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Dynamics of stigma in abortion work: Findings from a pilot study of the Providers Share Workshop

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ABSTRACT

Abortion is highly stigmatized in the United States. The consequences of stigma for abortion providers are not well understood, nor are there published accounts of tools to assess or alleviate its burdens. We designed The Providers Share Workshop to address this gap. Providers Share is a six-session workshop in which abortion providers meet to discuss their experiences, guided by an experienced facilitator. Seventeen workers at one US abortion clinic participated in a pilot workshop. Sessions were recorded and transcribed, and an iterative process was used to identify major themes. Participants highlighted stigma, located in cultural discourse, law, politics, communities, institutions (including the abortion clinic itself), and relationships with family, friends and patients. All faced decisions about disclosure of abortion work. Some chose silence, fearing judgment and violence, while others chose disclosure to maintain psychological consistency and be a resource to others. Either approach led to painful interpersonal disconnections. Speaking in the safe space of the Workshop fostered interpersonal connections, and appeared to serve as an effective stigma management tool. Participants reflected favorably upon the experience. We conclude that the Providers Share Workshop may alleviate some of the burdens of abortion stigma, and may be an important intervention in abortion human resources. We present a conceptual model of the dynamics of stigma in abortion work.

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Introduction

For complicated moral and political reasons, abortion is highly stigmatized in the United States (Luker, 1985; McKeegan, 1993). Stigma may arise from the conviction that women who have abortions deviate from feminine ideals, eschewing rather than embracing motherhood, and harming rather than nurturing children (Joffe, 1987; Kumar, Hessini, & Mitchell, 2009). Stigma's roots may lie in some people's belief that abortion is equivalent to killing a born person, or in disapproval of behaviors believed to have led to abortion – for example pre-marital sex, or "irresponsible" use of contraceptives. Abortions in the US are commonly performed in stand-alone clinics, which reflects and may reinforce its marginalized status (Gottlieb, 1995; Joffe, 1995). Significant adverse consequences of stigma for women who seek abortion have been documented, but the impact of stigma on abortion providers has received relatively little attention (Kumar et al., 2009; Littman, Zarcadoolas, & Jacobs, 2009; Major & Gramzow, 1999).

Goffman (1963a, p. 3) first described stigma as an "attribute that is deeply discrediting", and noted that stigma transforms people from "whole and usual" individuals to "tainted", discounted ones in the minds of those around them. Link and Phelan (2001) emphasized the relational nature of stigma – that it always includes a stigmatizer – and they accent the agency and resistance of those who are stigmatized. Hughes (1956, 1958, 1971, pp. 338–347) called stigmatized work "dirty work", and its practitioners "dirty workers". These workers perform socially necessary functions that are tainted by physically disgusting, socially degrading, or morally dubious elements. Classic examples include garbage collectors, gravediggers, and executioners (Hughes, 1956, 1958, 1971, pp. 338–347).

Abortion work is dirty work, associated with all three taints: physical (blood, fetal parts); social (contact with stigmatized patients); and moral (ambiguous fetal moral status) (Ashforth &

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Kreiner, 1999; Hughes, 1956; Joffe, 1978). Dirty workers, like all stigmatized individuals, risk adverse psychosocial consequences, including status loss, discrimination, and disclosure difficulties (Goffman, 1963b, p. 147; Healy, 1993; Major & O'Brien, 2005). Because work – especially professional work in the US – occupies a central role in personal identity, occupational stigma may carry particularly high costs, including social isolation and loss of self-esteem (Hughes, 1958, 1956, 1971, pp. 338–347; Kreiner, Ashforth, & Sluss, 2006). We do not know the extent to which these consequences of stigma adversely affect the abortion-providing workforce, or deter workers from doing abortion work in the first place. To date, efforts to address work-force issues focus on physician training (Bazelon, 2010; Eastwood, Kacmar, Steinauer, Weitzen, & Boardman, 2006). However, approximately half of trained providers do not ultimately provide abortions, citing institutional barriers and worries about strained collegial relationships – reasons that reflect pervasive abortion stigma (Freedman, Landy, Darney, & Steinauer, 2010). In light of these facts, stigma may be an abortion human resources issue.

The most frightening manifestation of stigma for workers is, of course, violence. Herek (1992, p. 89) has argued that violent hate crimes are a "logical, albeit extreme, extension" of pervasive social stigma. When degrading rhetoric (e.g., use of the phrase "baby killer") intersects with certain prejudices and attitudes, some individuals may be incited to acts of violence (Garnets, Herek, & Levy, 2003). Indeed, since 1993, 8 abortion providers have died in shootings and clinic bombings (Clinic Violence Statistics, 2009). For abortion providers, stigma is a workplace safety issue (Gottlieb, 1995; Todd, 2003). Workers may benefit from particular forms of support for combating stigma, and for managing the stress, threats to morale, and employee retention challenges that stigma brings.

While stigma may negatively affect abortion human resources, it can be associated with positive outcomes as well (Hughes, 1951, 1971, pp. 338–347; Meara, 1974). Abortion providers often describe their sense of pride and heroic motivating mission (Ashforth & Kreiner, 1999; Joffe, 1978, 1987). These aspects of stigma may be a source of resilience and strength for the abortion-providing workforce. Developing strategies for harnessing the positive dimensions of stigma could strengthen the abortion-providing workforce, and help alleviate the well-known shortage of US providers (Darney, 1993; Grimes, 1992; Jones, Zolna, Henshaw, & Finer, 2008; O'Connell, Jones, Lichtenberg, & Paul, 2008).

We do not know the extent to which either positive or negative aspects of stigma affect individual workers or abortion human resources more generally. Joffe's interviews with physician-providers reveal both professional and personal consequences – harassment, marginalization, status loss in medicine, and a constant "low-level wariness" in all interpersonal relations (1995, p. 172, 2010; Wicklund & Kesselheim, 2007; Freedman, 2010). Recently, Joffe (2010) described physicians' informal strategies for managing burdens of stigma, particularly embracing political activism and building communities of allies. With few exceptions, the effects of stigma on non-physician workers have been largely neglected (Joffe, 1987, 2010; Simonds, 1996). While not addressing stigma specifically, older studies suggest that doctors, nurses, and counselors experience some ambivalent feelings about their work (Char & McDermott, 1972; Hall, 1971; Hern, 1980; Kibel, 1972; Such-Baer, 1974). More recent systematic analysis of US providers and one Canadian study link abortion work to emotional conflicts, but do not consider stigma as a powerful mediating variable (Fitzpatrick & Wilson, 1999; Roe, 1989; Wear, 2002). Our work considers the possibility that worker responses to abortion work are responses to stigma itself. There are no published accounts of interventions designed to alleviate the burdens of stigma for providers. Thus, when workers at one US abortion clinic requested a safe space in which to discuss their experiences, we designed a workshop to address this need. In this paper, we offer a new window into the experiences of abortion workers and simultaneously provide the first data on an intervention designed to ameliorate stigma's burdens.

Methods

We present findings from a qualitative pilot study of the Providers Share Workshop, a six-session workshop in which abortion providers (broadly defined to include anyone with direct daily involvement in abortion care), meet to explore their experiences, guided by an experienced facilitator. The name, "Providers Share", reflects that providers both share experiences and receive their fair share of supportive attention. University of Michigan's Behavioral Sciences Institutional Review Board approved the study, and participants provided written consent for participation. The Workshop was held over a three-month period at a US abortion clinic, in Fall 2007. The clinic was selected because workers at that site approached one member of our research team with the request for an opportunity to reflect on their work in a supportive group setting. All workers at the site who had regular contact with patients seeking abortion were eligible to participate. Participants were compensated at their overtime hourly pay rate. Childcare and food were provided. Discussion topics varied by session, and were introduced each week by the facilitator. Topics included: 1) What abortion work means to me; 2) Memorable stories; 3) Abortion and identity; 4) Abortion politics; 5) Future directions for self-care; and 6) Reflections on the Workshop. Discussion was supplemented by journaling and collage-making, methods that have been demonstrated to help people in stressful environments reduce anxiety and increase self-awareness (Pifalo, 2006; Öster et al., 2006). Each session was audio-recorded and transcribed. The research team read all transcripts and used an iterative process to identify major themes. Two team members coded transcripts using NVivo 8.0 (QSR International, 2008). Coding disagreements were resolved in a collaborative fashion. We analyzed only data generated when participants spoke, including when they verbally described their collages, or read journal entries aloud. Compositional analysis of participants' artwork and linguistic or literary analysis of journal entries is beyond the scope of this paper.

We addressed issues of reflexivity in a variety of ways during data collection and analysis. In response to the six session topics introduced by the facilitator, participants engaged in free-ranging conversation. The facilitator served as an active listener – summarizing contributions from members and insuring balanced participation – but did not otherwise direct conversation. The facilitator's comments were not coded. Two team members took notes but did not actively participate. One team member functioned as an observing participant, a variation of participant observation in which the researcher is an insider to the work (Bernard, 2006). This researcher works in abortion care, and contributed to the discussion; however she did not play a role in developing the session topics, or introducing topics to the group. Because her presence had the greatest potential to influence outcomes, she spoke near the end of all sessions (but not last, so as not to have the "last word"). Neither the observing participant nor the facilitator coded transcripts. After coding was completed, all data were analyzed, both with and without the observing participant's contributions. Her comments did not substantively change the nature, salience or relative coding frequencies of themes.

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