Abortion Stigma: A Systematic Review

CONTEXT: *Although stigma has been identified as a potential risk factor for the well-being of women who have had abortions, little attention has been paid to the study of abortion-related stigma.*

METHODS: *A systematic search of the databases Medline, PsycArticles, PsycInfo, PubMed and Web of Science was conducted; the search terms were "(abortion OR pregnancy termination) AND stigma*." Articles were eligible for inclusion if the main research question addressed experiences of individuals subjected to abortion stigma, public attitudes that stigmatize women who have had abortions or interventions aimed at managing abortion stigma. To provide a comprehensive overview of this issue, any study published by February 2015 was considered. The search was restricted to English- and German-language studies.*

RESULTS: *Seven quantitative and seven qualitative studies were eligible for inclusion. All but two dated from 2009 or later; the earliest was from 1984. Studies were based mainly on U.S. samples; some included participants from Ghana, Great Britain, Mexico, Nigeria, Pakistan, Peru and Zambia. The majority of studies showed that women who have had abortions experience fear of social judgment, self-judgment and a need for secrecy. Secrecy was associated with increased psychological distress and social isolation. Some studies found stigmatizing attitudes in the public. Stigma appeared to be salient in abortion providers' lives. Evidence of interventions to reduce abortion stigma was scarce. Most studies had limitations regarding generalizability and validity.*

CONCLUSION: *More research, using validated measures, is needed to enhance understanding of abortion stigma and thereby reduce its impact on affected individuals.*

Perspectives on Sexual and Reproductive Health, 2016, 48(4):169–177, doi: 10.1363/48e8516

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Every year, a large number of women terminate a pregnancy by having an induced abortion. Since the early 2000s, the global rate of induced abortions has remained stable at approximately 28 induced abortions per 1,000 women annually.[1] Worldwide, an estimated one in five pregnancies, or 44 million, end in an induced abortion every year.1 The psychological implications of induced abortions for affected women have been widely discussed. While no studies have found a causal link between abortion and subsequent mental illness, some women experience psychological distress in the aftermath of their abortion.[2,3] Such experiences appear to be related to a range of contextual factors.[2,4] In many societies, a deep ambivalence about the legality and morality of abortions manifests itself in restrictive abortion laws and strong antiabortion attitudes. In the United States, for example, women who seek to terminate a pregnancy may face legal barriers such as gestational limits, waiting periods and mandated ultrasound viewing.[5] Print media predominantly portray abortion in a negative way, linking it with other socially discredited practices, such as alcohol abuse.[6] Where opposition to abortion is widespread, abortion-related stigma is likely to negatively influence women's abortion experience.

Over the past decades, the concept of stigma has been extensively studied, and its adverse impact on a multitude of social groups—such as people living with cancer, mental illnesses, or HIV or AIDS—is well documented.[7–9] Goffman first described stigma as an "attribute that is deeply discrediting" and that reduces the bearer "from a whole and usual person, to a tainted, discounted one."[10(p. 3)] Current conceptualizations have come to understand stigma primarily as a social process that is dependent on the social context.[11,12] Thus, stigma can be viewed as an exercise of power of a dominant group over members of a less powerful group, who are considered different, negatively stereotyped, discriminated against and marginalized within society.[11]

In recent years, scientists have started to explore the mechanisms of stigma related to abortion. Kumar et al. 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 the ideals of womanhood."[13(p. 628)] According to this definition, women who have abortions challenge social norms regarding female sexuality and maternity, and their doing so elicits stigmatizing responses from their community. To better understand how women experience abortion stigma, researchers have suggested the use of a three-domain framework.[14,15] First, perceived stigma refers to a woman's awareness of the devaluing attitudes of others concerning her abortion and her own expectation that these attitudes might result in discriminatory actions. Second, internalized stigma results when a woman incorporates devaluing

social norms, beliefs and attitudes related to abortion into her self-image, creating a sense of shame, guilt or other negative feelings. Finally, enacted stigma describes actual experiences of discrimination or negative treatment by others that are directly related to a women's abortion experience. Abortion stigma probably affects women who have had abortions most of all, but it can also extend to associated groups, like providers of abortion care or partners of women who have had abortions.[5] Additionally, abortion stigma can manifest itself in discourses within the media and in policies and practices of institutions, as well as of political and governmental structures.[13]

The psychological consequences of stigma are profound.[16] Research on stigmatized groups such as racial minorities and people living with HIV or AIDS has linked stigma to poor mental health, performance deficits, and loss of economic and social opportunities.[17–19] Likewise, the effects of abortion stigma on women are hypothesized to be substantial. A report released by the American Psychological Association in 2008 listed stigma as a major risk factor for the mental health of women who have had abortions and proposed that it may have a variety of negative psychological responses, among them anxiety, depression, increased physiological distress, and social withdrawal and avoidance.[20]

Although it is clear that abortion stigma has the potential to impair the well-being and mental health of a large number of women, little attention has been paid to its study. Thus, this review seeks to contribute to research on abortion stigma by assessing the scientific evidence available to date and thereby delineating directions for future research.

METHODS

A systematic literature search of the databases Medline, PsycArticles, PsycInfo, PubMed and Web of Science was conducted. To provide a comprehensive overview of the understudied issue of abortion stigma, any study published by February 2015 was considered for inclusion. The search terms were "(abortion OR pregnancy termination) AND stigma*." The search was restricted to empirical human research articles that were written in English or German and published in peer-reviewed journals. After removing duplicates, the first two authors identified potentially relevant articles by screening titles and abstracts and then retrieving articles in full text for a detailed evaluation against inclusion criteria. In addition, reference lists of relevant articles were checked to identify articles not covered by the database search. Articles were eligible for inclusion if the main research question addressed individuals' experiences with abortion stigma and its psychological consequences, public attitudes that stigmatized women who have had abortions or abortion stigma interventions. All samples were considered; quantitative and qualitative studies were included. Case studies, reviews, commentaries and theory papers were excluded. The following data were extracted from eligible studies: sample, design, stigma conceptualization, sources of stigmatization, main outcome measures and main findings.

RESULTS

Study Characteristics

The initial database search yielded 894 articles. After duplicates were removed, the titles and abstracts of 586 articles were screened and checked for inclusion. Twenty-five potentially relevant articles were identified, and the full text of each of these was retrieved for further evaluation. Overall, 15 articles met inclusion criteria. Two of these were based on the same sample and were thus treated as one study.[21,22] Of the 14 included studies, seven were quantitative (Table 1) and seven were qualitative (Table 2).

Some studies addressed multiple research topics related to abortion stigma.[14,21–24] Seven provided information on experiences of stigma among women who have had abortions, stigma management strategies and psychological consequences.[14,15,23,25–28] Five studies investigated stigmatizing attitudes in the public toward women who have had abortions,[14,23,29–31] three addressed experiences of stigma among providers of abortion care[21,22,24,32] and three investigated intervention strategies to counter abortion stigma.[21,22,24,33]

Quantitative studies were predominantly cross-sectional and had a wide range of sample sizes (55–4,188; median, 442). Five quantitative studies were conducted in the United States;[21,22,26–29] one took place in Ghana and Zambia,[31] and one in Mexico.[30] Two studies provided representative data (one for U.S. abortion patients[28] and one for Mexican Catholics[30]); the others used nonrepresentative samples.

Nearly all of the qualitative studies conducted semistructured interviews to collect data; some involved focus group discussions. Sample sizes ranged from 14 to 96 participants (median, 28). Five studies involved participants only from the United States or Great Britain;[15,24,25,32,33] one was cross-cultural (involving men and women from Mexico, Nigeria, Pakistan, Peru and the United States[14]), and one involved men and women from different regions of Mexico.[23]

Measurement of Abortion Stigma

Instead of providing an explicit definition for abortion stigma, studies frequently referred to the broad definition of stigma introduced by Goffman[10] and varied in their theoretical conceptualization of abortion stigma. Measures were often not clearly derived from theory, which resulted in the use of divergent assessment instruments in the quantitative studies.

Of the seven studies that measured abortion stigma among women, providers and the public, three used nonvalidated, single-item measures adapted from previous research or derived from the literature.[27–29] One study adopted a modified scale originally designed to measure mental illness stigma.[30] Three studies developed standardized scales to assess different aspects of abortion stigma: Cockrill et al.[26] presented the Individual Level of Abortion Stigma scale (ILAS) to measure manifestations of abortion stigma in women who had had abortions; Shellenberg et al.[31] developed the Stigmatizing Attitudes, Beliefs and Actions Scale to measure stigmatizing responses of the

TABLE 1. Summary of quantitative studies investigating stigma related to abortion

Study	Study design	Main outcome measures	Primary results
Cockrill et al.[26]	Cross-sectional; 627 women with abortion history; United States	Perceived and internalized abortion stigma; secrecy	• Level of perceived stigma was low; level of internalized stigma was moderate to high. • Protestant and Catholic women reported more stigma than nonreligious women. • Black women were less worried about judgment than white women. • Stigma level was positively associated with risk of withholding information on abortion.
Shellenberg and Tsui[28]	Cross-sectional; 4,188 abortion patients; United States	Perceived and internalized abortion stigma	• Perceived stigma from others was prominent; perceived stigma from health care provider and family or friends was less prevalent. • Majority of participants needed to keep abortion a secret from friends and family. • Protestant white women had higher risk of perceiving stigma from others and friends or family than white women with no religious affiliation. • Black women were the least likely to experience stigma.
Major and Gramzow[27]	Cross-sectional; 442 abortion patients; United States	Perceived abortion stigma; secrecy; psychological distress	• Perceived stigma was positively associated with need to keep abortion a secret and with thought suppression, which led to more intrusive thoughts and psychological distress.
Weidner and Griffitt[29]	Randomized-control trial; 144 students; United States	Public stigma toward women who have had abortions	• Women who have had abortions are less desirable to date and marry than women without abortion history.
McMurtrie et al.[30]	Cross-sectional; 3,000 Catholics; Mexico	Public stigma toward women who have had abortions	• Majority of participants expressed stigmatizing attitudes.
Shellenberg et al.[31]	Cross-sectional; 531 community members; Ghana and Zambia	Public stigma toward women who have had abortions	• Participants reported moderate levels of stigmatizing attitudes. • Level of stigmatizing attitudes was inversely associated with level of support for legality of abortion.
Martin et al.[22]	Longitudinal; 55 abortion workers; United States	Abortion provider stigma	• Majority of participants had experienced stigma. • Participants had high levels of pride about abortion work. • Worries about consequences of disclosure of abortion work were prominent.
Martin et al.[21]	Longitudinal; 79 abortion workers; United States	Abortion provider stigma; professional quality of life	• Level of stigma was inversely associated with professional quality of life. • Attendance at a workshop for providers was associated with decrease in feelings of stigma.

Note: Superscript numbers refer to the reference list.

public to women with an abortion history; and Martin et al.[22] developed the Abortion Provider Stigma Survey (APSS) to assess experiences of stigma among providers of abortion care. These three scales proved to be internally consistent (Cronbach's alphas, 0.80–0.90), and correlations with related constructs were observed in directions consistent with theory, providing indications of construct validity. However, scales were mostly correlated with nonvalidated measures; thus, the significance of results regarding construct validity was limited. No study provided information on convergent validity in terms of associations with other measures of abortion stigma, perhaps because of the restricted availability of such instruments. Furthermore, no study assessed test-retest reliability of the developed scales.

Women's Experiences of Stigma

Three quantitative[26–28] and four qualitative studies[14,15,23,25] explored manifestations of abortion stigma in women who had had abortions. All studies either implicitly or explicitly referred to the three domains of stigma (perceived, internalized and enacted). If studies did not explicitly define which domains were assessed, we categorized their results according to the established definitions of the domains.

•***Sources of stigma***. Women who had had abortions reported perceiving stigma from multiple sources. The most frequently cited sources were society (often referred to as "others" or "other people"),[23,25–28] the community[14,23] and significant others (family, friends and sexual partners).[14,23,26,28] Abortion stigma also appeared to stem from medical institutions, as some women gave accounts of stigmatizing experiences with providers of abortion care or general health care.[15,25,28] Religious institutions that voice strong negative attitudes toward abortion, such as the Catholic Church, were cited as another significant source of abortion stigma.[14,23,26] Abortion stigma appeared to be less prominent in regions with more liberal abortion laws than in more restrictive settings, suggesting that it can be influenced by political and legislative powers.[14,23]

•***Perceived stigma.*** Results of quantitative studies on perceived abortion stigma are ambiguous. Differences between findings appear to be linked to measurements used and, relatedly, assessed sources of stigmatization. Major and Gramzow[27] assessed perceived stigma by using a single dichotomous measure, which asked women whether they would feel looked down upon if others found out about the abortion. Nearly half of the women (47%) said they would. In a representative survey of U.S. abortion patients, Shellenberg and Tsui[28] assessed perceived stigma with three dichotomous items, asking women what they expected others would think if they knew about their abortion. In all, 66% of the women expected that some people would look down upon them, 40% thought that their friends and family would think less of them and 17% believed that their regular health care provider would treat them differently. As in the Major and Gramzow study,[27] the items used did not constitute a validated scale to measure abortion stigma. In a study done by Cockrill et al.,[26] perceived stigma was assessed with ILAS subscales labeled "worries about judgment" and "community condemnation." Answers on the worries about judgment subscale were concentrated on the low end (mean, 0.86 on a scale of 0–3; standard deviation, 0.86), indicating that women who had had abortions were

TABLE 2. Summary of qualitative studies investigating stigma related to abortion

Study	Study design	Study goal	Primary results
Cockrill and Nack[15]	In-depth interviews; 34 abortion patients; United States	Develop sociopsychological framework for understanding abortion stigma	• Most women reported internalized and perceived stigma; 14 reported enacted stigma. • Stigma resulted in negative self-evaluation, secrecy, deception and social isolation. • Collective social silence regarding abortion is partly an unintended consequence of using secrecy to manage stigma.
Astbury-Ward et al.[25]	Interviews; 17 women with abortion history; England and Wales	Explore perceptions of women who have had abortions	• Women understood abortion as a highly taboo and stigmatizing event. • Stigma was manifested in the form of self-blame, secrecy, shame and low self-esteem. • Fear of social responses, even long after the abortion, led to secrecy. • Some participants perceived providers of abortion care as judgmental.
Shellenberg et al.[14]	Total of 96 in-depth interviews and 15 focus group discussions with women with and without abortion experience, and men with partners with and without abortion experience; Mexico, Nigeria, Pakistan, Peru and the United States	Examine presence and intensity of abortion stigma	• Most participants perceived abortion stigma within their community setting; the level of stigma depended on legal status and religious influences. • Participants reported shame, guilt and secrecy. • Stigma prevented women from disclosing abortion experience.
Sorhaindo et al.[23]	In-depth interviews with 24 women and partners of women with abortion history; focus groups with 101 men and women from the general population; Mexico.	Analyze abortion stigma from the perspectives of general population and women with an abortion history in different social, regional and legal contexts	• Although abortion was accepted under certain circumstances, women were still severely criticized and judged. • Secrecy was a frequent response to abortion stigma and resulted in lack of emotional support. • Catholic doctrine exacerbated shame and guilt, but attitudes toward women who had had abortions normalized when abortion was less legally restricted.
O'Donnell et al.[32]	In-depth interviews; 14 abortion workers; United States	Exploratory analysis of abortion providers' experiences and coping strategies related to abortion stigma	• Stigma was pervasive, but the workplace was generally considered a safe place. • Because of stigma, some workers concealed abortion-related profession outside the workplace. • Working cultures of different professional groups in abortion care (e.g., physicians, nurses) can increase or decrease feelings of stigma.
Harris et al.[24]	Workshop discussions; 17 abortion workers; United States	Exploratory analysis of providers' experience with abortion stigma; piloting of stigma intervention	• Participants experienced stigma inside and outside the clinic. • Central issue in negotiating stigmatizing work is disclosure management, which can result in interpersonal disconnections. • No internalized stigma was observed; workers reported positive professional identity and strong workplace solidarity. • Intervention reduced stigma by increasing feelings of interpersonal connection.
Littman et al.[33]	In-depth interviews; 22 women with abortion history; United States	Piloting of intervention designed to reduce disapproval, stigma and misinformation	• Participants expressed great approval of intervention, saying that it was personally helpful and reduced feelings of isolation. • All participants reported feeling more capable of coping with judgmental actions and attitudes of others after the intervention.

Note: Superscript numbers refer to the reference list.

not very worried about being judged by others in general or by loved ones. Scores on the community condemnation subscale tended toward the middle of the possible range (mean, 1.85 on a scale of 0–4; standard deviation, 1.07), indicating that on average, participants believed that about half of the people in their community held strong negative attitudes about abortion. However, the distribution of answers suggests that perceived prevalence of antiabortion attitudes in women's communities varied significantly.

The quantitative results imply that perceived stigma can play an important role in women's lives, and they highlight the need for a differentiated assessment. Scales that lack differentiation regarding sources of stigmatization might yield different results than more specific measures.

Results from qualitative studies consistently show that women perceived stigma from friends, family, community and society as a result of their decision to have an abortion. Women viewed their abortion to be socially unacceptable and a potentially personally discrediting event.[14,25] They anticipated negative judgment as a result of their decision to terminate a pregnancy, such as being labeled "evil," "not normal" or "murderer," and expected overt discrimination.[14]

•Internalized stigma. Two quantitative studies assessed internalized stigma. Shellenberg and Tsui[28] used two dichotomous items, which revealed that 58% of women in their sample needed to keep their abortion a secret and 33% felt that other people's opinion about their abortion mattered to them. However, operationalization of these items varied significantly from existing definitions of internalized stigma;[14,15] neither one directly referred to women's negative feelings or judgment toward themselves, and thus the face validity of these measures and the interpretability of these results are limited. In the study by Cockrill et al.,[26] internalized stigma was assessed with the "self-judgment" ILAS subscale. Although the mean score was in the middle of the scale (mean, 2.0 on a scale of 0–4; standard deviation, 1.03), scores were concentrated on the high end, indicating that the majority of participants reported moderate to strong negative feelings like guilt, shame or selfishness in the aftermath of their abortion. It is difficult to compare

the results of these two studies because of significant differences in measurements used.

In qualitative studies, women frequently reported negative feelings, like guilt, shame, self-blame or selfishness, after their abortion. These are emotions often associated with internalized stigma.[14] In fact, Shellenberg et al.[14] observed that women's feelings of guilt following an abortion were based mainly on their perception of other people's stigmatizing attitudes toward women who have had abortions. However, other studies also found evidence that some women refused to take on a negative self-image after their abortion.[15,23,25]

•***Enacted stigma.*** No quantitative data on women's experiences with actual enactments of stigma were available. Experiences of overt discrimination either were not assessed[27,28] or did not emerge as a subscale in factor analysis aimed at constructing a general abortion stigma scale.[26]

Accounts of overt enactments of stigma were limited in qualitative studies as well. Discrimination appeared to be subtle, emerging in the form of negative judgment from friends or sexual partners.[15] Few women reported negative judgments from health care providers, providers of abortion care or antiabortion protesters.[15,25] In one study, only a few women reported having experienced enactments of stigma, but many told stories about poor and devaluing treatment that other women in their community experienced.[14]

•***Moderators.*** Two quantitative studies explored potential moderators of abortion stigma.[26,28] Characteristics associated with abortion stigma were religion, race and social support. Compared with women with no religious affiliation, Christian women were significantly more likely to perceive abortion-related stigma. Being highly religious was associated with an increased risk of internalizing stigma in the form of negative feelings and self-judgment. Black women were significantly less likely to perceive stigma than were women of other racial or ethnic backgrounds.* Lacking partner support for an abortion was furthermore observed to be associated with an increased risk of perceiving stigma from friends, family and other community members.[28] However, causal effects of moderating factors could not be determined because of the cross-sectional design of the quantitative studies.

Data from three qualitative studies provided evidence that norms and attitudes toward abortion, often in reference to religion, influenced experiences of abortion stigma.[14,15,23] Women who had had abortions frequently linked their perception of negative judgment from others to religious teachings that they viewed as being supportive of antiabortion attitudes. Cockrill and Nack[15] found that internalized stigma was most pronounced in women who had grown up in families in which strongly held antiabortion attitudes were the norm.

Stigma Management and Consequences

Three quantitative studies focused on secrecy as a strategy women used to manage abortion stigma and provided some insight into associated psychological impairments. Major and Gramzow[27] showed that women who perceived stigma after their abortion decision were more likely than others to feel the need to keep their abortion a secret from friends and family. Secrecy was related to increased suppression of abortion-related thoughts, which led to more intrusive thoughts. Both thought suppression and intrusive thoughts were associated with experiencing increased psychological distress. However, causal relationships between included variables could not be established because of the correlational study design. Cockrill et al.[26] also found a positive relationship between women's perception of abortion stigma and the need for secrecy, but did not investigate associations between stigma and mental health. Shellenberg and Tsui[28] did not investigate associations between stigma and secrecy or mental health, but found that 58% of participants felt the need to keep their abortion a secret. In total, 45–64% of women in the quantitative studies reported that they had felt the need to keep their abortion a secret or had withheld information about the abortion from someone with whom they were close.[26–28]

Data from four qualitative studies that investigated the effects of abortion stigma also consistently highlighted restrictive disclosure behaviors and a need for secrecy in women with an abortion history. Women cited anticipated negative judgment or treatment from friends, family, community and society as the main reason for keeping their abortion a secret.[14,15,23,25] Secrecy came at the cost of experiencing social isolation, loneliness or suppression of emotions.[15,25] Sorhaindo et al.[23] reported a different form of stigma management. In their study, some women perceived their abortion as an empowering means of resolving a serious problem. This appeared to help them buffer negative emotions associated with internalized stigma.

Public Attitudes Stigmatizing Abortion

Three quantitative studies examined public perceptions of women with an abortion history. Studies focused on assessing biased attitudes, stereotyping and intentional discriminatory behavior. In an early study, Weidner and Griffitt[29] investigated how a woman's social acceptability was affected by her abortion history. They found that women with an abortion history were significantly less desired as marital or dating partners than were women with no history of abortion. However, the study involved a selective sample, consisting only of university students. In a representative survey of Mexican Catholics, McMurtrie et al.[30] asked participants about their personal opinion of a woman who had had an abortion and

*Both religion and race have been linked to attitudes toward abortion; while some Christian churches hold strong antiabortion attitudes, the black community is more prochoice than the general U.S. population. (Sources: Jelen TG and Wilcox C, Causes and consequences of public attitudes toward abortion: a review and research agenda, *Political Research Quarterly*, 2003, 56(4):489–500; and Carter JS, Carter SK and Dodge J, Trends in abortion attitudes by race and gender: a reassessment over a four decade period, *Journal of Sociological Research*, 2009, doi: 10.5296/jsr.v1i1.156.)

how her abortion might influence their interactions with her. The majority (61%) revealed stigmatizing attitudes. Shellenberg et al.[31] studied public perceptions of women in Ghana and Zambia who had abortions. Participants were asked to indicate their agreement with items related to negative stereotyping, exclusionary or discriminatory behavior, and fear of contagion. Responses were concentrated around the middle of the scale (mean, 48.9 on a scale of 1–80; standard deviation, 14.2), indicating that the majority of participants held moderately strong stigmatizing attitudes.

Two qualitative studies assessed public perceptions of women with an abortion history. A study with participants from various states in Mexico revealed stigmatizing attitudes that broke down into two general opinions, both of which were viewed as making abortion "inexcusable": Abortion is against God, and it interrupts a woman's destiny.[23] Having an abortion was linked to "promiscuity, irresponsibility, and sin." In a study conducted among men and women from Mexico, Nigeria, Pakistan, Peru and the United States, Shellenberg et al.[14] found that intense judgment was brought against women who had had abortions; for example, some people viewed these women as murderers, prostitutes and possessors of evil spirits that could potentially harm other community members.

Providers' Experience of Stigma

One quantitative U.S. multicenter study investigated the impact of abortion stigma on providers' professional and personal lives.[21,22] Abortion provider stigma was assessed by the APSS, which consists of subscales measuring discrimination, disclosure management, and resilience or resistance. Descriptive analysis indicated that stigma was salient in providers' life. Between 54% and 71% provided responses indicating that they felt marginalized within the medical field and society. For many providers, how much to disclose about their abortion work was an issue of concern. Some 66% worried about disclosing their abortion work, and 67% sometimes avoided disclosing it. There was also evidence that providers resisted stigma and maintained a positive work identity. Eighty-three percent of providers indicated that they felt proud about their work in abortion care, and 84% felt that it made a positive contribution to society. Further findings from the same study showed that stigma was related to providers' quality of professional life, as assessed by the Professional Quality of Life scale.[21,34] The more providers reported stigma, the less pleasure they derived from their ability to do their work well. In turn, as stigma increased, providers reported more feelings of hopelessness and difficulties with doing their job effectively, and showed marked secondary stress responses, such as loss of sleep or intrusive thoughts. The study was subject to selection bias, however, as it was based on a self-selected sample of 79 female providers. Furthermore, the APSS did not assess negative aspects of internalized stigma that are included in other stigma measures, such as feelings of shame and guilt.

Two qualitative studies examined how abortion stigma manifests itself in the lives of providers of abortion care.[24,32] Providers reported that they perceived stigma from multiple sources, including public discourse, politics, institutions and communities. They gave frequent accounts of enactments of stigma within their workplace, mostly referring to discrediting comments made by patients and by health care workers not involved in abortion provision. However, the workplace was generally considered a safe place that fostered solidarity. Team support helped most providers to maintain a positive sense about their work. Qualitative studies provided further evidence that providers managed stigma in part by making careful disclosure decisions. Providers frequently reported that in social interactions outside the clinic, they concealed or only partly revealed their workplace identity in order to avoid negative judgment, loss of relationships and damage to their social network. Others chose full disclosure as a means to counter negative stereotypes associated with abortion work and to address social disapproval directly. For many providers, managing stigmatized workplace identity came at the cost of feeling disconnected from themselves and others.

Abortion Stigma Interventions

Three studies—two quantitative and one qualitative—explored and evaluated intervention strategies to reduce stigma among either providers of abortion care or women with an abortion history. Harris et al.[24] designed a six-session workshop that offered a safe space for abortion providers to discuss their work, including related stress and burden. The long-term goal was to promote workers' resilience against abortion stigma and to strengthen human resources within abortion care. Initial qualitative evaluation of the workshop involving 17 U.S. abortion workers indicated that the intervention increased feelings of interpersonal connection by fostering emotional bonds among participants. These new connections with coworkers were seen as a relief from the burden of stigma that often goes along with a disruption of interpersonal relationships. Martin and colleagues further evaluated the workshop within the scope of their U.S. multicenter study on abortion provider stigma.[21,22] Effectiveness of the workshop was assessed by observing responses to the APSS at three time points: before, immediately following and one year after the workshop. The authors found a significant decrease in providers' overall stigma scores over time. However, the study did not involve a control group.

In a qualitative study, Littman et al.[33] created an intervention with the goal of supporting women in coping with disapproval, misinformation and stigma following their decision to have an abortion. Participants were shown short film clips of other women talking about their abortion and were offered the opportunity to discuss their own abortion experiences in a safe, nonjudgmental environment. Participating women reported that communication about their abortion experience was a new idea to them, and that it helped them feel comfortable, supported and less alone.

The majority of women stated that after the intervention, they were better able to cope with being judged negatively by others. However, the study design did not include a control group or a pretest.

DISCUSSION

Although the total number of studies investigating abortion stigma is surprisingly low, results indicate that stigma can constitute a serious concern for women who terminate a pregnancy. The majority of studies found that large proportions of women perceived stigma, and that stigma can come from multiple sources: society, the community and, to a lesser degree, significant others and medical institutions. It is important to point out that not all women are equally affected by abortion stigma. Differences in perceptions of stigma are apparently linked to a range of contextual and individual factors, such as exposure to strong antiabortion attitudes and social support among women's close contacts and communities. However, many of the mechanisms that cause variance in women's levels of perceived stigma remain unclear. More research within and between groups is needed to understand the social processes that create and maintain abortion stigma in different social settings.[5,35]

Studies also did not differentiate among reasons women gave for their abortion, which might have masked variations in experiences of abortion stigma. Some reasons for having an abortion are more socially acceptable than others—for example, having an abortion because one's life is in danger is generally more acceptable than having an abortion for financial reasons. Consequently, women's perception of stigmatization from others might also depend on the reason why they chose to terminate their pregnancy. Furthermore, the majority of the available studies focused on women who had already had abortions. Thus, more research is needed to understand how perceptions of stigma affect the abortion-seeking behavior of women who wish to terminate a pregnancy.[13]

Study results also revealed that many women experienced abortion stigma in the form of negative feelings, like guilt, shame or self-blame. This finding is especially concerning because internalized stigma has been identified as a major risk factor for reduced mental health, impaired psychosocial functioning and delays in seeking professional care.[8,36,37] However, the consequences of internalized abortion stigma for women's well-being have not been investigated and deserve further attention. Some women also resisted taking on a negative self-perception in the face of stigma—for example, by reframing their abortion as successful problem solving. This finding is promising, as a deepened insight into the stigma management behaviors of these women could help in the development of broader initiatives for reducing abortion stigma.

The reviewed studies further showed that women frequently concealed their abortion history to manage stigma, providing an explanation for why few women reported experiences of actual discrimination. While secrecy can be a way to avoid enactments of stigma, there was also some, albeit limited, indication that this form of stigma management can come at considerable costs. One study found that secrecy is associated with elevated levels of psychological distress.[27] Additionally, results suggest that secretive behaviors can go along with more suppression of thoughts and emotions, as well as social isolation. This might reduce women's resources of social support for dealing with potentials strains related to their abortion experiences. Studies involving other stigmatized individuals (i.e., bisexual men or people living with HIV or AIDS) have found that loss of social support is associated with increases in symptoms of depression and anxiety.[38–40]

Overall, the available studies provide an important insight into the prevalence of abortion stigma in women's lives and point to a link between abortion stigma and impairments in psychological functioning, apparently mediated in part by secrecy as a means of stigma management. However, the available data are not conclusive because of the small number of studies investigating these issues. More research is needed to understand the complex interaction between abortion stigma (both perceived and internalized) and contextual variables, individual characteristics and mental health outcomes. Relatedly, a deepened insight into women's stigma management strategies apart from secrecy could facilitate the development of interventions for helping women affected by abortion stigma. In addition, most of the studies did not include partners of women who had had abortions. Because women's partners may be closely associated with their abortion decision, future research is needed to understand whether they are affected by abortion stigma.

Effects of abortion stigma also were found among medical personnel. Providers of abortion care reported that they perceived stigma related to their work, which had the potential to reduce the quality of their professional lives. Although the great majority of providers appeared to be capable of maintaining a positive sense of self-worth in the face of stigma, perceived stigmatization in abortion work is a serious concern. It might keep professionals from offering abortion services, thus increasing the barriers women face in trying to obtain safe and timely abortion care.[41,42] On the other hand, limited evidence from qualitative studies suggested that providers are not only targets, but also sources, of stigmatization. More research is needed to examine abortion providers' role as both perpetrators and objects of abortion stigma, since the number of studies investigating the issue was too small to allow definitive conclusions.

This review of the literature further revealed a paucity of studies testing stigma reduction interventions. Only two interventions,[21,22,33] designed for women who have had abortions and for abortion providers, were identified. While quantitative and qualitative evaluation of the interventions suggested that increasing social support may be a way to reduce stigma, small sample sizes and lack of control groups made it difficult to assess their efficacy. No studies sought to raise support in the public for women who have had abortions. This result is of special concern, given

that several studies suggest that public attitudes stigmatizing women who have had abortions are common. Thus, in addition to directly supporting affected individuals, future interventions should aim at fostering public empathy for women and the complex situations they face when making an abortion decision.[15,43–45]

A number of general methodological issues limited the validity of included studies and made comparisons among them difficult. First, most of the studies involved nonrepresentative samples and were vulnerable to selection bias. Because abortion stigma is a sensitive issue, underreporting is likely to occur, which could mean that the prevalence and impact of abortion stigma were underestimated in study populations. Second, many studies did not clearly derive their assessment instruments from theory, and thus measures of abortion stigma varied. Some measures were based on a single item and were not tested for reliability or validity, which limited the conclusions that could be drawn. Furthermore, the use of divergent measures made comparisons across studies difficult. Reliability and validity of existing scales that measure abortion stigma need to be further established as well. Nevertheless, these scales are useful as a starting point for assessing abortion stigma and its consequences. Third, some studies included in the review might not adequately reflect current manifestations of abortion stigma because of their early publication date.

Limitations of the Review

One limitation of this review is that searching only for studies written in English and German may have led to the exclusion of relevant studies published in other languages. Additionally, only studies published in peer-reviewed journals were included; this criterion was meant to ensure reporting quality, but may mean that relevant gray literature was missed.

Conclusion

Despite its limitations, this review has a number of important implications for a field of research that has received little attention. Induced abortions are common, and women who have them experience various types and degrees of stigma. Available findings indicate that abortion stigma has the potential to impair women's and abortion care providers' well-being. Current theoretical frameworks and instruments for measuring abortion stigma must be further developed in order to systematically advance understanding of the different aspects of abortion stigma and associated psychological outcomes. Literature from established research areas on stigma may be instructive. Future studies should also undertake representative investigations on abortion stigma using validated instruments. Additionally, a research agenda is needed to identify protective factors against abortion stigma. Once abortion stigma and its measurement are better understood, interventions can be designed with the goal of strengthening women's and providers' resilience to this stigma.

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Acknowledgments

The authors thank Franziska Lehnig for her helpful comments during the preparation of the manuscript. Anja Hilbert was supported by grant 01EO1001 from the German Federal Ministry of Education and Research.

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