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A good abortion experience: A qualitative exploration of women's needs and preferences in clinical care

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ABSTRACT

What do women ending their pregnancies want and need to have a good clinical abortion experience? Since birth experiences are better studied, birth stories are more readily shared and many women who have had an abortion have also given birth, we sought to compare women's needs and preferences in abortion to those in birth. We conducted semi-structured intensive interviews with women who had both experiences in the United States and analyzed their intrapartum and abortion care narratives using grounded theory, identifying needs and preferences in abortion that were distinct from birth. Based on interviews with twenty women, three themes emerged: to be affirmed as moral decision-makers, to be able to determine their degree of awareness during the abortion, and to have care provided in a discreet manner to avoid being judged by others for having an abortion. These findings suggest that some women have distinctive emotional needs and preferences during abortion care, likely due to different circumstances and sociopolitical context of abortion. Tailoring services and responding to individual needs may contribute to a good abortion experience.

1. Introduction

Many women experience both abortion and birth over the course of their reproductive lives. In the United States, an estimated 30% of women have an induced abortion by age 45 (Jones and Kavanaugh, 2011) and of those women who have had an abortion, 59% have previously given birth (Jerman et al., 2016). Abortion represents a transition for pregnant women, moving from the possibility of bearing that child to proceeding with one's life as is. As with birth, how abortion happens matters to women, their families and communities (Lie et al., 2008; Lyerly, 2013; Simkin, 1991). However, unlike with birth, researchers and policy makers have given less attention to what constitutes a good abortion experience. This reality may be due to a greater focus on defending access to abortion by creating a body of evidence demonstrating that it does not harm women physically or mentally and improving its technical aspects. Fortunately, undergoing an abortion in the U.S. is extremely safe (Biggs et al., 2017; Jatlaoui et al., 2016) and the process is effective (Ireland et al., 2015), permitting a shift in focus to improving other aspects of care quality, namely patient-centeredness, which encompasses care guided by a patient's values (Institute of Medicine, 2001). Prior studies suggest that most women tend to be satisfied with their care (Taylor et al., 2013; Tilles et al., 2016) but some women have challenging experiences (Kimport et al., 2012; Weitz and Cockrill, 2010), implying that there is room for improvement. Accordingly, we must learn from women who have sought abortion services about their experiences and how they would like their care to be.

A qualitative investigation of women's needs and preferences to improve care has been performed for maternity services and it offers a preliminary framework for studying abortion due to their commonalities—both birth and abortion affect pregnant women and are two among other reproductive health services that women's health clinicians provide. Bioethicist and obstetrician Anne Lyerly examined what constitutes a good birth experience by learning from childbearing women about what they valued, amounting to one of the most comprehensive efforts to date on this subject (Lyerly, 2013). She found that the five core domains for a

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good birth entail being the principal decider and actively witnessing the birth process (agency); trusting the health provider and feeling safe from physical harm in the face of risk, being free from unwanted intrusions and feeling at ease (personal security); having the birth experience respected as a significant event, being treated with dignity and possessing self-respect (respect); maintaining clear communication and access to information throughout the birthing process (knowledge); and feeling emotionally connected to the baby, loved ones, health professionals and other women (connectedness) (Lyerly, 2013).

Lyerly found that these domains for a good birth generally correspond to dimensions needed for individual wellbeing theorized by Powers et al. in their framework for social justice in health policy (Powers and Faden, 2006), implying that they are potentially broad enough to apply to other areas of healthcare. Moreover, previous studies on abortion suggest that there are parallels between women's needs in maternity and abortion care. With respect to Lyerly's domain "agency," researchers have found that women value being able to decide to have an abortion to plan their lives (Andrews and Boyle, 2003; Fielding et al., 2002) and to determine how the abortion happens (Elul et al., 2000; Fielding et al., 2002; Kerns et al., 2012; Simonds et al., 1998). Elements of "personal security" emerged in women's narratives in Kimport et al., in which women described a need to feel physically safe while obtaining care in abortion clinics that operated in hostile anti-abortion environments (Kimport et al., 2012). Findings from Castle et al. underscored the importance that women ascribe to having information to prepare for an abortion (Castle et al., 1995), consistent with the domain "knowledge." "Connectedness" and "respect" were also important to women, demonstrated as an appreciation for compassionate behavior from providers (Kimport et al., 2012; McLemore et al., 2014; Taylor et al., 2013) and having a sense of dignity upheld during abortion care (McLemore et al., 2014; Weitz and Cockrill, 2010).

Despite these commonalities in childbirth and abortion, there are also notable differences, such as women's circumstances at the time of pregnancy and the sociopolitical context within which these reproductive experiences occur. Birth tends to be viewed as joyous and physiological (Gaskin, 2011; Lyerly, 2013) and intrapartum services are well-integrated into healthcare: they are linked to antepartum and postpartum services, have private and public insurance coverage, and are accessible to most women (Kaiser Family Foundation, 2013; Rayburn et al., 2012). By contrast, abortion is politicized and stigmatized (Joffe, 2013; Norris et al., 2011). Services tend to be provided separately from other medical care in limited supply at specialized abortion facilities, requiring a majority of women to travel far and to pay out of pocket for care (Jerman et al., 2016; Jones and Jerman, 2014). Given these different contexts for birth and abortion, we sought to examine ways in which women's needs and preferences in abortion care differ from intrapartum care.

2. Methods

The study was conducted in Northern California through semi-structured intensive interviews from April to December 2014 with women who had individually experienced both birth and abortion. Participants were recruited through advertisements on Craigslist, at community colleges and at public libraries that targeted women residing in a geographical area with multiple birth and abortion facilities to choose from. We recruited women from the community rather than specific medical facilities to solicit variation in women's clinical experiences and to identify underlying patterns that were not influenced by a particular medical setting. We predicted this recruitment strategy would underrepresent women who had abortions for fetal or maternal indications given they account for less than 5% of all abortions (Jatlaoui et al., 2016). We did not view it as a limitation as those experiences have been studied (Lafarge et al., 2014). Inclusion criteria were age 18–49 years, had an abortion in the last 5 years and a prior birth at any time point in the United States, and not pregnant at the time of interview. These timeframes were selected because it has been demonstrated that women remember their births accurately and vividly as many as 10–20 years later (Simkin, 1992) but this information is unknown for abortion. All women gave informed consent prior to participating and received a $40 gift card as compensation for their time.

An obstetrician/gynecologist-researcher (AA) who had prior interview experience and did not know the participants personally or professionally conducted interviews in English over the phone and in-person in a nonmedical setting. Phone interviews allowed us to expand recruitment and to accommodate women who had childcare or transportation difficulties. AA did not identify herself as a physician unless asked as she noticed that participants shared less comfortably when they viewed her as more authoritative on the topic (Weiss, 1994). Participants were invited to describe their pregnancies by answering open-ended questions regarding the highs and lows of all their intrapartum and abortion experiences; decision to parent or not; selection of the provider and facility; interactions with the healthcare staff, support people and other patients; pain management, spiritual or religious support; and postabortion/postpartum care. Women who also wanted to discuss their miscarriages did so. We anticipated that many women would have had more than one abortion as per national statistics (Jones et al., 2017) and sought to contextualize their most recent abortion by inquiring about all of their past experiences. After sharing their stories, participants were asked to compare their preferences in birth and abortion and how they preferred care to have been. Following the interview, participants completed demographic questions and a validated Individual Level Abortion Stigma scale (ILAS) assessment (Cockrill et al., 2013) (Supplementary material). ILAS evaluates the degree of personal stigma from the most recent abortion through a series of statements about one's worries about judgment, feeling of isolation, self-judgment and sense of community condemnation. These four areas (sub-scales) are scored according to the degree of stigma. As the study took place in an area with relatively unhindered abortion access and more liberal abortion views, this scale permitted us to determine whether this context equated with less individual abortion stigma. To this end, we compared our participants' scores to the scores of a U.S.-based, regionally diverse abortion clinic population of women surveyed for the development of ILAS.

The content and style of the interview instrument were informed by consultations with experts in the field, Lyerly's work, aforementioned abortion-related studies, a narrative review of qualitative studies on abortion care (Lie et al., 2008) and a guide to abortion counseling (Perrucci, 2012). A full-spectrum doula from a different state who is not a medical professional (AOG) provided a client-advocate standpoint in the development of the instrument to complement AA's medical perspective. Full-spectrum doulas are individuals trained in providing emotional, physical and informational support during birth, miscarriage and abortion.

We used an iterative and flexible process for data collection to build a grounded theory (Charmaz, 2006). In parallel to conducting interviews, AA performed field observations of abortion and birth facilities unfamiliar to her to achieve a better understanding of care models and processes the participants described. She also spoke with doulas who provide abortion support in the geographical area studied and who have had an abortion themselves to explore potentially more sensitive questions and concepts in preparation

for interviews with participants. Each interview influenced the direction and depth of inquiry of subsequent interviews. Interviews were conducted until no new iterations of theoretical concepts emerged.

All interviews were audio-recorded, professionally transcribed verbatim, checked for transcription accuracy and de-identified prior to analysis. We utilized Dedoose® 6.2.10 software to code and facilitate analysis of qualitative data, and STATA®14.0 to perform descriptive statistics. Early in the interview process, we developed a codebook using a priori codes influenced by Lyerly's birth framework (Lyerly, 2013; Namey and Lyerly, 2010), codes that emerged from AA's analytic memos and independent initial coding by AA and AOG of five thematically different interviews. Once a preliminary codebook was agreed upon, AA coded the remainder of the transcripts. She continued to refine the codebook with AOG as new concepts and analyses emerged and consulted with LF to develop a theoretical perspective on the data.

In our initial analysis, we categorized all codes into Lyerly's five domains for a good birth and then, using grounded theory, we modified and expanded these domains according to our birth and abortion data (details not discussed here) (Kelle, 2013). We performed comparisons at the individual level (what each participant valued in her abortion and birth experiences) and how these values applied to the entire group of participants. We discovered phenomena in the abortion narratives that either did not emerge from the birth narratives or provided a distinct perspective for abortion care. These phenomena are this work's focus. Given its exploratory nature aimed to broaden our understanding of a good abortion experience, we sought to capture variations rather than commonalities, and this intention is reflected in the selection of quotations. This project was approved by Stanford School of Medicine Institutional Review Board (IRB-29296) and is reported according to Standards for Reporting Qualitative Research (O'Brien et al., 2014).

3. Results

Twenty-four women participated. Four of them did not meet all the eligibility criteria and were excluded from this analysis: one participant had an abortion nine years ago and three participants reported having an induced abortion, though per their narratives, they were miscarriages. The remaining twenty women contributed the experiences of 34 induced abortions, 31 births and 6 miscarriages.

Twelve of the twenty interviews were conducted by telephone and the richness of these interviews was similar to in-person interviews. Average interview duration was 70 min. A majority of the participants were black or Latina, in a romantic relationship and spiritual or with a religious affiliation (Table 1). Thirteen participants were first pregnant by age eighteen and six of these women ended that pregnancy. A majority of abortions occurred in the first trimester and were performed at a specialized abortion facility via a surgical procedure for non-medical indications. All births occurred at a hospital and 68% were vaginal deliveries.

According to the Individual Level Abortion Stigma scale, the degree of personal stigma of the participants was similar (slightly higher) in each sub-scale and the full scale compared to the larger national sample of women who were surveyed for development of this instrument (Table 2) (Cockrill et al., 2013). A higher number reflects higher stigma.

In general, participants described their experiences as good during birth and abortion care when they did not have to compromise their emotional wellbeing in the process. Needs and preferences in abortion differed from birth in three ways: women appreciated being affirmed as moral decision-makers by providers, having a choice about their degree of presence during an abortion, and receiving care in a discreet manner to avoid judgment from others for obtaining an abortion. Three pregnancies were ended for maternal or fetal indications and the aforementioned aspects of care also emerged in those women's narratives.

Table 1
Participants' characteristics, N = 20.

Age at interview; median, range	32 years (19–42)
Black	7/20 (35%)
Latina	7/20 (35%)
White	4/20 (20%)
Enrolled or completed ≥ Assoc. deg. or vocational school	15/19[a] (79%)
Religious or spiritual	11/19[a] (58%)
Family income $25,000/year or less	8/19[a] (42%)
Married or in a relationship	14/20 (70%)
Age at first pregnancy; median, range	18 years (14–38)
Had given birth before having abortion	11/20 (55%)
Years since last abortion; median, range	3.5 (0–5)
Total number of abortions	34
Abortion care at a specialized abortion facility	26/34 (76%)
Abortion in first trimester	30/34 (88%)
Medication abortion	6/34 (18%)
Abortion for fetal or woman's health reasons	3/34 (9%)
Total number of births	31
Total number of adoptions	1

[a] Among those who answered question.

Table 2
Individual Level Abortion Stigma scale comparison.

Scale	This study N=16-19[a] Mean (SD)	Cockrill et al., 2013 N=629-643[a] Mean (SD)
Full scale (range 0-3.5)	**1.6** (0.67) n=16	**1.35** (0.63)
Worries about judgment (range 0-3)	1.19 (1.00) n=19	0.86 (0.86)
Isolation (range 0-3.5)	1.32 (0.65) n=18	1.21 (0.81)
Self-judgment (range 0-4)	2.26 (0.97) n=18	2.0 (1.03)
Community condemnation (range 0-4)	1.95 (1.15) n=19	1.85 (1.07)

[a] Those who answered the relevant questions.

3.1. Moral decision-maker

For each pregnancy experience, participants were asked to reflect on making the decision to become a parent, to have an abortion or to pursue adoption. Irrespective of what they decided, women felt that the decision they made was the right one given their circumstances even if, in retrospect, they wished they had chosen differently. For some women, the decision carried some degree of emotional discomfort, such as sadness, disappointment or anxiety about the future, especially in circumstances when a pregnancy occurred at an inopportune time (e.g., unstable relationship or insufficient financial or other resources).

Unique to abortion decision-making, however, were instances of moral conflict. While some participants felt that their reasons for having an abortion were valid and sufficient, they struggled with the belief that having an abortion was at odds with being a good person. This belief stemmed from the notion that a woman's intrinsic biological responsibility is to become a mother and anti-abortion views that predominated in their communities of upbringing. Moral conflict undermined some participants' decision-making capacity and surfaced during clinical care, coloring their abortion experiences.

For instance, Gaby (39 years old; 2 abortions, 3 births) described ending a multifetal pregnancy, revealing she was certain about her

decision but morally conflicted (all names are pseudonyms). She explained that parenting was not an option because she lacked a stable job and housing and suffered from depression. Gaby had contemplated adoption and had pursued it in a different pregnancy but decided against it this time. She feared that the children would have been separated and regarded this possibility as devastating. Gaby talked about the seriousness with which she weighed her alternatives and the significance of what she was undertaking:

> I had to make a real life-changing decision. I mean, it's not easy … I don't think we just get up to just say, okay, today, you know what, I'm going to … kill a baby. You don't think like that. You look at all the things …. and I just didn't want to bring the kids in like that.

Even though having an abortion challenged her idea of herself as a moral decision-maker, she cited moral values in her reasoning. As she contrasted continuing the pregnancy with abortion, she realized that to "kill a baby" was a less harmful, less morally problematic situation than continuing the pregnancy and risking the separation of her children. Yet, during her abortion care, Gaby lacked someone who could witness and validate these moral values that guided her decision:

> I felt like the doctor was judging the person, my character … he didn't treat me like a person, an individual. He treated me like, 'Get on up on the table. Let's get this over with because you ain't nothing.' You know, 'Look at you … you're paying $500 to get rid of something you made.' That's the way I felt …. At least [he could have] assured me that he know[sic] that what I'm going through is not easy. I think that's what I was looking for.

Although the doctor did not actually tell her she was "nothing," she felt that his behavior was judgmental and dehumanizing. He did not recognize her as a person grappling with a real-life moral decision. Instead, she perceived him as thinking of her abortion as an impersonal business transaction. Gaby had hoped that the doctor would appreciate the difficulty of the decision for her and see her as a person confronted with a moral quandary.

Like Gaby, Katherine (31 years old; 2 abortions, 1 birth) felt morally conflicted about having an abortion and wished the medical personnel had identified this conflict and supported her. Katherine was 15 years old at the time and feared getting kicked out of the house if her mother found out about her pregnancy. When Katherine walked up to the abortion clinic, a woman emerged from a group of protesters holding signs plastered with images of macerated fetuses. She raised a cross to Katherine's head and declared, "May God forgive you for murdering your child." This interaction affected Katherine: she had not thought of the six-week pregnancy as her child but at this moment began to wonder if this woman was right, whether she was committing murder. While she still planned to end her pregnancy, she entered the clinic feeling overwhelmed, questioning the morality of her decision. Looking back as an adult, she wished care had been provided differently:

> [The doctor] looks at me and he looks at my chart and he's like, "How old are you?" And I was like, "15." He's like, "Wow." That was just like a horrible experience. It was already a bad enough day, and what an insensitive thing for a doctor to say to someone, a young girl who's obviously already completely like freaked out and upset …. Nobody at any time did or said anything that made me feel like [having an abortion] was okay, like other women go through this, like you're not a bad person. It was just the opposite. I felt judged … felt like everything I was doing was wrong.

To have moral clarity, Katherine needed help reconciling the aggressive anti-abortion messaging outside the clinic with what an abortion actually was. However, she did not achieve such understanding. On the contrary, the doctor's negative response to her age and the lack of compassionate care led her to conclude that she was, indeed, doing something morally wrong. She wished that her providers had normalized her decision to have an abortion and acknowledged it as moral.

In contrast, other participants who also had a moral conflict considered their interactions with medical personnel valuable if they felt that their decision was respected and viewed as moral. For example, Sofia (19 years old; 1 abortion, 1 birth) felt comforted during her abortion care. She became pregnant for the second time when she was three months postpartum. She knew she could not raise two children as she was already struggling to provide for her son. Sofia's parents pleaded with her to allow them to adopt this potential child, as she recounted: "[God] gives you children because they're a blessing and a gift. You have a gift and you're going to throw it away? Don't kill it and let me adopt it. It'll have our last name …. He or she will know that you're their mom but you won't have to take no [sic] responsibility for it." She felt distraught by this proposal because she took her obligation as a mother seriously and could not imagine not raising her own child. Sofia decided that ending the pregnancy was the right course of action for her, though she felt morally conflicted. She valued her conversation with the doctor, whose words she retold: "'You're not doing a horrible thing. I know why you're doing it …. Do not feel bad. Like this is for your life, to better your life.'" She also remembered the medical staff's conduct, "They didn't make you feel bad that you were doing it …. They were like supporting you." Sofia was grateful that her decision to end the pregnancy was validated and understood as moral by her providers.

Likewise, Natalie (37 years old; 3 abortions, 1 birth) had a helpful interaction with a medical assistant prior to the abortion. She was trying to end the relationship with her boyfriend and did not want to have another child with him. She shared, "I was crying and [the medical assistant] was just like, 'Don't, you're not doing anything wrong …. You're not a bad person.' And I had even told her … 'I have a kid and I can't believe I'm doing this.'" Her conflict stemmed for the idea that as a mother, when pregnant, she had a moral and biological obligation to continue that pregnancy as she had first-hand experience what an embryo inside her could become. Thus, she appreciated how the medical assistant saw her as a moral decision-maker in this context.

Participants took their responsibility to determine the outcome of their pregnancies seriously and tended to feel that they made the best decision for their circumstances, whether they chose abortion, parenting or adoption. They wanted to be respected as decision-makers. Yet, some women did not view their decision to have an abortion as moral based on their understanding of morality, and they were sensitive to negative judgment from medical personnel for this decision, whether perceived or actual. When medical personnel recognized this conflict and affirmed the decision as moral, women tended to assess this part of their experience positively.

3.2. Presence

In birth and abortion, women used pain medicine not only to alleviate physical pain but also to control their awareness and engagement in the process. Participants generally described birth as a joyous event, worthy of witnessing and sharing with others and wanted to maintain a sense of presence. Some needed labor support or an epidural to relieve their physical discomfort to

emotionally experience birth. In abortion, women's reasons to maintain or lessen their sense of presence were more nuanced, reflecting women's diverse emotional needs specific to abortion care. They determined how present they wanted to be with their selection of pain medicine and abortion method. The methods include removing the pregnancy via a surgical procedure (henceforth referred to as "procedure") or by taking abortifacient medications ("medication abortion").

Some women preferred to be less mentally aware during the abortive process, especially if they were struggling emotionally or morally and feared that witnessing some part of it would further affect them. In the case of a procedure, some women wanted to be asleep and sought a facility that offered anesthesia. Such facilities are not the norm as most procedures are performed while a woman is awake with local, oral or intravenous pain medicine because achieving a state of unconsciousness (with general anesthesia or monitored anesthesia care) is rarely medically necessary and is typically reserved for medically complex scenarios. For example, Isabel (35 years old; 4 abortions, 3 births) explained her rationale for being asleep during an abortion:

> I don't even think you're awake for laser eye surgery, are you? … You're awake for birth. Birth is not a medical procedure in the same way … I guess because it's giving life and, the welcoming, you need to be conscious for that. I prefer not to be awake [for an abortion]. It works too heavy on me, the afterthoughts of it all. I just couldn't imagine accidentally looking over and seeing something.

Isabel viewed abortion as more like other surgeries than a reproductive process akin to birth. She believed that being conscious during an abortion had only negative possibilities, such as seeing some aspect of the procedure that could trigger additional emotional pain.

Some women were willing to accept additional risks of anesthesia to make the process less mentally trying. For instance, Katherine (31 years old; 2 abortions, 1 birth; previously quoted describing her abortion at age 15, now describing a recent abortion) was awake during her procedure and reasoned why she would have preferred to have been asleep:

> A lot of people go under general anesthesia every day …. I would've accepted the risk to be able to just go to sleep and wake up and it's done …. Because it's an awful experience … it's painful. And you do kind of go into that experience feeling like guilt and shame about what you're doing. You just kind of like fall asleep and wake up, and it's over.

Katherine explained that feelings of guilt came from her upbringing, viewing abortion as morally wrong. She deemed the opportunity to be asleep as a temporary relief from these emotions.

Some women who witnessed the abortive moment unintentionally (as Isabel had feared) remembered it negatively, particularly if they wanted to have a child but their life circumstances made it not possible. This witnessing sometimes occurred during medication abortions when women saw the pregnancy tissue. A medication abortion is commonly completed in a private setting, such as one's home, and entails the woman inducing expulsion of the pregnancy with medications. Depending on the room's setup, sometimes it is also possible to see the pregnancy being removed during a procedure, as Carla (28 years old; 1 birth, 2 abortions) recalled, "You could see everything …. I even see [sic] my own baby … and I still call it my baby, they put my baby in a jar, that they had just slurped out of me … it was gruesome for me to see." At eight weeks of gestation, it is unlikely that the fetal form was perceptible, but she witnessed the precise moment when her pregnancy ended. The procedural approach appeared disturbingly ordinary (slurping, jar) and felt disrespectful to the embryo/her baby, which was "gruesome" for her as its mother. Consequently, when she had another abortion a few years later, she went to a facility that allowed her to be asleep and she described it as a better experience because she felt less emotional pain.

In contrast, some women wanted to be engaged in the abortion process and preferred having a medication abortion or being awake during the procedure as Laila (34 years old; 2 abortions, 3 births) described:

> I couldn't see anything but the nurse … I could hear the doctor … they slowly tell you what's going on and how much time is left and they talk you through it the whole time …. I felt good 'cause … it made me feel more in control and at ease, knowing they're being very patient and considerate and caring and they're talking you through it so you don't feel lost and alone.

Laila, like Carla, felt a strong sense of loss from ending her pregnancy and feared seeing the abortion happen. However, Laila assessed her experience positively because the procedure was done in a way that prevented her from seeing the pregnancy removal while allowing her to be awake and to hear the medical team guide her through the process, making her feel cared for.

Other women preferred to be alert for the procedure to ensure it was performed safely and respectfully. Facilities that were difficult to find, were surrounded by anti-abortion protesters or looked neglected in their appearance, contributed to women's concerns about their safety before their clinical experience began. These fears continued if the medical personnel did not provide assurance of safety as Raquel (29 years old, 3 abortions, 1 birth) remembered:

> It kind of creeped me out, the place, 'cause I've never heard of this clinic in the city …. My mom and my boyfriend came with me but when I went into the back room I was by myself with the doctor and his assistant … the place looked really old … I just felt kind of weird in that place. And then when they started the procedure [the doctor] asked me did I want … what puts you asleep or something, and I didn't feel comfortable there so I said no.

Being by herself during the procedure in that setting made her feel vulnerable and she declined sedation to see that nothing dangerous was done to her. In subsequent pregnancies Raquel ended, she had medication abortions to have full control over her physical environment. In contrast, other participants who were disturbed by their surroundings could let go of their fears when medical personnel reassured them that care would be provided in a professional manner.

Lastly, some participants preferred to be present for the abortion to fully experience it and satisfy their curiosity. Participants who felt this way tended not to view the abortion as emotionally or morally challenging. For instance, Jacqueline (22 years old, 1 abortion, 1 birth) shared:

> I kind of wanted to actually see what was happening. I just wanted to be there …. It sounds weird but I wanted to actually experience it … I wanted to know what this was. I mean … if anybody else had to go through this and I was the person to talk to about it … I could tell them exactly what happens.

It was important to Jacqueline to stay awake to take the mystery out of an abortion procedure and to be able to share her experience

with others in the future.

Although in birth women generally wanted to be fully engaged, in abortion they differed in how present they wanted to be. At times, women's preferences were influenced by the way they were treated by medical personnel and by how they perceived the clinical environment. Some women preferred to be less present if they were struggling emotionally or morally or feared witnessing the abortive moment. They tended to prefer to have an abortion procedure while asleep. Others wanted to maintain a sense of presence to feel safe, to receive emotional support and to have a say in or to see what the abortion entailed. They tended to decline sedating medicine or chose a medication abortion.

3.3. Discreet care

A need for privacy emerged in the participants' birth and abortion narratives, motivated by a desire for modesty and intimacy and an effort to decrease emotional discomfort from seeing others suffer. Some participants felt that being in communal spaces with other women such as waiting rooms, recovery rooms or shared postpartum rooms forced them to be part of other's experiences, which was often physically and emotionally uncomfortable as some women were visibly upset, nauseated or in pain. This issue was raised more often in the abortion narratives due to more time spent in group settings during abortion care.

Distinctive to abortion narratives, however, some participants feared judgment from others for having an abortion, which did not occur for giving birth, and it influenced their preference for receiving care discreetly. Participants most sensitive to judgment tended to be those women who felt ashamed for being pregnant and needing an abortion. Some participants who went to medical facilities that provided abortion services exclusively reported feeling exposed because the visit's purpose could not be confidential. One participant, Elisa (38 years old; 1 abortion, 2 births) explained that she began feeling judged outside the abortion clinic by anti-abortion protesters and she continued to feel uncomfortable after she entered the clinic:

> It's an abortion clinic, so you go there and you know that that person is getting an abortion … From the time you make it there … I was pretty embarrassed by it, because I walked into the clinic and I feel like all eyes on me, and I feel like everybody knows … and who knows what they're thinking …. it's some stuff that I'm very discreet about …. So, when … those types of situations arise, I just don't like that feeling … there's no privacy at all.

She felt self-conscious for needing an abortion and susceptible to the negative judgment of others, including clinical staff and other women having abortions, which compromised her ability to feel at ease.

Moreover, living in smaller communities often posed the risk of seeing familiar people, which compounded fears of judgment. For instance, Danielle (34 years old; 1 abortion, 1 birth) recalled, "It's embarrassing. Because … I knew a lot of people in there …. And I feel irresponsible. Because that's something you want to be discreet, not [involve] everybody in the neighborhood." She felt that needing an abortion reflected poorly on her and having people from her community witness her perceived shortcomings added another layer of discomfort.

Some participants also felt that being in a group setting reinforced their sense of shame about having an abortion and felt that it could have been avoided if care was provided more discreetly. For example, Faye (24 years old; 2 abortions, 3 births) received care at a busy abortion clinic and compared the type of experience she would have preferred to her actual experience:

> You go in. [I would have preferred not to have] a big line because there was[sic] a lot of people. Like are they scheduling us all to have an abortion together? … And something done privately, not where you're ashamed … Like you literally have to be on the list to get into the building even and you have to show the security guard your ID …. When I was put in the recovery room after [the abortion], there was no privacy. Like it was rows of girls in beds …. That was my main thing, was there was no privacy.

She viewed the security measures and being grouped with other women as ways of shaming her for having an abortion. She preferred to have been by herself to avoid this additional burden.

To decrease the possibility of feeling exposed, some participants purposely went to medical facilities that provided a variety of reproductive health services. Others had a medication abortion instead of a procedure like Teresa (29 years old, 1 abortion, 2 births), who elaborated about her choice: "I don't want anyone to know about this, besides the person that gives me the pill. And I want to take the pill, go home and be alone …. I was so ashamed of everything going on, that I had even gotten pregnant." At the time of this pregnancy, Teresa's boyfriend was in jail for assaulting her. She felt ashamed of their relationship and of being pregnant and prioritized having as few people as possible know about her circumstances.

While the need for discretion to avoid judgment from others was important to some participants, it was not absolute. There were some who appreciated sharing some aspect of the experience with other women also having abortions. They described the supportive environment created when women could all be together in one room, before and after the abortion, as Marcia (34 years old; 2 abortions, 2 births) articulated:

> I felt that I had a support group …. I'd rather be in the room with other people that's[sic] going through the same thing …. I think I would've been uneasy just laying there in the room by myself and thinking about what I just done. So, with the other ladies in the room with me … helped me through that process.

For Marcia, being with others took away a sense of isolation—the perception that she was the only one ending her pregnancy. In this facility, women were not permitted to be accompanied by someone they knew and they waited in a more intimate space, facilitating these interactions.

In summary, some participants felt vulnerable to judgment from others for having an abortion and desired to receive care in a discreet manner. In birth, discreet care was also important, but not for the sake of avoiding judgment for their decision to have a child. While some participants preferred for the facility to be structured in such a way that their reason for seeking care was unknown, other participants appreciated sharing their experiences with other women also having abortions if they felt a sense of camaraderie.

4. Discussion

We consider abortion as a normal reproductive experience, like birth, that pregnant women undergo and sought to explore what women need to have a good clinical experience. Lyerly's framework for a good birth provided a useful foundation for our inquiry, demonstrating that many elements that women value in birth also emerge in abortion. These findings suggest that approaching abortion care from this inclusive perspective may be a way to

improve care quality. Yet, as previous studies have demonstrated, the stigmatized and contested context of abortion can make women's experience especially sensitive (Kimport et al., 2012; Shellenberg and Tsui, 2012), influencing how they perceive their care and how they assess their experience. We found three elements distinct to abortion care, some of which may be related to the stigma that surrounds abortion: to be affirmed as moral decision-makers, to be able to determine their degree of presence during the abortion process, and to have care provided in a discreet manner to avoid being judged by others for having an abortion.

Our analysis offers several recommendations for abortion care providers. Providers may consider approaching each woman as if she might have additional emotional needs, recognizing that some women have internalized abortion stigma (especially in settings where women are targeted by anti-abortion protesters and policies) and others feel sad about not being able to have that potential child. Providers may further tailor care as they learn more about a patient's specific needs. Women value determining the outcome of their pregnancy and being respected as decision-makers by providers. Some women explicitly describe moral considerations that bring them to abortion (such as concerns for their families and what life may be like for the potential child), and decide to have an abortion, yet struggle to see it as moral decision due to conceptions that abortion is immoral or un-biological. In these cases, women also value being affirmed as moral decision-makers by their providers.

It is also helpful for providers to recognize that preferences for pain medicine and degree of presence are related yet distinct and need to be explored separately. Conversations about what having an abortion may be like both physically and emotionally may unveil some of a woman's concerns, offering the provider insight as to how to explain the abortion methods and analgesia options and to help her make an informed decision. Additionally, managers may investigate ways that they can offer women discreet care and increase feelings of safety within their logistical and legal constraints, such as being explicit with patients about the purpose of security measures and aspects of care that may be interpreted as stigmatizing, maintaining patient privacy when possible, creating more intimate settings, and personalizing care.

The study was conducted in a geographical area known for better comprehensive reproductive healthcare access compared to other areas in the United States, creating a unique opportunity to discuss a good abortion experience, which would be more difficult where women struggle to access abortion care and may have lower expectations for quality. Interestingly, according to our ILAS data, participants had a similar level of individual abortion stigma compared to a national cohort of women obtaining abortions at specialized facilities (Cockrill et al., 2013), suggesting that our findings may be applicable in other areas of the U.S. Furthermore, better access may not necessary equate with less stigma or better access alone may not counteract abortion stigma.

While this analysis presents opportunities for improving abortion care, there are some limitations. We focused on women who had experienced both birth and abortion and who received first trimester abortion services in specialized facilities for nonmedical indications [which describes most women who have abortions in the U.S. (Jerman et al., 2016).], whose preferences may be different from women who do not match these characteristics. For instance, women who have never given birth may have different expectations for care and women who obtain abortions from their medical providers rather than providers unknown to them (such as at specialized facilities) may express their concerns about judgment differently. Lastly, this work is exploratory rather than conclusive and there may be other ways that women's needs and preferences in abortion differ from birth that are not captured here.

Despite these limitations, a strength is the racial and ethnic diversity of the participants, like the diversity of the geographic region for study recruitment. Another strength is studying abortion in a normalizing way, achieved by interviewing women from the community in a non-medical environment, viewing participants as experts of their narratives and by studying abortion and birth experiences together, creating a broader forum to talk about a good reproductive experience. Approaching abortion as a reproductive experience in this way not only may contribute to improving abortion care for individuals. In addition, it may help to elevate its status to that of other reproductive services and thereby, more broadly, benefit communities.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at http://dx.doi.org/10.1016/j.socscimed.2017.09.010.

References

Andrews, J., Boyle, J., 2003. African american adolescents' experiences with unplanned pregnancy and elective abortion. Health Care Women Int. 24, 414–433.
Biggs, A.M., Upadhyay, U.D., McCulloch, C.E., Foster Greene, D., 2017. Women's mental health and well-being 5 years after receiving or being denied an abortion. JAMA Psychiatry 74, 169–178.
Castle, M.A., Harvey, S.M., Beckman, L., Coeytaux, F., et al., 1995. Listening and learning from women about mifepristone: implications for counseling and health education. Women's Health Issues 5, 130–138.
Charmaz, K., 2006. Constructing Grounded Theory. A Practical Guide through Qualitative Analysis. SAGE Publications Ltd.
Cockrill, K., Upadhyay, U.D., Turan, J., Greene Foster, D., 2013. The stigma of having an abortion: development of a scale and Characteristics of women experiencing abortion stigma. Perspect. Sex. Reproductive Health 45, 79–88.
Elul, B., Pearlman, E., Sorhaindo, A., Simonds, W., et al., 2000. In-depth interviews with medical abortion clients: thoughts on the method and home administration of misoprostol. J. Am. Med. Women's Assoc. 55, 169–172.
Fielding, S.L., Edmunds, E., Schaff, E.A., 2002. Having an abortion using mifepristone and home misoprostol: a qualitative analysis of women's experiences. Perspect. Sex. Reproductive Health 34, 34–40.
Gaskin, I.M., 2011. Birth Matters: a Midwife's Manifesta. Seven Stories Press, New York.
Institute of Medicine, 2001. Crossing the Quality Chiasm: a New Health System for the 21st Century. National Academy Press, Washington, D.C., pp. 39–60
Ireland, L.D., Gatter, M., Chen, A., 2015. Medical compared with surgical abortion for effective pregnancy termination in the first trimester. Obstetrics Gynecol. 126, 22–28.
Jatlaoui, T., Ewing, A., Mandel, M., Simmons, K., et al., 2016. Abortion surveillance - United States, 2013. MMWR Surveill. Summ. 65, 1–44.
Jerman, J., Jones, R., Onda, T., 2016. Characteristics of U.S. Abortion Patients in 2014 and Changes since 2008. Guttmacher Institute, New York.
Joffe, C., 2013. The politicization of abortion and the evolution of abortion counseling. Am. J. Public Health 103, 57–65.
Jones, R.K., Jerman, J., 2014. Abortion incidence and service availability in the United States, 2011. Perspect. Sex. Reproductive Health 46, 3–14.
Jones, R.K., Jerman, J., Ingerick, M., August 2017. Which abortion patients have had a prior Abortion? Findings from the 2014 U.S. Abortion patient survey. J. Women's Health. http://dx.doi.org/10.1089/jwh.2017.6410 (Ahead of print).
Jones, R.K., Kavanaugh, M., 2011. Changes in abortion rates between 2000 and 2008 and lifetime incidence of abortion. Obstetrics Gynecol. 117, 1358–1366.
Kaiser Family Foundation, 2013. Health Reform: implications for Women's Access to Coverage and Care.
Kelle, U., 2013. The development of categories: different approaches in grounded theory. In: Bryant, A., Charmaz, K. (Eds.), The SAGE Handbook of Grounded Theory. SAGE Publications Ltd, pp. 191–213.
Kerns, J., Vanjani, R., Freedman, L., Meckstroth, K., et al., 2012. Women's decision making regarding choice of second trimester termination method for pregnancy complications. Int. J. Gynecol. Obstetrics 116, 244–248.

Kimport, K., Cockrill, K., Weitz, A.T., 2012. Analyzing the impacts of abortion clinic structures and processes: a qualitative analysis of women's negative experience of abortion clinics. Contraception 85, 204–210.
Lafarge, C., Mitchell, K., Fox, P., 2014. Termination of pregnancy for fetal abnormality: a meta-ethnography of women's experiences. Reprod. Health Matters 22, 191–201.
Lie, M.L., Robson, S.C., May, C.R., 2008. Experiences of abortion: a narrative review of qualitative studies. BMC Health Serv. Res. 8, 150.
Lyerly, A.D., 2013. A Good Birth. Finding the Positive and Profound in Your Childbirth Experience. Avery.
McLemore, M.R., Desai, S., Freedman, L., James, E.A., et al., 2014. Women know best—findings from a thematic analysis of 5,214 surveys of abortion care experience. Women's Health Issues 24, 594–599.
Namey, E.E., Lyerly, A.D., 2010. The meaning of "control" for childbearing women in the US. Soc. Sci. Med. 71, 769–776.
Norris, A., Bessett, D., Steinberg, J.R., Kavanaugh, M.L., et al., 2011. Abortion stigma: a reconceptualization of constituents, causes, and consequences. Women's Health Issues 21, S49–S54.
O'Brien, B., Harris, I., Beckman, T., Reed, D., et al., 2014. Standards for reporting qualitative research: a synthesis of recommendations. Acad. Med. 89, 1245–1251.
Perrucci, A.C., 2012. Decision Assessment and Counseling in Abortion Care: Philosophy and Practice. Rowman & Littlefield Publishers.
Powers, M., Faden, R., 2006. Social Justice: the Moral Foundations of Public Health and Health Policy. Oxford University Press, New York.
Rayburn, W.F., Richards, M.E., Elwell, E.C., 2012. Drive times to hospitals with perinatal care in the United States. Obstetrics Gynecol. 119, 611–616.
Shellenberg, K.M., Tsui, A.O., 2012. Correlates of perceived and internalized stigma among abortion patients in the USA: an exploration by race and Hispanic ethnicity. Int. J. Gynecol. Obstetrics 118 (Suppl. 2), S152–S159.
Simkin, P., 1991. Just another day in a Woman's Life? Women's long-term perceptions of their first birth experience. Part 1. Birth 18, 203–210.
Simkin, P., 1992. Just another day in a woman's life? Part II: Nature and consistency of women's long-term memories of their first birth experiences. Birth 19, 64–91.
Simonds, W., Ellertson, C., Springer, K., Winikoff, B., 1998. Abortion, revised: participants in the U.S. clinical trials evaluate mifepristone. Soc. Sci. Med. 46, 1313–1323.
Taylor, D., Postlethwaite, D., Desai, S., James, E.A., et al., 2013. Multiple determinants of the abortion care experience: from the patient's perspective. Am. J. Med. Qual. 28, 510–518.
Tilles, C., Denny, A., Cansino, C., Creinin, M.D., 2016. Factors influencing women's satisfaction with surgical abortion. Contraception 93, 164–169.
Weiss, R.S., 1994. Learning from Strangers. The Art and Method of Qualitative Interview Studies. The Free Press, New York.
Weitz, T.A., Cockrill, K., 2010. Abortion clinic patients' opinions about obtaining abortions from general women's health care providers. Patient Educ. Couns. 81, 409–414.