its naturalness, for the privacy it affords, and to avoid the perceived pain and trauma of surgery. Throughout the interviews, personal control was the most*



Study/Perspective	Focus	Sample	Methods	Findings
<i>common theme that emerged from women's responses. Having an abortion at home was a relatively comfortable experience.</i>				
Andrist, Simmonds, Liebermann, & Healey (2006)  Nursing	To explore women's experiences of medical abortion	Large metropolitan city in northeastern United States; convenience; 33 women; > 18 years; 19 White, 5 Hispanics, 5 Blacks, 3 Asian, 1 Other; no other demographic data was collected	Qualitative  Interview	<p><u>Signs/Symptoms</u> Bleeding began after the dose of mifepristone was taken and ranged from "shortly after" to the "next day"; time to bleeding onset after misoprostol was inserted ranged from 45 minutes to 4 hours. Bleeding lasted 4 hours to 1 week; for most the heavy bleeding persisted for a few hours to overnight. Cramps developed 30 minutes to 4 hours after misoprostol insertion; cramps were experienced as severe by women who had not taken pain medicine</p> <p><u>Control</u> An important issue throughout the abortion experience; ability to choose the type of procedure; easier for them, more natural, avoid surgery, privacy, be at home; control of symptoms through comfort measures, preference for support persons, and information seeking.</p> <p><u>Expectations:</u> Uncertainty – fear, anxiety about the medication working; anxiety and nervousness about the process. Anticipated vs. Actual Experience – 10 as expected, 10 easier, 7 more painful, emotional</p> <p><u>Recommendations Based on the Experience</u></p>

Study/Perspective	Focus	Sample	Methods	Findings
				Changes in the counseling process; follow-up phone calls, reassurance, additional resources, discuss emotional/mental aspects more, include partners in counseling, assess support 16/33 would recommend, 7/33 recommend with additional, practical information, 2/33 not recommend, 3/33 unsure

*Implications: Medical abortion can be acceptable to women within the context of their life circumstances and feelings about being in charge of the process.*

Fielding & Schaff (2004)  Sociology, Medicine	To describe the social context and the experience of women taking RU 486 for early abortion.	Rochester, New York; Convenience; 50 women; 77% white; 74% college; 85% employed; 37% prior abortions	Qualitative  Interviews with 35 women; 1-6 weeks after their follow-up visit	<u>The Decision to Have an Early Abortion</u> – their reasons included finishing school, getting started in their careers, avoiding poverty, taking care of their current families, and/or preserving their health.  <u>Pregnancy Definition and Emotional Distress</u> – emotional distress was expressed by 5 of the 7 women who defined their pregnancy as a baby, 1 of the 3 who were not certain, and 8 of the 20 who defined their pregnancy as having only the potential to become a baby.
---	--	---	---	---

*Implications: To make abortion less difficult might require educating the public about the many ways in which pregnancy and abortion have been viewed historically. It might be important for abortion counselors to ask a woman about how she defines her pregnancy.*

Note. All participants were women. NP = Not provided; EGA = Estimated gestational age.

## Appendix D: Studies about Women's Experiences and Long-Term Significance of Abortion

Study/Perspective	Focus	Sample	Methods	Findings
Avalos (1999)  Feminist, Sociology	To explore how women construct meaning around their abortion experiences in retrospect.	Large city; convenience; 20; abortion an average of 9 years ago; ages 20-44; 90% white; 75% pro-choice	Qualitative Interpretive  Interview; unstructured	Narratives of four women profiled; critical points on a continuum: Looking back with satisfaction Mild struggles with loss over time Looking back with depth, complexity, and grief Seeking a safe place to explore buried emotions  How the pregnancy situation was defined at the time of the abortion decision influenced women's retrospective satisfaction
<p><i>Implications: Many emotional reactions are possible after abortion and retrospective interpretations of the abortion experience are subject to change over time, particularly as personal growth and changing circumstances prompt women to reevaluate the original experience. The ways women speak about their abortion experiences years after the actual procedure are quite different than the terminology often employed in the dichotomized political debate.</i></p>				
Hess (2004)  Nursing, Phenomenology	To explore and describe the long-term postabortion experience as lived by women	Ohio; purposive; 17 women who had a legal, first trimester, induced, elective abortion >5yrs before the study; ages 23- 60; race NP; religion NP	Qualitative  Interview, in-depth, semi-structured	Five themes: Making the Decision Coping With the Memories Gaining Perspective Seeking Help Recognizing Its Worth  The decision-making process can be stressful.  Women may experience significant anxiety during the waiting period preceding the procedure.

Study/Perspective	Focus	Sample	Methods	Findings
				A higher percentage of women in this study expressed negative effects than what has been found in short-term studies; almost all of the women used various avoidance strategies to cope with the memory of the abortion; religion played a major role in the post abortion lives of many of these women.
<i>Implications: Most women were able to integrate the abortion experience into their lives; the passage of time and intervening events could broaden a woman's perspectives on her abortion decision and provide alternative meanings to the abortion experience. Nursing should encourage women to prevent unplanned pregnancies through fertility control.</i>				
Trybulski (2005)  Nursing, Hermeneutical Phenomenological Reflection	To understand the characteristics of women's abortion experiences over an extended time	Location NP; convenience; 16; elective abortion for nongenetic reasons at least 15 years previously; ages 38-92; 100% white; well-educated; 44% Catholic	Qualitative  Interview; open-ended	Nine themes: Caught up in the moment Betrayed – by my body, by my birth control Very personal, very private, very yours The past reaches into the present Embodiment - giving form to the child Stowing away feelings about the abortion Abortion disrupts aspects of life Making sense of the abortion Relationships affected the abortion experience  Relationships influenced women's decisions about the unintended pregnancy.
<i>Implications: The lived experience of abortion for women is complex and has effects beyond the time of the actual occurrence of the procedure.</i>				

Note. All participants were women. Ages are provided in years. NP = Not provided.

## Appendix E: Studies about Under-Represented Women's Experiences of Abortion

Study/Perspective	Focus	Sample	Methods	Findings
Andrews & Boyle (2003)  Nursing, Ethnographic Interpretive Theory	To generate an interpretive theory about how African American adolescents experience unplanned pregnancy and elective abortion.	Georgia; purposive; 12 African American females; experiencing unplanned pregnancy and elective abortion; 4 first trimester; 8 second trimester; ages 15-18	Focused ethnography  Interviews: while waiting for the abortion; 6 and 8 months after	Four themes: Relationships with partners; two distinctly separate decisions: To continue or sever their relationship Not to become a mother Confiding in others and finding support Unselfish decision for self Resolution of the crisis  Empowerment integrating theme; young women gained control, refined ability to make decisions  This study helped to dispel pervasive myths.
<p><i>Implications: This study highlighted the influence of the social and cultural context on women's experiences of abortion. Young women based their decision for abortion on their financial and emotional readiness to parent, consideration of their future, educational plans and goals, and the impact of having a child on their families. During the experience of an unintended pregnancy, these young women examined and evaluated their relationship with the male partner; making decisions about the relationship based on his reactions to the confirmation of the unintended pregnancy. Although the young women experienced some sadness, they reported no psychiatric problems as a result of their abortions. Unplanned pregnancy and elective abortion can be a positive, growth-enhancing experience for African American adolescent women.</i></p>				

## **Appendix F: Exclusion of Reviews of Literature about Women’s Mental Health and Abortion**

An initial examination of the 15 reviews of empiric literature pertaining to women’s experiences of abortion and mental health (Adler, 1979; Adler et al., 1990; Blumberg & Gollbus, 1975; Blumenthal, 1991; Bracken et al., 1974; Coleman et al., 2005; David, 1972; Keasling & Davis, 1975; Major et al., 2009; Mudd, 1973; Osofsky et al., 1971; Remeikis, 2001; Rogers et al., 1989; Shusterman, 1976; Turell, Armsworth, & Gaa, 1990) was conducted to assess the meaning of “literature review”. Each article was considered a review of empiric literature if the author(s) critiqued the existent sources to synthesize results into a summary of what was and was not known, identified areas of controversy in the literature, and formulated questions that needed further research. These criteria were applied to distinguish between literature critiques and those review articles which provided a descriptive overview or summarization of the findings from a distinct group of studies without critical analysis. My reasoning for this approach was to delineate literature reviews that critically analyzed what has been published in the psychological, psychiatric, and medical literature pertaining to women’s experiences of abortion and mental health by accredited scholars and researchers from a descriptive overview, an individualized perspective, or a selective review of the literature. My intent was to convey to my reader what knowledge and ideas have been established, along with their strengths and weaknesses. Additionally, given the vast volume of studies conducted and published in the disciplines of psychology and psychiatry, this was my way of managing the amount of information in an efficient and useful manner.

An examination of the 15 sources revealed that 11 review articles (Adler, 1979; Blumberg & Gollbus, 1975; Blumenthal, 1991; Bracken et al., 1974; Coleman et al., 2005; David, 1972; Mudd, 1973; Keating & Davis, 1975; Osofsky et al., 1971; Remeikis, 2001; Rogers et al., 1989) did not meet the selection criteria and were therefore excluded from my review of empiric literature pertinent to women's experiences of abortion and mental health. To foster understanding of my thinking and decision-making process for the reader, a brief explanation of my analysis and rationale for elimination will be discussed. The article by Mudd and the article by David presented commentaries on sociological and/or psychological aspects of abortion; they were not reviews of the literature. Rogers et al. conducted a methodological critique; these authors did not review the literature for critical points of current knowledge regarding substantive findings. Both Bracken et al. and Osofsky et al. offered a review of the literature as background for their individual studies, the findings of which are presented in these two articles respectively.

Similar to Bracken et al. and Osofsky et al., several studies were found to provide a descriptive overview of the extant literature pertaining to women's experiences of abortion and mental health without critique. These six studies (Adler, 1979; Blumberg et al., 1975; Blumenthal, 1991; Keasling & Davis, 1975; Remeikis, 2001; Coleman et al., 2005) were the most difficult for me to assess because the authors provided a descriptive overview of selective empiric literature pertaining to women's experiences of abortion and mental health. Closer examination revealed that these authors did not critique the sources reviewed in the strictest sense of a critical analysis. Breadth and scope of the studies included in each of these reviews appears to have been influenced by investigator biases, hidden political agendas, and a specific theoretical perspective. While these reviews of literature are

important in particular contexts, I sought to identify reviews of empiric literature broad in scope and inclusive of much of the literature published during a given time period in the United States. Adler provided an overview of the literature in discussing a social-psychological perspective for studying abortion. Blumberg et al. reviewed psychological studies of abortion from the perspective of medical and obstetrical providers, while Keating and Davis, a medical student and a psychoanalyst, described findings from psychiatric literature specific to therapeutic abortion. Influenced by post-abortion women in her clinical psychoanalytical practice, Remeikis reported an overview of the psychoanalytic literature on abortion. Blumenthal wrote a comprehensive review of literature based on distinct time periods; she discussed psychological consequences of denied abortion, illegal abortion, and carrying through an unintended pregnancy and cited conclusions and methodological limitations from Shusterman (1976) and Adler et al. (1990). Coleman et al. provided a descriptive summary of selected research findings and offered an ecological framework for the study of abortion along with suggestions for future research. None of these publications critiqued the extant literature by identifying strengths or weaknesses of the sources cited.



## Appendix G: Free Clinics in Wisconsin

Free Clinics							
Last Updated		9/6/2011					
<a href="mailto:David.Hippner@wisconsin.gov">Email David.Hippner@wisconsin.gov for updates</a>							
Organization Name	Contact Person	Street Address	Phone #	Fax #	Special Info	E-Mail Address	Website
Albrecht Free Clinic (site #1)	Lynn Pasorig, Jennifer Zaskowski	1110 Oak Street Suite 1200 West Bend, WI 53095	262-334-8339	262-306-7717	General Business Hours: Monday – Thursday, 9a.m. – 5p.m.  Hours of Clinic Operation Tuesdays: morning appointments only; walk in from 6:00p.m. -7:30p.m. Wednesdays: morning appointments only Thursdays: afternoon appointments only; walk in from 6:00p.m. -8:00p.m.		<a href="http://www.albrechtfreeclinic.org/">http://www.albrechtfreeclinic.org/</a>
American Community Medical Center, Inc.	Mahmud Safavi	1421 S. Park St. Madison, WI 53703	608-441-6888 (Leave Message) 608-967-3000		Tue - Sat: By Appointment Sun: Closed If it is an emergency, please call 911 immediately.		<a href="http://www.acmedicalcenters.org/">http://www.acmedicalcenters.org/</a>
Asthma Clinic	Lynne Edebohis	4633 D Verona Rd (in Madison Plaza) Madison, WI 53711	608.446.3344		Call for hours.		<a href="mailto:dearfoundation@deancare.com">dearfoundation@deancare.com</a>
Benevolent Specialist Project Free Clinic	Kathy Williams	2711 Allen Blvd, Lower Level Middleton, WI 53562	608-827-2308	608-827-2344	Call for hours.	<a href="mailto:kathleen.williams@deancare.com">kathleen.williams@deancare.com</a>	
Bread of Healing at Cross Lutheran Church	Rick Cesar	1821 N. 16th Street Milwaukee, WI 53205	414-977-0001	414-755-6971	Call for hours.	<a href="mailto:bread_of_healing@yahoo.com">bread_of_healing@yahoo.com</a>	
Bread of Healing (BOH) Agape Community Center		6100 N 42nd Street Milwaukee, WI			Call for hours.		
Bread of Healing Clinic (at Cross Lutheran Church)		1821 N. 16th St. Milwaukee, WI 53205	(414) 977-0001	Fax (414)755-6971	Call for hours.	<a href="http://www.breadofhealing.org">www.breadofhealing.org</a>	
City on a Hill Clinic	Karol Mirenda, RN	2224 W. Kilbourn Ave Milwaukee, WI 53233	414-931-6670	414-931-1804	Second Saturday of each month from 12:00 - 3:30. Offering monthly BP and BS screenings, foot care and health education topics and limited physician visits to the uninsured. Cholesterol Screening 2-3 times per year. Vision screening every other month starting with January. Physical Therapy every other month starting with February. Lunch and food pantry available to participants in health screenings.	<a href="mailto:karolm@aol.com">karolm@aol.com</a>	
Chippewa Valley Free Clinic	Jenny Regala	421 Graham Ave PO Box 231 Eau Claire, WI 54702	715-839-8477	715-839-8521	Open Tuesdays and Thursdays only, offering walk-in services, mental health, diabetic, ophthalmologic, and foot clinics		<a href="mailto:jenny@cvfreeclinic.org">jenny@cvfreeclinic.org</a>
Church Health Services, Inc. Beaver Dam	Dilana Molhe, RN Clinic Coordinator	308 Oneida St. Beaver Dam, WI 53916	920-887-1766	920-887-2322	Patient Application Process and patients are seen by appointment only	<a href="mailto:info@churchclinic.org">info@churchclinic.org</a> <a href="mailto:DilanaM@churchclinic.org">DilanaM@churchclinic.org</a>	
Church Health Services, Inc. Mayville	Heidi Weiss, RN	16 S. Main St., Mayville, WI 53050	920-387-2995	920-887-2322		<a href="mailto:info@churchclinic.org">info@churchclinic.org</a> <a href="mailto:HeidiW@churchclinic.org">HeidiW@churchclinic.org</a>	

Organization Name	Contact Person	Street Address	Phone #	Fax #	Special Info	E-Mail Address	Website
Community Clinic of Door County	Laura Moeller, PhD, MA Executive Director	1623 Rhode Island St, POB 3 Sturgeon Bay, WI 54235	920-746-8989	920-746-8960	Call for hours.	<a href="mailto:laura@communityclinicofdoorcounty.org">laura@communityclinicofdoorcounty.org</a>	
Community Connections Free Clinic	Aaron A. Dunn, MD, Therese Hess	101 E. Fountain Street P. O. Box 184 Dodgeville, WI 53533	608-930-2232	608-935-5168	Hours are 9:30 to 6:00 p.m. every Tuesday and Thursday, except holidays. email address will change March 1, 2011 to: <a href="mailto:info@ccofododge.org">info@ccofododge.org</a>	<a href="mailto:CCFC@charternet.net">CCFC@charternet.net</a>	
Community Chronic Disease Management Clinic (CCDM)	Heather Puente	205 E. Concordia Milwaukee 53212	414-568-9178	414-270-4806	CCDM screens and manages the care of hypertension and non-insulin dependent diabetes	<a href="mailto:hpunte@columbia-stmarys.org">hpunte@columbia-stmarys.org</a>	
Community Outreach Health Clinic	Linda Smith, NP	W180N5095 Town Hall Rd Menomonee Falls, WI 53051	262-257-3394	262-253-7162	Call for hours.	<a href="mailto:linda.smith@roedterhealth.org">linda.smith@roedterhealth.org</a>	
Dental Clinic – Waukesha	Terri Terill	10565 Lawndale Dr. Cedarburg, WI 53012	262-546-0613		Call for hours.	<a href="mailto:tterill@mindspring.com">tterill@mindspring.com</a>	
Free Clinic of the Greater Menomonee Area, Inc.	Mary Blanchard, Dennis Ciesielski	2321 Stout Rd. Menomonee, WI 54751	715-308-3808/ 715-231-2710	715-233-7860	Red Cedar Medical Center, Level A. Clinic hours are Tuesday only, registration between 5:00 and 7:00 PM.	<a href="mailto:blanchard_mary@mayo.edu">blanchard_mary@mayo.edu</a> <a href="mailto:dadesie@gmail.com">dadesie@gmail.com</a>	
Free Clinic of Pierce St. Croix Counties	Linda Robertson, Mary Steelen, Mary Conroy- Johnson	1687 E. Division St. P.O. Box 745 River Falls, WI 54022	715-307-3948 715-307-3949 715-426-4503		Open on Tuesdays only	<a href="mailto:heather.logelin@allina.com">heather.logelin@allina.com</a> <a href="mailto:linda_robertson@allina.com">linda_robertson@allina.com</a> <a href="mailto:mary_steele@allina.com">mary_steele@allina.com</a> <a href="mailto:mconroy@sbcdglobal.net">mconroy@sbcdglobal.net</a>	
Good Neighbor Clinic	Joan Mack, RN	1906 North Street Prairie du Sac, WI 53578	608-643-4749 608-644-0504		Call for hours.	<a href="mailto:gnccrc@gmail.com">gnccrc@gmail.com</a>	<a href="http://www.goodneighborclinic.org">www.goodneighborclinic.org</a>
Granville Neighborhood Health Center	Melissa Wolffgram, Rebekah Carey	9550 W Brown Deer Road Milwaukee, WI 53224	262-385-5138		Call for hours.	<a href="mailto:granvilleNHC@hotmail.com">granvilleNHC@hotmail.com</a>	
Greater Milwaukee Free Clinic	Kathleen Schnelder	9330 W. Lincoln Ave West Allis, WI 53227	414-546-3733 414-546-3746		Call for hours.	<a href="mailto:schnelkg98@yahoo.com">schnelkg98@yahoo.com</a>	
Health Care Network, Inc.	Barb Tylenda	904 State St. Racine, WI 53404	262-632-2400	262-632-7988	Call for hours.	<a href="mailto:barbtylenda@tds.net">barbtylenda@tds.net</a>	
HealthNet of Rock County Inc.	Jean Randles	23 W. Milwaukee St. Janesville, WI 53548	608-756-4638	608-756-4928	Call for hours.	<a href="mailto:execotr.healthnet@gmail.com">execotr.healthnet@gmail.com</a>	<a href="http://healthnet-rock.org">healthnet-rock.org</a>
Hulas Ozaukee Community Health Clinic	Sharon Streff, Chris Doers, Mary	13111 N. Port Washington Rd Mequon, WI 53097	262-243-7533	262-243-7319	Call for hours.	<a href="mailto:ssstreff@columbia-stmarys.org">sstreff@columbia-stmarys.org</a> <a href="mailto:mschnel1@columbia-stmarys.org">mschnel1@columbia-stmarys.org</a>	
InHealth Community Wellness Clinic	Robin Tranzo	109 East Bluff Street Boscobel, Wisconsin 53805	608-375-4324		Serving Grant and Crawford Counties - Call for hours.	<a href="mailto:ptranzo@mchsl.com">ptranzo@mchsl.com</a>	
La Clinica Family Health and Dental	Nancy Pulver	400 S Town Line Rd Wautoma, WI 54982	920-787-5514		Call for hours.	<a href="mailto:nancy@famhealth.com">nancy@famhealth.com</a>	
Lake Area Free Clinic	Paul Baumgartner	856 B Armour Rd Oconomowoc, WI 53066	262-569-4990	262-569-1712	Call for hours.	<a href="mailto:manyteich@lakeareafreeclinic.org">manyteich@lakeareafreeclinic.org</a>	
Living Healthy Community Clinic	Linda Booker	510 Doctors Court Oshkosh, WI 54901	920-424-1242	920-424-2045	Call for hours.	<a href="mailto:whitman@uwosh.edu">whitman@uwosh.edu</a>	
Marquette Clinic for Women & Children	Linda Booker	1821 N 16 <sup>th</sup> St. Milwaukee, WI 53205	414-755-6970	414-755-6970	Call for hours.	<a href="mailto:maryann.lough@marquette.edu">maryann.lough@marquette.edu</a>	

Organization Name	Contact Person	Street Address	Phone #	Fax #	Special Info	E-Mail Address	Website
MCW-Hessac Coggs Saturday Clinic	Adam Ronan, Co-Director	2770 North 5 <sup>th</sup> St Milwaukee, WI 53212			Call for hours.	<a href="mailto:adamronan@hotmail.com">adamronan@hotmail.com</a>	
MEDIC	Sharon Younkin	2202 S. Park St. Madison, WI 53713	608-265-4972		Open Saturdays only. Doors open at 8 am, first come first served. First appt. at 9 am	<a href="mailto:medic@rso.wisc.edu">medic@rso.wisc.edu</a>	
Middleton Teen Clinic		2711 Allen Blvd. Suite 300, Middleton, WI 53562	(608) 827-2300	(608) 827-2399	Call for hours.	<a href="mailto:deanfoundation@deancare.com">deanfoundation@deancare.com</a>	
NEW Community Clinic	Bonnie Kuhr	622 Bodart St. Green Bay, WI 54301	920-437-9773	920-437-0984	Call for hours.	<a href="mailto:newcomm@net.net">newcomm@net.net</a>	
Open Door Free Clinic-Unity Church	Georgia Sels	1025 E. Oklahoma Ave Milwaukee, WI 53207	414 481-1778	414 481-1778	Call for hours. Mailings: 3965 S. Lake Dr St Francis, WI 53235 c/o Georgia Sels	<a href="mailto:gsels@merr.com">gsels@merr.com</a>	
Our Lady of Hope Clinic	Dr. Michael Kloess	6425 Odana Road, Madison, WI 53719	608-819-8544	608-819-8547	Call for hours.		<a href="http://ouradyofhopeclinic.org/">See http://ouradyofhopeclinic.org/ for more information</a>
Packard Avenue Community Clinic	Ed Wrench	5854 S. Packard Ave Cudahy, WI 53110	414-769-2239 ext 306	414-769-2291	Call for hours.	<a href="mailto:wrench@cl.cudahy.wi.us">wrench@cl.cudahy.wi.us</a>	
Repairers of the Breach	Melita Biese, Mary Ann Radowski	1345 W Vliet St Milwaukee 53205	414-342-9323		Hours vary week to week. Call first.	<a href="mailto:melitabiese@att.net">melitabiese@att.net</a>	
Richland Community Free Clinic	Gloria Basset	301 E. 2nd St. Richland Center, WI 53581	608 647-6161 x4135		Open tuesdays 8 - noon for those without insurance.		<a href="http://www.rcfreeclinik.com/">http://www.rcfreeclinik.com/</a>
Rice Lake Area Free Clinic	Bette Coville	1035 N. Main Street, Suite G02 Rice Lake, WI 54868	715-736-3733 (736-FREE)	715-736-3734	We are open for patient care on the 2nd and 4th Tuesdays of each month. Our doors open at 5 PM, providers start patient visits at 6 PM and we close at 9 PM.	<a href="mailto:bcoville@centurytel.net">bcoville@centurytel.net</a>	<a href="http://rifa/c.org/">http://rifa/c.org/</a>
Rock River Free Clinic	Gail Scott, RN	1541 Annex Road Jefferson, WI 53549	920-674-7275	920-674-7477	Call for hours.	<a href="mailto:gails@jeffersoncountywi.gov">gails@jeffersoncountywi.gov</a> <a href="mailto:barbd@co.jefferson.wi.us">barbd@co.jefferson.wi.us</a>	
Salvation Army Clinic	Nancy Szudzki	1730 N. 7 <sup>th</sup> St. Milwaukee, WI 53205	414-265-6360	414-265-8151	Call for hours.		
Red Shield Free Clinic	Pam Sandee	710 Pennsylvania Ave Sheboygan, WI 53082	920-458-3723	920-694-0035	Call for hours.	<a href="mailto:pam_sandee@usc.salvationarmy.org">pam_sandee@usc.salvationarmy.org</a>	
Samaritan Health Clinic-Fond du Lac		430 E. Division Fond du Lac, WI 54935	920-926-4841 or 926-4805	920-926-8874	Call for hours.	<a href="mailto:samaritan@aqnesian.com">samaritan@aqnesian.com</a>	
Samaritan Health Clinic-Waupun	Liz Hoffman	620 W. Brown St Waupun, WI 53983	920-324-6540		Call for hours.	<a href="mailto:samaritan@aqnesian.com">samaritan@aqnesian.com</a>	
Saturday Clinic for the Uninsured	Jim Sanders, MD	1121 E. North Ave Milwaukee, WI	414-588-2665		Call for hours.		
Seton Dental Clinic	Liz Nelson	1730 S. 13th Street, Milwaukee	414-383-3220	414-383-3363	Urgent Care is available to people on a walk-in basis according to eligibility criteria. Call for criteria.	<a href="mailto:nelsonl@columbia-stmarys.org">nelsonl@columbia-stmarys.org</a>	
St. Clare Health Mission	Sandy Brekke	916 Ferry St. LaCrosse, WI 54601	608-791-9544	608-791-9570	Call for hours.	<a href="mailto:brekke.sandra@mayo.edu">brekke.sandra@mayo.edu</a>	
St. Clare Health Mission of Sparta	Patricia Raftery, DO	310 W. Main St. Sparta, WI 54656	608-269-1770	608-269-1017	Call for hours.	<a href="mailto:raftery.patricia@mayo.edu">raftery.patricia@mayo.edu</a>	
St. Francis Community Clinic		1965 Oshkosh Ave Oshkosh, WI 54902	920-230-2273	920-231-2502	Call for hours.		
St. Joseph's Medical & Dental Clinic	Kathy Pleper, Jennifer Evans	826 N. East Ave Waukesha, WI 53186	262-544-6777	262-544-6667	Call for hours.	<a href="mailto:kplepersmd@yahoo.com">kplepersmd@yahoo.com</a> <a href="mailto:stjosephsmed@wlr.com">stjosephsmed@wlr.com</a>	
St. Vincent de Paul Free Clinic	Christy O'Dea	1004 E. Main St. Merrill, WI 54452	715-539-9566	715-539-9606	Call for hours.	<a href="mailto:freeclinic@verizon.net">freeclinic@verizon.net</a>	

Organization Name	Contact Person	Street Address	Phone #	Fax #	Special Info	E-Mail Address	Website
The Good Neighbor Clinic of Sauk Prairie	H.P. Carlson, MD Stefani Moreno	1906 North St. Prairie du Sac, WI 53578	608-643-4749 ext 14	608-644-0504	Call for hours.	<a href="mailto:the2csat104@verizon.net">the2csat104@verizon.net</a> <a href="mailto:gnocrc@charternet.net">gnocrc@charternet.net</a>	<a href="http://www.goodneighborclinic.org">www.goodneighborclinic.org</a>
The Open Door Clinic, Inc.	Dr Tom Chisholm, MD, Deb Bleging	Site: 130 West Central Street Chippewa Falls, WI	715-720-1443	715 720-4656	Open Tuesdays 4 - 8 pm Mailing address: PO Box 271 Chippewa Falls 54729	<a href="mailto:deb@chippewaopendoor.org">deb@chippewaopendoor.org</a>	
Twin Counties Free Clinic	Candy Shendan	1301 Cherl Boulevard Suite 116 Marinette, WI 54143	715-732-1349	715-732-1386	Call for hours.	<a href="mailto:tcfc@tcmc.org">tcfc@tcmc.org</a>	
Walker's Point Community Clinic	Steve Ohly	611 W. National Ave. #400 Milwaukee, WI 53204	(414) 384-1400	414-672-7012	Call for hours.	<a href="mailto:steve.ohly@aurora.org">steve.ohly@aurora.org</a>	
Watertown Area Cares Clinic	Roberta Manley, Carol Mertins, John Basarich	415 S. 8 <sup>th</sup> St Watertown, WI 53094	920-206-7797		Call for hours.		
L:\BEMTWBCP-Web\Clinics-final.xls							

**Appendix H: Participant Contact Information**

Name:

Address:

Telephone:

Cell Phone:

Email:

How do you prefer to be contacted?      Phone      Cell      Email

Preferred day:

Preferred time:

May I leave a message?   YES   NO

Should I contact you as a reminder of our meeting?

## Appendix I: Informed Consent Document

# UNIVERSITY OF WISCONSIN – MILWAUKEE CONSENT TO PARTICIPATE IN RESEARCH

THIS CONSENT FORM HAS BEEN APPROVED BY THE IRB FOR A ONE YEAR PERIOD

### 1. General Information

**Study title:** The historical influence of politics and society on women’s experiences of abortion.

**Person in Charge of Study (Principal Investigator):**

My name is Sandy Schumacher. I am a doctoral nursing student in the College of Nursing at the University of Wisconsin-Milwaukee. I am working with Dr. Patricia E. Stevens PhD, FAAN, a professor at UWM, who is the chair of my dissertation.

### 2. Study Description

You are being asked to participate in a research study. Your participation is completely voluntary. You do not have to participate if you do not want to.

**Study description:**

The purpose of this study is to learn more about the abortion experiences of women from their perspective so that health care providers can better understand their needs and issues of importance to them. A total of 10 to 15 women will be sought to participate in the study.

Each woman will be asked to participate in two audio-recorded interviews, each about 2 hours in length. They will occur about 2 to 4 weeks apart. We will schedule the interviews at a time and place that is convenient for you and private. Names will not be associated with the interviews in order to protect confidentiality.

### 3. Study Procedures

**What will I be asked to do if I participate in the study?**

You are under no obligation to participate in the study and may withdraw from the study at any time. If you agree to participate you will be asked to talk with me about your abortion experiences in two interviews, 2 to 4 weeks apart. Each interview will last about 2 hours. I will also ask you for some descriptive information about yourself like your age, how far you went in school, income, etc. We will arrange a convenient time and place for the interviews.

With your permission, I will be recording our interviews so that I can better concentrate on what you are sharing with me. Everything you say from those recordings will be typed out so that I can understand all the details of what you share with me. Your name and identity will not be kept in the recordings or in the typed documents. Information about who you are and what you have told me will be kept confidential. If at any time you want to tell me something that you do not want recorded, I will temporarily turn off the recorder and, with your permission, I may take a few notes. If you refuse to have your interviews recorded, I will not be able to include you in the study.

After I have completed everybody's interviews and written up the results of the study I may contact you to talk with me for about 30 minutes on the phone or in person to see if you agree with the results or not. You do not have to participate in this conversation if you do not want to.

#### 4. Risks and Minimizing Risks

##### **What risks will I face by participating in this study?**

It is possible that it may be distressing for you to talk about your abortion experiences. If you become uncomfortable in any way, we can stop the interview at any time and I will stay with you until you feel more comfortable. I will not be providing any counseling for you, but will be listening as you share your experiences and watching for any signs of distress. I will be available to help you get in touch with supportive resources if you need it.

#### 5. Benefits

##### **Will I receive any benefit from my participation in this study?**

You will not receive any direct benefits from being in the study except to know that you are contributing to research that may help others understand more about what women need in relation to abortion. I appreciate your time and efforts on behalf of the study.

#### 6. Study Costs and Compensation

##### **Will I be charged anything for participating in this study?**

You will not be responsible for any of the costs from taking part in this research study.

##### **Are subjects paid or given anything for being in the study?**

You will not be compensated for taking part in this research study.

#### 7. Confidentiality

##### **What happens to the information collected?**

All information collected about you during the course of this study will be kept confidential to the extent permitted by law. I may decide to present what I find to others, or publish my results in scientific journals or at scientific conferences. No information that identifies you personally will be attached to the data, and your contact information will not be released. Your recorded interview and your contact information will be stored in separate locked cabinets, accessible only by me and my professor, Dr. Stevens. However, the Institutional Review Board at UW-Milwaukee or appropriate federal agencies like the Office for Human Research Protections may review this study's records.

Following the study, with your permission, your contact information will be kept in a locked cabinet for 10 years in case of follow-up study. The recorded interviews will also be kept for 10 years in a locked cabinet. After 10 years have passed, all of the data and contact information will be destroyed.

## 8. Alternatives

### **Are there alternatives to participating in the study?**

I believe that talking with women is the best way to understand about their experiences of abortion. Although I could study abortion from the point of view of the doctor or nurse, I feel you as the woman who has experienced abortion can best describe this experience to me. There are no known alternatives available to you other than not taking part in this study.

## 9. Voluntary Participation and Withdrawal

### **What happens if I decide not to be in this study?**

Your participation in this study is entirely voluntary. You may choose not to take part in this study. If you decide to take part, you can change your mind later and withdraw from the study. You are free to not answer any questions or withdraw at any time. Your decision will not change any present or future relationships with the University of Wisconsin Milwaukee.

If you choose to withdraw from the study, I will use the information that you have shared with me up to that point, including any interviews that were recorded, unless you tell me that you want me to discard the data.

In the event that you are not able to talk about your abortion experiences or doing so causes emotional distress, I might end your participation in this study without regard for your informed consent.

## 10. Questions

### **Who do I contact for questions about this study?**



For more information about the study or the study procedures or treatments, or to withdraw from the study, contact:

Sandy Schumacher PhD (c), MSN, RN, CNM, WHNP, BC  
 College of Nursing, University of Wisconsin – Milwaukee  
 Cunningham Hall,  
 1921 E. Hartford Street  
 Milwaukee, WI 53201  
 Phone: 920-818-0184  
 Email: [sandys2@uwm.edu](mailto:sandys2@uwm.edu)

**Who do I contact for questions about my rights or complaints towards my treatment as a research subject?**

The Institutional Review Board may ask your name, but all complaints are kept in confidence.

Institutional Review Board  
 Human Research Protection Program  
 Department of University Safety and Assurances  
 University of Wisconsin – Milwaukee  
 P.O. Box 413  
 Milwaukee, WI 53201  
 (414) 229-3173

**11. Signatures**

**Research Subject's Consent to Participate in Research:**

*To voluntarily agree to take part in this study, you must sign on the line below. If you choose to take part in this study, you may withdraw at any time. You are not giving up any of your legal rights by signing this form. Your signature below indicates that you have read or had read to you this entire consent form, including the risks and benefits, and have had all of your questions answered, and that you are 18 years of age or older.*

\_\_\_\_\_  
 Printed Name of Subject/ Legally Authorized Representative

\_\_\_\_\_  
 Signature of Subject/Legally Authorized Representative

\_\_\_\_\_  
 Date

**Research Subject's Consent to Audio/Video/Photo Recording:**

It is okay to audiotape/digitally record me while I am in this study and use my audiotaped/digitally recorded data in the research.

Please initial: \_\_\_Yes \_\_\_No

**Principal Investigator (or Designee)**

*I have given this research subject information on the study that is accurate and sufficient for the subject to fully understand the nature, risks and benefits of the study.*

---

Printed Name of Person Obtaining Consent

---

Study Role

---

Signature of Person Obtaining Consent

---

Date

## **Appendix J: Demographic Information**

Following a brief description of the study and completion of the Informed Consent Document (ICD), I will explain to women that I would like to know more about them both at the time of the abortion(s) and presently. I will ask participants about demographic variables as opening interview questions.

### **At the time of the first interview:**

Age – How old are you currently?

Religion – Do you associate with a particular religion? If so, which one?

(Protestant, Catholic, Jewish, Hindu, Islam, Spiritual but not religious, Other)

Relationship with partner – length of the relationship, type of relationship

Education level – highest grade completed, additional education

Employment (FT, PT, none)

Occupation (type of work)

Income (\$)

Race

Ethnicity

Obstetrical history:

Number of pregnancies

Number of living children

Number of abortions

Other outcomes of pregnancy

**At the time of your first abortion:**

Was it hard for you to make ends meet? Were you uninsured or on medical assistance?

Age

Religion

Marital status

Education

Employment

Income

Type of abortion procedure

When/Date

Where

**At the time of your second abortion:**

Was it hard for you to make ends meet? Were you uninsured or on medical assistance?

Age

Religion

Marital status

Education

Employment

Income

Type of abortion procedure

When/Date

Where

## **Appendix K: Interview Guide**

### **First Interview**

Date:

Time Started:

Time Ended:

Location:

Participant:

### **Initial Question**

What was having an abortion like for you? Tell me about your (first) abortion experience.

### **Discovering and Confirming the Unintended Pregnancy**

Tell me about finding out that you were pregnant.

When did you first think you might be pregnant?

How did you find out you were pregnant?

Tell me about persons you talked with about your suspicions/confirmation.

### **Making the Decision for Abortion**

Tell me about how you decided to have an abortion.

Were there any specific persons in your life at that time that influenced your decision?

Did you talk with anyone in particular at the time?

Were there other things going on in your life at that time that influenced your decision?

Were there other factors that influenced your decision?

Why did you decide to have an abortion?

### **Arranging for the Abortion Procedure**

Tell me about the process of getting an abortion.

Did you have access to health care?

How far did you have to travel?

Did you have to wait 24 hours?

Did you need parental consent?

What was this experience like for you? Can you describe it to me?

Tell me about the health care professionals who cared for you.

Did you have options counseling prior to your abortion? What was that experience like?

### **Having the Abortion**

Did insurance pay for your abortion?

Did anyone else help you financially with your abortion experience?

Provide transportation? Give you a day off work?

Tell me about the day you first went to the abortion clinic.

Tell me about other visits to the clinic.

Tell me about the health care professionals who cared for you.

How did the nurses and provider treat you during the abortion?

Have you had any experiences with health care providers since your abortion experience?

Can you tell me about these?

Tell me about your experience with pain. Did you have any during the abortion?

### **After the Abortion**

Tell me about the abortion in your life since the actual procedure.

How have your thoughts and feelings changed?

### **Other Prompts**

- Can you tell me about your social circumstances at the time of the abortion? Who did you tell about the abortion at the time? Later? Family? Friends? Your partner? Others? Was there anybody that helped you? How did he/she/they help? At the time, did you know anyone else who had had an abortion? How about now?
- Describe the economic and financial factors you encountered in your abortion experience. Were you worried about how to pay for a child? The abortion? Did anyone else help you financially with your abortion experience? Provide transportation? Give you a day off work?
- Tell me about any religious beliefs that influenced your decision to have an abortion. What was that like at the time of the abortion? Has that changed for you over time? How about now?
- Did you think about the legality of abortion before you had yours? Tell me about your thoughts about abortion being legal since you had your abortion.
- Did you tell others about your abortion? How did you do this? When and where? Under what conditions did you share information about your abortion?
- What do you believe it has meant for you as a woman to have had an abortion? Has the meaning for you changed over time? Can you tell me about that?
- What do you want to tell other women about your experience? Other people?

### **Closing Remarks**

Thank you so much for sharing your experiences with me.

Is there anything about the interview process that could be Please provide with me some feedback about the interview process.

When would you like to schedule our second interview (2-4 weeks)?

**Second Interview**

Date:

Time Started:

Time Ended:

Location:

Participant:

**Initial Questions**

Since our first interview, is there anything you would like to add about your experience of abortion? Any insights you would like to share with me about your abortion experiences? Other details of specific events that you remembered since our first meeting that you would like to discuss?

**Historical Events (Political, Social)**

I want you to think about events in your life, since your abortion. Can you tell me about a specific event you recall that caused you to think back on your abortion? What thoughts and feelings do you remember having at that time about your abortion experience? What about this event triggered your memory of the abortion? How did your perceptions of the abortion change?



## **Appendix L: Field Notes**

### **Environmental Circumstances**

- Spatial arrangement
- Contents of the setting
- Frame and boundaries
- Emotional atmosphere
- Background action/concurrent activities
- Aesthetic elements
- Sensory elements
- Others present

### **Temporal Elements**

- Time of day, season, year
- Sequencing of events
- Duration
- Fit in daily schedule/larger structure of life

### **Participant Characteristics**

- How recruited/referred
- Demographics
- Appearance
- Demeanor
- Similar/dissimilar to researcher
- Special proximity
- Motives for participation (explicit/implicit)

**Interactions**

- Verbal content
- Process and flow
- Emotional expression
- Nonverbal behaviors
  - Body posture
  - Gestures
  - Facial expressions
  - Delivery of speech

**Rapport**

- Open/guarded (content)
- Ease/friction (process)
- Depth and specificity of information shared
- Verbal indications of comfort and openness

**Power Dynamics**

- Direction/domination of interactions
- Mutuality of exchanges
- Interruptions
- Silences

**Interview Process**

- Success eliciting depth of description/narrative
- Effectiveness of questions/probes
- Procedural problems

Comparison to other interviews

### **Discrete Events**

What happened?

Critical incidents

Turning points

### **Interpretations:**

Intuitive impressions

Emotional reactions (my feelings) (Reflexivity)

Analytic ideas (my thoughts) (Reflexivity)

What is going on here?

- Motivations for behaviors
- Imagery
- Contingencies
- Constraints

What are the ramifications?

- Interactional themes
- Meanings of events
- Underlying values

## **Appendix M: Analytical Notes and Methodological Memos**

Analytical notes and methodological memos will be made throughout the data collection and analysis to document decisions made relative to methodological and analytical processes along with personal reflections. This may include decisions regarding thematic identification and classification or changes incorporated into the data collection process.

### **Perception of the participant:**

Referred by another study participant? (Rapport)

Nonverbal indications of the participant's comfort and openness (Rapport)

Verbal indications of the participant's comfort and openness (Rapport)

Depth and specificity of information shared? (Rapport)

### **Interview:**

Reflexivity - deliberately focus on the researcher-participant relationship during data collection and analysis, pinpointing mutual influences affecting the nature of the response.

Coherence - Does this interview "hold up" internally? Is this account comparable to accounts from other participants?

### **Second Interview:**

Relevance – Did the questions address women's concerns? Can the answers to these questions serve women's interests and improve the conditions of women's lives?

### **Review and analysis of transcribed interview:**

Identification of themes –

Credibility – my research findings/report will be credible when it presents such faithful interpretations of participants' experiences that they are able to recognize them as their own; member checks, other feminist scholar/nurse assess the believability of my interpretation and

analysis of the participant's accounts of their experience. The results of attempts to establish credibility should be reported and discussed, including those that stand in stark contradiction to the final conclusions of the study (p. 21-22).

Rapport -

Coherence - Is this account comparable to accounts from other participants? Are there inconsistencies among various sources of data? How cogent are the analytic interpretations? Are they sound renderings that communicate the essential meanings of the raw data? Do they make logical sense in the light of a broader understanding of social, economic, and political realities? Is the emerging theoretic picture whole? Is it faithful to participants' narratives, to the historical record, to the variety of observations made? How well are the interpretations related to basic research questions, overall research goals, and findings of other investigations?

Complexity – across different women's experiences – conscious identification of similarities? Dissimilarities?

Consensus - What are the areas of broadest agreement among participants? Which participants are not included in this area of agreement? At what level of analysis does this apparent similarity become relevant or irrelevant? What are the consequences of assuming that the similarities or areas of agreement are universal? Which women's experiences are not represented by the accounts given in this sample of participants?"

Discuss with other feminist scholars – adequacy and dependability

## Curriculum Vitae

Sandra R. Schumacher

Place of Birth: Pueblo, Colorado

### Education

B.S.N., University of Wisconsin-Madison, December 1984  
Major: Nursing

M.S.N., University of Minnesota-Minneapolis, May 1994  
Major: Nursing, Midwifery

M.S., University of West Florida-Pensacola, May 1994  
Major: Health, Leisure, and Sports

Graduate Certificate, University of Wisconsin-Milwaukee, May 2006  
Major: Women's Studies

Dissertation Title: The Historical Influence of Society and Politics on Women's Experiences of Abortion.

### Affiliations/Memberships

Midwest Nursing Research Society (MNRS)  
Organization of Doctoral Nursing Students (ONDS)  
Sigma Theta Tau International Honor Society of Nursing (STTI)  
International Association of Qualitative Inquiry (IAQI)  
American Academy of Nurse Practitioners (AANP)

### Research Experience

Nursing Practicum in Research with Professor P.E. Stevens PhD, 2004

### Awards/Honors

Recipient of the Marie T. McFarland Memorial Scholarship, 2003  
Recipient of the Nursing Economic\$ Foundation Scholarship, 2004  
Member of Sigma Theta Tau International Nursing Society, 2005  
Graduate Certificate in Women's Studies, 2006  
Study Abroad in Malawi: Nursing and Community Health, 2010  
Recipient of the Harriet H. Werley Graduate Student Research Award, 2010  
Recipient of the STTI Eta Nu Chapter Graduate Student Research Award, 2010

### Publications

Schumacher, S. R. (2010). *Nursing and Midwifery in Malawi: A Personal Narrative of Learning Cultural Safety*. Manuscript submitted for publication.

#### Presentations

Schumacher, S. R. & Wrabl, C. A. (2006, October). *Organizational Communication Throughout the Magnet Journey and Beyond*. Presentation at the Tenth National Magnet Conference, Denver, CO.

Schumacher, S. R. & Wrabl, C. A. (2006, October). *Staffing Effectiveness: Clinical Outcomes and Human Resource Indicators*. Presentation at the Tenth National Magnet Conference, Denver, CO.

Schumacher, S. R. (2006, April). *Discovering My Area of Passion to Research – A Performance of One Researcher's Experience*. Paper presented at the 13<sup>th</sup> Annual Critical and Feminist Perspectives in Nursing Conference “Bridging Across Perspectives”, Milwaukee, WI.

Schumacher, S. R. (2006, April). *Women's Experience of Abortion – A Discussion of Theoretical Frameworks*. Paper presented at the 13<sup>th</sup> Annual Critical and Feminist Perspective in Nursing Conference “Bridging Across Perspectives”, Milwaukee, WI.

#### University Service

September 2010 – Informal presentation to UWM students and professors on the study abroad experience in Malawi.

March 2012 – Formal presentation to the Sturgeon Bay Business Women about the study abroad experience in Malawi and the continuing relationship between the UW-Milwaukee College of Nursing Foundation, research, and community care in Malawi.