Evaluation of Abortion Stigma in the Workforce: Development of the Revised Abortion Providers Stigma Scale

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Abstract

Objectives: We report on the development of a scale measuring abortion providers’ experiences of stigma.

Study Design: Using previous measures, qualitative data, and expert review, we created a 49-item question pool. We administered questions to 315 abortion providers before participation in the Providers Share Workshop. We explored the factor structure and item quality using exploratory factor analysis. We assessed reliability using Cronbach’s alpha. To test construct validity, we calculated Pearson’s correlation coefficients between the stigma scales, the Maslach Burnout Inventory, and the K10 measure of psychological distress. We used Stata SE/12.0 for analyses.

Results: Factor analysis revealed a 35-item, five-factor model: worries about disclosure, internalized states, social judgment, social isolation, and discrimination (Cronbach’s alphas 0.79–0.94). Our stigma measure was correlated with psychological distress (r = 0.40; p < .001), and with Maslach Burnout Inventory’s emotional exhaustion (r = 0.27; p < .001), and depersonalization (0.23; p < .001) subscales, and was inversely correlated with Maslach Burnout Inventory’s personal accomplishment subscale (r = –0.15; p < .05).

Conclusions: Psychometric analysis of this scale reveals that it is a reliable and valid tool for measuring stigma in abortion providers, and may be helpful in evaluating stigma reduction programs.

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Abortion remains highly stigmatized in the United States and many countries around the world. Erving Goffman described stigma as an “attribute that is deeply discrediting,” moving an individual “from a whole and usual person to a tainted, discounted one” (Goffman, 1963). Stigma relies on a dynamic social process by which individuals are identified, judged, and devalued based on a characteristic that society has identified as deviant or wrong. Kumar et al. (2009) defined abortion stigma as a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood. Building on Kumar’s work, Norris et al. (2011) considered how abortion stigma also impacts abortion providers and those who support abortion rights. They identify four additional causes of abortion stigma: attributing personhood to the fetus, legal restrictions, the idea that abortion is dirty or unhealthy, and the use of stigma as a tool for anti-abortion efforts.

Some consider abortion providers’ work to be “dirty work”—work that is socially necessary but commonly regarded as physically disgusting or morally degrading (Harris, Debbink, Martin, & Hassinger, 2011; Hughes, 1951). Pervasive stereotypes of abortion providers as callous, immoral, and less competent than other medical colleagues can create isolation and marginalization within the medical community, creating the conditions for violence and harassment aimed at abortion care providers (Harris, Martin, Debbink, & Hassinger, 2011). Persistent stigma, harassment, and discrimination can also deter trained providers from offering care after training (Freedman, 2010; Harris et al., 2011; Joffe, 2009; Norris et al., 2011). Approximately one-half of physicians trained to provide abortion care do not go on to do so later in their careers (Freedman, 2010; Steinauer et al., 2008). There are inadequate numbers of providers in many...
regions of the United States. Indeed, as of 2014, 90% of U.S. counties do not have clinics that provide abortion care and 39% of U.S. reproductive-aged women live in these counties (Jones & Jerman, 2017). Stigma plays a role in the training–provision gap and the overall reluctance of health care providers to include abortion care in their practice (Freedman, Landy, Darney, & Steinauer, 2010). For those who do go on to provide, abortion stigma also contributes to increased stress, burnout, and strain on collegial relationships (Harris et al., 2011; Harris et al., 2013; Joffe, 2009). To assess interventions aimed at reducing stigma or managing its consequences, accurate measurement tools assessing stigma in abortion care providers are needed.

Recognizing the importance of abortion stigma, and interventions to reduce or manage it, researchers have developed several new tools to assess and measure stigma in a range of settings and populations. Cockrill, Upadhyay, Turan, and Greene Foster (2013) developed the Individual-Level Abortion Stigma Scale, which measures stigma’s impact on women who have had an abortion. Working in Ghana and Zambia, Shellenberg, Hessini, and Levandowski (2014) created the Stigmatizing Attitudes, Beliefs, and Actions Scale (APSS) to assess community attitudes toward women who have had abortions. We (2014) constructed a survey to evaluate abortion providers’ stigma experiences. Here, we report on the psychometric properties of a revised measure of providers’ stigma experiences, the Abortion Provider Stigma Scale. Although a valid and useful measure of stigma, the previous 13-item version of the instrument only captured three dimensions of abortion stigma: disclosure management, resilience and resistance, and discrimination. Qualitative work with abortion providers suggested that additional domains, including internalized stigma, might be missing from the 13-item version. Additionally, the original instrument was derived from a small initial item pool (15 items) and tested in a relatively small sample (N = 89; see Martin et al., 2014 for a detailed explanation). Finally, we wished to revise the wording of several items to make them more clear. The revised measure presented here overcomes these limitations.

**Methods**

**APSS Item Pool Development**

Procedures for creating the new Abortion Provider Stigma Scale items included multiple stages: 1) review and modification of the original items from the previous survey, 2) review of qualitative data generated by providers participating in a series of supportive workshops (6 workshops, including 89 participants) to identify dimensions of stigma not captured in the older measure, and 3) expert review of the final item pool by eight professionals, researchers, and clinical care providers whose work focused on abortion.

We reviewed the 15 items used to develop the original scale. The earlier version had three subscales, disclosure management (7 items), resistance and resilience (4 items), and discrimination (2 items), and two items that were not retained because they did not adequately load in the factor analysis (Martin et al., 2014). We modified three original items for the current item pool. The first item originally read, “I have been physically or verbally threatened or attacked as a result of working in abortion care,” and was split into two questions, one on verbal threats and another on physical threats or attacks. The second excluded item, “I feel that society does not appreciate the work I do in abortion care,” was modified to, “I feel that society (the general public) does not value me as an abortion worker.” Finally, the item, “I feel marginalized by other health workers because of my work in abortion care,” was split into two items in the new scale, one assessing feelings of moral judgment by one’s colleagues, and the second, an assessment of the provider’s skills—stemming from the stereotype that someone who chooses to work in abortion care must not be skilled enough to work in another subspecialty. The revised items were: “I feel that other health workers look down on me because of my decision to work in abortion care,” and “I feel other health care workers question my professional skills when they learn that I work in abortion care.” All other items from the original scale were included in this version verbatim.

Second, our qualitative analysis of providers’ stigma experiences suggested we needed new items to reflect providers’ internalized stigma, self-judgment, and negative feelings about their work. The original scale had been developed using data from a single pilot site of the Provider Share Workshop (Harris et al., 2011). To create this expanded item pool we reviewed qualitative data from an additional six workshops (Harris et al., 2013). This review resulted in new items regarding disclosure of their abortion work (e.g., “I feel that disclosing my abortion work is not worth the potential hassle that could result” and “I feel that when I disclose my abortion work to strangers, they are supportive of me”) and questions about the impact of their work on their families (e.g., “I am afraid that if I tell people I work in abortion care I could put myself, or my loved ones, at risk for violence”). Finally, eight experts assessed content validity of the expanded item pool. They included two clinical abortion providers who are not physicians (a clinic manager and a counselor), two obstetrician-gynecologists who focus on abortion in their practice, and four family planning researchers who were not members of our research team. We asked these experts for feedback on whether the items assessed a comprehensive range of experiences related to abortion provider stigma. Based on their feedback, several items were added that specifically addressed internalized stigma (e.g., “I feel ashamed of the work I do,” “I feel guilty about the work I do,” and “I question whether providing abortion care is a good thing to do”) and some items’ wording was adjusted (e.g., using consistent language regarding providing abortions—always using the term abortion care—and trying to balance the number of positively and negatively worded items). Additionally, the panel suggested including more items about social support from friends and family members. We made these changes using an iterative process that lasted several weeks, resulting in a final pool of 49 items.

We randomly ordered the items rather than using a priori grouping, and the word stigma was not used in any items. Participants received the instruction: “Please consider your experiences as someone who works in abortion care. How often have you felt or experienced the following?” We used a five-level Likert scale for scoring: 5 (all of the time), 4 (often), 3 (sometimes), 2 (rarely), and 1 (never). Where necessary, items were reverse coded so that higher scores always indicate greater stigma.

**Participant Recruitment**

We partnered with a large women’s health care organization to administer the new 49-item questionnaire to 315 abortion providers, across 22 clinic sites in the United States.

Respondents were participating in a workshop administered by their employer as a supportive intervention to alleviate some of the unique burdens associated with providing abortion care. A recruitment email was sent to all abortion-providing sites
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