Stigma, Abortion, and Disclosure—Findings from a Qualitative Study

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DOI: 10.1111/j.1743-6109.2011.02604.x

ABSTRACT

Introduction. This study qualitatively explores perceptions of women who have experienced abortion care. It explores women’s journey through abortion from confirmation of pregnancy to post-abortion.

Aim. The study seeks to understand the implications of these perceptions for policy and practice.

Main Outcome Measures. A qualitative study involving in-depth semi-structured interviews with 17 women, aged between 22 and 57 years, who had undergone legal induced abortion in the UK when they were 16 years or older. Participants were not recruited under the age of 16 because of the ethical and legal complexities of interviewing minors. Additionally, 16 years was deemed to be the most appropriate age as this is the legal age of consent in the UK.

Methods. Participants were recruited from 12 community contraception and sexual health clinics in two NHS trusts, one in England and one in Wales. Participant recruitment was set at a minimum of 12 and participants were recruited on a “first come first served basis” (i.e., the first 12 who contacted the researcher). The number of participants was raised to seventeen as this was the number deemed to be the most suitable for data saturation in this particular qualitative research.

Results. Women in this study understood abortion as highly taboo and a potentially personally stigmatizing event. These perceptions continued to affect disclosure to others, long after the abortion, and affected women’s perceptions of the response of others, including society in general, significant others, and health professionals.

Conclusions. Women’s experiences of abortion may be influenced by perceived negative social attitudes. Health professionals and abortion service providers might combat the perceived isolation of women undergoing abortion by attending not only to clinical/technical aspects of the procedure but also to women’s psychological/emotional sensitivities surrounding the event. Astbury-Ward E, Parry O, and Carnwell R. Stigma, abortion and disclosure—Findings from a qualitative study. J Sex Med 2012;9:3137–3147.

Key Words. Abortion; Pregnancy; Stigma; Disclosure; Qualitative Research; Phenomenology

Introduction

Abortion is highly prevalent in the UK, where it is estimated that by the age of 45, one in three women will have had an abortion and 34% will have more than one [1]. In 2009, the total number of abortions in the UK was 202,105, comprising 189,100 in England and Wales, and 13,005 in Scotland [2,3]. Despite this high prevalence, abortion remains a highly controversial, contentious, and hidden event. While there has been much clinical research documenting the safety and efficacy of abortion, there have been few studies exploring the voices of women requesting and experiencing abortion. Understanding women’s emotional and psychological experiences of abortion is complex and multifactorial.

Many clinical studies have documented the safety and efficacy aspects of abortion [1,4–7]. However, clinical outcomes are not the only evidence required to reach understanding about the experiences of women requesting abortion,
particularly as adverse clinical events are rare for routine abortion procedures [1,8].

A literature search was conducted most recently in February 2010. The search strategy used the following keywords: “induced abortion,” “abortion care,” “attitude to abortion,” “nurses and abortion,” “termination of pregnancy,” “stigma and abortion,” and “emotional and psychological consequences of abortion.” The databases searched included: BMJ Journals Collection, British Nursing Index from 1985, Cumulative Index to Nursing and Allied Health Literature from 1982, EBSCO Host databases, Embase from 1980, Google Scholar, Ingenta Connect, Inter-nurse, International Bibliography of the Social Sciences from 1951, JSTOR, National Libraries for Health, Medline from 1966, Proquest, PsyclINFO from 1872, Sage Journals, Science Direct, and Scopus. Additionally, a Zetoc email alert (table of contents from the British library that identifies new papers in specifically selected journals) was established in April 2009, using the key words “abortion” and “stigma.”

The search revealed that to date, few studies have examined patients’ non-clinical experiences of abortion [9], or have focused specifically on perceptions of care as a central dimension of that experience [10,11]. The few studies that have been conducted on abortion care, have focused primarily on women’s perceptions of negative outcomes of abortion procedure rather than taking a broader view of their experiences [12]. There has been little qualitative research on abortion care in the UK, which explores the voices of women who have undergone the procedure [13]. That women’s voices have seldom been sought in research focusing on abortion, mirrors reticence of women themselves to talk about their experiences of abortion. Reticence to disclose has been associated with women’s perceptions of stigma which is one aspect of the social disapprobation surrounding abortion. Reticence to disclose has rendered the gathering of evidence about women’s experiences of abortion, difficult [14,15].

Furthermore, there has been little research [16] that locates women’s experiences in the wider social context of abortion. Hence there is lack of understanding about the implications of the social context for the way in which women experience and respond to abortion. This study has identified new knowledge surrounding the ways in which abortion contributes to women’s perceptions of it as a stigmatized event in their lives which they are reluctant to disclose.

Methodology and Theoretical Framework

Phenomenology

The study which this paper describes was informed by a broadly interpretive approach, which draws theoretically upon phenomenology and hermeneutics. Interpretivism is characterized by the assumption that reality is complex, holistic and context dependent, and hence rejects the basic tenets of positivistic enquiry [17]. As the name suggests, the starting point of phenomenological enquiry is with the phenomenon being studied, rather than theories about the phenomenon [18]. While the main objective of phenomenology is to examine and describe phenomena as they are consciously experienced [19,20], hermeneutics is concerned with understanding that world through language and the “art of interpretation” [21]. In carrying out this study, the first author was interested in how individuals construct the meaning of their experiences and about the inter-subjective nature of qualitative enquiry. Phenomenology appealed as a methodology primarily because of its focus upon the phenomena studied through individuals’ lived experiences and shared meanings, and as the study of others’ experiences as they perceive them. Although none of the phenomenological philosophers developed research methods, their philosophies are often used to inform qualitative research [22]. Consequently, although phenomenology is essentially a philosophy adapted as a research approach, it is now frequently referred to as both a philosophy and a research approach suitable for qualitative enquiry.

Methods

The study involved collecting data from individual participants through semi-structured interviews, which were audio recorded (with respondent consent). Seventeen interviews were conducted over an 8-month period in 2009. Interviews were primarily conducted in participants’ homes and the researcher’s work place. Interviews lasted 1–1.5 hours. The interviews were conducted and transcribed by the author and were analyzed by the author and two senior research clinical academics for validity and rigor.

Ethical approval for the study was obtained from the sponsoring university and from the local branch of the National Research Ethics Service. Participants were asked to sign a consent form both prior to, and following, the interview, to ensure participant satisfaction with the study. All
data were stored securely and audio recordings were erased following transcription. Participants are not identified in any research outputs and pseudonyms are used throughout this article to preserve participant anonymity.

Issues of Reflexivity in Qualitative Interviews

An important concept in qualitative research is reflexivity. A narrow definition of reflexivity found in the literature is self-awareness [23]. Generally, however, reflexivity is deemed to have more agency than mere self-reflection [24], and operates on both personal and epistemological levels [25].

On a personal level, reflexivity demands that the researcher must maintain awareness of, and acknowledge, their influence on the research process. Moreover, Guba and Lincoln ([26]:201) emphasize how throughout the research process qualitative researchers must reflexively evaluate and reevaluate their own relationship to both participants and the data, so their own identities are “fluid and multiple” [26]. Reflexivity is not always easy to achieve, especially where the boundaries between researchers and their professional roles blur or are broached [24].

Indeed in this study the first author presented a potential source of bias because of her own professional socialization into abortion care work. Before considering ways in which potential researcher bias can be minimized, it is important to note that there are also advantages linked to the researcher as an “expert.” Hence, the clinician/researcher, for example, brings to the interview a wealth of technical and professional knowledge that provides him/her with understanding not available to those outside the profession. Moreover, the clinician/researcher is able to understand or pick up on issues raised by participants, which might not be noticed or grasped by those lacking professional insight. In this study, the first author’s professional training was particularly useful because it alleviated the necessity of probing for technical clarity when discussing potentially sensitive or upsetting issues.

Colbourne and Sque ([27]:300) suggest that self-vigilance, insight, and self-awareness are important to minimize the effect of researcher bias [27]. With this in mind, the researcher in this study rigorously adopted these principles; in addition, a reflective diary was kept, which enabled the researcher to document her feelings and moods during the study.

Sampling and Respondent Recruitment

The study used purposeful sampling to recruit participants who had undergone legal induced abortion aged 16 years or older. Participant recruitment was set at a minimum of 12 and participants were recruited on a “first come first served basis” (i.e., the first 12 who contacted the researcher) the number of participants was raised to seventeen as this was the number deemed to be the most suitable for data saturation in this particular qualitative research. Patient information sheets were distributed throughout 12 community contraception and sexual health clinics in two NHS trusts, one in England and one in Wales. The information sheet invited prospective participants to volunteer for inclusion in the study by contacting the study author.

Participant Characteristics

The sample comprised 17 women aged between 22 and 57 years. The women comprised a mixture of socioeconomic, educational, and marital status. Seven women had more than one abortion, which was slightly higher than the UK national average (34%). Average age at abortion was 24 years (which is the same as the UK average). Time elapsed since abortion ranged between 2 weeks and 37 years at time of interview. Post-abortion studies have been conducted from as early as a few hours post-procedure [28] to as long as 27 years post-abortion [29]. There is, however, no consensus on how women experience the process. A qualitative study using in depth interviews with 20 women suggested that women’s retrospective accounts of abortion differ because their emotions are not static, and the meanings that they attach to the experience change according to life circumstances at different stages of their lives [29]. Avalos [29] thus argued that the passage of time is an important variable when women retrospectively revisit their abortion experience in later years. She further argued that static models that have tended to guide understanding of women’s experiences are inappropriate because women’s lives continually grow and change.

Other authors have agreed with Avalos [29] in acknowledging that research has not done justice to the complexity and depth of women’s abortion experiences [30]. Certainly, authors like Coleman and Nelson [31] have noted the difficulty in capturing women’s emotional experience, despite research efforts to do so over the past 30 years [31].
Data Collection

Interviews were conducted using semi-structured interview schedules that focused on women's perceptions of different aspects of their abortion journey from discovery of the pregnancy to post-abortion (see Appendix I). Using an interview schedule in semi-structured interviews can be problematic because it pre-defines the questions asked and may constrain responses [32]. The interview schedule focused on women's perceptions about different aspects of the abortion process, from the initial decision to post-abortion care. Some demographic data about participants were also collected.

It is acknowledged in relation to analyzing and coding the data, because some themes were readily identifiable from the interview schedule, that the researcher might unconscious force the data unnaturally into pre-determined categories. To counter this, the interviews in this study focused on exploring respondent meanings and gaining the emic (the insider's view of their world) perspective.

In particular, care was taken to ensure that the topic areas were identified by both interviewer and the participants, and that the latter controlled the interview pace and the time spent on particular topics. In addition, participants were encouraged to identify and discuss issues, not necessarily identified in the interview schedule, which they themselves perceived as important. The themes that emerged were subsequently explored using a variety of open-ended and probing questions to elicit a response from the interviewee in their own words. Dearmley [33] suggests that the open nature of questions encourages depth and vitality from interviewees and, in turn, allows new concepts to emerge [33]. Hence, in this study, data collection was constructed as a reflexive process.

Qualitative interviews can provoke anxiety, particularly where research is considered sensitive, and may cause both parties to become defensive. The ethical unacceptability of interviewing individuals and leaving them in emotional distress is well documented in the literature [34,35], as are the responsibilities of the researcher in this respect [36]. In acknowledgement of the sensitive nature of the interview, support arrangements were put in place for research participants, should they require it. A consultant obstetrician and gynecologist, trained in psychosexual medicine, was available to provide support for any participants affected adversely by the study. Information about sources of support which could be independently accessed by participants was also provided on the participant information sheet.

Data Analysis

In this study, a form of content analysis was used, which took direction from grounded theory [37]. Accordingly, a thematic analysis was undertaken. Some identified themes related to topics in the interview schedule (themselves informed by the literature review), while others emerged more spontaneously through the process of data collection. Initial themes identified were tested on the complete data set for consistency and refined for further analysis. They were further validated by inter-researcher verification with two senior academics (one clinician and one expert in qualitative methodology). A qualitative software package (NVivo 8™, QSR International (UK) Limited, Southport, UK) was also used to assist with the management, organization, and retrieval of data. Transcripts were offered to all participants to read and validate afterwards, but no participant took advantage of this offer; most indicated they were “just happy to have helped” and requested no further involvement in the study.

Within the interviews, themes and categories were allowed to develop naturally and participants were encouraged to raise and talk about issues that were important to them. As new themes emerged throughout the data collection period, the focus of interviews changed to reflect respondent identified themes. In semi-structured interviews, the interviewer can deviate from the schedule to for an in-depth probe of comments made, which may lead the discussion into new areas. The interview schedule was thus continuously revised, informed by participants’ accounts about what they perceived as important. Hence, the focus of the interviews evolved over time as data from one interview was purposely followed up or sensitized in subsequent interviews.

As is typical in reflexive interviews, the schedule became less important and more of a guide or aide memoire as further interviews were completed and the researcher became more competent in her interviewing skills. One of the main advantages of the semi-structured interview in this study was that the data gathered were rich in quality, and this is particularly useful when exploring people’s attitudes and experiences about sensitive issues [38].

Findings

The voices of the women are reproduced verbatim here in the data extracts to illustrate the identified
themes. This study explores participants’ perceptions of stigma in relation to disclosure of abortion. The central themes are presented as narrative quotes. No claims to statistical representation have been made as quantification would be misleading in a small qualitative, exploratory study. The study reported here does not seek to generalize from the findings reported.

"Bottom Drawer Stuff" and the Imperative to Conceal

All the women in the study acknowledged abortion as socially unacceptable. Because of this, women like Jaya and Trish, who had undergone abortions within the last 6 months, described knowledge about their abortions as potentially personally discrediting:

Lots of people don't want to talk about it and are ashamed about it, I mean, it is a very private thing. I couldn’t tell the other person, and it was difficult to tell my friends, because of the culture. (Jaya)

I think people think you are Satan if you've had an abortion. I just think people should wake up to it and not ignore it all the time and think that you're Satan, because you've had it done. (Trish)

Secrecy

The unacceptability of abortion was linked in respondent accounts with the imperative of keeping the abortion “secret,” and blamed by participants like Morag for causing women to “suffer in silence”:

What I've learnt one of the biggest things women have is the burden of keeping the secret and the not sharing it with other people. I think you're worried about what people are going to say to you. (Morag)

Participants talked about experiencing difficulty telling others about their abortion, even those with whom they had close relationships. Younger participants appeared anxious not to “disappoint” their mothers if the pregnancy was disclosed to them and this has been found in other similar studies [39]. While some participants said they had wanted to talk about their abortion to significant others, most remained silent, and it has been found that concealment has negative implications for future intimate relationships [40].

The main reason given by participants, for reticence to disclose (irrespective of when the abortion was carried out), was their perception that abortion was not widely accepted by society and the information might provoke disapproval from others. In other words, knowledge about the abortion was perceived by participants as discrediting information about themselves. It was the understanding of most participants that abortion was generally socially unacceptable and that many had strong feelings surrounding the subject:

I think we live in a climate where you're never really sure if that person thinks of abortion as murder or not. (Celia)

Furthermore, this understanding reinforced respondent reticence to disclose information about the abortion. Many participants anticipated that they would be severely judged for having an abortion and negatively labeled accordingly by others, and to some extent they experienced self-blame and self-stigmatization as a result of abortion. Indeed, non-disclosure was as important for women who had undergone the procedure recently, as it was for women like Val whose abortion was carried out two decades ago:

We were talking about top, middle and bottom drawer stuff and it was like well, what's your top drawer stuff that you tell everyone? And what's your middle drawer stuff that you might only tell your close and personal friends? But what's your bottom drawer stuff? And my bottom drawer stuff is that I've had a termination. That was the one thing that I did not want people to find out about me, the one thing that I would have been ashamed of. . . A woman will say “oh, I've had a termination” as if that defines her and labels her as some baby killing monster. (Val)

Information about recent and past abortions was deemed equally sensitive. Women like Trudi described the anxiety of not knowing how others, including family and friends, might respond to disclosure about abortions because she claimed “You never know how people are going to react.” (Trudi).

One woman felt unable to tell her husband about an abortion, performed 20 years previously, which had been carried out before she had met him:

It's not something I am able to talk to my husband about, I mean, I've been close, so close to telling him, so close. (Jenny)

Keeping knowledge of an abortion secret was a source of unease for most women in the study, serving to exacerbate feelings of loneliness and isolation. Ruth, who had under gone her second abortion within the past year, described how she felt that no one (including her boyfriend) was prepared to listen to her talking about the experience:

It would be nice to talk about it to somebody who actually wants to listen because I can’t talk about it to my boyfriend; nobody really wants to know.
Women like Val talked about the burden of silence, which denies legitimacy to expression of a range of often conflicting emotions surrounding the abortion:

This is a loss. It feels like you’ve never been able to grieve for this child. You know there’s grief mixed with relief, but because of the secrecy and silence... women just carry this for the rest of their lives. (Val)

The research interview was perceived by Jenny and others, as a unique opportunity to disclose in a non-judgmental context:

It’s quite nice to talk about it now and not to be judged or you know, “oh God did you do that?” kind of attitude. Do you know what I mean? (Jenny)

Given women’s reticence to disclose information, and the unwillingness of others to listen, it is perhaps unsurprising that many women, like Morag, welcomed the opportunity to disclose to a “friendly” stranger, in what was perceived as a safe context:

I don’t believe anybody who says, and I do say it, “I’m fine,” we’re not fine, obviously, I think you could possibly be fine, if somebody was prepared to do what you’re doing, to listen and to let everything that’s in here come out, rather than just keeping it all in there. (Morag)

Overall, attitudes toward disclosure over time were also surprisingly resilient. Hence, women indicated that irrespective of whether the abortion was two years or two decades ago, it was, for example, still “never really talked about” (Jenny) or “we still don’t talk about it 22 years later” (Morag). While in some cases, time did not erode women’s determination to conceal their abortion from others, for some participants this was not the case. One respondent, for example, reported that the passage of time had enabled her to speak about her abortion:

But you see now in adulthood, I don’t care now, I don’t care. (Morag)

To reiterate, some participants claimed that it would be advantageous for those contemplating or indeed having an abortion, if more women were open about their experiences. Several participants talked about themselves as being in “a minority” or as feeling “isolated,” and in the words of one respondent feeling at the time like “the only person in the world who had an abortion” (Val). That many women in the study perceived themselves as unable to talk about the abortion arguably had negative implications for their mental and psychological well being, and (in some cases) emotional recovery from the event. While some attributed their silence solely to disapproval of others (thus externalizing the reason for non disclosure), in other cases non disclosure appeared in part a function of negative self-assessment of themselves “at fault” and “to blame.”

The study findings also suggest that support from others, which is necessarily dependent upon disclosure, may have been beneficial and indeed welcomed at the time of, and following, the abortion [41,42]. This finding is also supported by previous research, which suggests that social support might be “especially critical” ([43]: p. 383) following elective abortion.

Certainly, participants talked about the beneficial effects of disclosure. Outlets for women to disclose in safety are increasing in number, but are mostly internet/remote based (see for example, http://www.4exhale.org/ and http://www.womenonweb.org [44,45]). These internet sites provide the advantage of anonymity but lack the “warmth” that is often provided with face-to-face contact; however, in the absence of abundant alternatives, women can at least join a virtual community of other women who have experienced abortion and feel disempowered to share through disclosure.

The respondent cited below described her disclosure in the research environment as an opportunity to revisit and reflect on the issues which the episode had raised for her at the time, but which at the time she had not felt able to engage with:

It was an opportunity to engage with those feelings of loss, shame, of grief mixed with relief. (Val)

Perceived Stigmatization in Abortion Services

Dissatisfaction with some abortion services expressed by women in the study was directed more to the psychological and emotional aspects of their experiences than to technical/clinical aspects of the procedure. For the most part, women’s dissatisfaction centered on health professional attitudes and demeanors, which were perceived by some participants in the study as judgmental. Women like Trudi, for example, whose most recent (of two) abortions had been performed within the previous 6 months, felt themselves to have been judged negatively by health professionals because of their decision to have a termination:

I just think that people shouldn’t be like that judgmental towards you. They don’t know your situation, and they shouldn’t pass judgement on you.
Defending personal sexual morals and reputation appeared as much a concern for women (like Kate) who had an abortion recently as it was for women like Morag, who had undergone the procedure two decades previously:

Because you were treated like, you stupid little immature, like as if you were a bit of a tart to be honest, and I was very much in love with my boyfriend at the time, infatuated in fact, but that's how you were made to feel, that's how I felt. (Morag)

**Stigmatization Through Self-Blame**

A minority of women, including Kate (whose abortion had been carried out within the previous month) said that their expectations of being treated judgmentally by health professionals had not been realized. In retrospect, Kate acknowledged how her own perception of guilt had colored her anticipation of the treatment she would receive:

They weren't judgemental at all… I thought they would be a bit cool towards you to be honest, but perhaps that was my guilty feelings. I think it was just you as the individual. You felt like you had made a mistake and you had to explain yourself in some sort of way, which you know you weren’t a tart basically, and you know it happened as a mistake. (Kate)

The data suggested how some participants had, following the abortion, developed negative self perceptions. Participants like Michaela, for example, claimed that they had “let themselves down,” and others, like Jenny, talked about the abortion changing the way they viewed themselves:

I couldn’t believe that I’d got myself into that situation, it changed the way I saw myself. (Jenny)

Linked to negative self assessment was the perception that the participants had brought this situation upon themselves and were therefore culpable of, to blame for, or guilty of, a “misdemeanour.” Hence, participants like Jenny said “half of me did think well it’s your own fault” (Jenny) and others such as Ruth said “I feel quite bad about it. To a certain extent it was my fault and I understood that.” Indeed, as one respondent, Vanessa, noted, women undergoing abortion were their own harshest “judges.” Moreover, self blame and self stigmatization often went hand in hand with a perception that poor care was an acceptable form of “retribution”:

You just accept in your own mind that this is not a very nice thing that you are doing. So therefore you think I’ve got to be punished for that. And this is how I’m punished. (Sally)

It is important to note, however, that not all participants were equally willing to take on the mantle of societal disapproval. Indeed, some participants acknowledged the abortion as a “mistake” or “error,” and were determined to move on from the experience. Likewise, other participants rejected the negative label conferred as a result of the abortion:

I don’t believe that I should spend the rest of my life in penance for the one mistake that I have made. (Val)

**Discussion**

This paper, which is based on a small qualitative study, drew on a self-selected sample, and it is acknowledged that those women who did not volunteer to take part in the research may have had different perceptions of abortion to those who opted in to the study.

It might be expected that because the study drew on the experiences of women across a wide time frame (respondent abortions had been carried out between 2 weeks and 37 years prior to interview), the social context of their abortion experience would differ. To the contrary, in this study, women’s perceptions about the social unacceptability of abortion were remarkably similar irrespective of when the procedure was performed and despite health care changing from a paternalistic model to a patient centered model. Rather, women’s perceptions were thought to be related to meanings that individuals themselves ascribed to the event, and these meanings were informed by a range of factors at both the macro and micro level.

At the micro level, a range of factors appeared to inform women’s experiences. These included: the reasons for abortion, anticipated (and real) responses from others (including significant others), abortion service provision, and attitudes/behaviors (anticipated and real) of health care staff. Many of these micro factors, however, may be best understood in the wider social context and perceived social climate of abortion. At the macro level, women’s experiences were informed by perceived social attitudes toward abortion. The study findings suggest that women’s perceptions of abortion, and abortion services, must be understood in the context of wider societal attitudes toward abortion. What this study surprisingly identified was that social attitudes to abortion were perceived by study participants as condemnatory, irrespective of whether their abortion was carried out within the previous month or three decades ago.
Women’s understanding about the social unacceptability of abortion, had implications for how they perceived others might see them and how they saw themselves. Abortion was acknowledged by participants as personally discrediting. Study participants feared that knowledge of their abortion would meet with the disapproval of those with whom they had significant relationships, wider society generally and those upon whom they depended for abortion care services.

An important manifestation of women’s perceived unacceptability of abortion was their reticence to disclose information about their abortion, for fear of others’ responses [46]. Few women admit to having had an abortion, because the experience is considered “too personal and too taboo” ([47]:719). Certainly, it has been argued that women who perceive abortion as a private issue are often highly selective in whom they confide because of fears of negative comments from others [48]. Likewise, research has suggested that women conceal their abortion from others because of shame or fear of adverse reactions from family and friends [49]. Moreover, it has been argued that the stigma associated with abortion discourages women not only from disclosing their experiences but also from asserting/advocating their rights to abortion [50].

The consequences of non disclosure are twofold. First, it may have negative consequences for the woman herself. For example, Mufel et al. [50] have argued that inability to disclose abortion may prohibit emotional expression, with negative consequences for mental health. Here, it has been argued that social disapprobation surrounding abortion may contribute to the internalization of negative self perceptions, in some cases. Irrespective of the length of time that had elapsed since their abortion, for the most part, study participants maintained secrecy as an imperative. The burden of non-disclosure was described as considerable by most study participants, who saw themselves as denied the opportunity to talk about their experiences or “grieve for their loss.”

A second manifestation of the social unacceptability of abortion was apparent from women’s evaluation of abortion services and health professionals. In terms of abortion care, women expressed no dissatisfaction with technical/clinical aspects of the procedure. However, irrespective of when the abortion was performed, many were dissatisfied that their psychological/emotional sensitivities were poorly addressed and understood.

A third manifestation of their perceived social climate toward abortion was apparent in the way in which some study participants appeared to blame themselves for having an unplanned pregnancy that ended in abortion. Negative self-images, in relation to the abortion, led some study participants to talk about shame, blame, punishment, and stigma. This had implications for study participants’ unwillingness to disclose to others or challenge abortion care services.

What Is Already Known about the Subject
Despite the high prevalence of abortion in the UK, its social acceptance is contested both within wider society and within the literature. Perceived social unacceptability of abortion results in women’s reticence to disclose personal information about an abortion because of fear of disapproval from others.

What This Study Adds to Knowledge
Non-disclosure of abortion to others is related to women’s perceptions of abortion as a deeply discreditable and personally stigmatizing event. Stigma was perceived by the women in the form of internalized self-blame, which manifested itself as secrecy, shame, and low self-esteem as well as external stigma that was experienced and perceived as exclusion, isolation, prejudice, and discrimination from others.

Recommendations for Practice
Abortion care that focuses on clinical/technical aspects of the procedure, at the expense of women’s emotional/psychological sensitivities, may be perceived as uncaring and judgmental by women who undergo the procedure. This contributes to the perception of abortion as an isolating experience for women. Women may benefit from greater opportunities to talk about their abortion experiences with others in a safe, understanding, and non-judgmental environment.

Future Research
Future research on abortion might usefully take a more longitudinal approach. While relatively unusual, qualitative longitudinal studies could offer the opportunity to explore abortion issues in depth and across a longer period of time. This is suggested here because previously used static models that have tended to guide understanding of women’s experiences are inappropriate because
women’s lives continually grow and change. However, a caveat to this would be that women may be reluctant to revisit their abortion experience over time. Indeed, as shown in this study, all participants declined the offer to read the research when it was available. This suggests women may be more comfortable taking part in research that reflects a moment in their history and that the data is captured in a brief snapshot of time.

Acknowledgement

Dr. Astbury-Ward won a scholarship from Research Capacity Building Collaboration/Health Foundation Wales toward her PhD research.

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Conflict of Interest: None.

Statement of Authorship

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(a) Drafting the Manuscript
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Edna Astbury-Ward

Category 3

(a) Final Approval of the Completed Manuscript
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References

I want to ask you about the care that you received before, during and after your abortion.

Can I begin by asking you some questions about yourself? How old are you? What part of the country do you live in? Who do you currently live with? Do you have any children? What ages are your children?

I would now like to ask you some questions about your experience of abortion.

How old were you at the time of your abortion? (1st or subsequent) How long ago did you have the abortion? Was that your only abortion? How many weeks pregnant were you when you found out you were pregnant? Did you have your abortion because of fetal abnormality? Where were you living at the time of your abortion? Who were you living with at the time of your abortion? Where did you have your abortion? Was it an NHS abortion or private?

MAKING THE DECISION

Can you tell me how you felt when you discovered you were pregnant? How long did it take you to come to a decision? How did it feel at the time to make those decisions? What helped you to make the decision?

CARE PRE ABORTION

Can you tell me what it was like accessing abortion services? Who did you see first about getting an abortion? How many weeks pregnant were you when you found out you were pregnant? How far did you have to travel to access abortion services? What were they like towards you? Was there anything that made it difficult for you? Was there anything that made it easy for you?

Can you tell me about your impressions of the different staff members who you met before, your abortion? Can you tell me about your impressions of the different staff members who you met during your abortion? Was there anything particularly good or poor about the service you received before the abortion? Was there anything particularly good or poor about the service you received during the abortion?

THE PROCEDURE

How many weeks pregnant were you when you had the abortion? Did you have a medical (pills) or surgical (operation) abortion? Why did you feel that this procedure was the correct one for you? How did you find the procedure, what did you feel about it? Do you think anything could have been done differently for you?

How long did you stay in hospital? What was the type of department you stayed in (general gynae ward or special unit)?

Was anyone allowed to stay with you? (If yes-was this helpful or not. If no would you have liked someone to accompany you)

Who did you choose to accompany you? Can you tell me about your impressions of the different staff members who you met during your abortion? What, if any, were the most positive experiences of the care, which you received during the abortion?

What, if any, were the most negative experiences of the care, which you received during the abortion?

Appendix I

Patient Interview Guide

A qualitative study of abortion care: perceptions of patients and staff.
PERCEPTIONS OF STAFF
Can you tell me about your impressions of the different staff members who you met from the initial request to post abortion follow up?
How did you respond to different staff members?
How did they respond to you?
CARE POST ABORTION
Tell me about the care you received after your abortion.
Can you tell me what your care was like immediately after your abortion?
Can you tell me about the care you received later on?
Did you feel that you had sufficient care following your abortion?
How did you feel about the care you received after your abortion?
What did you think about the facilities that were available?

What, if any, were the most positive experiences regarding the care you received after the abortion?
What, if any, were the most negative experiences of the care, which you received after the abortion?

GOING HOME
What were your feelings around going home?
What did you think about the discharge information given to you?
Did you feel you had sufficient post abortion follow-up and support?
How did you feel physically?
How did you feel emotionally?
Is there anything else you would like to tell me about your abortion care that I have not asked you, that you feel is important?