

LIVED EXPERIENCES OF STIGMA: NURSES WHO WORK IN ABORTION CLINICS

A Thesis
Submitted to the Graduate Faculty
of the
North Dakota State University
of Agriculture and Applied Science

By

Rosa Leigh Jacobs

In Partial Fulfillment of the Requirements
for the Degree of
MASTER OF SCIENCE

Major Department:
Nursing

April 2015

Fargo, North Dakota

North Dakota State University
Graduate School

Title

Lived Experiences of Stigma: Nurses Who Work in Abortion Clinics

By

Rosa Jacobs

The Supervisory Committee certifies that this *disquisition* complies with North Dakota State University's regulations and meets the accepted standards for the degree of

MASTER OF SCIENCE

SUPERVISORY COMMITTEE:

Molly Secor-Turner, PhD, RN

Chair

Kristen Benson, PhD

Shila Thompson, PhD, RN

Mykell Barnacle, DNP, FNP-BC

Approved:

April 13, 2015

Date

Carla Gross, PhD, RN

Department Chair

ABSTRACT

The profession of nursing is respected and trustworthy, but certain nursing specialty fields are looked at less favorably than others. Abortion nursing can be highly stigmatized because of society's ethical, religious, and legislative arguments about abortion. This qualitative study with ten licensed nurses who work in abortion care in the United States sought to answer two research questions, "What are the lived experiences of nurses who work in abortion clinics?" and "How do nurses who work in abortion clinics experience stigma?"

Three stigma themes and seven lived experience themes emerged from the research. The stigma themes pertain to participants' experiences with stigma and were identified as: experiences with public stigma, occupation disclosure, and job satisfaction. The lived experience themes detail the broader experiences of nurses who work in abortion clinics. Those themes were identified as: feminism/women's rights, lack of education, providing support, positive impact, challenging experiences, resilience, and social support.

ACKNOWLEDGEMENTS

Thank you to the members of my thesis committee for your valuable input and for your support of my research. I would like to express my utmost gratitude to the chair of my committee, Dr. Molly Secor-Turner. This research would not have been accomplished without the encouragement, guidance, and commitment you brought forward, so I am incredibly appreciative of all your efforts.

Of course, I would also like to thank my family and friends for all their support and encouragement during my graduate studies. Thank you to Becca for knowing when I needed distraction and when I needed motivation, always being able to make me smile, and letting me spoil the dog; to my parents and Jess for listening to me, guiding me, and providing endless support; to Kolby for being my grad school buddy and getting us through it together; and to my dear friends for keeping life fun and interesting! I am overwhelmed with gratitude for all those who have made this journey possible. Thank you for everything.

TABLE OF CONTENTS

ABSTRACT	iii
ACKNOWLEDGMENTS	iv
LIST OF TABLES	vii
LIST OF FIGURES	viii
CHAPTER I. BACKGROUND AND SIGNIFICANCE	1
Statement of the Problem.....	1
Purpose of the Study	2
Significance for Nursing.....	2
CHAPTER II. LITERATURE REVIEW AND STUDY FRAMEWORK	4
Review of Related Literature	4
Theoretical Framework.....	22
Research Questions.....	22
Conceptual and Operational Definitions.....	22
Assumptions	24
CHAPTER III. METHODOLOGY	26
Research Design.....	26
Population and Sample	27
Institutional Review Board Approval	27
Data Collection	27
Data Analysis	30
CHAPTER IV. RESULTS.....	32
Demographic Information.....	32

Data Analysis	34
CHAPTER V. DISCUSSION AND CONCLUSIONS	45
Interpretation of Results.....	45
Limitations and Strengths	63
Implications for Nursing Practice	63
Recommendations for Further Research.....	67
Conclusion	69
REFERENCES	70
APPENDIX A. EMAIL REQUEST FOR PARTICIPANTS	76
APPENDIX B. DEMOGRAPHIC QUESTIONNAIRE.....	77

LIST OF TABLES

<u>Table</u>	<u>Page</u>
1: Interview Schedule	29
2: Compiled Results from Demographic Questionnaires	33

LIST OF FIGURES

<u>Figure</u>	<u>Page</u>
1: Four Types of Stigma (Bos et al., 2013).....	15
2: Stigma Faced in Abortion Nursing. Adapted from Four Types of Stigma by Bos et al. (2013).....	20

CHAPTER I. BACKGROUND AND SIGNIFICANCE

Mental illness, homelessness, criminal convictions, drug use and abuse, and abortion all carry stigma because of their deviance from the perceived pro-social behavior in modern society. Therefore, the nurses working with these populations are likely to face the effects of stigma as well due to their relationship to the individuals and communities. Those patients and nurses may face judgment, harassment, and/or discrimination because of their stigmatized identities (personal or occupational). Thus, a problem for the nursing profession within the multiple settings has been identified. However, the proposed research study will focus on only one subgroup of stigmatized nurses: those who work in abortion clinics.

Statement of the Problem

Stigma associated with abortion is not likely to go away in any foreseeable future. Religious beliefs, ethical/moral views, personal experiences, and cultural/media depictions are a few means that continually impact opinions about abortion (Lipp 2011b). In the political arena, the topic of abortion has continued to become a more polarized and partisan issue over time with each side using such rhetoric as accusing the other of waging ‘war on women’ (Caldwell, 2014). Much of the existing research about the topic of abortion is focused on the patient perspective, while fewer studies address the nurses who work in the setting (Lipp, 2011b). Therefore, further research is needed to explore how stigma impacts nurses who work in abortion services.

Not only are nurses who work in abortion care at higher risk for social stigma, but they also have an increased risk for violence. According to an Anti-Choice Violence and Intimidation fact sheet from 2010, there have been more than 6,100 reported acts of violence perpetrated against abortion providers since 1977 (NARAL Pro-Choice America, 2010). These acts of violence include assaults, harassment, bombings, arsons, kidnappings, death threats, and

murders. Since 1991, eight murders and 17 attempted murders of abortion clinic workers have occurred (NARAL Pro-Choice America, 2010). Therefore, nurses who work in abortion care may face legitimate concerns for their safety in addition to other potential problems from stigma.

Purpose of the Study

The purpose of the proposed study was to gain insight and understanding into the concept of stigma and its actualization and effects on nurses working in abortion clinics. A critical literature review reviewed existing research sources to determine what is already known about the phenomenon of interest. After the literature review, a qualitative research study was conducted with licensed nurses currently working in abortion clinics. The findings were analyzed as to add to the existing body of knowledge about the phenomenon of stigma in abortion nursing.

Significance for Nursing

Current research indicates that one half of all pregnancies in the United States are unintended, and of those, four in ten will end in abortion (and nine out of ten of those abortions occur within the first trimester of pregnancy) (McLemore & Levi, 2011). Numerically, that means over a million legal abortions occur each year in the US (Jones & Jerman, 2014). Hospitals and clinics throughout the country perform abortions, and nursing professionals are key team members assisting with these gynecological procedures. “Gynecological nursing has been described as women in a woman’s job carrying out women’s work. This makes the world of gynecological nursing a closed one with its own professional culture and shared meanings” (Lipp, 2011b, p. 115). Due to the ‘closed world’ of gynecological nursing, one can imagine that the world of abortion work is even more closed off from outsiders.

Nurses working in abortion services realize that the decision to terminate a pregnancy is profound and is likely to affect the woman explicitly and/or implicitly for a significant period of

time (Lipp, 2008b). Researchers Lipp (2008b) and McLemore and Levi (2011), offer the following observations about some of the demands on nurses working in abortion (respectively): “Dealing with a woman undergoing abortion demands great skill and sensitivity often within a constrained period with the nurse circumnavigating embarrassment and vulnerability to ensure that the woman has made the right decision” (p. 16) and “The sensitive and controversial nature of abortion decisions and the emotional, spiritual, and psychological effects these decisions have on women, their social support systems, and health care professionals who care for them must be managed by well-trained nurses” (p. 675-676). Difficult and complex demands are often made of nurses in all settings. Assisting people through both the mundane and the traumatic is considered to be a normal part of the job and nurses are expected to be able to manage and cope effectively with the circumstances facing them (Huntington, 2002). However, nurses are still biopsychosocial beings who are affected by their experiences. Having an expanded understanding of nurses’ experiences with stigma in the context of working in abortion clinics, the effects of the stigma, and how nurses manage and cope with the stigma adds to existing knowledge about the phenomenon. In addition, findings may inform conversations about stigma amongst other professions and has the potential to produce findings which may be beneficial to other areas of research in health care, sociology, and psychology.

CHAPTER II. LITERATURE REVIEW AND STUDY FRAMEWORK

For the purpose of the current study, the literature review is divided into three parts. Additional components of this chapter include the study's theoretical framework, conceptual and operational definitions, and assumptions. The research questions are also presented in this chapter.

Review of Related Literature

Each section of the literature review pertains to a specific topic. The first section explores existing literature about occupational dirty work. Second, the literature regarding nurses who work in the abortion services is reviewed. Finally, the third section covers existing literature about stigma and how it pertains to nursing.

Occupational Dirty Work

Dirty work is conceptualized to mean physically, socially, or morally tainted work. The 'dirtiness' is a social construct, meaning that it is not necessarily inherent in the work or workers themselves, but it is imputed by others based on subjective ideals of cleanliness and purity (Ashforth & Kreiner, 1999). Because other members of society regard themselves as clean, they also tend to feel superior. That feeling impacts people's relationships with dirty workers, as they will generally try to distance themselves, both behaviorally and psychologically, from the dirty work and those who do it (Ashforth & Kreiner, 1999). Nurses working in abortion may be considered tainted physically (due to working closely with intimate parts of the female body), socially (due to generally taboo topics such as abortion, sex, contraception, and menstruation), and morally (because abortion is a controversial issue in many cultures due to the demise of the fetus) (Bolton, 2005). The concept of dirty work has implications for this research because dirty workers (abortion nurses) become affected mentally and emotionally by how society views them.

While this conceptualization is similar to that of stigma, occupational dirty work can be differentiated from stigma.

Researchers point out that the dirty workers are influenced primarily in two ways. The first way is simply because prior to entering the dirty work job, they were likely exposed to the same social beliefs that permeate communities (such as negative depictions of the dirty work and/or disparaging comments about dirty workers) and therefore may have come to internalize some of that taint about their eventual line of work. Secondly, the influence of the media and popular culture is quite inescapable and often that influence can be shown through demeaning questions (“How can you do it?”), putdowns, and a lack of respect for the occupational identity (Ashforth & Kreiner, 1999). Because of these external influences, dirty workers are often more acutely aware of the stigma attached to their work. Thus, the real question for these workers is really not “How can you do it?” but “How do you do it while retaining a positive self-definition in the face of the social assault on the work that you do?” (Ashforth & Kreiner, 1999). Research suggests that dirty workers do not tend to suffer from lower occupational esteem than any other type of worker because the dirty work stigma fosters the development of a strong workgroup culture; the strong cultures then facilitate esteem-enhancing social identities (Ashforth & Kreiner, 1999).

Occupational dirty work is conducted across a range of professions (janitors, prison guards, etc.) and occupational identity is often a prominent badge that serves to identify oneself to others (Kreiner, Ashforth, & Sluss, 2006). While certain types of stigmas (such as physical ailments) may be thought to be beyond one’s control, society may blame the individuals for entering into the stigmatized work, therefore perceiving occupational stigma as controllable (Kreiner, Ashforth, & Sluss, 2006). So while nursing is generally thought of as a prestigious

field, nurses who work in abortion clinics must deal with the public's perception of the dirty work they do and face the realities of living with a stigmatized occupational identity (Ashforth, Kreiner, Clark, & Fugate, 2007; Kreiner, Ashforth, & Sluss, 2006). The literature regarding nurses who work in abortion settings will be explored next.

Nurses Working in Abortion

Throughout the history of abortion in the US, and particularly since the legalization of abortion, nurses have been partaking in the education, counseling, and care of women who seek abortion services (McLemore & Levi, 2011). Many of the studies examining nurses and abortion between 1971 and 2010 were conducted in the United Kingdom (UK) (McLemore & Levi, 2011) while few were conducted in the US. The vast majority of nurses working in abortion services are female, abortion is a uniquely female procedure, and many of the efforts to make abortion legal have been led by women (Huntington, 2002); thus, many of the studies reviewed used feminist theory as the theoretical framework. According to recent research, nurses in the US and UK have views on abortion that mirror general public statistics, but views on abortion of nurses in the US are less favorable than those of other health care professionals and are often more radical/polarized (Lipp, 2008a). Also, attitudes of nurses toward abortion are the least favorable in the Midwest and the most favorable on the West Coast (Lipp, 2008a).

Legally, the responsibility of the nurse in abortion care is quite straightforward as nurses can choose whether or not to provide care for women seeking abortions and workplace laws do not mandate the provision of abortion so hospitals and clinics are able to choose whether they offer abortion services or not (McLemore & Levi, 2011). Even in settings where abortion services are provided, nurses are not required to participate in abortions in which they choose not to assist (Gallagher, Porock, and Edgley, 2010). Also, not all abortions are performed in

designated abortion clinics (as some abortions are performed in hospitals). According to Kumar, Kumar, Polis, and Schaffer (2004), hospital-based services are often better equipped to perform late-term abortions, perform abortions for those with special medical needs, and to deal with medical complications. Research conducted by Kumar et al. (2004) was performed in Massachusetts, which is within the New England area of the US and is an area considered to offer some of the most accessible abortion services within the country. Their study explores how barriers to abortion access in the form of nursing staff unwillingness to assist in abortions may also exist. Kumar et al. (2004) found in their study that nurses sometimes resist assisting in hospital-based abortions not only because of personal convictions, but also because of fear for personal safety and anti-choice sentiments within the work environment.

Research has illustrated that nurses have clear views about their own participation (or lack thereof) in an occupational role in abortion care including religious beliefs, the reason for abortion as stated by the patient, and the potential financial impact of unintended pregnancy (McLemore & Levi, 2011). Overall, nurses who have negative attitudes toward abortion and are not likely to participate in abortion care state that their primary reason for this is religion (McLemore & Levi, 2011). Also influencing attitudes toward abortion is 'termination criteria' or reasons women are seeking abortion such as gestational age, rape or incest, failed contraception, physician/clinician advice, and health of the mother (McLemore & Levi, 2011). For instance, advanced gestational age nearing 24 weeks causes discomfort even in nurses who are comfortable assisting in earlier-term abortions (Gallagher et al., 2010), which would be an example of a negative influence. Criteria that lead to nurses feeling more comfortable about terminations are the other factors such as physician advice to obtain an abortion or failed contraception being the cause of the pregnancy (McLemore & Levi, 2010). Finally, financial

reasons for seeking abortion, such as the inability to pay for additional children, also influence nurses' opinions in that they are more likely to support termination if the woman has inadequate socioeconomic resources (McLemore & Levi, 2011). While those are a few factors influencing the perceptions and opinions of whether nurses may want to participate in abortion procedures or are against abortion altogether, studies explore many more questions in terms of nursing involvement.

In a study conducted by Wolkomir and Powers (2007), abortion workers often identified 'helping women' as a reason for entering the occupation and expressed that they want to keep reproductive choice available in people's lives. Similar to Ashforth and Kreiner's (1999) findings, abortion workers highly value the support of team members, as colleagues seemed better able to understand and support the experiences and views of those who worked in abortion services (Gallagher et al., 2010).

Lindstrom, Wulff, Dahlgren, and Lalos (2011) conducted focus group sessions with gynecologists (n=25) and midwives/nurses (n=15) to elucidate their experiences, interactions, and perceptions of working in abortion services, which was some of the first research specific to the topic. The midwives and nurses related that when working with induced abortion, they focused on caring for the women and attempting to ease pain while also dealing with feelings of frustration, powerlessness, and sympathy. Therefore, the researchers noted that the people working in abortion care often felt paradoxical emotions in that their work was frustrating at times, but challenging and rewarding at others (Lindstrom et al., 2011). This finding of having paradoxical thinking and contradictory feelings was found in previous research with men and women choosing abortion as well (Lindstrom et al., 2011). One of the most frustrating subjects for the participants was that of repeat abortions. The participants felt like they had failed by not

preventing a repeat abortion and ensuring proper contraception (Lindstrom et al., 2011). In regard to late-term abortion, the midwives and nurses had a harder time coping with this type of abortion than did the gynecologists; the nursing professionals suggested it may be explainable because nurses are closer with the patient throughout the whole process (Lindstrom et al., 2011). The midwives/nurses in the study spoke about wanting more of a forum for reflection about their experiences. The study also highlighted the need for collaboration between the medical doctor and the nursing team. Building trust and security amongst the team members was discussed as being an important function when working in abortion services (Lindstrom et al., 2011). Additional suggestions for nurses are that they need to remain cognizant of their own complex thoughts, beliefs, and perceptions of abortion and women who seek abortion in order to provide appropriate and meaningful care to these women (Lipp, 2008b). Nurses who work in abortion services undoubtedly make a strong impact on the immediate experience of the woman and on the long-term recovery after the procedure (Huntington, 2002), therefore the importance for self-awareness among nurses is substantial in terms of how it has the potential to influence the patient experience.

Gallagher et al. (2010) conducted an exploratory qualitative study of nine registered nurses and nurse midwives who worked in abortion clinics in the UK. They found that the participants had experienced a range of reactions to their occupation. The participants spoke of being hesitant to identify to others where they work and what they do and would attempt to control situations in which they could be pressured to discuss their jobs (Gallagher et al., 2010). The nurses in the study indicated that within the occupational context, however, they felt they were providing a valuable service and helping women. The nurses highlighted that the choice to have an abortion was not theirs to make, they wanted to make sure the decision was right for the

woman and supported her if it was her choice, and wanted to ensure that she could obtain an abortion in a safe environment (Gallagher et al., 2010). A study by Lipp (2008b), also found that nurses wanted to make sure the woman was making her own decision and that she was confident in that choice. Nurses stated that when a woman was not confident and elected not to have an abortion, they did not view that as a problem and were glad to have facilitated a decision-making process which resulted in the woman choosing what was right for her (Lipp, 2008b). Gallagher et al. (2010) conclude their research study by stating “The concept of nursing in this situation, therefore, appears to be ensuring that client choice is respected through facilitation of this choice as part of professional duty” (p. 855). By focusing on the client and action for her benefit (woman-centered service), nurses are able to support and empower women in their decision-making (Lipp, 2008b), thus defining the nature of nursing in abortion services (Gallagher et al., 2010).

The study by Gallagher et al. (2010) also found that nursing professionals working in abortion services were deliberate in how they interacted with patients; one example being in their language (using the term ‘fetus’ instead of ‘baby’ to avoid connotations which may make the woman feel distressed). Deliberate interactions seem necessary for the benefit of the patient as well as the nurse. In terms of dealing with their own emotions regarding abortion care, nurses sometimes have to ‘shut off’ (remove access to the emotions), ‘harden’ (raise a barrier to the emotions), and ‘step back’ (mentally distance oneself from the emotions) (Lipp, 2008b). Research indicates that dealing with women’s grief can be emotionally intense, but doing so is a gift that is not often regretted (Bolton, 2000). Studies show that nurses can clearly recognize the emotional difficulty, yet remain primarily focused on the emotional impact of abortion on the women and push their own emotions to the background (Bolton, 2000; Lipp, 2008b). Individuals

in the healthcare world are expected to experience emotion in order to cope with difficult situations and interact meaningfully with people in distress (Huynh, Alderson, & Thompson, 2008).

Emotional labor can have positive and negative consequences. Emotional involvement may lead to increased performance, productivity, and an individual's sense of personal and professional accomplishment. However, emotional exhaustion has been shown to cause depersonalization of patients, exhaustion, stress, and less job satisfaction (Huynh et al., 2008; Wolkomir & Powers, 2007). Workers who are more heavily invested in their job are often more vulnerable to the negative consequences of emotional labor because their sense of self becomes heavily intertwined in their work identities and they cannot always adequately distance themselves from client hostilities and high-demand stressors (Wolkomir & Powers, 2007). Thus, concepts such as self-preservation and 'protecting the self' were found to be employed by nurses when working with particularly challenging or ambivalent women (Wolkomir & Powers, 2007; Lipp, 2011a). One study by Bolton (2005), describes an example of emotionally challenging work nurses face such as when assisting with an abortion for a woman who is relieved when the unwanted pregnancy is terminated then next attend a termination of a wanted pregnancy with a grieving woman.

Managing the unique needs and demands of each patient can prove challenging for nurses (Nicholson, Slade, & Fletcher, 2010). A study by McQueen (1997) found that nurses caring for patients who were emotionally upset may not always know what to say to the patients who may start crying or become upset, but reflected compassion and empathy in their behavior by doing such acts as sitting with the patient and making physical contact to legitimize the patient's feelings. Interactions with family members and/or partners of the female patients may also be

difficult. Nurses are holistic care providers, thus caring for patients' relatives/partners is an additional experience and the feelings and behaviors of these individuals must also be managed by nursing professionals (McQueen, 1997). Meeting all of these people on an individual level in their own unique contexts means that nurses have to provide a wide range of individualized care.

Generalization of findings from the literature are limited by the use of qualitative methods and small sample sizes. However, the use of qualitative methods provides an intensive review of the particular and unique experiences of nurses working in abortion services. Other limitations include the detail that many of the research studies reviewed were carried out in the UK, primarily in Great Britain. It may be notable to mention that the role of nurses in the procurement of abortion services is often different than the role of nurses in the US, particularly in regard to medical abortions (which is the use of medications to create a miscarriage effect). In Great Britain, physicians are required to prescribe the medications, but the administration of the medications and the supervision of the procedure is usually done by nurses (Berer, 2009). Also, women seeking medical abortions are almost always required to come into the clinic or hospital twice, once to receive the first medication and then two days later to receive the second medication and complete the abortion, which is attended most often by a nurse (National Health Services, 2012). Whereas in the US, women are usually not required to come back to the clinic or hospital for a second time (so they take the medication and have the abortion at home), and states have varying laws about who can prescribe and administer the medications, but those options are limited to physicians and advanced practice providers such as physicians' assistants, nurse practitioners, and nurse midwives (Berer, 2009). From 1971 to 1991, the American College of Nurse Midwives prohibited midwives from performing abortions. Now, advanced practice nurses such as nurse practitioners and certified nurse-midwives are legally allowed to

perform surgical abortions in 14 states and are allowed to perform medication abortions in one state (McLemore & Levi, 2011). So in terms of nurse involvement, the literature indicates that nurses working in abortion services in the US (perhaps with the exception of advanced practice nurses) have a lower degree of involvement with the actual abortion than nurses who work in the field in Great Britain, which could influence the applicability of some of the findings.

Nurses who work in abortion services often have additional causes of stress beyond typical healthcare-related factors. These additional causes of stress for nurses may be fear for their physical safety and concerns related to societal stigma (Wolkomir & Powers, 2007). The concept of stigma will be explored next.

Stigma

Erving Goffman's theory on stigma, which will be used as the theoretical framework for this study, originated in sociology, but its influence has been felt in psychology, criminology, and the health sciences (Bos, Pryor, Reeder, & Stutterheim, 2013). The term stigma dates back to the Greeks who would cut or burn marks into the skin of slaves, traitors, and criminals to identify them as those who should be avoided (Goffman, 1963). The term has since evolved from merely a physical distinguisher to an attribute that is discrediting and results in social disapproval (Bos et al., 2013). Stigma is recognized to occur within social interaction; meaning that stigma is not something which resides in a person, but rather it exists in a social context (Bos et al., 2013). Because it is socially constructed, what may be stigmatized in one setting may not be stigmatized within a different context (Crocker, Major, & Steele, 1998). Goffman posited that every society has stereotypes and expectations from its members (Lipp, 2011b). One example is that of a young woman of child-bearing age in American society: that woman is expected to enter into a serious relationship, eventually become pregnant, and then give birth to a healthy baby. That sort

of expectation is termed one's 'virtual social identity', but sometimes the 'actual social identity' does not match with the virtual, expected one; thus, stigma is born (Lipp, 2011b).

One of Goffman's main contributions was that he recognized that there is commonality across a wide range of social stigmas and each is dynamically interwoven into society's fabric (Bos et al., 2013). Take for example, that stigmatization has many functions including: evolutionary functions (avoiding those who are diseased and thus preventing infection and illness); social norm enforcement functions (threat of stigmatization encourages deviants to conform); and dominance/exploitation functions (attempts to keep others down and maintain inequality between groups) (Bos et al., 2013).

Stigmatization may be subtle or overt. Its manifestations may come in the forms of social rejection, dehumanization, discounting or discrediting, avoidance, or non-verbal signs of discomfort which lead to tense social interactions between those who are stigmatized and those who are not (Bos et al., 2013). Prejudice and stigma are similar concepts, however differentiation between the two has been a recent undertaking in psychosocial research. Bos et al. (2013) suggests that stigma "necessarily involves reactions to perceived negative deviance" (p. 5) whereas prejudice "does not necessarily connote a reaction to deviance" (p. 5).

Research has shown that stigma exists on societal, interpersonal, and individual levels. Pryor and Reeder (2011) developed a conceptual model showing four dynamically interrelated

levels of stigma: public stigma, self-stigma, stigma by association, and structural stigma. The model is included as Figure 1.

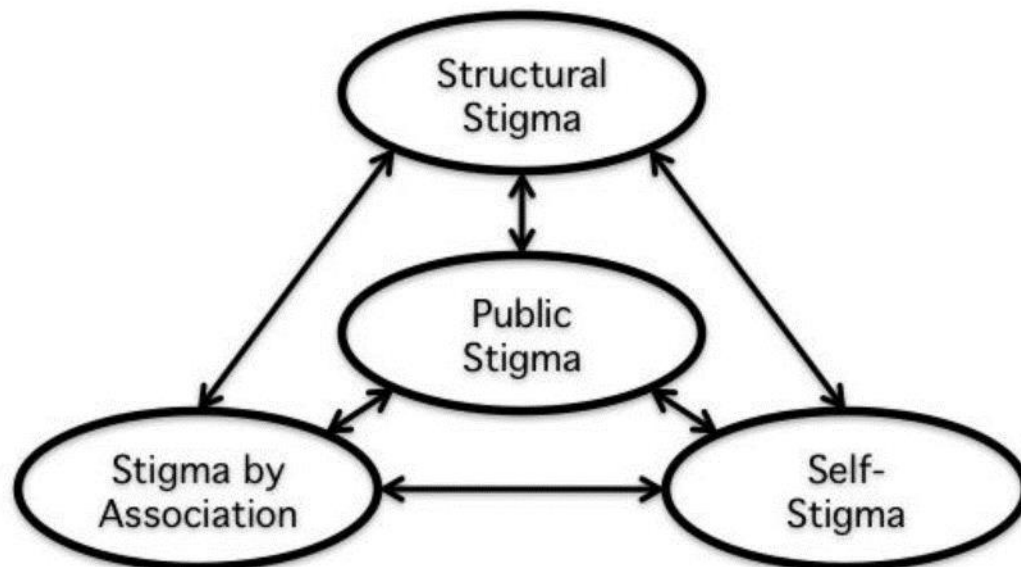


Figure 1: Four Types of Stigma (Bos et al., 2013)

Public Stigma. Public stigma is the core of the model as it represents people's reactions (socially and psychologically) to someone they perceive as stigmatized. Public stigma is comprised of the cognitive, affective, and behavioral reactions of those who perceive the stigmatized one (Pryor & Reeder, 2011). This is the center of the model because stigma lies primarily within the representations that people (perceivers) hold about those who have the stigmatized attribute (Bos et al., 2013). Those representations trigger negative emotional and behavioral responses. The perceived severity and perceived dangerousness of the attribute contribute to public stigma and how people respond to the stigmatized individuals (Bos et al., 2013). Examples that impact and dictate public stigma within the context of this research are anti-abortion protestors, anti-abortion violence, and polarized views and discussions between those who are pro-choice and anti-choice.

Additionally, perceptions of norm violation are negatively related to sympathy and positively related to feelings of anger and social exclusion (Bos et al., 2013). Researchers have identified that perceivers typically manifest an automatic and immediate aversion to stigmatized individuals which is then followed by control and thoughtful reflection which may reduce the immediate negative reaction or further polarize it (Bos et al., 2013). Those who are stigmatized may likely sense these types of reactions and hope that interaction and reflection will lead to more positive views regarding their stigma.

Important to note is how public stigma can often be dependent upon labels. For instance, clinics performing abortion may mostly exist for that purpose, but other clinics may be full-service gynecological clinics. Women entering a place labelled as an abortion clinic may be stigmatized whereas women entering a gynecological clinic or hospital may not be (Lipp, 2011b). This differentiation may be even truer in smaller and tight-knit communities.

Self-Stigma. Like public stigma, self-stigma also has cognitive, affective, and behavioral aspects. Self-stigma is a reflection of the social and psychological impact of possessing a stigmatizing attribute (Bos et al., 2013). Public stigma influences the self through enacted stigma (negative treatment of the person with the stigmatized attribute), felt stigma (the experience or anticipation of stigmatization on the part of the individual with the attribute), and internalized stigma (the psychological distress and reduction of self-worth experienced by those with a stigmatized attribute) (Bos et al., 2013). Individuals have to cope with the onset of the stigma, the continued presence of the stigma, and sometimes the transformation back to normality. In some cases, individuals retain some of the taint even after removal of the stigma (such as a pregnant woman seeking prenatal care who must disclose that she has previously had an induced abortion) and this ‘stickiness’ can last for a long time after the onset of stigma (Lipp, 2011b).

One of the fundamental features of self-stigma concerns the degree to which the stigma can be concealed. Individuals who hide their stigma may ‘pass’ as ‘normal’ but nonetheless remain ‘discreditable’ so long as the stigma remains (Goffman, 1963). Since occupational identity can be concealed in most settings, nurses who work in abortion care may experience a varying degree of self-stigma. Disclosure concerns and anxieties can manifest in psychological distress by these individuals out of concern for who to tell and the fear of being discovered and being looked at as ‘discredited’ in the eyes of others (Bos et al., 2013; Quinn & Chaudoir, 2009). Types of distress resulting from stigmatization include depression, anxiety, defensiveness, self-derogation, and self-hate (Macdonald, 2003). The level of distress can be associated with the centrality of the identity to the self. The greater the centrality, the more distress (Quinn & Chaudoir, 2009). Also, because identities are mostly self-definitional, individuals differ in what the psychological implications may be if the identity is revealed. Based on how much devaluation and prejudice a person may expect if their stigmatized identity is revealed and what intrapersonal factors are in place to handle them, a person may be more or less vulnerable to distress (Quinn & Chaudoir, 2009). Stigma research has demonstrated that on an individual level, people who live in cultures which devalue them can be depressed and anxious, or they may be happy, resilient, and well-adjusted (Quinn & Chaudoir, 2009). This finding highlights that individuals can clearly cope with stigma positively if they have the right tools in place to do so. Because those who work in abortion nursing may choose to disclose their occupational identity or not, differing levels of self-stigma exist.

Finally, stigma consciousness affects the extent to which people experience distress. Stigma consciousness is a type of self-consciousness in which those who are stigmatized sense subtle or overt negative treatment from others. Those who are highly stigma conscious may

perceive more discrimination and, thus, be more distressed than those who are low in stigma consciousness (Pinel & Bosson, 2013). With nurses who work in abortion clinics, their perceptions and experiences may vary depending on how stigma conscious they are.

Stigma by Association. The third level of stigma is stigma by association. Stigma by association highlights that stigma does not only affect those who are stigmatized, but also impacts others. Stigma by association is also comprised of cognitive, affective, and behavioral aspects and entails the reactions (social and psychological) to people who are associated with a stigmatized individual, such as a friend, family member, or caregiver (Bos et al., 2013). Research has demonstrated that those who are associated with stigmatized individuals are routinely devalued because of their connection, whether that connection is meaningful or arbitrary (Bos et al., 2013). Nurses who work in abortion clinics may experience this type of stigma as well because of their relationship with women who are seeking abortion (Pryor, Reeder, & Monroe, 2012; Lipp, 2011b). Additionally, the impact of how their own job affects others may be a considerable factor for the nurse. For instance, nurses who work in abortion care may wonder about or be impacted by questions such as: “What do my parents say about me and my job?”, “Are my loved ones proud of me?”, or “Do they wish I worked somewhere else?” However, some research has shown that individuals with high levels of self-esteem are not as vulnerable to the psychological impact of stigma by association (Dwyer, Snyder, & Omoto, 2013). So nurses’ perceptions may also vary in regard to stigma by association depending on their level of self-esteem.

Structural Stigma. The last level of stigma is structural stigma. Structural stigma refers to how societal institutions and ideologies perpetuate and legitimize stigmatized statuses (Bos et al., 2013). These sort of structures vary culturally and historically. Therefore, like all other

parts of stigma, structural stigma exists within a social context (Bos et al., 2013). A current structural issue within the United States is a lack of abortion training and education. A release from the American College of Obstetrics and Gynecology (ACOG) in 2014 stated that less than half of medical schools provide required education about abortion to medical students and only 51% of residency programs in obstetrics and gynecology offer routine abortion training. A 2001 survey of accredited nurse practitioner (NP), certified nurse midwife (CNM), and physician assistant (PA) programs in the US showed that only half of the 202 programs which responded to the survey offered didactic instruction and only 21% offered routine clinical training about any type of pregnancy termination procedure (Foster, Polis, Allee, Simmonds, Zurek, & Brown, 2006). No quantifiable data was found regarding the commonality of abortion-related education for undergraduate nursing students. However, also within the current context of the United States, an increasing number of legislative efforts to impose restriction on abortion access and procurement exist. In 2013, the North Dakota Legislature passed, what were at the time, the most restrictive abortion laws in the United States (Keen, 2013). Also, in 2015 there are ten states which have laws restricting insurance coverage for abortion in all private insurance plans, 25 states have laws restricting abortion coverage for plans offered through health insurance exchanges, and 21 states have laws which restrict insurance coverage for abortion for public employees (Guttmacher Institute, March 1, 2015). These insurance laws segregate abortion from other types of medical procedures, which leads to societal views of abortion not being a routine reproductive health procedure, which clearly contributes to societal stigma. With the conclusion of the discussion surrounding the four interrelated levels of stigma conceptualized in the model by Bos et al. (2013), Figure 2, an adapted version of the stigma model with examples for each of the areas related to abortion care, is shown on the following page.

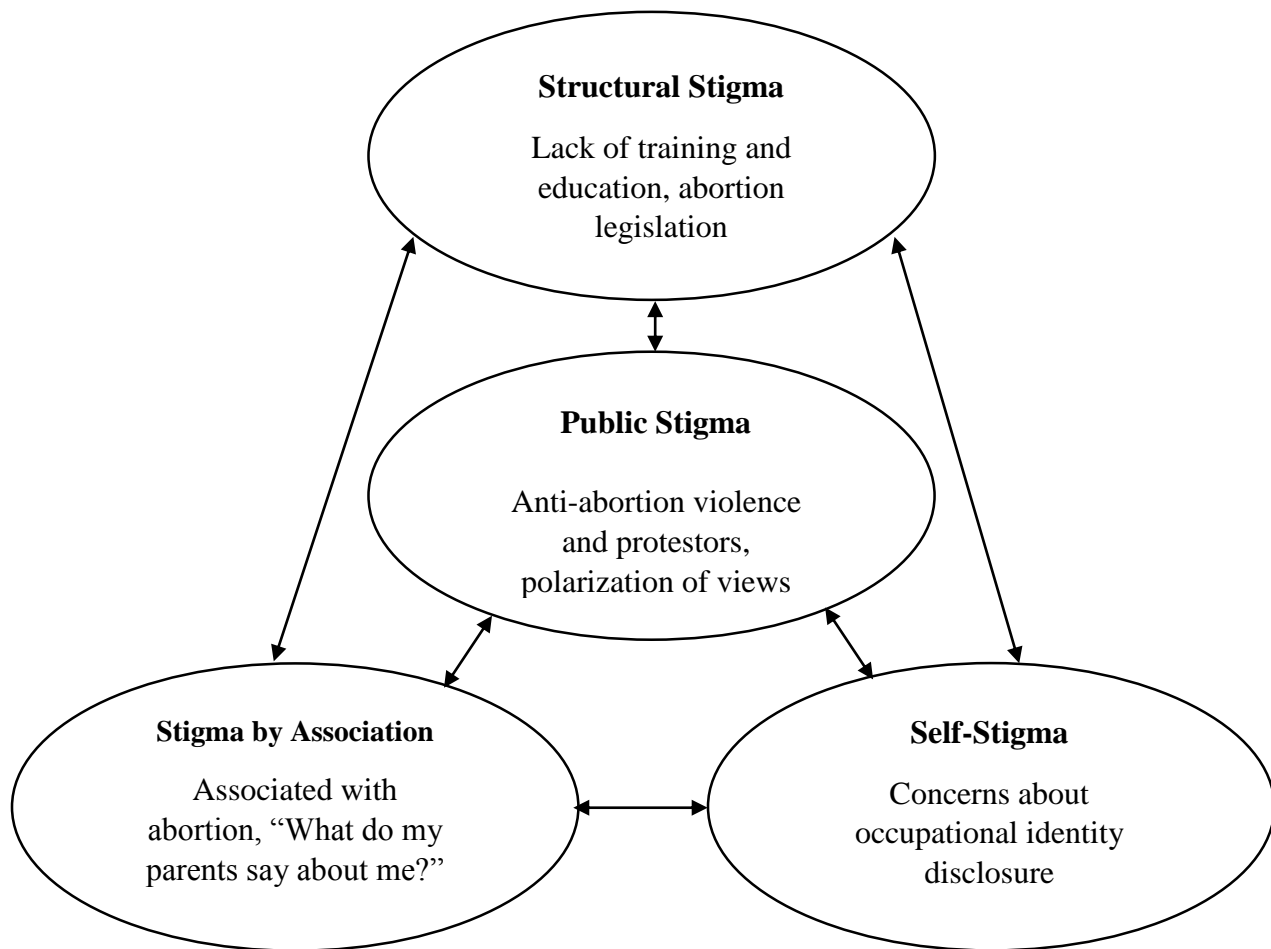


Figure 2: Stigma Faced in Abortion Nursing. Adapted from Four Types of Stigma by Bos et al. (2013)

Abortion Stigma. As an expansion of general stigma, it is necessary to address abortion stigma. Despite abortion being one of the most common gynecological experiences in our society, the procedure is still widely stigmatized (Kumar, Hessini, & Mitchell, 2009). While abortion stigma is often thought of as a universal truth, the experience of stigma is often played out locally and can differ depending on cultural beliefs (Kumar et al., 2009). Researchers hypothesize that the reason abortion stigma is so present is because women who seek abortion end up challenging archetypal constructs of womanhood and defy long-held ideals of subordination to men and community expectations (Kumar et al., 2009). Social scientists argue

that abortion stigma is perpetuated due to unequal access to resources and power, rigid gender roles, and systematic attempts to control feminine sexuality (Kumar et al., 2009). Stereotypically, a woman seeking abortion would be one in early adulthood, single, having had multiple partners, not taking contraception, and be choosing abortion (Lipp, 2011b). While this may fit many cases, the reality is likely much more diverse.

Abortion workers are therefore stigmatized based on their role in the procurement of abortion services. Understanding abortion stigma is necessary to provide meaningful care to women seeking abortion. Goffman (1963) used the term ‘wise’ to describe those who were without stigma themselves, but whose situations made them privy to the lives of the stigmatized. Licensed nurses are undoubtedly considered ‘wise’ in the eyes of society, as they are accepted as being credible as they attend to difficult situations (Lipp, 2011b). ‘Ordinary others’ would be those who are stigmatized with whom the ‘wise’ nurse must build a relationship (Lipp, 2011b). So while abortion workers may not have obvious stigma attached to them, they still carry stigma and must considerately interact with those who are seeking abortion services and likely carry heavier stigma.

The concealable stigma of occupational identity provides for a public-private schematization that is likely different than many other forms of stigma. Often times, home settings are considered private contexts in which individuals feel safe to express themselves honestly and work settings are considered public contexts in which individuals feel the need to constrain their self-expression (Sedlovskaya et al., 2013). However this is not always true in the case of abortion care, as evidenced by the fact that abortion workers likely feel comfortable expressing certain viewpoints amidst their colleagues but may not feel comfortable sharing their views at home. The public-private schematization was found to link concealment with

heightened distress (as evidenced by perceived social stress and depressive symptoms) (Sedlovskaya et al., 2013). With these findings and implications reviewed, thus concludes the review of literature.

Theoretical Framework

Application of Erving Goffman's (1963) stigma theory provides the theoretical framework for the study. The framework posits that stigmatized identities are contextual within society. As previously described, four levels of stigma exist. The core level is public stigma, and that is surrounded by self-stigma, stigma by association, and structural stigma (Figure 1).

Utilization of the framework guides the formation of the research questions. By examining the self-reported experiences of nurses who work in abortion clinics and how they perceive and experience stigma, understanding can be gleaned from these experiences. Identifying and analyzing the experiences of individuals who work as licensed nurses in abortion clinics with respect to stigma is the focus of the research.

Research Questions

The research study addressed the following questions: "What are the lived experiences of nurses who work in abortion clinics?" and "How do nurses who work in abortion clinics experience stigma?"

Conceptual and Operational Definitions

In order to ensure accuracy through the study and for clarity for readers, definitions of concepts and terms follow. While many of the terms identified in the theoretical framework by Erving Goffman are discussed above, they will be defined below along with additional terms to provide a more complete picture. Conceptual definitions as discussed in Goffman (1963) and Bos et al. (2013) are as follows:

Personal Identity. The unique combination of life history and societal facts which is attached to the individual and can be differentiated from all others.

Actual Social Identity. Character and attributes actually possessed by the individual.

Virtual Social Identity. Character imputed to the individual through the eyes of the other.

Stigma. An attribute which is deeply discrediting.

Public Stigma. The cognitive, affective, and behavioral reactions of those who perceive the stigmatized one.

Enacted Stigma. Negative treatment of the individual possessing a stigmatized attribute.

Self-Stigma. The cognitive, affective, and behavioral impacts of possessing a stigmatized attribute.

Felt Stigma. The experience or anticipation of stigmatization on the part of the individual possessing a stigmatized attribute.

Internalized Stigma. The psychological distress and reduction of self-worth experience by those with a stigmatized attribute.

Stigma by Association. The cognitive, affective, and behavioral reactions to those who are associated with a stigmatized individual.

Structural Stigma. The mechanisms of how societal institutions and ideologies perpetuate and legitimize stigmatized statuses.

Covering. Reducing, hiding, or overcoming the effect of one's stigma.

Visibility. Individual adaptation of stigma to show or not show.

Discredited. Stigma is apparent to others.

Discreditable. Stigma is not readily apparent but nonetheless does exist.

Passing. Individuals hiding their stigma and appearing ‘normal’.

Voluntary Disclosure. Individuals are open about their stigmatized status.

Deviance. Departure from the norm or accepted standards.

Impression Management. Control of images/behaviors that the individual displays or wants others to see (managing differences between actual and virtual social identities).

Operational definitions of the terms to be studied as identified in the research question are as follows:

Lived Experience. A first-hand account or story of an experience with a phenomenon of interest.

Nurses. All those who are licensed in the nursing profession including licensed practical nurses (LPNs) and registered nurses (RNs).

Abortion Clinics. Stand-alone health care clinics which provide abortion services.

Stigma. Possession of discreditable attribute.

Definitions are vital to the research so as to establish consistence and clarity among researchers, participants, and readers.

Assumptions

Assumptions of the research study which are held to be true for the research study are as follows:

1. Since participation in the study is voluntary, it is assumed that participants will answer honestly and thoughtfully.
2. Due to their occupation, it is assumed that nurses who work in abortion clinics will have had experiences with public stigma, self-stigma, and stigma by association.

3. Because of current understandings about stigma, it is assumed that stigmatized individuals are viewed as an outgroup; people react to stigmatized individuals in a negative manner; and stigmatized individuals may feel shame, embarrassment, humiliation, and may experience status loss and discrimination because of their stigma.

Through the chapter, the literature related to occupational dirty work, nurses who work in abortion, and stigma was explored. A theoretical framework was identified and research questions were proposed. Finally, conceptual and operational terms were defined and assumptions were stated. Upon completion of the chapter, the methodology for the research will be explored next.

CHAPTER III. METHODOLOGY

Research Design

Interpretive phenomenological analysis (IPA) was utilized in this project due to its focus on lived experience research. The intent of IPA is to discover how individuals create meaning from certain experiences (phenomena) and how they use those to make sense of their personal and social worlds (lifeworlds) (Smith & Osborn, 2008). IPA is a whole research methodology rather than simply a means of analyzing data. IPA involves the processes of phenomenology and hermeneutics to examine participants' lifeworlds and how they interpret the phenomena they encounter and experience (Smith, 2004). The purpose of going through these processes is to “come to an understanding of the deeper meaning or significance of an aspect of human experience, in the context of the whole of human experience” (Van Manen, 1997, p. 62).

As with most qualitative research, there is not a definitive or single method for utilizing IPA. Seemingly, the IPA method has been utilized often to give voice to under-researched, or novelty, groups (Smith & Osborn, 2008), which makes its application particularly relevant to the population of interest. With IPA, the research questions being answered are open and broad and the aim of the research is simply to explore, flexibly and in detail, the subject of interest (Smith & Osborn, 2008). The research questions being addressed in this study (“What are the lived experiences of nurses who work in abortion clinics?” and “How do nurses who work in abortion clinics experience stigma?”) were framed broadly to meet the standards for IPA.

Therefore, the purpose of this IPA qualitative research study was to learn about the lived experiences and effects of stigma for nurses who work in abortion clinics. The participant nurses were interviewed with a focus on the research questions using an interview schedule as a guide.

The interviews were recorded and transcribed verbatim. Thorough analysis using the IPA method was then conducted.

Population and Sample

Purposive sampling methods were used to recruit nurses who work in abortion clinics in the US. Chain referral sampling was utilized to gain access to potential participants due to the exclusive nature of abortion care. Consistent with IPA methods, the study resulted in a sample of ten participants who were licensed nurses working in abortion care from locations throughout the US. Studies guided by IPA method utilize a smaller sample size because of the emphasis on an idiographic mode of inquiry. The purpose of having smaller sample sizes and the intent of idiographic inquiry is to push researchers to thoroughly investigate and share unique perspectives of a particular people in a particular context (Smith & Osborn, 2008). In-depth investigation of the lived experience of nurses who work in abortion clinics can be best performed with a relatively small sample size.

Institutional Review Board Approval

Before the study was initiated, North Dakota State University Institutional Review Board approval was obtained. The individual participants' identities were made known only to the researcher. All participants signed written informed consents prior to involvement with the study.

Data Collection

To begin the participant recruitment and data collection process, the researcher initially sent an email request for participants to the director of the local abortion clinic. The local director was also asked to forward the email on to other abortion clinic directors and managers. The email request is attached as Appendix A. After the request was sent out, potential participants contacted the researchers via email with their interest. When an interested participant

met the qualifications of the study, the informed consent was emailed or mailed to the potential participant. Finally, after the informed consent was signed and returned to the researchers, an interview was scheduled.

The exemplary method for collecting data for IPA is the semi-structured interview. According to Van Manen (1997), by using hermeneutics and phenomenology an interview serves the purposes of “exploring and gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of a human phenomenon” (p. 66) and also to “be used as a vehicle to develop a conversational relation with a partner (interviewee) about the meaning of an experience” (p. 66). Additionally, this method allows for flexibility while still focusing on the topic of interest, facilitates rapport, allows the researcher to delve into novel areas, and tends to produce rich results (Smith & Osborn, 2008). Thus, a semi-structured interview format was utilized during the participant interviews.

Due to the various locations of participants throughout the US, interviews were primarily conducted over the phone, with the exception of two local participants who chose to have face-to-face interviews. All the interviews were conducted at a time deemed to be convenient for the participant and the interviews ranged from 20 to 45 minutes in length. Face-to-face interviews were conducted in a private location determined by the participant. When phone interviews were scheduled, the participants were instructed that during the interview, they should be in a location which was quiet, relatively free of distractions, and somewhere they could talk openly. Both the phone and face-to-face interviews were recorded and transcribed verbatim.

An interview schedule was utilized by the researcher while interviewing participants. Having an interview schedule is recommended in IPA because it forces researchers to explicitly identify some topics the interview is to cover, and it also allows the interviewer to focus more

thoroughly on the participant because a set idea about some areas which should be discussed during the interview already exist (Smith & Osborn, 2008). The interviewer must attempt to draw the person into the question, make him or her curious about it, and facilitate an environment where the interviewee feels comfortable discussing the subject (Van Manen, 1997). The interview schedule detailed in Table 1 was utilized for the study.

Table 1

Interview Schedule

Interview Schedule: nurse's lived experience and stigma effects	
1.	Can you give me a brief history of your career as a nurse? a. Why did you want to become a nurse?
2.	What about who you are drew you to this profession?
3.	Tell me about how you ended up working in abortion care.
4.	During your nursing education, what were you taught about abortion?
5.	What is important to you when working in abortion care? a. How has working in abortion care made a difference in how you see yourself?
6.	Are there experiences that have been particularly challenging to working in abortion care?
7.	How has working in abortion care changed the way other people see you or interact with you? a. What about family and friends? b. What do you think about that?
8.	Can you tell me about a meaningful experience you have had working as a nurse in abortion care?
9.	How does the political climate affect the work you do? a. How do you see it impacting the experiences of your patients?
10.	How have you experienced stigma in your role as a nurse working in abortion care? a. Can you tell me a story about a time you felt particularly stigmatized? b. Are you stigmatized in other ways than your work?
11.	I'm curious about how you are able to deal with stigma as a nurse who works in abortion care. What is it like to be a licensed nurse dealing with stigma? a. Can you tell me about a personal attribute that helps you deal with stigma? b. What types of support do you have? c. Do you have people in your life who are particularly supportive? Who are they? d. What keeps you going? e. What makes you feel resilient to stigma? Why?
12.	Are there any other experiences you would like to share with me?

After conclusion of the interview, the participants were sent a demographic questionnaire to complete and return to the researcher. The results from the demographic survey were used to determine the makeup of the sample and for comparison in data analysis. The demographic survey is attached as Appendix B.

Data Analysis

The process of a data analysis in the realm of qualitative study is to examine and interpret the data “to elicit meaning, gain understanding, and develop empirical knowledge” (Grove, Burns, & Gray, 2013, p. 279). A principal tenet of IPA is that the researcher is interested in learning about participants’ lifeworlds. Meaning is central to IPA analysis, so the researcher must attempt to capture and adequately portray the meanings of the participants, which must be done through an intentional and interpretive engagement with the transcripts (Smith & Osborn, 2008). Thus, the analysis process was lengthy in its insistence on thorough and exhaustive completion.

Interview analysis was first conducted transcript-by-transcript. The first transcript was read and reread multiple times while insights and observations were listed, exemplary quotations were noted, and research codes were identified (Smith & Osborn, 2008). Then the first transcript was set aside and the process started over with the second transcript and so on until all ten transcripts were analyzed. When analyzing the interview transcripts, the researcher adhered to the emphasis that “IPA has a theoretical commitment to the person as a cognitive, linguistic, affective and physical being and assumes a chain of connection between people’s talk and their thinking and emotional state” (Smith & Osborn, 2008, p. 54). However, the researcher realized that these connections are complicated because people were not always able to fluidly verbalize

what they were thinking and feeling so the researcher sometimes had to interpret the mental and emotional state of the individual based on their verbalizations (Smith & Osborn, 2008).

Because of all the factors to consider, superordinate theme and theme identifications were useful. First, the researcher compiled a list of all the research codes which were identified throughout the ten transcripts. Based on this list, the researcher identified a list of preliminary themes and determined the clustering of themes. The researcher then took on the challenging task of clustering, reducing, and prioritizing the complete set of themes. Three themes were identified in response to the research question of “How do nurses who work in abortion clinics experience stigma?” and seven themes were identified in response to the research question of “What are the lived experiences of nurses who work in abortion clinics?” Once the themes were identified, the transcripts were reread to determine the inclusion and completeness of the analysis in terms of actual transcribed data. For example, after the theme of ‘job satisfaction’ was identified the transcripts were reread to ensure the theme and its meaning was accurately understood and reflected.

Through the methodology chapter, design of the study was established. The population and sample of participants for the study were identified. Next, the data collection methods were reviewed. Finally, the data analysis pathway was outlined. In the next chapter, the results of the study will be explored.

CHAPTER IV. RESULTS

In this chapter, the results from the qualitative study will be presented. Participant demographics will be reviewed first, followed by the presentation of qualitative themes. Both major themes and minor themes will be addressed.

Demographic Information

The participants in the study were all women who live and work throughout the US. Two participants were local nurses and the rest hailed from regions of the US including the Northeast, South, West, and Midwest. Six of the participants were white, six participants were married, seven participants worked in large cities or metropolitans, and seven participants were in their 20s and 30s. Six of the participants were registered nurses and of those, five had baccalaureate degrees. Also, six of the participants were parents. Length of nursing employment varied greatly, but the average length of nursing career was 13 years whereas the average length of employment in abortion services was 5.2 years. Half of the participants have another job in addition to working in abortion nursing (only two of the participants were employed full-time in abortion services). All but one of the participants identified as working in an outpatient, clinic setting. One of the participants only worked in a hospital-based abortion unit, and one participant worked at both a hospital-based unit and an outpatient clinic. Results from the compiled surveys can be viewed in Table 2 on the following page. Completed formal demographic questionnaires were received from nine of the ten participants, though demographic responses from the tenth participant which were discussed during the interview were included in the compiled results.

Table 2

Compiled Results from Demographic Questionnaires

Topic	Results
Gender	Women: 10
Sexual Orientation ⁺	Heterosexual: 7 Bisexual: 1 Heteroqueer: 1
Relationship Status	Married: 6 Single/not living with a partner: 2 Cohabiting/living with a partner: 2
Living With:	Romantic partner/spouse: 8 Children: 4 Roommate: 1 Sibling: 1 Living alone: 1
Parental Status	Parent: 5 Mean # of children: 2 children Median: 2 children Range: 1-3 children
Age ⁺	Mean age: 37 years old Median: 32 years old Range: 23-71 years
Race/Ethnicity	White/Caucasian/European American: 6 Latino(a)/Hispanic/Chicano(a): 3 Black/African American: 1
Work Status	Per Diem: 4 Part-time: 4 Full-time: 2
Annual Household Income ⁺	\$50,000 to \$74,999: 4 \$0 to \$24,999: 2 \$25,000 to \$49,999: 2 Not disclosed: 1
Licensure ⁺	Bachelor's Degree RN: 5 Diploma Nurse: 1 Associate Degree RN: 1 MS Nurse Practitioner: 1 PhD Nurse: 1
Work Location	Metropolitan Area/Large City: 7 Small City: 3 States: CA, CT, LA, MN, ND, NY, PA
Years of Nursing Employment ⁺	Mean: 13 years Median: 5 years Range: 1-50 years
Length of Clinic Employment*	Mean: 5.2 years Median: 4.5 years Range: 1-14 years

Table 2. *Compiled Results from Demographic Questionnaires (continued)*

Work Outside of Abortion Care ⁺	Yes: 5 Mean # of days working at clinic: 2.1 days Median: 1.5 days Range: 1-5 days Mean # of days working elsewhere: 2.6 days Median: 2 days Range: 1-5 days
Roles at the Abortion Clinic ⁺	Recovery Room: 8 Patient Education: 7 Operating Room: 5 Ultrasound: 4 Lab/Bloodwork/IVs: 3 Administrative: 3
+This information not reported by one participant *This information not reported by two participants	

Data Analysis

Following IPA analysis methods, three superordinate themes were identified in response to the research question of “How do nurses who work in abortion clinics experience stigma?” and will be referred to as ‘Stigma Themes’. Seven superordinate themes were identified in response to the research question of “What are the lived experiences of nurses who work in abortion clinics?” and will be referred to as ‘Lived Experience Themes’.

Stigma Themes

The first stigma theme which will be presented pertained to public stigma. The second stigma theme that emerged pertained to occupation identification and disclosure. The third and final stigma theme to be presented relates to the presence of anti-abortion protestors at the workplace.

Public Stigma. The first emergent stigma theme regarded public stigma. Public stigma was earlier conceptually defined as the cognitive, affective, and behavioral reactions of those who perceive the stigmatized one. Within the public stigma theme, three subordinate themes existed.

Health Care Professionals. Seven of the participants identified that most of the stigma they experienced came from other nurses and members of the health care profession. Participants primarily talked about this theme in terms of the negative reactions they received from other health care professionals. These seven participants described scenarios about feeling discredited and stigmatized by these professionals. One participant described reactions from other nurses by stating, *“There’s a couple nurses like ‘Oh that’s just horrible, how can you work there?’ and ‘How do you handle that?’ and some that are actually like devastated in a way, like ‘How could you do that all day and be okay with it?’”* Another participant who had taken a job outside of abortion services between employment periods in abortion care discussed a conversation she had with the physician she was working for, *“He said, ‘Yes, I know you used to work at an abortion clinic and I hired you anyway’, and I’ll just never forget that moment because it was like he was doing me this huge favor and ignoring some black mark on my resume which I was very proud of.”*

While not all participants spoke of specific instances where they experienced stigma from health care professionals, five of the participants identified that nursing seems to be largely a conservative profession where abortion nursing felt like an outgroup. One participant stated, *“I feel like there’s a subversive culture in nursing that doesn’t really want to talk about this, that doesn’t really want to address the expert nurse’s role in abortion care.”* This participant spoke in depth about how abortion nursing is not only ostracized from mainstream nursing, but how her experiences particularly rooted in academia and research faced even more scrutiny and stigma. Negative reactions from other nurses and health care professionals was discussed by the majority of the participants and was discussed as being more troubling than negative reactions or stigma from other individuals.

Political/Cultural Climate. Experiences with stigma differed greatly based on the political and/or cultural climate of the area in which the participant lived and worked. Seven of the participants stated or alluded to the idea that they considered themselves to have liberal and/or Democratic identities (with one notable exception of a participant who identified herself as a conservative Republican). However, despite their personal beliefs, the political climate surrounding them did not always match their own ideologies.

Four of the participants identified that they lived and worked in supportive and liberal environments. These participants identified that the political climate surrounding them was unique when considering the current political state of affairs in the US and they were grateful to be able to work in a supportive climate. The participants hailing from these areas discussed negative reactions and stigma less frequently than participants from other areas. One participant who identified as being located in a supportive climate stated, *“I definitely think that the political climate around us is encouraging too. I definitely wouldn’t feel the same way if everybody around me was stressed out about really having to fight for women to have access to abortion services. I definitely think it would be different in a different situation.”*

The other side of the spectrum were the six participants who identified that they live and work in areas with political challenges and stress. As one participant noted, *“Having to work in an area where we know we’re providing excellent care and we know we’re doing an incredibly safe procedure but then to have to constantly defend ourselves to politicians and religious people, it’s pervasive and it’s probably in every area of our work.”* The participants who identified as being from a politically stressful climate were able to provide examples of how the political environment created noticeable differences. The biggest negative effects came in terms of how the clinic was managed administratively such as through staffing requirements,

physical/structural requirements, and Targeted Regulation of Abortion Provider (TRAP) laws. However, participants also noted that certain effects were observed through patients and the participants expressed concerns about misinformation and rumors about clinic closings and abortion no longer being legal. Based on the participants' statements and comparing that with their demographic information, clear differences in responses about public stigma were seen based on whether the participants were located in a liberal or conservative area.

Protestors. Anti-abortion protestors at the workplace were a source of stigma, stress, and disdain for nine of the participants, and a source of fear of harassment also for two participants. The only participant who did not discuss the presence of protestors at the workplace was the participant who only worked in a hospital-based setting. The remainder of the participants all discussed various encounters and thoughts on anti-abortion protestors. Some of the participants verbalized that protestors only show up on one workday (typically Saturday); others stated there are one or two permanent protestors only; and yet others stated their workplace dealt with a heavier force of protestors on daily basis or fluctuating throughout the workdays.

While some of the participants expressed that they felt upset about how the protestors made their patients feel, most of the discussion surrounding protestors focused on the negative interactions between the nurse and the protestor. One participant stated, *"My husband used to drop me off and my kids were in the backseat so [the protestors] would go on this huge rant... I take the train to work now, I don't even let the kids come."* Another participant summed up her feelings toward the protestors by stating, *"I don't like the protestors that stand out there and holler at me because they are judging me... they haven't walked in my shoes either and I don't like that."* This sentiment echoed the thoughts of many of the participants in that the nurses felt judged and stigmatized by the people protesting at their workplace.

When discussing the presence of protestors, the focus was primarily on the stress, stigma, and disdain caused by the protestors' presence and action, but two of the participants also addressed another feeling: fear. Anti-choice harassment was discussed by participants from differing areas of the US. One participant told a story about an experience when a protestor followed her home after work. Another participant said, *"We've had situations where staff members have been outside smoking or whatever and they've been verbally attacked and physically attacked by people when they went into the corner store just to go buy something to drink."* This participant went on to explain that she always tried to bring lunch to work so that she would not have to walk outside on her lunch break in her work clothes. She also talked about her fear when leaving after her shift, *"So there's always just that like [thought] when I turn the corner 'is there going to be someone standing there and want to do something?'"*

Experiences with protestors at the workplace were a significant source of stigma and negativity among the participants. The participants were variable in how they described coping with the protestors' presence, but most surmised that their presence was unwelcome. Thus, public stigma from other health care professionals, from protestors, and across political landscapes encompassed the first stigma theme of the data analysis.

Occupation Disclosure. The second stigma theme identified from the data analysis related to occupation identification or disclosure. Eight of the participants identified hesitancy in job-identification and/or providing vague job descriptions, especially when interacting with new people. These participants described scenarios where they felt nervous or apprehensive when asked about what they do or where they worked. As one participant stated, *"I still hold my breath a tiny bit when I use the word 'abortion' because I don't know if people are going to be supportive, if they're going to be hostile, if they say they're going to pray for me, whatever the*

reaction may be.” This sentiment was shared by the majority of participants. Some of the participants were able to detail how they decided who to disclose to, how they coped with disclosure stress, and how they recognized this as a type of self-stigma. Some participants also stated that when asked about their job, they may identify their other job only (for those who worked in other areas than abortion nursing) or that they provide vague job descriptions. For instance, one participant said, *“If someone asks me outright, ‘Do you work at an abortion clinic?’ I’m going to say yes. But otherwise if they ask what kind of nursing field I work in, I say women’s health.”* This stigma theme was discussed by eight of the participants and seemed to be personally significant to all of those who did discuss their experiences with occupation disclosure.

Job Satisfaction. The final emergent stigma theme that emerged in the data analysis pertained to job satisfaction. All of the participants explicitly stated or implied that they were satisfied with their jobs. What truly seemed to be impactful and the greatest source of this satisfaction came from helping women and hearing their appreciation and gratitude. Eight of the participants stated that receiving gratitude from their patients had a profound and positive impact on the worth they felt and their overall job satisfaction. A notable example came from a participant who stated, *“There’s just that moment when you connect with a patient and they just hear you and they just turn to you and say ‘Thank you’.”* The participant described how a simple ‘thank you’ can be impactful to hear. Another participant described how she felt satisfied by saying, *“I think the most meaningful experiences were with patients who really felt like they came in really, really scared and left feeling very comfortable with the care they received and were very thankful and very supported throughout the whole process.”* This final theme of receiving gratitude and how it contributed to job satisfaction was a significant finding through

the data analysis. How this emergent theme relates to the research question of nurses experiences of stigma will be explored in the Chapter V. With this final theme explored, thus concludes the presentation of stigma themes.

Lived Experience Themes

The lived experience themes being presented pertain to a variety of experiences and thoughts detailed by the participants as provoked by questions asked in the Interview Schedule. The lived experience themes pertain to the research question of “What are the lived experiences of nurses who work in abortion clinics?” The data analysis concluded that these themes were noteworthy when discussing the big picture of experiences of nurses who work in abortion clinics.

Feminism/Women’s Rights. The first theme details participants’ motivations for working in abortion nursing and came in response to introductory interview questions about why the participants wanted to become nurses and how they ended up working in abortion care. Seven participants identified that being a feminist and/or wanting to support reproductive autonomy and access as part of the reason for entering abortion nursing. A prime example came from a participant who stated, *“I just wanted to help women exercise that right to make that decision, to give themselves permission to make that hard decision because it’s their life and no one else gets to make these decisions for them.”* At one point or another during the interviews, seven of the participants discussed one of more of the following thoughts: women’s rights, pro-choice feelings, reproductive autonomy, reproductive access, and feminism. Therefore, these motivating factors are notable when looking at the participants as cognitive and affective beings.

Lack of Education. Following the interview schedule, one of the next questions asked participants what they were taught about abortion in their nursing education. Eight of the

participants received no formal education about abortion during their undergraduate nursing education. Two of the participants stated they received education about spontaneous abortion only. One of the participants who is a nurse practitioner stated she did receive education about induced abortion during her graduate education. Otherwise, two of the participants stated they received some education about birth control and two of the others stated that information about surgical or induced terminations was presented in the textbook though it was not discussed in class.

Providing Support. There were eight participants who identified wanting to make the abortion experience as positive and supportive as possible for the patient. These participants identified that this was part of how they made their jobs more meaningful. This theme primarily came out of responses to the interview questions asking “What is important to you when working in abortion care?” Responses to this question included sentiments about wanting to provide support, provide the patient with a good, comfortable experience, wanting to bring humor into care, and being present for the patient. Participants spoke in depth about why providing a positive, supportive experience was important for both the patients and for their own sense of job satisfaction. One participant described her thoughts as follows: *“Sometimes it is sad and sometimes my patients are sad, but being a person who provides access to abortion care is not sad at all. I feel awesome. I just feel like it’s so positive to be able to provide someone with a service that they really want and need. Once someone makes that decision, everyone she comes into contact with wants to be there and it just feels really great, especially in healthcare, to be able to provide people with what they’re looking for.”* Therefore, providing a positive, supportive patient experience was a minor theme which was notable to include because six of the participants identified that this was an important aspect of their jobs.

Positive Impact. This theme came in response to an interview question which asked “How has working in abortion care made a difference in how you see yourself?” Eight of the participants identified that they have viewed changes in themselves as positive since working in abortion nursing. Responses to this question were primarily positive. For example, one participant stated *“I think it’s the fulfillment for my career as a nurse”*. Other participant responses included: feeling stronger; being a better resource; being more empathetic, respectful, empowered, understanding, and self-confident; and feeling validated as a nurse.

Clearly, the majority of responses were positive, but a notable exception is one participant who discussed feeling colder, tougher, and more robotic after working in abortion nursing. As she stated, *“...on the surgical side, there’s a sense of coldness that comes across the staff, you do notice the difference. There’s no real socialism between the staff and the patients. They go to sleep right away and they wake up in recovery.”* The importance then of patient interaction will be explored in Chapter V. Otherwise, the impact of working in abortion nursing showed a positive influence on the self.

Challenging Experiences. All of the participants were asked to describe a situation that was particularly challenging. All participants were able to identify challenges they faced in abortion nursing, but what they deemed to be most challenging varied widely based on their experiences. Four of the participants mentioned that experiences with anti-abortion protestors and activists were among the most challenging experiences they faced. Two participants spoke of being distressed about the experiences their patients had to deal with (such as sexual abuse). Three participants spoke of challenges relating to turning patients away (such as them having advanced gestational age or seeming unsure of their decision). Two participants also spoke about frustrations pertaining to “frequent flyer” patients and patients who do not seem to care about

birth control. Other mentionable challenges include: experiences with English as a second language (ESL) patients; patients who are emotionally conflicted and/or project their anger onto others; not having enough time to counsel patients and deal with other health issues (such as mental health concerns); and a lack of evidence-based practice (EBP) and research in abortion nursing. The challenging experiences discussed by participants covered a range of topics and concerns. These findings show a more complete picture of lived experiences of nurses who work in abortion clinics.

Resilience. Participants were asked during the interview, “What makes you feel resilient to stigma? Why?” Eight of the participants discussed that their own beliefs and/or past experiences help them feel resilient to the negative parts of being a nurse in abortion care, such as experience with stigma. The participants identified several factors which contributed to their resilience such as: belief that women deserve great care; belief in providing evidence-based care; experiences of receiving positive patient feedback; feelings of anger and frustration; and personal experiences with pregnancy. These experiences and/or beliefs contribute to the feelings the participants had about being resilient to the stigma they faced.

Social Support. Another theme which emerged from interview questions asking about participants’ support systems and resilience was social support. There were eight participants who identified that they have people in their lives they can talk to and who are supportive of them. The types of support identified by participants were supportive friends, family, coworkers, and husbands or boyfriends. The presence of established supporters in the lives of the participants was identified as an area of relief and positivity.

Other Results. After analyzing the data and exploring themes, the researcher reviewed the demographic surveys to see if any conclusions could be drawn based on demographical

differences. One finding of note was that the participants who reported working in abortion nursing for less than two years did not discuss feeling stigmatized as frequently or as clearly as those who have worked in abortion nursing for a longer period of time. Another discovery was that there appeared to be no discernable differences in experiences with stigma when comparing the participants who were mothers as compared to the participants who were not. Additionally, participants were asked if they felt stigmatized in ways other than their occupation and there was only one participant who demonstrated a noticeable difference between the participants who did or did not feel otherwise stigmatized (this participant identified as being non-Caucasian and verbalized more empathy for patients who will become stigmatized themselves after having an abortion). Only two of the participants addressed their own religious beliefs, but one participant who did discuss her religious beliefs talked about how she was very religious and how she reconciled her own beliefs and actions with God. Two of the participants who have employed in abortion nursing for the two of the longest periods of time were the ones to emphasize most the importance of EBP, research, and high-quality care. One participant discussed frustrations about how abortion care has been partitioned off from the rest of obstetrics and gynecology (OB/GYN) care and how this has led to professional stigma about abortion. These findings are additional results which round out the entirety of the data analysis for this study.

CHAPTER V. DISCUSSION AND CONCLUSIONS

The purpose of this study was to gain insight and understanding into the concept of stigma and its actualization and effects on nurses working in abortion clinics. The researcher utilized interpretive phenomenological analysis to discover how individuals create meaning from certain phenomena and how they use those experiences to make sense of their personal and social lifeworlds (Smith & Osborn, 2008). In this chapter, the findings from Chapter IV will be interpreted. Limitations of the study, nursing practice implications, and further research recommendations will also be presented.

Interpretation of Results

Through the data analysis process, three superordinate stigma themes and seven lived experience themes emerged. Much of the qualitative data reflected what previous research studies have found when investigating stigma among nurses who work in abortion clinics. Throughout this section, these themes will be explored and compared to previous research.

Stigma Themes

The stigma themes serve mainly to answer the research question of “How do nurses who work in abortion clinics experience stigma?”

Public Stigma. Stigma is recognized as not residing within a person, but rather it exists in a social context (Bos et al., 2013). Public stigma is comprised of the cognitive, affective, and behavioral reactions of those who perceive the stigmatized one (Pryor & Reeder, 2011). In society, nursing is seen as an honorable and respectable profession and nurses are often thought to be caring and nurturing individuals due to the long contextual history of what nursing is (e.g., women in white hats caring for soldiers, a nurse holding the hand of a dying patient). Due to society’s contentious views about abortion, nurses who work in abortion care are not viewed as

favorably as most other nurses. This dissociation abortion nurses have from society's positive view of the profession of nursing as a whole is largely due to public stigma. As described in Chapter IV, participants of this study spoke of experiences pertaining to different components of public stigma. Those components are explored here.

Health Care Professionals. Lipp (2008a) discussed in her study that the views of nurses within the US on the topic of abortion generally mirror that of the general public but are less favorable and often more polarized than those of other health care professionals. The findings from this study seem to both confirm and negate aspects of the previous findings. Participants in this study tended to agree that most of the stigma they experienced came from nurses and other health care professionals. Most spoke of negative reactions and stigmatized interactions with other nurses, though some did discuss these types of experiences with physicians as well. These findings would seem to confirm that nurses' views on abortion are less favorable and more polarized than that of other health care professionals.

The other aspect is regarding how nurses' views on abortion supposedly mirror the general public's views. Through the study, the participants discussed more negative experiences with nurses (and protestors) than with members of the general public. These findings do not necessarily mean that the views of nurses on abortion do not match those of the general public but do raise a question if abortion views of nurses match those of the public, why do nurses stigmatize those who work in abortion more than the general public does? In fact, when study participants told stories of disclosing the occupation to members of the general public, two of the participants were able to recall very positive interactions. While eight of the participants described feeling anxious about these disclosures because of the possibility of negative reactions, one participant told a story about sharing a cab with a stranger who ended up paying for the cab

ride because he appreciated her work as an abortion nurse. Another participant spoke of an experience where she disclosed her occupation to the passenger sitting next to her on an airplane and now each year that stranger donates to their local abortion fund during the holidays. These examples are a few instances where participants were able to come up with stories about positive experiences with the general public (though noteworthy to mention that negative experiences with strangers were also mentioned during the study), but none of the nurses spoke of particular instances of positive reactions from other health care professionals. Based solely on the data analysis from this qualitative study with a small convenience sample, the results seem to show that while views on abortion among nurses and health care professionals may be similar to those of the general public, nurses and other health care professionals seem more likely to react negatively and/or stigmatize nurses who choose to work in the field of abortion care.

Theories about why the phenomenon of nursing reacts more negatively to abortion care nurses can be presented. First, nurses who work in abortion care may be more likely to be a part of a social circle of friends who hold pro-choice attitudes. Family members of those nurses may vary in opinion, but some of the study participants expressed that they simply did not discuss the topic with those family members. Also in the general public it is often acceptable to give vague job descriptions (as explored later as one of the superordinate themes), which is in contrast to health care professionals who often like to know more specifics about the specialty in which a nurse works. Therefore, an increased likelihood exists that abortion nurses disclose their occupational identity more specifically to other health care professionals, who are people who may or may not share the same abortion attitudes as those of the nurse who works in abortion care.

Once the occupational disclosure is made to a health care professional, a persistent problem of horizontal hostility (also termed lateral violence or more loosely as bullying) exists in nursing and medical communities. Horizontal hostility is overt or covert behavior aimed to direct dissatisfaction toward a peer or group to diminish or devalue them (Embree and White, 2010). An example of horizontal hostility comes directly from one of the participants who described disclosing her job to other nurses and their reactions: *“There’s a couple nurses like ‘Oh that’s just horrible, how can you work there?’ and ‘How do you handle that?’ and some that are actually like devastated in a way, like ‘How could you do that all day and be okay with it?’”* Horizontal hostility, therefore, is another possible theory to explain why the most stigmatized and negative reactions to abortion nursing seem to come from other nurses or members of the health care field.

Political/Cultural Climate. One finding from the literature review revealed that attitudes about abortion among nurses were the most favorable on the West Coast and least favorable in the Midwest (Lipp, 2008a). The attitudes of nurses who participated in this study were all pro-choice and agreed that abortion must be safe and legal. So while the attitudes of nurses cannot be directly compared across regions based on this study, other regional factors can be explored.

When looking at participants on the West Coast, these participants identified that their situations were unique among the political landscape in the US right now. Participants from the West Coast noted that while across the country during each legislative cycle more and more abortion restrictions are proposed and passed, on the West Coast (California in particular), abortion provision is going the opposite direction in that regulations are more lenient in allowing advanced practice nurses to provide more abortion care than in the past. Additionally, these West Coast nurses noted that they felt fortunate to be in a political and cultural situation that was more

accepting of abortion because they felt less stress than they imagined nurses felt in other regions. So while the attitudes of nurses could not be directly compared, it appears that nurses who work in abortion on the West Coast at least recognize that abortion attitudes in the region lead to less stress in abortion provision.

Nursing participants from the Midwest region varied in their responses based on the states in which they worked. Nurses from North Dakota spoke of and dealt with much more significant concerns related to abortion access and provision than did the nursing participant from Minnesota. One of Midwest nurses did describe significant negative reactions to her career in her small hometown, such as being verbally berated by a group of men at a local bar. These participants also all had specific family members they spoke of who were not supportive of their career and with whom they would avoid having conversations about their work or abortion in general. Reflective of more social conservative norms in the Midwest, participants in this study described experiencing a more difficult political environment related to abortion care compared to participants on the West Coast.

Other US regions represented in this study were the South and the Northeast. The participant from the South discussed a political landscape similar to that of North Dakota's in that there are many protestors, high levels of legislative scrutiny, and many conservative residents in the region. Also, the participant from the South was also the one who spoke most directly and impactfully about the influence of religion on abortion provision. She discussed how living in the Bible Belt of the US gave way to some very unpopular and polarized opinions about abortion. This participant stated that because of this she was very careful in not disclosing her work in abortion care to anyone other than her immediate family. The highly conservative and

religious views of the populace in the South seems to make this region arguably the most difficult environment in which abortion care nurses could work in the US.

The remainder of the study participants hailed from the US's Northeast region. The experiences of nurses in this region were varied. One participant from Connecticut spoke of it being a liberal and supportive environment to work in, but a participant from Pennsylvania discussed the stress and frustrations from various TRAP laws passed in the state. A participant from New York worked at a clinic in a state with more liberal laws, but expressed significant problems with protestors and noted how legislation in other states caused ripple effects at her local clinic. Because four participants came the Northeast, more diverse opinions and experiences were shown from the region.

Experiences of nurses are diverse and are influenced by multiple factors. Geographical factors relate to the socio-political makeup of a region. This research showed that sometimes even within the same region nurses' experiences may vary, which illustrates that geography is just one context to consider that influences the personal experiences of nurses working in abortion care.

Protestors. As shown in Chapter IV, all but one of the study participants spoke of experiences with anti-abortion protestors. Wolkomir & Powers (2007) discussed how nurses who work in abortion services may have extra causes of stress in that they may fear for their physical safety and have concerns about societal stigma. Fear for physical safety and fear of harassment were specifically discussed by two participants in the study. One participant described how a protestor followed her home and another participant spoke of the lengths she went to in order to avoid confrontation with protestors because of previous altercations her co-workers have had

with protestors involving verbal and physical attacks. This fear certainly caused additional stress for the participants, especially in the latter case.

Regarding fears about societal stigma, one participant described a situation she felt was particularly concerning because of how extreme the stigma was. The nurse described a story of a pregnant woman who scheduled an abortion but was actually a ‘fake’ patient with an anti-choice group. The participant said, “...*that made me feel so hurt that anybody would be questioning whether or not I had good clinical judgment or just basically sort of trying to see if it’s a shabby operation and the nurse just didn’t care if you had like pneumonia*”. She added, “*I just felt like this is something that would never happen in any other type of health care setting.*” This participant was from the Northeast region of the US and stated that because of a recent high-profile case in Pennsylvania where a physician was illegally and unsafely providing abortions, there has been a lot more noticeable stigma in the community. She stated there was a lot of work which would need to be done to undo the damage that case did to those who provide safe and legal abortions. Though similar experiences were not shared by others, this story is a good case example of how additional stress can be caused because of fears from societal stigma.

Occupation Disclosure. Eight of the participants from this study identified that they were hesitant when identifying the occupation and/or they tended to provide vague job descriptions, particularly when interacting with new people. These participants discussed scenarios where they felt anxious or apprehensive when they were asked what they did for a living or were in a situation where the topic would likely be brought up, such as when meeting new neighbors. These findings mirror study results by Gallagher et al. (2010) in which researchers found nurses who worked in abortion services were hesitant to identify their

occupation to others and would attempt to control situations where they could be pressured to discuss their occupations.

When discussing occupation disclosure with the study participants, in addition to providing vague job descriptions some of the participants stated that they would identify their other job first (as eight of the participants were not full-time employees at abortion clinics). The phenomenon of ‘passing’ was conceptually defined earlier to mean ‘individuals hiding their stigma and passing as normal’ (Goffman, 1963). Because occupational identity is a trait which may be hidden, these nurses may be ‘passing as normal’ prior to their identities being disclosed. Researchers found that concerns and anxieties about disclosure can manifest in psychological distress out of concern for who to tell and with the fear of being discovered and being viewed as ‘discredited’ in the eyes of others (Bos et al., 2013; Quinn & Chaudoir, 2009). While the participants in this study did not discuss suffering chronic psychological distress from disclosure concerns, eight mentioned the acute stress and difficulties they faced when forced with (or anticipating) the disclosure of their career as a nurse who works in abortion services.

The participants in this study also noted how their job disclosure situation feels unique. For instance, one participant who described feeling nervous when disclosing where she worked because she did not know if people would be supportive, hostile, or say they want to pray for her, noted, “...if I worked in an orthopedic surgeon’s office I wouldn’t expect that. I’d probably expect to be solicited for advice about their sore knee, but not that kind of reaction.” Another participant had stated, “...if they ask what kind of nursing field I work in, I say women’s health. And I don’t know if there are other professions and other areas of nursing like that so I do think that may be unique.” So nurses who work in abortion clinics are clearly aware of the perceptions others have about their specialty. Thus, disclosing their occupational identity creates some

hardships. To cope with these feelings about disclosure, some nurses identified that they have learned to ignore the negativity; others state they avoid the topic because they do not want to get into it with anyone; and others stated they felt obligated to discuss their roles in order to increase exposure and normalize the work. One participant stated that she felt bad that she did not more readily disclose her occupation because she wanted to do more to normalize abortion and abortion care. This participant discussed the reason she did not open up more to others was likely a result of self-stigma and that she was anticipating more negative reactions than those she would actually receive.

Self-stigma likely plays a significant role in the amount of apprehension and distress abortion nurses experience in relation to occupation disclosure. Felt stigma is an aspect of self-stigma which was earlier conceptually defined as ‘the experience or anticipation of stigmatization on the part of the individual possessing a stigmatized attribute’ (Bos et al., 2013; Goffman, 1963). Additionally, researchers determined that individuals who are highly stigma conscious may be more distressed and perceive higher levels of discrimination than those who have lower stigma consciousness (Pinel & Bosson, 2013). During this study, stigma consciousness did not emerge in participant descriptions of their experiences of stigma, however this could have been a factor which contributed to how much distress and apprehension was felt by study participants when it came to job disclosure.

Quinn and Chaudoir (2009) found that stigmatized individuals can be happy, resilient, and well-adjusted despite living in cultures which devalue them or their work. Though the cultures surrounding the participants varied significantly (very negative abortion attitudes in the Bible Belt and more lenient and positive abortion attitudes on the West Coast), the participants in the study were found to be overall resilient and well-adjusted individuals. This is evident by the

fact that all of the participants were satisfied with their jobs. Also, two participants had successfully completed graduate degrees (and a third participant is currently in graduate school), which shows that these nurses are well-adjusted and motivated to achieve professional advancement.

Job Satisfaction. A 2007 study with abortion workers by Wolkomir and Powers showed that those working in abortion care often identified helping women and keeping reproductive choice available as reasons for choosing the specialty. These findings mirror the ones found during this study. Helping women, supporting them, and keeping reproductive options available were great motivators for the nurses in the study and also contributed positively to job satisfaction and resilience.

In a study by Ashforth and Kreiner (1999), they determined that dirty workers are acutely aware of the stigma attached to their work, which mirrored what was found in this study. Despite the stigma awareness, Ashforth and Kreiner found that dirty workers still retained positive self-definitions (1999). Therefore, figuring out how these workers were able to retain positivity about the value and worth of their work despite the social negativity was important. Overwhelmingly, the participants in this study thought that their work was important and that they were satisfied in their jobs. Although they each experienced some distress due to occupational disclosure, having family members or friends who were anti-abortion, or negative experiences with other health care professionals, protestors, or the general public, the participants strongly believed in the value of their work. In fact, one participant said she would even continue working at the abortion clinic without pay if the director asked her to do so. Differences in amount of job satisfaction based on geographical region were not brought out by this study, but the potential for differences is further discussed as a future research suggestion.

The sense of job satisfaction likely serves as a buffer to the occupational stigma experienced by abortion care nurses. The sense of job satisfaction seemed to emerge in the participants primarily due to the genuine gratitude they received from patients and family members that was directly expressed to the nurses. In the field of nursing, an unfortunate reality is that nurses do not often hear “thank you” every day and from more than one patient. The reasons patients undergoing abortion seem to express more gratitude than other patients is likely multifactorial. In society, women do not often tell stories of their “good” abortion experiences so the primary abortion stories which are discussed are negative experiences. Also, society is accustomed to seeing graphic images of fetuses and “botched abortions” presented by anti-abortion groups on street corners, college campuses, and even billboards. So between the graphic imagery, negative abortion stories, and the language used in society to evoke fear about abortion such as “murder factories”, “abortion mills”, and “baby killers”, women going in to seek abortion likely have fearful and stigmatized ideas about the treatment they could receive and the experience they could have. However, when those women are greeted with educated, nonjudgmental staff members who want to support their decision and provide them with a good experience, the women likely feel relieved and grateful because their expectations were substantially different. This phenomenon is one possible reason patients seem to express more gratitude in this setting which leads to that sense of job satisfaction among the nurses employed in abortion services.

Lived Experience Themes

The lived experience themes developed through data analysis of the participant interviews provided a more comprehensive look at the lifeworlds of abortion nurses. This data

provides information to the research questions of “What are the lived experiences of nurses who work in abortion clinics?”

Feminism/Women’s Rights. From Gallagher et al.’s 2010 study, they found that nurses also highlighted that the choice to have an abortion was the choice of the woman’s and not theirs, so those nurses wanted to ensure the decision was right for her and that she could obtain an abortion in a safe environment. Gallagher et al.’s findings are replicated through this study. For instance, related to ensuring the decision was right for the woman, one participant spoke of turning patients away because they seemed unsure of the decision. This example shows how nurses use their assessment skills to ensure that only women who are confident in their decision to get an abortion are the ones going through with it (and not those who may have been coerced or forced).

In regard to women’s choices and ensuring safety, one participant from the study stated, *“These women come in by their choice, we’re not forcing them to come in, they come in and we are offering a service. And if we do not offer the service, they may go out and find it elsewhere where it may be more damaging to them physically and emotionally.”* This example illustrates what Gallagher et al. wrote in 2010, “The concept of nursing in this situation, therefore, appears to be ensuring that client choice is respected through facilitation of this choice as part of professional duty” (p. 855). Seven of the participants in the study discussed how providing access to safe abortion contributed to reproductive autonomy and how this was a topic which motivated them to continue working in abortion care.

Lack of Education. As noted by the ACOG in 2014 and a study by Foster et al. in 2001, education and training in the US about abortion is lacking. None of the study participants received formal education about elective abortion during their undergraduate nursing career.

This absence of education leads to a lack of normalization of abortion as a routine medical procedure to a very large group of health care professionals. Additionally, if nurses are not taught about abortion at all during their nursing education, they are less able to provide adequate and accurate education to patients who have questions about the procedure unless they receive training outside of their nursing departments, which further contributes to the structural stigmatization of abortion.

The lack of abortion education likely stems at least somewhat from another structural cause, which is nursing's religious roots. There is a long history of religion being involved in health care which is still evident in modern times. Many colleges, universities, and health care systems in the US are affiliated with a religion and religion can be a strong factor contributing to anti-abortion views (though noteworthy to mention that several religions take a more liberal stance on abortion, such as the Evangelical Lutheran Church in America [1991]). If nursing students attending public universities and non-religious private universities receive no formal education on abortion, the probability of receiving abortion education at a religious institute of higher learning is improbable. Additionally, health care workers employed in any of the large number of religious-affiliated health care systems in the US likely obtain no professional exposure to abortion and emergent abortions or abortion referrals may even be prohibited. Therefore, religious influences likely play a structural role in health care which limits the dissemination of education about abortion.

Lastly, one structural source of why abortion education is likely lacking is because abortion care has largely been partitioned off from the rest of OB/GYN care. As described passionately by one participant in this study, the fact that standalone clinics exist solely for the purpose of abortion has partly contributed to abortion's stigmatization in society and in health

care. This has facilitated a health care attitude which views abortion as something other than a routine procedure in reproductive medicine. Therefore in nursing education, abortion is arguably left out of the OB/GYN curriculum for these reasons as well.

Providing Support. Related to the feminism/women's rights theme, another common goal identified by study participants was wanting to make the abortion experience as positive and supportive as possible for the patient. Providing support to the women seeking abortion was a significant part of what made their jobs meaningful for the nurses in this study. One component of providing support and helping women is the use of therapeutic touch during experiences with women as part of abortion care. One study participant told of a meaningful patient experience where after the woman's abortion was complete, the patient began crying and pulled the nurse in for a long hug. The nurse said it felt so meaningful because she was able to just be present in the moment and hug her while letting the patient know it was okay to be emotional. This nurse's experience coincides with findings from a 1997 study by McQueen which found that nurses showed their empathy and compassion through acts such as sitting with the patient and making physical contact. In emotionally-charged situations, as some women's abortion experiences may be, finding the right words to say may be difficult. Therefore, simply being present or providing therapeutic touch may serve as a means of conveying support and caring without having to navigate the challenging task of finding the right words to say.

Positive Impact. Of the nurses participating in this research, nine of them had positive comments when asked about how working in abortion care changed the way they viewed themselves. Likely these feelings are due to the high amounts of job satisfaction previously discussed. The notable exception then is the one nurse who did not feel positively impacted by the job.

The literature seemed to indicate that in order to cope with the moral difficulty of abortion, nurses would have to put up walls, become harder, or step back (Lipp, 2008b) and that nurses would have a difficult time coping with later-term abortions as well (Lindstrom et al., 2011). These feelings were expressed by one of the participants, who stated she felt harder and colder than when she first started her job. She did seem to attribute this especially to working with patients who were at a later gestational age (nearing 24 weeks). Through discussions with this nurse, a contributory factor seemed to be that most of the patients at her clinic received intravenous sedation for the abortion and she interacted with patients for little time when they were awake. So while dealing with a more developed fetus was part of the reason she felt colder and harder, she also was not able to interact with or provide much one-on-one care to the woman who was undergoing the abortion while the patient was awake. Therefore, patient interaction and having the opportunity to provide patients with support and a positive experience seem to be indicators of how the job impacts the nurse.

Challenging Experiences. The experiences study participants found challenging varied greatly. Previous research by Lindstrom et al. (2011) seemed to show that the subject of repeat abortions was one of the most frustrating experiences faced by abortion workers. These findings were only matched minimally, as only two participants from this study indicated women receiving repeat abortions was a challenging experience. However, study participants were not specifically asked about their feelings on this topic (as they were asked about challenging experiences in general), so this may indeed be a more universal theme than is indicated by this study alone.

The study by Lindstrom et al. also discussed that abortion workers may find it challenging that their work could be frustrating at times due to feelings of powerlessness and

sympathy, and then rewarding at other times (2011). None of the study participants here talked about this being a challenging experience they faced. However, this dichotomy of having challenging and rewarding experiences side-by-side is common to most health care settings. In a medical-surgical setting, for instance, a nurse may care for a patient in one room who is recovering well and feels much better after a small spinal surgery (rewarding experience) but then may have a patient in another room who is dying or going through severe alcohol withdrawal (challenging experience). This is similar to abortion care in which a nurse may care for one patient who is willfully terminating an unwanted pregnancy and has been grateful and pleasant throughout the day (rewarding experience) but then the next patient he or she cares for may be having a difficult experience because they were sexually assaulted or are terminating a wanted pregnancy due to health reasons (challenging experience).

These types of difficulties are experienced by nurses across the health care spectrum and will be situations nurses must learn to cope with throughout their professional careers. However, abortion nurses may face some unique circumstances when it comes to coping with these problems. Society-at-large is more willing to hear about the challenges of nurses taking care of dying or critically ill patients, whereas discussion about patients electively obtaining abortions is a topic which causes discontent and fierce debate in society. More personally, family and friends of nurses who work in abortion care may be supportive of their occupation but not want to hear about the daily occurrences inside the clinic walls. Additionally, nurses who work in abortion care do not have the broader audiences of the nursing community with which to discuss the highs and lows of job. While most nurses can carry on detailed discussions about stool and sputum without thought, the discussion of menstrual bleeding and vaginal discharge are taboo and

stigmatized topics even for seasoned nurses. Therefore, abortion nurses have a much smaller pool of people with whom they can discuss their meaningful and challenging experiences.

Another unique difficulty these nurses face is their unique role with sexual assault and incest victims. Sexual assault nurse examiners (SANE) are revered in health care because of the difficult and important work they do with sexual trauma victims. Nurses who work in abortion care also have intimate experiences with these victims if they decide to terminate a pregnancy which may have resulted from the assault. For instance, one participant spoke of an experience she had with a teenage girl who came in for an abortion and divulged that her older brother had been molesting her. The nurse then facilitated the emotional conversation between the teen and her parents and then provided care to the teen during her abortion. The nurse stated that clinic staff followed up with the teen and family for several months after and were informed that after the teen's brother was incarcerated and her pregnancy terminated she felt as though she could move on with her life. This experience was impactful for the nurse because she felt like she was assisting this patient move forward from the assault and get to the life she wanted for herself. Abortion care nurses likely all have stories of caring for victims of sexual violence and those nurses must learn to cope with those stories of trauma. SANEs were mentioned previously as an example of nurses who are generally welcomed and appreciated in health care and work with sexual assault survivors, this was brought up to juxtapose abortion care nurses who also work with sexual assault survivors but do not receive the same level of reverence and appreciation in health care. So not only do abortion nurses provide care to victims of sexual violence, they do it generally without recognition and support from most of the health care world.

Resilience. Resilience was also an individualized experience which likely helped to combat the effects of minority stress, and participants were motivated by different influences.

Reflecting back to Quinn and Chaudoir's 2009 study which found that devalued workers could be resilient despite some of society's beliefs, the findings from this study reflect that by showing that resilience can clearly be maintained, but the sources of resilience are unique factors for each nurse. For instance, one participant stated she felt resilient because she was frustrated and angry that she had not had a choice when faced with an unwanted pregnancy in the 1960s while another participant stated she felt resilient because of all the positive patient feedback she had received. One participant who stated she lived in a very supportive political environment in the Northeast mentioned that the culture was part of what made her feel resilient. In fact, this particular nurse stated that she had very few negative experiences and had not been subject to much stigma at all (her interview lasted the shortest at 20 minutes in length). Attributes unique to each person, such as coping abilities and previous experience with adversity may also impact feelings of resilience. Therefore, many personal, societal, and environmental factors may contribute to resilience.

Social Support. Supportive people in the lives of study participants were positive factors which contributed to job satisfaction for some and resilience for others. Some of the study participants indicated that the biggest sources of support were their significant others, family members, or friends. Also, four of the participants indicated that their co-workers were an impactful source of support. This finding supports earlier research which found that abortion workers highly value co-worker support because colleagues seemed better able to relate to and support the experiences and views of others who worked in abortion care (Ashforth & Kreiner, 1999; Gallagher et al., 2010). Also, colleagues are able to understand shared experiences about the case load, business, and local issues. These shared experiences can lead to team bonding and social interaction which could lead to increased job satisfaction and social well-being.

Limitations and Strengths

Certain limitations were identified in this study. The findings from this study represent the experiences of the ten participants who are currently working in abortion care and have been doing so for at least one year. Therefore, the experiences of those who have left the profession or are newly employed are not included in this study. The majority of participants functioned in staff nursing and/or management roles, meaning experiences of nursing advanced practice providers may have experiences which were not adequately represented in this study. An additional limitation was the demographic questionnaire being administered after the interview. Questions asked during the interview may have brought up negative responses and feelings as nurses may not have been asked similar questions about their work previously. This phenomenon possibly contributed to why some of the demographic questionnaires were incomplete.

Several strengths of this research study were identified. First, participants came from multiple geographical areas in the US which meant different cultural, environmental, and political contexts were able to be explored. Second, 40% of the study participants were women of color. According to 2015 data from the US Department of Health and Human Services, nurses of color constitute 21% of registered nurses and 32% of licensed practical/vocational nurses, which means having 40% nurses of color in this study reflects more diversity than what exists in the current makeup of the nursing workforce. Lastly, a small sample size (as recommended in IPA) meant that in-depth analysis of the data could be conducted.

Implications for Nursing Practice

Several implications for nursing practice have surfaced related to the study findings. The following section describes implications for abortion nursing management and health care

education. Based on the results of the study, these areas were identified as being the most appropriate areas to affect change in nursing practice.

Abortion Nursing Management

Ashforth et al.'s 2007 study titled "Normalizing Dirty Work: Managerial Tactics for Countering Occupational Taint" explored how managers of stigmatized occupations countered the difficulties from the taint associated with their professions. The researchers believed that managers were better equipped to combat occupational taint than frontline workers. Through their research, they identified several ways in which managers can help workers normalize their experiences and lower the burden of stigma (Ashforth et al., 2007). Some of these tactics are relevant to how abortion nursing management can help with the negative effects of stigma.

Social Buffers. While social support was identified in this study as being a source of positivity and coping within the lives of participants, social buffers are networks of people which serve to protect the dirty workers from the stigmatizing attitudes of the public (Ashforth et al., 2007). Social buffering appears to validate occupational identities as well as insulate the tainted individuals from the pejorative views of the out-group (Ashforth et al., 2007). Social buffers can be applied and promoted by abortion nursing managers and directors of abortion clinics.

Creating and promoting social networking and interaction between those who work in abortion nursing is a task which could be best handled by managers and/or directors. Social events promoting interaction outside of work hours amongst those who work in abortion services could help those workers cope with the negative effects of stigma. One of the nursing participants from this study talked about how her experiences with going to abortion network conferences helped her to see that she was not alone and there were many others out there who had similar beliefs and experiences. Therefore, abortion nursing managers could promote,

require, and/or subsidize abortion network conference attendance by nurses working in abortion services. Attendance of these conferences could assist abortion nurses with developing helpful social buffers.

Social buffer creation could be accomplished locally as well. Facilitating group outings or get-togethers amongst abortion services staff themselves could be a beneficial means of developing social buffers. Debriefing, social engagement, and social support are a few potential positive outcomes which could be brought about by these gatherings. Managers and/or directors could again promote, mandate, and/or subsidize such events and highlight them as a means of positively dealing with the negative social aspects of being abortion care workers.

Pre-Employment Education. One participant from the study stated during her interview, *“I don’t have any bias against anyone... and I don’t stigmatize women... so I didn’t realize until after I had started working there and people would ask me where I work and sort of react to it that I realized that I’d have stigma on me too”*. This nurse had not factored in that stigma by association could lead to others devaluing her because of her association with women seeking abortion (Bos et al., 2013). While this nurse stated that she had learned to ignore negativity from others, not all nurses may be able to do that. Abortion nursing managers and abortion clinic directors should be able to discuss occupational stigma with employees and prepare them for potential experiences they may have. While there is obvious importance of not wanting to frighten or turn away new employees, adequate preparation should help to ensure those employees are equipped to deal with potential negativity associated with abortion stigma.

In the study by Ashforth et al. (2007) with dirty work managers, the researchers found that managers frequently discussed how workers could learn to distance themselves as a method of protection. Distancing was then speculated to entail workers’ reactivity to counter acute and

specific threats to occupational esteem (Ashforth et al., 2007). How this could be applied to abortion nursing would be that managers and/or directors take initiative to prepare nurses for such distancing practices. Managers could create in-services, host group discussions, or do one-on-one sessions with employees. During these events, employees and managers could role play scenarios of potential negative interactions then debrief and discuss how to respond to, cope with, learn from, and overcome these encounters with stigma.

Health Care Education

As discussed in the review of literature, abortion training for medical students and NP, CNM, and PA students is limited (ACOG, 2014; Foster et al., 2006). Showing that through even the highest levels of health care education, abortion is often left out of the curricula. As for this study, only two participants received any kind of formal undergraduate nursing education about abortion, and it was about spontaneous abortion only.

Discussing and normalizing the process of abortion could serve to eliminate some of the stigma and misconceptions about the topic. However, the method and delivery could have the potential to either positively or negatively affect abortion attitude. For instance, a Master's thesis research study conducted by Shrestha (2013) from Cedarville University in Ohio titled "The Impact of Pro-Life Education on Abortion Attitude among College Students in Nepal" showed evidence that providing pro-life (conceptually defined in this study as meaning strictly 'anti-abortion') education to 145 college students in Nepal (over half were Health Science majors) resulted in statistically significant changes in students' attitudes as being more anti-abortion after the education was completed. Therefore, attitudes of college students about abortion could seemingly be influenced by the beliefs of the education presenter. One may theorize that pro-

choice and/or objective abortion education could lead to more accepting abortion attitudes amongst the learners.

Assuming nursing and medical students would not typically experience formal anti-abortion education in their nursing program, increased exposure to and discussion about the procedure should lead to less mystery and stigma surrounding abortion. With less mystery and overall abortion stigma, one would theorize that health care professionals would then be less likely to react negatively and stigmatize not only those who obtain abortions, but also those work in abortion services. Therefore, the final implication for nursing practice is to increase education about abortion in order to normalize the procedure and lead to less overall abortion stigma amongst nursing professionals.

Recommendations for Further Research

Most of the existing research pertaining to abortion is from the patient perspective and fewer studies focus on the nurses who work in abortion care (Lipp, 2011b). Due to a lack of comparative studies, the stigma faced by nurses who work in abortion services should continue to be explored to gain further understanding about how to create less negativity for these members of the nursing workforce. Expanding on this study by recruiting a larger number of participants would yield better comparative data across regions, work settings, and other demographics. Revising the interview schedule to further elucidate experiences with stigma could provide additional rich data for analysis.

Another recommendation for future research would be the development of an appropriate stigma assessment tool. A tool would be beneficial in order to conduct quantitative studies about the topic of stigma in nursing. While the use of qualitative methods provide an intense look into the unique experiences of nurses who work in abortion care, quantitative research could lead to

objective findings about the concept of stigma and give numeric evidence to the types of experiences faced by stigmatized nurses.

Research could also be done to explore in depth the differing experiences between nurses who work in states with highly restrictive abortion laws and those who work in states with more liberal abortion legislation. One could theorize that nurses who work in more restrictive states may actually have a higher sense of job satisfaction because the local societal beliefs about abortion are likely more negative. The cultural negativity could impact patients' pre-conceived notions, creating an atmosphere where they express much gratitude for the care they received. Additionally, more conservative states may not be allowed to see patients beyond a certain gestation, such as the 18 states that restrict abortion after 20 weeks postfertilization (Guttmacher Institute, April 1, 2015). These bans mean the nurses do not have to care for patients undergoing abortions nearing fetal viability, which the research has shown to often be a hardship on nurses (Gallagher et al., 2010). Comparing experiences and job satisfaction in these states to more liberal places where patients may have higher expectations and later abortions are performed.

Finally, studies comparing lived experiences of stigma across nursing occupations would be another important research area to explore. Other stigmatized nursing occupations include those who work in mental health, correctional facilities, homeless shelters, needle-exchange programs, and more. Recruiting nurses from these occupations as well as comparative nursing occupations, such as medical-surgical nurses, could help to develop a wider understanding of the experiences of professional nurses who deal with occupational stigma. This type of research could provide valuable insight into a lesser-known side of nursing. Additionally, a large comparative study could help to identify methods of combating stigma, positive coping techniques, and various other findings which could be applicable across the disciplines.

Conclusion

Nursing is often considered to be one of the most trusted and respected professions in the US because nurses are health care workers who strive to provide excellent patient care in their chosen specialties. However, lived experiences of nurses can be differ based on what that specialty entails. For the nurses who choose to provide care to those utilizing abortion services, they can have uniquely negative experiences because they work in a highly stigmatized environment. Through this study, nurses disclosed both the negative and positive experiences they have had since working in abortion care. Nurses who work in abortion care provide a valuable role in health care provision, so providing exposure to their experiences is important to move forward and decrease the stigma surrounding their roles.

REFERENCES

- ACOG Committee opinion no. 612: Abortion training and education. (2014). *Obstetrics And Gynecology*, 124(5), 1055-1059. doi:10.1097/01.AOG.0000456327.96480.18
- Ashforth, B., & Kreiner, G. (1999). "How can you do it?": Dirty work and the challenge of constructing a positive identity. *Academy Of Management Review*, 24(3), 413-434. doi:10.5465/AMR.1999.2202129
- Ashforth, B., Kreiner, G., Clark, M., & Fugate, M. (2007). Normalizing dirty work: Managerial tactics for countering occupational taint. *Academy Of Management Journal*, 50(1), 149-174. doi:10.5465/AMJ.2007.24162092
- Berer, M. (2009). Provision of abortion by mid-level providers: International policy, practice and perspectives. *Bulletin of the World Health Organization*, 87(1), 58-63. doi:10.2471/BLT.07.050138
- Bolton, S.C. (2000). Who cares? Offering emotion work as a 'gift' in the nursing labour process. *Journal Of Advanced Nursing*, 32(3), 580-586
- Bolton, S.C. (2005). Women's work, dirty work: The gynaecology nurse as 'other'. *Gender Work & Organization*, 12(2), 170-186
- Bos, A.E.R., Pryor, J.B., Reeder, G.D., & Stutterheim, S.E. (2013). Stigma: Advances in theory and research. *Basic and Applied Social Psychology*, 35(1), 1-9
- Caldwell, L.A. (2014, January 22). Abortion: A polarizing, emotional debate 41 years after court ruling. *CNN*. Retrieved from <http://www.cnn.com/2014/01/22/politics/abortion/>
- Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D.T. Gilbert, S.T. Fiske & G. Lindzey (Eds.), *The handbook of social psychology* (4th ed., vol. 2.) (pp. 504-553). Boston, MA: McGraw-Hill

- Dwyer, P.C., Snyder, M., & Omoto, A.M. (2013). When stigma-by-association threatens, self esteem helps: Self-esteem protects volunteers in stigmatizing contexts. *Basic and Applied Social Psychology*, 35(1), 88-97
- Embree, J.L., & White, A.H. (2010). Concept analysis: Nurse-to-nurse lateral violence. *Nursing Forum*, 45(3), 166-173. doi:10.1111/j.1744-6198.2010.00185.x
- Evangelical Lutheran Church in America. (1991). *A social statement on: Abortion*. Retrieved from http://download.elca.org/ELCA%20Resource%20Repository/AbortionSS.pdf?_ga=1.267233101.2108823234.1426038771
- Foster, A.M., Polis, C., Allee, M.K., Simmonds, K., Zurek, M., & Brown, A. (2006). Abortion education in nurse practitioner, physician assistant and certified nurse-midwifery programs: A national survey. *Contraception*, 73(4), 408–414.
- Gallagher, K., Porock, D., & Edgley, A. (2010). The concept of ‘nursing’ in the abortion services. *Journal Of Advanced Nursing*, 66(4), 849-857.
doi:10.1111/j.1365-2648.2009.05213.x
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Eaglewood Cliffs, NJ: Prentice-Hall
- Grove, S., Burns, N., & Gray, J. (2013). *The practice of nursing research: Appraisal, synthesis, and generation of evidence*. St. Louis, MO: Elsevier
- Guttmacher Institute. (2015, March 1). *State policies in brief: Restricting insurance coverage of abortion*. Retrieved from http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf
- Guttmacher Institute. (2015, April 1). *State policies in brief: State policies on later abortions*. Retrieved from http://www.guttmacher.org/statecenter/spibs/spib_PLTA.pdf

- Huntington, A. (2002). Working with women experiencing mid-trimester termination of pregnancy: The integration of nursing and feminist knowledge in the gynaecological setting. *Journal Of Clinical Nursing, 11*(2), 273-279.
doi:10.1046/j.1365-2702.2002.00586.x
- Huynh, T., Alderson, M., & Thompson, M. (2008). Emotional labour underlying caring: An evolutionary concept analysis. *Journal Of Advanced Nursing, 64*(2), 195-208.
doi:10.1111/j.1365-2648.2008.04780.x
- Jones, R.K. & Jerman, J. (2014). Abortion incidence and service availability in the United States, 2011. *Perspectives on Sexual and Reproductive Health, 2014, 46*(1).
doi:10.1363/46e0414
- Keen, J. (2013, March 29). N.D. governor signs nation's strictest abortion laws. *USA Today*. Retrieved from <http://www.usatoday.com/story/news/nation/2013/03/26/north-dakota-abortion-ban/2021215/>
- Kreiner, G., Ashforth, B., & Sluss, D. (2006). Identity dynamics in occupational dirty work: Integrating social identity and system justification perspectives. *Organization Science, 17*(5), 619-636.
- Kumar, A., Hessini, L., & Mitchell, E. (2009). Conceptualising abortion stigma. *Culture, Health & Sexuality, 11*(6), 625-639. doi:10.1080/13691050902842741
- Kumar, K., Kumar, D., Polis, C., & Schaffer, K. (2004). Effect of nurses' attitudes on hospital based abortion procedures in Massachusetts. *Contraception, 69*(1), p. 59-62
- Lindstrom, M., Wulff, M., Dahlgren, L., & Lalos, A. (2011). Experiences of working with induced abortion: focus group discussions with gynaecologists and midwives/nurses. *Scandinavian Journal of Caring Sciences, 25*(3), 542-548

- Lipp, A. (2008a). A review of termination of pregnancy: prevalent health care professional attitudes and ways of influencing them. *Journal Of Clinical Nursing*, 17(13), 1683-1688. doi:10.1111/j.1365-2702.2007.02205.x
- Lipp, A. (2008b). A woman centred service in termination of pregnancy: a grounded theory study. *Contemporary Nurse*, 31(1), 9-19. doi:10.5172/conu.673.31.1.9
- Lipp, A. (2011a). Self-preservation in abortion care: a grounded theory study. *Journal Of Clinical Nursing*, 20(5/6), 892-900. doi:10.1111/j.1365-2702.2010.03462.x
- Lipp, A. (2011b). Stigma in abortion care: Application to a grounded theory study. *Contemporary Nurse*, 37(2), 115-123. doi:10.5172/conu.2011.37.2.115
- Macdonald, M. (2003). Stigma and its potential to inform the concept of the difficult patient. *Clinical Nurse Specialist*, 17(6), 305-310
- McLemore, M. & Levi, A. (2011). Nurses and care of women seeking abortions, 1971 to 2011. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 40(6), 672-677
- McQueen, A. (1997). The emotional work of caring, with a focus on gynaecological nursing. *Journal Of Clinical Nursing*, 6(3), 233-240. doi:10.1111/1365-2702.ep11552061
- NARAL Pro-Choice America. (2010). *Anti-choice violence and intimidation* [Fact sheet]. Retrieved from <http://www.prochoiceamerica.org/what-is-choice/abortion/abortion-clinic-violence.html>
- National Health Services. (2012). *How an abortion is carried out*. Retrieved from <http://www.nhs.uk/Conditions/Abortion/Pages/How-is-it-performed.aspx>
- Nicholson, J., Slade, P., & Fletcher, J. (2010). Termination of pregnancy services: experiences of gynaecological nurses. *Journal Of Advanced Nursing*, 66(10), 2245-2256. doi:10.1111/j.1365-2648.2010.05363.x

- Pinel, E.C. & Bosson, J.K. (2013). Turning our attention to stigma: An objective self-awareness analysis of stigma and its consequences. *Basic and Applied Social Psychology*, 35(1), 55-63
- Pryor, J.B. & Reeder, G.D. (2011). HIV-related stigma. In J.C. Hall, B.J. Hall, & C.J. Cockerell (Eds.), *HIV/AIDS in the Post-HAART era: manifestations, treatment, and epidemiology* (pp. 790-806). Shelton, CT: PMPH-USA, Ltd.
- Pryor, J.B., Reeder, G.D., & Monroe, A.E. (2012). The infection of bad company: Stigma by association. *Journal Of Personality And Social Psychology*, 102(2), 224-241.
doi:10.1037/a0026270
- Quinn, D., & Chaudoir, S. (2009). Living with a concealable stigmatized identity: The impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. *Journal Of Personality And Social Psychology*, 97(4), 634-651.
doi:10.1037/a0015815
- Sedlovskaya, A., Purdie-Vaughns, V., Eibach, R., LaFrance, M., Romero-Canyas, R., & Camp, N. (2013). Internalizing the closet: Concealment heightens the cognitive distinction between public and private selves. *Journal Of Personality And Social Psychology*, 104(4), 695-715. doi:10.1037/a0031179
- Shrestha, M. (2013). *The impact of pro-life education on abortion attitude among college students in Nepal* (Unpublished Master's thesis). Cedarville University, Cedarville, Ohio.
<http://dx.doi.org/10.15385/tmsn.2013.5>
- Smith, J.A. (2004). Reflecting on the development of interpretive phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1(1), 39-54. doi:10.1191/1478088704qp004oa

Smith, J.A. & Osborn, M. (2008). Interpretive phenomenological analysis. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed.) (pp. 53-80).

London: Sage

U.S. Department of Health and Human Services. (January 2015). *Sex, race, and ethnic diversity of U.S. health occupations*. Retrieved from <http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/diversityushealthoccupations.pdf>

Van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy*. Ontario, Canada: The Althouse Press

Wolkomir, M., & Powers, J. (2007). Helping women and protecting the self: The challenge of emotional labor in an abortion clinic. *Qualitative Sociology*, 30(2), 153-169.

doi:10.1007/s11133-006-9056-3

APPENDIX A. EMAIL REQUEST FOR PARTICIPANTS

Directors/Managers,

My name is Rosa Jacobs RN, BSN and I am a graduate student at North Dakota State University in Fargo, North Dakota. For my Master's Thesis, I am conducting a research study along with Molly Secor-Turner PhD, RN entitled *Lived Experiences of Stigma: Nurses Who Work in Abortion Clinics*. The purpose of the research is to gain insight and understanding into the concept of stigma and its actualization and effects on nurses working in abortion clinics. We aim to expand the limited body of knowledge surrounding stigmatized occupational identities in the field of nursing.

I am hoping you can identify potential participants for the study. We are looking for nurses (LPNs and RNs) who have been working in an abortion clinic for longer than six months and work on average more than one day a month. I would be conducting a 30-60 minute interview with each of the nurses. We would be discussing the nurse's experiences as a licensed nursing professional who works at an abortion clinic. Additionally, there would be a brief questionnaire (would take less than five minutes to complete) following the interview. The interview would likely be completed over the phone at a time which is convenient for the nurse.

If you think there may be any nurses working in your clinics who would be eligible to participate, please let them know about this study! You can have them send me an email at Rosa.Jacobs.1@ndsu.edu. We know that research in this area is minimal, so the contributions of the nurses would be greatly appreciated. If you have any further questions, please contact me.

Thank you,

Rosa Jacobs RN, BSN
Co-Investigator

APPENDIX B. DEMOGRAPHIC QUESTIONNAIRE

1. What is your gender? _____ Woman _____ Man _____ Transgender _____ If these categories do not accurately represent you, please fill in your response)

2. What is your sexual orientation? _____ Heterosexual _____ Bisexual _____ Gay/Lesbian _____ Asexual _____ If these categories do not accurately represent you, please fill in your response)

3. What is your relationship status?
 - Single/not living with a partner
 - Cohabiting/living with a partner
 - Married
 - Dating
 - Other (*please specify*): _____
4. Who do you live with? Check all that apply.
 - Children
 - Romantic partner/spouse
 - Roommate
 - Parent(s)
 - Siblings or other family members (*please specify*): _____
 - Living alone
 - Other (*please specify*): _____
5. Are you a parent (step parent, biological, adoptive, foster)? _____ Yes _____ No
If yes, to how many children? _____
6. What is your current age? _____
7. What is your race/ethnicity?
 - Asian/Pacific Islander
 - Black/African American
 - Latino(a)/Hispanic/Chicano(a)
 - White/Caucasian/European American
 - Native American/American Native
 - Middle Eastern
 - Biracial/Multiracial
 - Other (*please specify*): _____
8. What is your current work status at the abortion clinic?
 - Full-time
 - Part-time
 - Per Diem (As Needed)

9. What is your annual household income from all sources?

- \$0 to \$24,999
- \$25,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 - \$200,000
- \$200,000 or higher
- I prefer not to answer

10. What is the highest level of licensure you maintain?

- Licensed Practical Nurse
- Associate Degree Registered Nurse
- Bachelor's Degree Registered Nurse
- Nurse Practitioner, MS
- Doctoral Degree, PhD or DNP
- Other (*please specify*): _____

11. Where do you work? Please indicate state: _____

- Metropolitan area/ Large City
- Small City
- Rural/ Country
- Other (*please specify*): _____

12. How many years have you held active employment as a nurse? _____

13. Do you currently work as a nurse in places other than the abortion clinic? ____ Yes ____ No

If yes, how many days on average do you work at the abortion clinic? ____ How many days do you work elsewhere? ____

14. How long have you been employed at the abortion clinic? _____

15. On an average day at the abortion clinic, please indicate how much of your time you spend in each of the following roles (indicate as a percentage of your day):

- ____ Patient education
- ____ Lab/blood work
- ____ Ultrasound
- ____ Operating room
- ____ Recovery room
- ____ Administrative
- ____ Other (*please specify*): _____