



Original research article

A randomized pilot evaluation of individual-level abortion stigma resulting from Pennsylvania mandated abortion counseling^{☆,☆☆}

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Received 19 January 2017; revised 21 June 2017; accepted 27 June 2017

Abstract

Objective: The objective was to investigate the effect of mandated abortion counseling requirements intended to dissuade women from having abortions on patients' individual-level abortion stigma.

Methods: We randomized women presenting for abortion to complete a demographic survey and the validated Individual Level Abortion Stigma (ILAS) scale either before (unexposed) or after (exposed) hearing the mandatory Pennsylvania Abortion Control Act counseling via a standardized video. A sample size of 46 (23 per group) allowed us to detect a 1-standard-deviation difference in mean ILAS score between the groups. The ILAS scale ranges from 0 to 3.5, with higher scores indicating greater stigma.

Results: From November 2015 to April 2016, 46 participants completed the study. All baseline characteristics were balanced except that the unexposed group had a greater proportion of low-income participants. The mean ILAS score among all participants was 1.02±0.60. ILAS scores were significantly higher among the unexposed group (median 1.25, interquartile range [IQR] 0.7–1.9) compared to the exposed group (median 0.75, IQR 0.5–1.05; $p=.016$). However, when controlling for participant income category, the effect of the mandated counseling on stigma scores was no longer present ($p=.068$).

Conclusions: In this randomized trial, stigma scores were higher among women who had not heard the mandated abortion counseling when compared with stigma scores for those who had heard the script, but this effect was confounded by participants' income category.

Implications: Despite the small sample size in this pilot study, differences in stigma scores for women exposed and unexposed to mandated counseling approached significance even after controlling for income category. Women who heard the mandated counseling had reduced stigma scores. A larger study is needed to better characterize this effect. Further research is needed to understand how state policies, counseling interactions and socioeconomic status are related to abortion stigma.

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Keywords: Abortion; Pregnancy termination; Stigma; Policy; Counseling

1. Introduction

Abortion stigma is defined 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” [1]. A systematic review of abortion stigma research found that the majority of women who have had abortions have negative

emotional experiences, such as feeling self-judgment or a need for secrecy surrounding the abortion, and that they fear negative social judgment about their abortion [2].

Individual-level abortion stigma has three components: (a) internalized stigma, resulting from a woman's acceptance of negative cultural valuations of abortion; (b) felt stigma, encompassing her assessment of others' abortion attitudes as well as her expectations about how these attitudes might result in actions; and (c), enacted stigma, a woman's experiences of clear or subtle actions that reveal prejudice against people involved in abortion, such as physical or emotional abuse, or discrimination [3,4].

A 2012 study estimated the proportion of abortion patients reporting “perceived and internalized” individual-level stigma from a large cross-sectional survey of over 9000 women

☆ NCT# 02672605

☆☆ Funding: This research was supported by the Society of Family Planning Research Fund (grant number 567323).

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seeking abortion across the United States [5]. This study defined perceived stigma as an individual's perception of whether she will be perceived or treated differently or negatively by other people for having an abortion, incorporating aspects of both felt and enacted abortion stigma. Internalized stigma was defined as feelings of secrecy, guilt, shame, anxiety or concern about other people's beliefs or opinions about abortion, consistent with the first component of individual-level abortion stigma. Stigma was common in this population of American women, with more than half feeling the need to keep their abortions secret from close friends and family. Interestingly, women living the southern, western and Midwestern regions of the United States were more likely to perceive stigma from their health care provider compared to women living the northeast [5], supporting the notion that stigma is affected by factors from a woman's local environment. The local culture and political climate, and the state laws that reflect these social mores, including laws related to counseling requirements, may contribute to regional variations in stigma.

Mandated abortion counseling requirements can contain elements that are misleading and inaccurate. These counseling requirements may exacerbate stigma, as they often direct women seeking abortion toward continuing the pregnancy, and underscore unproven risks of abortion [6]. For example, of the 35 states that require mandated counseling before an abortion, 28 include information on fetal development throughout pregnancy, 5 include information that incorrectly states a link between abortion and breast cancer, and 12 include misinformation on the ability of a fetus to feel pain [7].

The Pennsylvania Abortion Control Act of 1989 expresses the Commonwealth's "supreme value on protecting human life... and further[ing] the public policy of encouraging childbirth over abortion" [8]. In addition to other provisions, the Pennsylvania Abortion Consent Act of 1989 mandates that at least 24 h prior to initiating an abortion, the woman seeking abortion must be informed of the following:

1. "The Commonwealth of Pennsylvania publishes printed materials that describe how a pregnancy develops and lists agencies that offer alternatives to abortion. You have a right to review these materials, and a copy will be provided to you free of charge if you choose to review them.
2. Medical assistance benefits may be available for prenatal care, childbirth, and newborn care if you continue the pregnancy. More information about this is contained in the printed materials.
3. If you continue the pregnancy and deliver a baby, the father of the child is responsible to assist in the financial support of the child, even if he has offered to pay for the abortion" [8].

In Pennsylvania's mandated abortion counseling, information on fetal development and an emphasis on the availability of medical assistance benefits for prenatal, childbirth and

newborn care, as well as the paternal financial obligation, are irrelevant to patients who have already decided on abortion. The mandated presentation of these alternatives could be perceived negatively by women who have already chosen abortion, as they clearly indicate that other pregnancy outcomes are preferred by the government. In fact, prior research that measured norms and stigma regarding outcomes after unintended pregnancy found that stigma was highest for abortion and lower for unintended pregnancy that resulted in parenting or adoption [9]. We designed this study to investigate the effect of mandated abortion counseling requirements on patients' individual-level abortion stigma.

2. Material and methods

We conducted a randomized controlled trial to pilot-test the hypothesis that the Pennsylvania Abortion Control Act [6] counseling increases individual-level stigma scores as measured by the validated Individual Level Abortion Stigma (ILAS) scale. The 20-item ILAS scale measures overall individual-level stigma and contains 4 subscales, each measuring a unique dimension of stigma: worries about judgment, isolation, self-judgment and community condemnation. Scores on the full ILAS range from 0.0 to 3.5, with higher scores indicating increased stigma [10].

The institutional review board at the University of Pennsylvania approved the study protocol prior to recruitment. We included English-speaking women aged 18 years or older seeking their first induced abortion at less than 24 weeks' gestation for any indication and receiving the mandated counseling at their initial abortion visit in our clinic. We excluded women who had any prior induced abortion or who had previously heard the mandated counseling in the current pregnancy. We approached potentially eligible patients prior to initiation of clinical care and informed them that the study would assess their perceptions about the abortion experience. To minimize subject awareness bias, we did not inform participants of the study's particular focus on abortion stigma.

We developed a standardized video containing the mandated counseling. In this 90-s video, an obstetrician–gynecologist read the Pennsylvania Abortion Control Act verbiage in a neutral tone. Participants saw the video prior to interacting with their health care provider. No additional counseling was offered in either group after the video was shown.

A statistician not involved in data collection conducted computerized block randomization with random block sizes utilizing REDCap (Research Electronic Data Capture, Vanderbilt University) [11]. We randomized participants after confirmation of eligibility, verbal informed consent and enrollment by the research team.

In the unexposed group, study staff administered a demographic survey and the ILAS scale immediately after group assignment. After completing the ILAS scale, the staff then played the mandated counseling video to participants in this group. In the exposed group, the research staff played the

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