A Word, a Shadow, a Breath: A Phenomenological Investigation of Therapists' Perceptions of the Stigma Experienced by Women Residing in Ireland Who Have Had Abortions

A DISSERTATION
SUBMITTED TO THE FACULTY OF THE GRADUATE SCHOOL OF THE
UNIVERSITY OF MINNESOTA
BY

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IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

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August 2018

Acknowledgements

With the utmost sincerity, I thank the participants of this research study. You shared an abundance of sacred words in sacred spaces. I was and continue to be humbled by your honesty, presence, and care when discussing your client's narratives and your own thoughts, feelings, and narratives. The gratitude cannot be expressed enough.

Thank you to my committee for your willingness to take part in this journey with me. Keisha, you were a wonderful professor and I am so honored to have your presence on my committee. Mike, thank you for your kindness, generosity with time, and willingness to answer any and all of my data analysis questions. You really helped me out.

I also wish to thank my co-advising team, Pat and Carrie. Your mutual respect for one another really made this an exciting and (relatively) smooth process. Pat, your sense of humor, genuineness, and strength left *such* an imprint on my academic identity. I cannot express the gratitude I have for your willingness to accept me as your advisee, and for that I will forever be grateful. Carrie, we have shared advising moments in the basement of Ed Sci to the cliffs of Howth looking over the Muir Éireann. You consistently brought all of yourself to every advising appointment, meeting, brainstorming session, etc. Thank you for teaching me that it never hurts to throw an idea out into the universe and to explore possibilities to there fullest.

Thank you to my Ireland Soul Sisters. You have challenged me, provided insight into every corner of my life, and we co-created a space built upon honesty, connection, unconditional positive regard, and strength. Women saving women. Ursula, without you

and your soulful connections to the world of Irish psychotherapy, this project would not exist and that is a fact.

I wouldn't have had the thought of this project if it wasn't for Mick O'Shea. Thank you for wearing the Repeal the 8th Button and the great conversation.

To my parents, Elizabeth and Stephen. Your endless support, confidence in my abilities, and unconditional love are all pieces I will never forget. You both have had a significant impact on me, and will continue to do so. There aren't enough words to capture the amount of love, respect, and endless support I have for each of you. To quote Florence, "You can lose everything, but the one thing that cannot be taken away from you is your education." I have lived by her words and your value of educational pursuit.

To my best friends, the spooky collective, the funniest women I know, and two women I am *honored* to call my sisters; Abigail and Margaret. I have never (and will never) laugh as hard as I do when I am around you two. I love you both with all of my being. From riding the 'rollercoaster' prairie hills outside Estherville, Iowa to gallivanting around Salem, Massachusetts, our time together is *so* precious to me, and your support has meant the world.

A large heartfelt piece of gratitude to you, Gina. Your kind raccoon heart has been nothing short of unconditionally supportive, a healthy dose of challenging, and impactful on the way I view my professional identity. You and I have been on parallel journeys this past year, and even through your own moments, you still found time to share small notes with warm words and lots of coffee. I support, respect, and unconditionally love you. Thank you.

Lastly, thank you to all the strong women in my life who I have had the honor to learn from and collaborated alongside with throughout my life. Patriarchy is ever-present, but in moments of togetherness and sacred solitude, we have built structures that cannot be recognized, permeated, and/or demolished --- this is for *all* of you.

Abstract

Objectives: Abortion stigma is a phenomenon arising from beliefs that abortion is morally wrong and/or socially unacceptable. Abortion stigma varies in how it is created, supported, perpetrated, and experienced depending various cultural factors. The present study strived to describe the lived experience of Irish women who experience stigma post-abortion from accounts by their psychotherapists. The focus was on how stigma is experienced by these women and the variety of systems that potentially influence that experience. ***Method:*** The present study was guided by hermeneutic phenomenological methods, including thematic phenomenological analysis. Nine Irish psychotherapists (eight female, one male) who were active practitioners and members of an accrediting Irish psychotherapy agency participated in face-to-face, in depth semi-structured interviews. Interviews were transcribed and analyzed at an individual and general level. ***Results:*** Responses yielded both unique and similar experiences of psychotherapists and their female clients. Four themes emerged from the data analysis process: Secrecy; Cultural Barriers: Breathing in Irish Culture and Irish Identity; Systems Working against Women (this theme contained three subthemes: Political/Governmental, Religious, and Interlinkage of religion and politics); and Personal is Professional. The themes and sub-themes were present in every participant's narrative. ***Discussion:*** Women in Ireland uniquely experience abortion stigma due to a variety of factors that lead to internalized stigma. Abortion stigma can cause them to experience grief, guilt, and sadness in isolation and secrecy. Mental health professionals might best serve Irish women who are experiencing abortion stigma by increasing their awareness of its precipitating factors,

including the unique effects growing up an in Irish culture can have on these women and on the practitioner's ability to fully serve this population. Future researchers might directly investigate Irish women's experiences of abortion stigma as well as the experiences of mental health professionals who serve them.

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Introduction

Current research illustrates the prevalence of abortion-associated mental health issues (e.g., depression, anxiety, post-traumatic stress) women experience due to larger psychosocial factors such as stigma (Astbury-Ward Astbury-Ward, Parry, & Carnwell, 2012; Cockrill & Nack, 2013; Cockrill, Upadhyay, Turan, & Greene Foster, 2013; Littman, Zarcadoolas, & Jacobs, 2011; Major & Gramzow, 1999; Mueller & Major, 1989; Shellenberg & Tsui, 2012; Sorhaindo, Juarez-Ramirez, Olavarrieta, Aldaz, Mejia Pineros, & Garcia, 2014). Stigma is defined "as negative views or potential stereotypes that are attributed to a person or groups of people when their behaviors or characteristics are viewed as different from or inferior to societal norms" (Dudley, 2000, p. 449). There is a growing body of literature specifically addressing stigma experienced by women who receive abortions. As this research focus, particularly on abortion stigma, is relatively nascent, most of the published studies are exploratory in nature. Furthermore, in countries where abortion is illegal, the research is scant and does not document the experiences of women who have illegal abortions and their unique experiences of stigma associated with their procedure.

Several studies demonstrate that society has a strong influence on the well-being of women who receive abortions (Astbury-Ward et al., 2012; Cockrill & Nack, 2013; Cockrill et al., 2013; Littman et al., 2011; Major & Gramzow, 1999; Mueller & Major, 1989; Shellenberg & Tsui, 2012; Sorhaindo et al., 2014). The majority of this research is comprised of qualitative methods that have yielded several broad themes regarding factors affecting abortion stigma. First, the political landscape and broader discourse

around abortions may affect how women perceive themselves and how they believe others view them (Astbury-Ward et al., 2012; Cockrill & Nack, 2013; Littman et al., 2011; Major & Gramzow, 1999; Shellenberg & Tsui, 2012; Sorhaindo et al., 2014). Participants in these studies have reported that the political and social opinions of other people directly negatively impacted how they viewed themselves and how they coped with the stigma they experienced after their abortion procedures (Cockrill & Nack, 2013; Littman et al., 2011; Major & Gramzow, 1999). Participants experiencing abortion stigma found it difficult to share their abortion narratives with others due to fear of judgment, perceived lack of support, and increased feelings of stigma (Cockrill & Nack, 2013). Another broad theme suggests sociopolitical forces may be important to consider when working with women who experience internalized stigma pre- and/or post-abortion (Astbury-Ward et al., 2012; Shellenberg & Tsui, 2012; Sorhaindo et al., 2014).

Another theme concerns the findings of several studies showing that religion/spirituality has a notable relationship with the stigma women experience pre- and/or post-abortion (Cockrill & Nack, 2013; Cockrill et al., 2013; Littman et al., 2011; Shellenberg & Tsui, 2012; Sorhaindo et al., 2014). For instance, one study examining stigma in Mexico, where abortion is highly regulated by the government, revealed that the dominant religious landscape directly hindered access to abortion services and to mental health services after an illegal abortion procedure (Sorhaindo et al., 2014). Findings demonstrating connections between broader religious landscapes and abortion stigma have been obtained in studies conducted in the U.S. (Cockrill & Nack, 2013; Cockrill et al., 2013; Littman et al., 2011; Shellenberg & Tsui, 2012) and internationally

(Astbury-Ward et al., 2012; Sorhaindo et al., 2014); however, each nation and culture are unique in the ways in which their religious perspectives relate to larger governmental regulation of women's reproductive rights. These regulations themselves can be seen in of the types of abortion that are deemed legal or illegal (e.g., medicinal, operational, natural), the timeframes within which abortions may be deemed legal or illegal, and whether there is a mandated waiting period is intended to require women to reconsider their decision to have an abortion.

A final theme concerns a major gap in research examining the mental health of women post-elected termination who live in countries where abortion is illegal or highly regulated, such as in the Republic of Ireland. In 1983, Irish legislators passed the Eighth Amendment of the Constitution Act which gave specific recognition to the life of an unborn child and bans all abortion-related services (Human Rights Watch, 2010). Furthermore, Irish medical professionals who assist in abortion procedures are charged with a criminal offense and may receive up to 24 years in prison. The Catholic Church supported this constitutional act via public campaigns and donations to the Irish government (Human Rights Watch, 2010). There have been a series of cases in which Irish women have died due to "back-alley" abortions or where the mother's life was at risk, but the fetus was still viable. Due to a national and international backlash, the Irish government passed the Protection of Life During Pregnancy Act in 2013. This law states that abortion is illegal unless performed in order to save the life of the mother (Hug, 2016).

A projected 160,000 Irish women have traveled to Great Britain to obtain abortions in the past 33 years (Gentleman, 2015). This only includes women who provided an Irish home address therefore it is believed to be a conservative estimate; most women choose not to disclose this information (Gentleman, 2015). Multiple international human rights organizations continue to harshly critique the Irish government for their legal restrictions. In 2016, the United Nations' (UN) Human Rights Committee stated that Ireland's abortion law breaches the UN's International Covenant on Civil and Political Rights (Amnesty International, 2016).

According to the United Kingdom (UK) Department of Health, about nine Irish women each day travel to the U.K. for access to abortion services. In 2009, 1,200 abortion pills were seized by Irish customs (Bloom & O'Dowd, 2014), and according to the UK Department of Health (2008), abortion is the most common gynecological procedure for Irish women, with an estimated 1 in 10-15 Irish women of reproductive age having received an abortion.

Ireland has historically been a country where abortion was made inaccessible to it female citizens. Through restrictive legislation, the Irish government has continued to limit information regarding safe and legal abortion services, and has refused to take legal action against agencies who spread false medical information about abortion procedures to Irish citizens (Human Rights Campaign, 2010). In 2016, an Irish Supreme Court judge ordered the formation of a Citizens' Assembly of the Eighth Amendment charged with debating whether this Amendment should continue. In April 2017, the Citizens' Assembly recommended to the Irish government that the Eighth Amendment be revisited

due to its potential human rights violation against Irish women (Reuters, 2017). To date, it is unknown what actions may arise in response to this recommendation. Although the Irish government has taken steps towards legalizing abortion in the past couple of years, Ireland continues to have a longstanding anti-abortion history supported by legal rhetoric, religious beliefs, and societal norms/attitudes (Hug, 2016).

As noted in this brief overview of the literature, research regarding abortion stigma experienced by women who reside in countries where abortion is illegal is in its infancy. Investigations of the mental health concerns associated with abortion are based largely on studies performed in countries where abortion is legal (Singh et al., 2009). For this reason, generalizing research results from countries where abortion is legal to countries/cultures where abortion is illegal (e.g. Republic of Ireland) is risky. More research specific to particular countries/cultures is necessary in order to accurately depict the mental health experiences of women who receive abortions. This issue constitutes a very large gap in the counseling psychology literature given the field's social justice focus and interest in how research findings can be applied to increase the well-being of others internationally. Given the Republic of Ireland's unique religious, cultural, and political framework that continually holds abortion illegal, women residing in Ireland who have had abortions comprise a unique population. No published research to date has investigated abortion stigma in Irish women. Accordingly, the purpose of this qualitative study was to explore the stigma experienced by Irish women. Given the highly sensitive nature of the topic being studied and the potential legal ramifications that could occur by directly interviewing Irish women who have had abortions, psychotherapists who have

worked with women that had abortions were interviewed. Psychotherapists comprised the study sample in order to protect these women's confidentiality and safeguard them from legal repercussions.

Positionality Statement

As a woman-identified person with a strong understanding of reproductive healthcare, particularly the ongoing discussion and debate concerning the legalization of abortion, I realize the various perspectives and viewpoints surrounding this issue in the broader international political and medical landscapes. I was raised in a household that was completely supportive of a woman's right to elect for an abortion and to have full access to reproductive healthcare. I began volunteering and working with Amnesty International when I was 16 years old, focusing upon international sexual violence issues and reproductive healthcare. I eventually volunteered with Planned Parenthood during my undergraduate career at a large public research university where I was also heavily involved with the Women's Student Activist Collective and the University Pro-Choice Coalition. I feel strongly supportive of a woman's right to elect for an abortion and firmly advocate for this position. Furthermore, as an Irish American, I am aware of the unique cultural frameworks that intersect with my identity as a Pro-Choice activist. I do, however lack an understanding of certain core areas that this study explores. First, I have no first hand knowledge of what it is like to be a practicing Catholic and/or to be raised in a culturally Catholic familial system. I am of Irish Protestant and Northern Irish Protestant descent; therefore I am unaware of the unique impact of Catholicism. Second, I have no understanding of what it is like to reside in a country whose government and

laws are so highly influenced by Catholic Church doctrine. Third, considering the likely substantial influence of the Catholic Church on the Irish identity, I have no understanding of what it is like to reside in Ireland as a female-identified person. Considering these limitations in the literature and my positionality as a female identified Irish American with progressive views on reproductive healthcare, I conducted a hermeneutic phenomenological research study to investigate this unique phenomenon.

Methods

Design

The purpose of this study was to examine how Irish psychotherapists whose clients include women who reside in Ireland and who have received abortions experience abortion stigma, and what these psychotherapists perceive as barriers and supports these women experience after they have received an abortion. Hermeneutic phenomenology was chosen as the most appropriate data analysis method because of its emphasis on the depth of material captured and the respect for the nuances of lived experiences. van Manen (2016) defines hermeneutic phenomenology as building beyond the typical phenomenology framework by focusing on the subjective experience of individuals and with the intention to reveal the world as experienced by the participants through their unique narratives. This approach is a "research methodology aimed at producing rich textual descriptions of the experiencing of selected phenomena in the life world of individuals that are able to connect with the experience of all of us collectively" (Smith, 1997, p. 80). Hermeneutic phenomenology differs from phenomenology in two ways: first, by focusing upon self-reflection as a critical step by the researcher, and second, by

using the hermeneutic circle (i.e., reading, reflective writing, and interpretation) as a repeated step of the data analysis process (Laverty, 2003; van Manen, 2016).

van Manen (2016) further states that in hermeneutic phenomenology the researcher sees a fundamental truth in how an individual experiences her or his world through lived experience (i.e., relativism). Additionally, the researcher acts as a conduit for sharing the individual's unique lived experience; therefore the researcher does not have any expertise or knowledge over the individual and is presenting her or his own unique perspective to the narrative shared (van Manen, 2016). Hermeneutic phenomenology argues that the very description of a narrative is an interpretive process because all one has is her or his individual interpretation of said narrative (van Manen, 2016).

Participants

This study was conducted during March 2017. The sample consisted of 8 adult women and 1 adult man who were born and/or spent the majority of their lives in Ireland. All participants spoke English and were psychotherapists who operated under an accredited Irish psychotherapy association. In order to minimize risk of legal repercussions and loss of anonymity, a decision was made to not interview Irish women who had received abortions. Instead, psychotherapists were interviewed as they were thought to be able to provide a detailed depiction of the experiences of their Irish women clients who had received abortions. Inclusion criteria included they must belong to a psychotherapy professional association, they must have been practicing for at a minimum of three years post-certification, they must have resided over half of their lifetime in

Ireland, and they must have worked with at least one Irish female who had received an abortion (whether illegally in Ireland or traveled abroad for the procedure and returned to Ireland).

An Irish psychotherapist who is a member of an accredited Irish psychotherapy association assisted with the recruiting of participants. Participant recruitment was extremely challenging due to several cultural factors. The recruiter noted that members of the Irish psychotherapy community expressed a great deal of apprehension about participating. Their apprehension included concerns about risking their clients' confidentiality, particularly around an act that is illegal in Ireland; possible legal ramifications for discussing their clinical work around this topic; due to how physically small and limited in population the country of Ireland is; and viewing their clients' narratives as "sacred" to share for a research project. Another factor posed logistical challenges. The recruiter noted a cultural norm within the Irish psychotherapy community is to avoid advance scheduling and finalizing of appointments until the week of the potential meeting. This practice helps to increase client appointments and decrease interruptions during therapists' business hours. In order to respect this norm, all participants were finalized and scheduled one-week prior to the week in which data collection occurred.

Eleven potential participants contacted me to state they were interested. One potential participant resided in Northern Ireland and was informed they did not meet inclusion criteria. One potential participant was unresponsive to follow-up emails from the investigator. Nine participants were finalized via phone and email communication,

and individual interviews were set up between participants and myself. All nine met eligibility criteria. In phenomenological research there are no set criteria regarding sample size (van Manen, 2016). Moreover, the difficulty in recruiting participants due to the extremely sensitive nature of the study precluded timely recruitment of additional participants.

At the end of each interview, I asked participants about their motivation for participating in this research study. All participants highlighted the importance of the topic in regards to Ireland's unique cultural context. Seven participants stated that their motivation was rooted in their beliefs that abortion regulation in Ireland is a "human rights issue" that needs further representation in the media and in research. One participant stated that their motivation to participate was because it is a "complicated issue" with the influence of Catholicism, and therefore felt it necessary to speak from their identities as a psychotherapist and a practicing Catholic.

Instrumentation

Screening form. A screening form was created via Qualtrics to elicit information from potential participants. In order to protect confidentiality, questions were limited to requesting potential participants' initials, minimum participation criteria information, contact information for follow-up, and availability for an in-person or Skype interview (see Appendix E).

Interview guide. An interview guide consisted of a series of nine questions designed by myself and the dissertation committee pertaining to the perception of abortion stigma (See Appendix F). The questions are based on extant literature and on

knowledge of the Irish psychotherapy community. The questions were designed to be open-ended to encourage participants to reflect on their experiences. A semi-structured approach facilitates consistency of topics discussed while allowing for prompts and follow-up questions for clarity or elaboration. The approach also promotes a more conversational interaction in the interviews. I piloted the questions on two Irish psychotherapists who operate under an accredited body and made minor modifications to some of the wording for clarity.

Procedures

The University of Minnesota Institutional Review Board approved this study prior to its commencement. Consent to participate in the study was obtained prior to the interviews (see Appendix D). Prior to the interviews, I provided a link to a Qualtrics screening form to all potential participants. I followed-up via email with all potential participants informing them whether they qualified for participation. I emailed the interview questions to all nine participants one week prior to their interview in order for them to prepare as they wished.

The face-to-face interviews occurred at a private location, either a clinical space or in a room at a hotel in a large metro area in Ireland. Due to logistical factors (e.g., travel times to participants' location) Skype interviews were conducted with two individuals. All interviews were audio recorded. An outside confidential service transcribed all nine interviews. I collected all transcripts, re-listened to all audio files, and corrected errors in transcription services.

In order to preserve confidentiality, I kept the names and contact information of the sample and all data collected on a secured, password protected flash drive that I carried by myself at all times while abroad. Upon return to the U.S., I kept the secured flash drive at the University in a locked cabinet, along with the signed consent forms. Transcripts and audio files were coded and did not contain the participants' names or any other identifiers. Participants were assured that no reference would be made to their name, their clients' names, or any details that might be identifying. I contacted all participants via email to discuss four key components that needed to be addressed before the finalization of this paper. First, I verified that their interviews, as reflected in the results section, respected their privacy due to the nature of the study. Second, I acknowledged that not all portions of their interview were reflected in this paper, but they may be reflected in future scholarly work. Third, I acknowledged the sensitivity of the material reflected in the paper and stated that their participation would be important to share so others may understand their lived experiences. Fourth and finally, I acknowledged that they may disagree with the interpretation of the data and if they felt that a piece of information captured was incorrect, to contact me within a week of receiving this email. All participants either replied saying they consented to the results section or did not respond via email within one week.

Data Analysis

Hermeneutic phenomenology has been utilized in psychology research (e.g., Binder, Holgersen, & Moltu, 2012; Busygina, 2009; Hoshmand, 2005; Kvale, 1983; Larkin, Watts, & Clifton, 2006; Osborne, 1994; Sandage, Cook, Hill, Strawn, & Reimer,

2008) where the goal was to gain a more accurate understanding of participants' individual experience and their point of view. Hermeneutic phenomenology was utilized for this study for several reasons. First, the focus of this analysis is on capturing the description of a lived experience with various participants who have experienced a specific phenomenon (Marshall & Rossman, 2011). Additionally, it builds upon a shared experience by emphasizing the subjective experience of an individual and thereby bringing to light a topic that may be full of complexity due to a variety of factors (e.g., shame, silence, patriarchy, legal barriers, religious implications, historical trauma). Next, hermeneutic phenomenology has a particular focus upon my role in how I am experiencing the process of gathering the narratives by acknowledging my biases before, during, and after the data have been collected, as well as focusing on the importance of my intuition as a guiding research tool throughout the process. Lastly, this method rejects having a set list of methods because the very rigidity of such a list takes away from the very nature of the data: the narrative captured.

van Manen's (2016) Hermeneutic cycle and four essential criteria provided the frame for this study. First, the researcher is a key element to Hermeneutic phenomenology research. I created a written description of how I experienced the phenomenon in order to begin the process of bracketing my experiences (van Manen, 1990; 2016). In order to describe a phenomenon while being aware of my own biases, I engaged in a reduction process that involved bracketing my own reactions, thoughts, feelings, and so forth, that emerged before, during, and after data collection and analysis (Kafle, 2011; Morrow, 2005; Merleau-Ponty, 1962).

I engaged in a process of bracketing in order to begin the research project. Before data collection occurred, I utilized a journal to write down my initial reactions, emotions, and thoughts concerning abortion stigma amongst Irish women. During data collection, I kept a record of any patterns or insights gained that emerged in my reactions throughout the interview process. Bracketing allowed me to actively notice the feelings, thoughts, and biases that emerged within me that may have actively affected how I interpreted the data. Bracketing continued into and throughout data analysis when I took care to note my reactions and biases regarding what would emerge from the data. I then developed a list of significant statements from the data and refined them to produce a list of the participants' experiences. Next, I grouped these unique experiences into themes for meaning and organized direct quotes into categories reflecting themes that emerged across the participants' transcripts.

van Manen (2003) recommends a general dynamic interplay among four rigorous criteria; Orientation, strength, richness, and depth. *Orientation* considers the involvement of the researcher in relation to the participant's world. *Strength* considers the capacity of the text to be inclusive of the core intention of the inherent meanings expressed in the research participants' narratives. *Richness* considers the aesthetic quality of the narratives captured. *Depth* considers the ability of the narrative to penetrate and fully express to the best of the participants' abilities. These four components, when actively applied to the process of the Hermeneutic cycle, increase the quality of the data and the themes that emerge through the process.

Results

Participant narratives illuminated their perceptions of the essence that has not been specifically documented and/or experienced, of the abortion stigma phenomenon experienced by Irish women. Each participant had a unique narrative and description of her or his clients' narratives, yet the essential dimension underlying the phenomenon for their clients can be captured in one word: Shame. The central struggle repeatedly vocalized by every participant was the shame that is broadly felt, lived, and experienced on an ongoing basis by women in Ireland, particularly those who have had abortions. The central struggle also emerged during the data gathering itself (i.e., the interviews). Participants appeared unable to limit their discussion to their clients' experiences of abortion stigma; they also spoke to the emotional, political, and personal links they too have had to this human rights issue, revealing a parallel process shared between the psychotherapists and their clients.

I discovered that participants used four prominent ways to describe the shame of Irish women who have had abortions and experienced stigma related to their abortions: Secrecy, cultural barriers, systems working against women, and personal is professional (see Figure 1). The *Secrecy* theme illustrated the dominant notion of secrecy leading to whether and how abortion stigma was experienced by Irish women. The *Cultural Barriers: Breathing in Irish Culture and the Irish Identity* theme depicted the power of the Irish culture and its influence on how stigma was experienced by Irish women. The *Systems Workings Against Women* theme captured the experiences of women navigating various structures of oppression blocking access to abortion through stigmatization. This theme had three sub-themes: governmental/politics, religious, and the interlinkage of

religion and politics. The *Personal is Professional* theme captured the participants' own narratives and commentaries on what it was like for them to work with women who have experienced abortion stigma and how they view their upbringing in Irish culture impacting their clinical roles. Figure one illustrates the themes and sub-themes. In the following sections, I describe the themes and subthemes in greater depth and embed verbatim quotations throughout for illustrative purposes. The order of the themes and sub-themes is intentional, moving from those spoken about repeatedly in all of the interviews, to those that while present in every interview, were mentioned less frequently. The names used below when describing the themes present in the data are fictitious and are not reflective of the participants' actual identities.

Clinical Impressions: "The Personal is Political"

Throughout the data collection process, clinical impressions were gathered via the hermeneutic journaling process. The variety yet similarity of emotional reactions and what was stimulated for each participant with respect to the subject matter of abortion stigma in Ireland was noteworthy as the interview process continued. All participants spoke of the "anger" and/or "frustration" they feel towards the larger systems that reflected a history of hierarchal and patriarchal influence (e.g., Irish government, Catholicism, familial histories and/or traditions, Irish culture). When discussing their sentiments of "injustice" for their clients, eight participants brought up their own incidents of feeling "injustice" related to how they grew up in Ireland and the cultural beliefs they internalized over time related to abortion. Six participants were consistently tearful throughout the interviews when discussing the stigma experienced by Irish women

who have had abortions and when discussing their experiences with "unjust" systems. As I continued conducting the interviews, I noticed a consistent phenomenon occurring that participants could not separate their own emotions and beliefs regarding abortion stigma in Ireland from their clinical impressions when working with women who have experienced abortion stigma in psychotherapy settings. The core feminist tenant of "the personal is political" was present throughout this study due to the inability of participants to separate out their identities, clinical work, and cultural and political beliefs.

Theme: Secrecy

Participants spoke of their clients' unique narratives and the significant impact of secrecy contributing to their abortion stigma. Stigma was fueled by the great amount of abortion secrecy clients said they consistently carried with them. Anna described the difference between Ireland and other countries where abortion is legal, defining this difference based on the lived experience of residing in another country (i.e., U.K.) for part of her childhood:

> *And my experience of working with clients, that in [the U.K.] it's more about change, because in Ireland, abortion is secret; in other country it's private. Seems to be, my experience is based on the difference of having grown up in a different country and experienced the subject myself. There is no secrecy around [abortion], you need just to be private [in the U.K.]. Whereas over [in Ireland], you have to do it secretly. Now, is that because of stigma, shame? Who knows?*

> *No, really, I think it's much due to secrecy, because no one is opening up and talking about it. I had an English friend that I was working with, through an English company before I became a therapist, and [she shared that she] had an abortion (in the U.K.) [and she wasn't] shook from it. And it's just like an everyday conversation. I was like, "Why is it that you would say that? It's not allowed here!" So I don't know, my clients [have] been the opposite of that; they have to hide it, they have to keep it secret. Unless they were in a family were they can allow it to be normalized.*

Anna reflected on this experience walking with a friend from the U.K., who so openly shared her abortion experience without any apparent presence/experience of the stigma that surrounds abortion in Ireland. This experience led the participant to stop and reflect on the cultural difference; it also illuminated a distinction between private and secret. In countries where there may be increased stigma towards abortion, secrecy is the expected norm. Once again, secrecy concerning abortion is ever present and the expected cultural norm.

Emily highlighted the subtlety in communications that support a culture of secrecy in Ireland and cause women to silence themselves. This is made apparent in relationships with other people through verbal feedback that reinforces this behavior:

> *And there was the thing about that client, with my last client, and she just kept mentioning how when people talked about [her abortion] they dropped their voice. Their voice lowers, so it's like simple things. It's all very shady. There's no empowerment in there, or there's no "Okay, this is what you're doing."*

Emily described a subtle, yet massive feedback mechanism internalized by Irish people; that shame is not intentionally ascribed to a situation, but rather is instead the result of the general Irish society that would deem a stance of shame aimed towards a woman who received an abortion to be an appropriate response. This type of behavior continues to indirectly and/or directly silence Irish women and implicitly perpetuates judgment from individuals in the culture, leading to abortion stigma.

Sean highlights the internalization process Irish women have experienced from the larger systems that forces them into silencing themselves. Abortion stigma occurs from a slow and steady internalization process rather than the recipient of blatant feedback.

> *No one has actually told me that this was all said, like kind of their own inner critic. That you're a bad person. So, some of the stuff out there about the unborn child and that you've taken a life away. I think that that actually sticks to many women. And somewhere inside [they think] they're a bad person. That's the judgment I suppose. Yeah. I think that they actually have given themselves [judgment]. In most cases I found they often didn't say to somebody they had an abortion. Maybe a partner, like a boyfriend or something like that. So, they often didn't receive the judgment from them because they actually had somebody who was maybe important to them. So, it was kind of saying like, "Okay, this is what you want, I'll accompany you, I'll help you, I'll support you. If you need money, whatever it is. And so, they often had somebody who was close to them that knew*

about it. Most cases because of the judgment and criticism, they haven't really told anybody else because of the judgment.

As stated in a previous theme, the Catholic Church has a strong cultural influence on Ireland and how Irish women build and come to understand their identities as women. This slow and steady internalization of church "rules" leads Irish women to foreclose on accessing support post-abortion. This silence, combined with the guilt associated with the religious meaning of an abortion, promotes an internalized stigma and shameful understanding of themselves.

One of the unique experiences Irish women endure due to abortion being illegal is the physical process of leaving Ireland to travel to another country for an abortion procedure. Grace spoke about the effect on clients' regarding their mental health after returning from having an abortion procedure in another country:

I was shocked that she had no support. Her friends basically -- although they weren't anti-abortion -- they just didn't seem to care, or they didn't seem to say, "Do you need any help?" She travelled over to the UK on her own. She couldn't tell her family, which is another thing that surprised me, because I would reckon her parents would probably be my age or even a bit younger, and I thought, "God! That's strange that you couldn't tell your parents." But there's obviously reasons for that which I-- See, she only came to me once, and she was very scared and very traumatized, and I never really got further than that. And then, she was drinking a bottle of wine at night to sort of soothe herself, and I was just shocked that person in that-- I think it was end of [year], something like that, there would

> *be a young person in that place. I would expect someone of her age to just sort of say, "I am not going to have an abortion. I'm going to have the baby and I'm going to manage because I can afford it." or "I'll go off and do this." And that's it. End of story. But she was really, really traumatized by the whole thing, and I just thought this is just ridiculous in this day and age that young women are having to fly off on their own into such a horrible, lonely place.*

This practitioner spoke of a specific client and the secrecy she endured planning the trip, traveling alone, having the procedure, and then returning without any support system in place. The client experienced fear and trauma, as well as the "horribly, lonely place" that she endured in secrecy. Additionally, Grace mentioned the maladaptive coping mechanism (drinking) that living in the secrecy produced for the client and the potential detrimental effects this secrecy caused for her and how she thought about her abortion.

Mia builds upon the secrecy by describing how working with clients who have endured years of secrecy after their abortion stigma "stay with one's self," This description depicts an isolation and lack of support that is produced in her clients by the broader Irish culture, and whose cultural norm of secrecy regarding abortions leads to trauma:

> *I've really met an awful a lot of women who still live in me and their experiences resonate, and I still wonder how intact their lives are, having experienced with them that journey through unplanned pregnancy, decision-making, and secret furtive trip to England. When I was thinking about the question, I thought of a particular woman, and she was married, and it was a much wanted pregnancy.*

Their baby was discovered to have a condition that made it incompatible with life. It would live in the womb, but it would not survive once it was born. But she still chose to continue with the pregnancy. However, she became seriously ill, recurring infections, and her and her husband were just terrified because it was soon after the death of the woman in Galway. And they were terrified, and they decided that they would have to terminate in order to ensure that her health was intact … They had to travel secretly to England while her health was very, very horrible and have a termination. She returned to Ireland. Her physical health returned, improved, but grief and mental health totally incapacitated her. I met both of them. Both were absolutely heartbroken for the loss of their baby. Had their baby become full-term, they would have had a family community around them grieving the loss of it. Their baby's ashes were delivered by a courier three weeks afterwards; a knock at the door, and that's how they got the baby's ashes back. They couldn't tell anybody what they had done. They did have a burial, but a lot of lies and loss, shock, grief … and [they] were never able to speak openly about what happened. They did have the burial and the ceremony, but nobody in their family knew the truth of what had happened, and it's their secret, their silent grief, loss, shame, guilt. That's what they're carrying…. It was so unfair. They had lost a baby, and it brought up number 1, the law here that they couldn't terminate the pregnancy even though it was non-viable. I think I'm crying because I don't think they're going to get over it, because they feel they did something bad, and

> *yet such bad things happened to them, and they did nothing bad. But I could name dozens of people I still see, words, a shadow.*

Mia shared a personal narrative of a client whose trauma resonated from not only the secrecy required for her to travel abroad to have an illegal procedure, but from the post-abortion coping and the lack of support this client (and her partner) experienced. Mia's continual thoughts of how these women have continued to be isolated and live in secrecy while holding stories of trauma has produced "a shadow" within Mia, a weight of secrecy that must be born as a practitioner who has worked and continues to work with women who experience abortion stigma due the phenomenon of secrecy.

Even in a therapeutic space, clients experience secrecy. Quin stated that a particular client years after her abortion continued to feel that her abortion was something to hide and feel shame around, even in a confidential therapeutic space:

> *And this particular client had an abortion when she was younger…when she was 17. Um, so she's been carrying that with her throughout those years and not telling- not telling very many people about it, and not talking about it, you know? Um, so just that feeling that, like, you know, it's not something we can talk really about. And that is its- it's so, I suppose, deeply ingrained that, um, even when you come specifically to- to therapy, where you're, I suppose- where, I suppose, the conditions are- are, I would hope, more ideal to talk about stuff, even in that sort of an environment, it still proves a dark secret that's very difficult to talk about*

Quin noted the extent to which this secrecy had occurred, for "years at a time" which produced an ever-increasing silencing effect for the client. This was so "ingrained"

within the client's lived experience that this secrecy led to the client internally experiencing her abortion as a "dark secret" that was difficult to reveal. Irish women, even in traditionally safe spaces (e.g., a therapeutic room), may experience the stigma linked to their abortion that is so thick it may inhibit them from accessing the help they need.

Some women may choose not use the therapeutic space to discuss the stigma they may be experiencing related to their abortion because they are unwilling/unable to allow others to find out about their "dark secret." Catherine noted that sometimes clients have opted to not ever share that they have received abortions to anyone at all because of the overwhelming fear of what would come from their disclosure:

> *What came to me was the clients that I have seen are so incredibly terrified of anybody discovering that they've had an abortion, that they haven't come back to me saying that they've been stigmatized because they haven't told anybody. This is the incredible thing about it. So the stigma is again, I suppose, we recall it self-stigma, again because of the attitude of our society, Ireland. I suppose the people who are against abortion will campaign very, very obviously on the street, and they will have very graphic photographs, and women, most of them, have seen this. When we talk of people coming back saying that they've been stigmatized, they don't tell [others] because of the fear of stigma, fear.*

The ultimate secrecy that occurs for Irish women is when they never share with anyone that they had an abortion. Catherine acknowledges the power that self-stigma may have over these women over time, particularly when reinforced by visible messages

"informing" women that they do not deserve to share their narratives, and they do not merit support because of their egregious act, thereby reinforcing self-stigma regarding their abortions.

Beyond the therapeutic space, clients experience stigma leading to secrecy in their other support systems. Riley shared that even in healthy and supportive relationships, clients may not allowing themselves to access those mechanisms of support:

> *I think that's how you see how the stigma. She wasn't able to tell anybody about it, you know. How that stigma kind of acted out, you know. It was very back there, you know. I remember her saying, it took her a very long time to even tell her current partner.*
>
> *Like, she had seen this as some kind of terrible act. And it took her ages to come around, to feeling safe enough to discuss that with somebody. Um, I guess she would've been from kind of like a similar background to mine, a Catholic kind of working class sort of a background.*

Riley found it important to highlight the sociocultural background of her client who was experiencing stigma related to her secrecy regarding her abortion. The sociocultural background, in this case with a Catholic working class female client, may lead to a unique narrative of how secrecy is experienced and eventually leads to abortion stigma. The self-stigmatizing (e.g., "she had seen this [her abortion] as a terrible act") denotes a silencing experience wrought with self-judgment that is perpetuated by the amount of time that it took for the client to share her narrative with others (and allow herself to access support).

The secrecy around abortion also produces a lack of awareness and preparatory measures by Irish women to cope effectively post-procedure. Rachel described one client who suffered detrimental effects because secrecy prevented her from anticipating the self-stigma she experienced upon return to Ireland:

> *I think, especially the young girl that I had, she thought that [she would make] the trip over to England, have the abortion, come home, forget all about it, and that's it, it's over and done with, gone. It really upset her. She said that just after the abortion, while she was waiting in the recovery room, she felt guilty and sad and really upset, and she didn't expect that to happen. So I think the young girls' not knowing the effect it can have on them, not being aware, not being told, not having any counseling beforehand, and just doing it impulsively or very quickly, not having time to think about it first. So I think that's a big factor.*

Rachel highlighted an effect of secrecy that may uniquely contribute to self-stigma; a lack of awareness of what to expect and how to cope in terms of their mental health process post-abortion procedure. Counseling services are offered in Ireland that specifically offer options to Irish women considering abortion. Because of the heightened secrecy around abortion, however, some women "impulsively" choose to have one without considering the potential detrimental mental health effects that could occur, not because of the abortion procedure, but because of the effect of returning to a country where it is illegal and immoral within the larger cultural context.

Theme: Cultural Barriers: Breathing in Irish Culture and the Irish Identity

As the interviews progressed, the impact and power of the Irish identity became a prominent narrative. Participants spoke of the complexity around their relationship with their Irish identity. Broader statements regarding the relationship between Irish women and the country of Ireland were frequent and laid out an ever-present backdrop to the narratives gathered.

Emily described slowly realizing the learned shame experienced while growing up in Ireland. This was an internalized shame about holding the identity of being a female. Emily was only able to realize the internalized shame through a large amount of self-reflection and personal growth that exposed this internalized piece. Emily shared that most of clients who experience abortion stigma come into psychotherapy not even questioning their internalized shame:

> *I felt a lot of shame from within that I couldn't quite identify for a long time. I didn't understand what it was and where the words were coming from. Then I realized it was my own internalized shame that I take on just for being who I am in this country. A female. It was really interesting. When clients sit in front of you and they tell you these experiences that are really-really unpleasant and really isolating and hurtful, I felt shame of being Irish for one thing, which is definitely something that I didn't know what [having an abortion] was like … I think Ireland is very blind. Ireland has itself upon some pedestal of – of um... the land of friendliness, and it's not at all... And I think it's time that we start realizing that.*

The shame was not only tied to this participant's born sex, but also from a quickness to judge others for their decisions, actions, identities, etc. Emily was not able to quite identify or articulate the source of the shame initially; it took time to realize the shame was tied to having an Irish identity that was filled with patriarchal influences. The combination of shame tied to being female and being Irish powerfully portrays the environment that Irish women who elect for abortions may be operating within, thereby leading to internalized abortion stigma.

Grace asserted that abortion stigmatization is not upon Irish women, but rather upon the Irish state. This practitioner identified the Irish state as being the cause of abortion stigma due to its lack of progressiveness with respect to recognizing and responding to Irish women's rights (i.e., the right to reproductive healthcare, including abortion services):

> *I kind of turned the question a bit on its head, and I suppose what I'm thinking is really the stigma is with the state, the Irish state for just being completely antiquated and out of touch. So I think it's the state that carries the stigma and not the women of Ireland. Even going back 30 years when it was still kind of hush-hush, you could say there was a stigma attached to it. But the thing is that the women have not accepted this [stigma]. They've come out fighting [this stigma] and the fact that it's a criminal offense punishable by 14 years in jail. That has never been repealed. I can't understand why that [hasn't been] done … Do you know what I mean? My feeling is the stigma is on the Irish state for having this criminalizing law and and also being very stagnant and never legislating. They*

> *bounce it around to committees, and they talk about referenda, but they never actually take the bull by the horns and legislate, take it out of the constitution, make it a women's health issue and legislate it.*

Grace stated that the abortion stigma present in previous generations may not be the case in current Irish society, and thus the Irish government is reflecting "antiquated" ways of viewing abortion. This practitioner went on to describe themes of empowerment in working with women who experienced abortion stigma, for example, conceptualizing who is responsible for the stigma experienced: not the women, but the Irish state as a whole.

Anna shared a unique piece of Irish identity relating to physical space and the resulting fear of judgment by those around you. Various environmental factors common to the Irish identity (e.g., the small population of the country, the physical closeness and proximity for women living in rural areas) cause Irish women to have ongoing concerns of being "found out":

> *For [Irish women] have to do it [have an abortion] in a very quiet way, because you may be stoned by your neighbors. Probably not as much as we think, so I think it's not as much as we perceive, but we can't risk it because we live in a very, from where I live, we live in close proximity.*

Anna identified the broader Irish identity factor of proximity and how this may have negatively impacted Irish women and increased potential abortion stigma. The closer proximity coupled with the strong Catholic presence (particularly present in rural Ireland) creates a climate in which abortion stigma may be heightened. The Irish identity for the

rural portion of the population provided a unique perspective to how the Irish identity may impact abortion stigma.

Mia discussed the history of Ireland and its oppressive and harmful relationship to women. Although historical shifts have occurred, there has not been a progression, rather a change in of what type of woman is oppressed at a given time:

> *Abortion has now taken the place formerly occupied by unmarried mothers, and the scandal that is now being excavated in Ireland (see Appendix G). We look at what's happening ... bad women who cannot be tolerated in their own country ... similar to what happened in the past, pregnant], good women went to England to have their babies or were incarcerated in unmarried mothers' homes, and their pregnancy ... was hidden from the community, babies adopted, women returning to their communities, never to speak about the events of pregnancy and childbirth. This is now replicated in the current journey to England and the return to Ireland. Never to speak to anyone about the experience. Shame-filled, traumatic experience of being labeled a sexual woman in a country where sex and women were deemed dangerous and needed to be controlled.*

Mia discussed the changes in oppression, judgment, and stigma put upon Irish women from the current historical context. Unmarried mothers were targeted by the larger Irish culture for judgment and stigmatization; however the ways in which women threaten the Irish identity has evolved, with the most recent target being women who travel abroad for abortions. Abortion stigma, in the opinion of Mia, may be a recent focus and perpetration by the Irish state. Mia acknowledges this type of oppression and judgment has always

existed and has been propagated by the country as a whole; however, the focus has changed overtime and now the stigma is aimed towards a different group of Irish women: Women who access abortion in other countries and return to Ireland. She articulated the trauma and shame that comes from this history, and continues to be perpetrated.

Control is exhibited in religious and legal systems, all with a backdrop and support of patriarchy. Rachel articulated the historical continuation of patriarchy and how it is experienced by Irish women:

> *Years of repression, suppression, wrong thinking, Catholic domination, and domineering parents who don't listen, even maybe one parent who's controlling and dominant and doesn't allow the other to speak. There's a lot of that in this country. There's huge control issues especially with men in Ireland, huge, so women feel that they don't have a voice. They can't speak up.*

Rachel highlighted the broader structures (e.g., Catholicism) and the more intimate structures (e.g., familial norms) that reinforce the value of control. Control is the underpinning of the legal system, and the legal system perpetrates continual control over women's bodies via anti-abortion legislation. This practitioner also denoted an important consequence from this historical and systemic control: the silencing of women's voices and the potential impact this historical trauma has had on how women currently experience abortion stigma (or are not even aware they are experiencing it).

Beyond the Irish government laws that have continually policed a woman's right to elect for an abortion and propagate abortion stigma, the images of the Catholic Church and its strong linkage to the Irish identity are influential as well. Mia articulated the

dominant Catholic image of what an idea woman exhibits in her character and what she must emulate in order to be considered a proper Irish woman:

> *At the internalized belief that sexuality is bad, that women who are sexually active are bad, that pregnancy is proof of sexual activity, and that's really the problem. It's not the pregnancy in itself. It's just what it's saying about, this woman being sexually active. The good women are naturally maternal, that motherhood is a natural destiny of women, and that's the internalized piece. Of course, enshrined in our Constitution was [sic] the woman's place belongs in the home. So that's very much part, the homemaker, the mother, and the Blessed Virgin, very Irish and very cultural. Control of women and women's bodies. It's just a huge problem in Ireland around the image of the Blessed Virgin and replicating her.*

Mia depicted the Blessed Virgin in her description of what *should* be depicted by Irish women, which is impossible to emulate. Furthermore, within this tapestry of the Blessed Virgin, is the expectation that sexuality will not be made overt in any way that does not fully reflect the values of the Catholic Church. The maternal drive is an innate and expected role; to ultimately reject this role via an abortion goes against the very essence of female Irish identity (i.e., the Blessed Virgin, Catholic morals, female anti-sexuality). Violation of this role results in punishment via shame and abortion stigma, which Mia has witnessed in her clients.

Quin spoke of "the Irish psyche" – a phenomenon that is bred from an historical internalization of Catholicism and is experienced both consciously and unconsciously.

Building upon the Blessed Virgin trope, Quin spoke of the Irish identity being linked to Catholic doctrine and the internalization process of the Catholic canon:

> *"Thou shalt not kill." I think it's had a huge, huge influence on women. You don't kill—now I know it's not just the Church that will say, you know, that you don't kill. There are laws you don't kill people. But I just think, in particular, in Ireland—I don't know about abroad, but in Ireland this belief is linked to the Catholic Church. And, yes, it's still there in this day and age, the stigma is still there. And the Church isn't so strong in Ireland now because of the abuse, and it's not so strong. But I think it's sort of in the psyche of the Irish. It's not just the Church, it's actually in the psyche that you don't kill, you don't have abortions. Even if, you know, you hear all the people saying, you know, "It's ok," and—it's not ok. It's society, it's not ok. Yeah, I think it's the Irish psyche, it's not just the Church.*

Mia acknowledged, similar to other participants, that the stronghold of the Catholic Church has decreased in recent years. Yet the influence has been so present in the country and the people of Ireland that Church doctrine has embedded itself into how laws are interpreted, how people view and judge others, and how women experience abortions (i.e., stigma). The Catholic belief of "Thou shalt not kill" is exemplified in all institutions in Ireland, including (according to Mia) the medical and legal interpretation of what killing means (e.g., abortions). "The Irish psyche" weighs upon women in how they experience post-abortion stigma because of the liberally applied presence of the "thou

shalt not kill" doctrine. It may be that "the Irish psyche" is so internalized that it mirrors the Irish women's psyche, and that they are inseparable.

"The Irish psyche" derives from both conscious and unconscious awareness. Sean described the Irish cultural identity as being pieces that you breathe in over time and become habituated to believe. The following quote denotes the impact the Catholic Church has on how Irish people view abortion and the judgments linked to it, thereby reflecting the impact of the Catholic Church on abortion stigma via it's broader influence on the Irish identity:

> *The Church for instance, still has a huge influence. Something like 25% or something like that of the population would be regular church-goers now, which is a huge decrease. And the ability of the Church to maybe actually influence the day-to-day lives is lessening. But the message is still out there, and it's in our culture. For so many people, you've just heard it. When did you hear it? You don't even know. It's like it's in the atmosphere, in a way. It's something ... that is wrong or illegal.*

Sean emphasized that an ongoing belief system operating at all levels of the Irish identity cannot be traced or even questioned by most Irish people. Sean further spoke to the potential impact on clients --- the larger societal belief structure is literally a phenomenon in the air that cannot be seen, but is fully felt. Furthermore, when one envisions an atmosphere, one thinks of life and breathing in the atmosphere in order to live. This powerful image depicts a sociocultural environment in Ireland that is literally inescapable for women experiencing abortion stigma.

Riley builds upon these images by sharing that abortion stigma supported by the Irish culture is potentially caused by unconscious beliefs and conscious actions:

> *It kind of happens insidiously, you know. It kind of just seeps into you. It seeps into those around you. It's hard-- nobody I suppose, or really, overtly kind of talks about it enough, but it's just seen in your actions. It's just seen in the things that you do, you know? Almost unconscious, as well as being conscious. It's something that I guess you won't talk about it that much. You hold it back to a certain extent when it's definitely there.*

Riley emphasized the perspective that abortion stigma from the Irish identity is an automatic response and not a belief that is questioned. If it is questioned, however there are various social systems that police and punish those that question a woman's right to choose. The actions associated with causing abortion stigma are so intertwined into the Irish identity that they are not made conscious, let alone spoken about explicitly.

Emily spoke about the internalized shame she experienced by being born female and being raised Irish, but continued to later state that Ireland must own the historical trauma it has created and currently perpetrates against women who have had abortions in order to decrease and prevent stigma:

> *It's all in the shadow. It's all about the shadow. Ireland has a huge shadow, and our shadow is sex which is then being thrown into sexuality and gender, and we don't really want to notice it, but it's there. It's really interesting because I've obviously had different kinds of clients, different forms of abortions, that have been... medicinal, they take pills, and actually it's not socially preferable to have*

> *an operation. It's almost like, one is favored over another, or time wise it's favored, but it's really having to take all of that out of the shadow. Literally just... talking about what happened. The country needs to hear it. And I think the more – even as therapists, we need to be able to talk about it, and a lot of therapists don't talk about it.*

Emily stated the importance of Irish therapists rejecting the Irish cultural piece of judgment and prejudice concerning the methods of abortions, time line of abortion, etc. and instead to radically reject the Irish cultural identity by questioning its structure. Emily spoke of "the shadow" being the unspoken or unseen experience of women who have abortions and they identified "the shadow" as the source of abortion stigma. In order to decrease abortion stigma for Irish women, the Irish identity must be questioned, oppression must be owned, and psychotherapists must take an active role in advocating for their clients by becoming aware of their own biases and judgments linked to their own Irish identity.

Theme: Systems Working Against Women

One of the primary ways in which participants discussed abortion stigma was by speaking to the various systems working against women. These systems are representative of larger institutions that dominate the daily lives of Irish women. Participants spoke about client's experiences with navigating various systems of oppression that directly effected how they faced stigma related to their abortions. Participants spoke from a variety of perspectives, mainly identifying the various systems oppressing Irish women and sharing their client's experiences and narratives in how they

lived within these systems. This theme was generally thought of by participants as being represented in three themes; political/governmental, religious, and the symbiotic relationship between the two.

Subtheme: Political/Governmental.

All participants spoke about clients who traveled abroad to the U.K. for their abortion procedures and the legal barriers. Catherine spoke about how the larger governmental structure promotes internalized stigma for women who have had abortions. This practitioner explained that the Irish government has oversight on women's right to choose and she described the potential emotional effects this control has on women. Currently in Ireland, no woman is allowed to have an abortion under any circumstances. The simplicity of Catherine's statement speaks to the broader understanding of the government's influence on the conscious decision of women to have abortions outside of Ireland:

And then, you would have the fact of the matter that it's illegal in Ireland. They get to feel that they're doing something terrible, but they still feel that whatever their personal reasons are, that it's a choice that they feel they need to make [to travel abroad for an abortion or not]. Yeah.

Catherine expressed the illegality of abortion in Ireland while also expressing her personal anger and resentment towards the Irish government by stating that women "get to feel" they did something wrong. Catherine, however, articulated the power of these women functioning beyond the larger governmental system and its oppression by knowing they are making the best decision for their individual circumstances.

Emily built upon the basic understanding that abortion is illegal in Ireland and may cause emotional distress by saying the government is responsible for victimizing Irish women as a whole. This participant speculated about a potential emotionally corrective experience the Irish government could offer women if they did not dictate laws that police female bodies:

> *We have leaders currently ... They won't actually just stand up and make a decision. So, they [the clients] have experienced people debating things in a public forum. We've got people calling you all sorts of things. It's one thing to have the government on your side that says "You can all have your own opinion, but we're still going to make this legal and free and safe for you to be able to access this within this country. You shouldn't have to go abroad in order to access this." Nobody's ever stood up and said that, so they [the women] experience [no one speaking on their behalf within the government].*

This participant said the Irish government may be alienating the female population further by having public discourse and debate around a topic that by its very nature is intimate. Also articulated is the hesitancy and lack of advocacy the government has consistently displayed against Irish women. Lastly, Emily captured the potentially negative emotional impact Irish governmental officials have had using negative labels for women who want the right to choose (i.e. criminal, perpetrator, etc.). All of these factors demonstrate the distancing effect Emily has witnessed between the government and the women of Ireland.

The absence of advocacy or representation of the female lived experience of having to travel abroad for abortion procedures in the debates elicited emotional responses from participants and prompted them to express their own judgments of the Irish government. Grace shared that the Irish government has taken minimal responsibility for its impact on the mental health of women in Ireland who cannot access abortion services. Grace also speaks to the monotony of repeated debates and continued legal measures that block abortion services:

> *I think [the government] has been pathetic. They've had lots of opportunities where they could have done something. Even now with this eighth amendment, they've just passed the buck to another committee where they're [the] same old, same old. It becomes very emotive. It doesn't change or do anything really.*

Participants' personal anger and exhaustion regarding the Irish government and their failure to update Irish laws was a repeated sentiment throughout the interviews. Furthermore, participants' discussed how their female clients who have had abortions possessed similar emotions of anger and exhaustion towards the Irish government. Additionally, Grace captured the unique perspective that the monotony of repeated failed attempts to change the law has a large emotional impact on women who have had abortions. Victimization by the government continues to create distance from and distrust in the system by Irish women.

The effect of broader international conversations on abortion and a woman's right to choose may have an impact on the debate within Ireland. Sean illuminated the potential relationship between international politics and Irish politics. They shared,

> *Some of the stuff that actually happens internationally, affects us as well. Other countries legalizing abortion... Maybe that could ease some of the stigma. So, for instance countries like Portugal, I think, which they've been Catholic. And they have brought in much more open systems. So, that could have reduced the stigma on abortion, but other countries have gone the opposite way. Bringing in much more restriction to countries like the [United] States. Quite conservative groups can be forming all kinds of messages as well. But that will make its way into the space. Sometimes that's part of it, too.*

Sean spoke to the broader affects international politics have on Ireland, and the impact other traditionally Catholic countries that legalize abortion may have on Ireland. Ireland does not operate within a vacuum and may be affected by larger international conversations regarding abortion; however Sean spoke hesitantly about a shift happening soon. Sean discussed witnessing other countries shift to a more politically conservative government and the potential reinforcement this may provide to the Irish government to continue banning abortion. Sean identified abortion stigma experienced by Irish women being at the mercy of not only Irish governmental rules, but the broader international discussions occurring as well.

Subtheme: Religious.

Ireland is historically and traditionally a strongly Catholic country. Participants discussed that this does not necessarily mean most people practice Catholicism regularly anymore; however everyone stated the Catholic Church's impact on abortion stigma and how it is experienced by Irish women remain strong and present.

Catherine noted the internalization of abortion stigma fueled by the Catholic Church begins at a young age. Exposure to the heavy judgments towards women who elect for abortions is well integrated into the Catholic education of Ireland:

I suppose [internalized stigma results from] their religious education from childhood in that they would have internalized that abortion is not okay. That's forbidden by the Church. So you would have that.

Religious education occurs in the public educational system in Ireland, and therefore it influences the broader Irish population, not just children who attend Catholic schools, Catholic Churches, and/or are raised in practicing Catholic families. Building upon this broader Catholic framework, Grace discussed the strong presence of Catholicism in the systems perpetuating abortion stigma on Irish women. This practitioner acknowledges the influence the Catholic Church has waned over the years; however it is still heavily present in how abortion stigma is fueled:

> *The religious [e.g. Irish people who practice Catholicism] when I first came here would have been very strong, but it's less strong now, but there would still be quite a strong Catholic element, and that would just [be] absolutely "No way. No way." That would tie in then with family. There would be some really religious famil[ies] who would be anti[-abortion].*

According to Grace, the Irish cultural landscape has shifted to a slightly less Catholic-dominated landscape; yet even with a slight decrease in a strong religious presence, the anti-abortion beliefs and stigma are still heavily present for Irish women. Similar to Catherine, Grace notes the substantial relationship between the Catholic Church and

familial beliefs/values, highlighting the potentially emotionally harmful and stigmatizing impact having an abortion can have on an Irish woman from a traditionally Catholic and "anti-abortion" family.

Participants highlighted the permeating relationship between the Catholic Church and familial beliefs/values and the educational system. Moreover, Emily noted the relationship does not stop at familial and educational systems, but infiltrates professions where abortion stigma might be expected not to be exist (i.e. primary school, nursing school, etc.). Emily highlighted that even in certain professions where one would expect a more supportive and non-judgmental environment, the internalized shame and judgment the Catholic Church promotes may be present:

> *And it's mostly the religious shame, though. It's mostly the people that are coming at you from the standpoints that you are doing something really wrong all the time. The professions are really hard. Like I said, primary school teaching, even nursing...Places you're kind of expecting to have some sort of compassion and empathy and a regulation system going on, doesn't exist because it's been embedded within Catholic Church, sadly, Catholic judgment. I think that's also internalized for a lot of clients most of the time.*

Clients are unable to escape the potential breeding ground for abortion stigma in various institutions, including those they might assume are safe because of their traditionally empathic and humanistic stances (e.g., primary school teachers, nurses). Emily went on to highlight the imperative role these professions, and other traditional helping fields,

have to either challenge the societal stigma against abortion that is fueled by Catholic doctrine or to continue victimizing Irish women.

Mia described the source of Irish women's continual internalization of abortion as a negative choice filled with judgment. This participant draws from what clients have directly stated as well as from personal knowledge regarding Catholic doctrine. Mia expressed that women commonly share the religious source of abortion stigma:

> *"God will punish me. I cannot go into church anymore. If anyone knew what I have done, they would hate me. I will never be forgiven. I will never forgive myself. I am selfish. I am bad."*

This practitioner noted that Irish women who have had abortions will commonly express these sorts of words and concepts in therapy. Mia theorized that women receive such rhetoric and concepts directly from either their Catholic upbringing or from "swallowing the larger Catholic cultural influence" as they were raised in Ireland.

Subtheme: Interlinkage of religion and politics.

The Irish government and the Catholic Church have a close relationship which is evident in the history of Ireland. Participants spoke to the power of this relationship and it's strong influence on how abortion stigma is continually experienced and perpetuated within their clients and the broader society.

Rachel discussed the enormous influence the Catholic Church has on the Irish government and the empathy evoked when clients who are experiencing abortion stigma speak to the heaviness and oppressiveness of this relationship on their mental health:

> *It was difficult. I had great compassion and grace, empathy for them. I supported them. I do feel it should be legal. Abortion should be legal, and I think that would take away a lot of the stigma. I do feel the Church has a huge part. I was born a Catholic, reared a Catholic, but I'm not now.*

It was difficult for Rachel to refrain from sharing a personal perspective on abortion in Ireland and whether it should be legalized. Self-disclosure of one's personal beliefs about legalizing abortion and views regarding the potential impact on of legalization on how their clients experience abortion stigma was common across participants.

Rachel also captured the generational shift in Ireland from practicing Catholic to a more religiously independent ideology. While expressing a logical and cultural understanding of the influence the Catholic Church has on the Irish government, this practitioner nevertheless rejected that relationship.

Riley highlighted the symbiotic relationship between the Catholic Church and the Irish government, it is so normative that one may not even realize the symbiotic system at work:

> *As I mentioned before, I suppose I would see religious and government as being quite closely linked. I suppose I'm familiar with each one of those outside influences or outside systems [and how each] has an effect on the other. Like, I suppose, the religion has a profound effect on the government, and the government has a profound effect on religion.*

That trickles down into the [i.e., foundation]. I guess our parents would have gone to church each week, and these values would've been instilled in our parents. And in turn those values would've been instilled in our clients. So, yeah, self-stigma will become internalized…

You've kind of swallowed things whole, um, assimilation. Where you swallow things whole without chewing through and thinking, "What do I take out of this? What do I not take out of this? What out of this is nourishing to me?"...

I suppose, you'd use the term 'religion' and all the time it's down your throat. A lot of my clients sort of had this experience where you're brought up in a school and the religion is kind of spoken about on a daily basis. It's been run down their throat and you internalize that whole system into your psyche…

Um, and that's the system by which you judge yourself and by which you might judge others. You're stigmatizing yourself. It's that self-stigma. And to have that reinforced by your government, who usually says what's right and what's wrong, who sets the law in the country … I suppose, it reinforces what you've internalized.

Riley described the "swallowing" process that occurs for many women in Ireland through the educational, governmental, and religious systems that continually reinforce one another. This individual noted the potential impact this can have on clients when they do not realize the systems they have "swallowed" over time and the potentially devastating

effects this might have on how they view themselves, thereby leading to potentially high abortion stigma for Irish women. These systems act as traditional benchmarks of how one may judge themselves and their decisions. Due to the symbiotic relationship and the system being so ingrained at a young age via various systems discussed, abortion stigma may be so entrenched in the psyche of Irish women, they may not be able to separate the various oppressive systems from their self-concept.

Theme: Personal is Professional

The third theme that emerged from the data concerns personal anecdotes offered by the practitioners' regarding their personal beliefs about abortion, and various other factors that impact how their clients' experience of abortion stigma. Working within a field of psychotherapy and with clients who have navigated systematic barriers to access abortion produced strong emotional responses from everyone. These responses were at times elicited and other times participants voluntarily shared their beliefs and/or opinions regarding their lived experiences related to abortion and a woman's right to choose.

Anna began wholly rejecting the idea and concept of stigma, regarding this concept as promoting a terminology that creates distance between the woman and her lived experience:

> *My concern is if I look…through lens of stigma, then I victimized my client, and they are already victimized, so I can't do that. I can't allow it, because isn't [abortion] a woman's natural right, or birth right? … So I want empower women around [their right to choose to have an abortion] and where they can still stay*

> *safe, unharmed, without them [being] victimized, so maybe that's why looking at it through the lens of stigma I may victimize*.

This practitioner discussed the concept of stigma as having a foundation within the idea of victimization. Regarding the concept of abortion stigma for this individual's clients, the clients have already been victimized by various systems by not having access to safe and healthy abortion services in their home country and from being reinforced to keep quiet about it, thereby causing shame about their decision. Using stigma as a clinical term would perpetuate the victimization of such a personal experience for Irish women. Anna discussed the importance of empowering women by choosing how abortion is discussed in a clinical setting with intention and reflection.

Emily expanded upon the theme of the importance of discourse and victimization, by highlighting the concept of patriarchy. Repeated public discourse in the Irish public forum is intended to reinforce institutions, which to Emily, fuels the argument that patriarchy and institutional misogyny must be discussed if abortion stigma will truly be broken apart:

> *But it's internalized. It's embedded. It's so deeply engrained. And a patriarchal system, sorry, it's the biggest one. Boyfriends, fathers, governments…We've had a strong history of men running this country that have no clue and don't want to know about women's rights. They don't care. So the huge amount of internalized misogyny and... I've talked patriarchy, which isn't just in this country…They don't get it. But patriarchy is the overarching [factor]. Patriarchy is the one that*

> *runs the religious community. Patriarchy is the one that runs the government, so it's essentially overarching.*

Emily candidly expressed personal sociopolitical opinions regarding the root of oppression against Irish women, particularly women who experience stigma post-abortion. Throughout the narrative, Emily repeatedly spoke of patriarchy being the force fueling the subjugation of Irish women, and the invisible and visible powers patriarchy has over the Irish psyche, the individual experience of Irish women, and the literal governing institutions (e.g., religion, government).

Beyond examining the discourse, Grace spoke of the importance of respect for autonomy. This practitioner also personally valued privacy regarding a woman's right to choose, acknowledging the disrespect resulting from the Irish government regulating and needing to know the individual choices of Irish women:

> *I mean being pregnant is a health risk. My personal feeling is that if a woman doesn't want to have a child, whether she's married, single, whatever, if she just doesn't want to do it, she shouldn't be made to do it. And then if she's been raped, or for whatever reason, we shouldn't even know the reasons. It's none of our business. It's a woman's health issue, and it's between a woman and her doctor, and if she's in a relationship with somebody be it same sex or heterosexual, it's up to her and the partner to discuss what they want to do. And even then, at the end of the day, if she's the one carrying the baby, she's going to have to make the decision whether she does it or not. It's quite a responsibility, really.*

Grace highlighted the politicization of Irish women's bodies and expressed disagreement with the public display of individual women's healthcare decisions. Also, Grace denoted that no matter the circumstances, it is of the utmost importance to respect autonomous decisions in order to decrease any stigma that may be present for Irish women post-abortion procedure.

Another element that emerged through the data is the idea of partitioning one's cultural upbringing from working with clients in order to decrease harm and countertransference. Quin shared that because of a strong Catholic cultural upbringing, it was difficult, but absolutely necessary, to parse out personal cultural biases and instantaneous judgments from what the client was saying regarding her abortion stigma:

> *That was her job [as a client], she didn't want to deal with guilt or anything like that; she just wanted to tell someone so that she could live with herself. And she did that, and I was pleased that she was able to do that. But [it] certainly challenged my own beliefs because I supposed I grew up thinking abortion is a wrong thing, that people shouldn't have abortions. I wouldn't be so black and white now myself. But, you know, I had to sort of hold myself and not give my opinion because this woman was suffering.*

Quin recognized the necessity to consider personal cultural upbringing and how it affects conceptualization and work with clients in order for formative change to occur. A strong Catholic faith upbringing had the capacity to cause distance her the client's emotional state and stigma they experienced in Ireland after they had their abortion. This realization

led Quin to consistently check-in/reflect upon personal cultural biases in order to separate those biases from the client's experience.

Awareness of religious and cultural bias was essential for Quin in order to separate personal experience from the clients' experience, and provide a therapeutic relationship. Catherine spoke to the importance of reflecting upon women in one's personal life, and continually contemplating how this trauma may be laid upon some of those women in the future, in particular what the future of abortion stigma in Ireland would illicit for a daughter:

> *I felt very sad for these women, very, very sad, very sad that they felt that they had to make this decision. I would have to say. Initially when I started the work, when I met with women who had had abortions, I would kind of start thinking of my own daughter and sometimes, it just - see in them my daughter. Sad, I suppose, is the word because it is very sad….*

For Catherine, therapy work did not operate separately from personal values, which in this case was valuing the autonomy of women, and the therapeutic work with women who have had abortions evoked an internalized sadness. This sadness occurs despite acknowledging that women who elected for abortions often felt "they had to" make this decision due to their individual life circumstances.

In addition to talking about the women currently in their lives, participants spoke about women in their past who experienced the ubiquitous stigma and how those women's experiences impact their work presently. Mia mentioned having friends when

growing up who had been the victims of the larger Irish systems that shunned young women who were pregnant out of marriage:

> *...I have lived through Ireland where my friends had to disappear because they were pregnant, where they were Magdalene laundries[1], bastard children, bad women, where a woman or a girl would prefer to have cancer, TB or terminal illness than to be pregnant [because then] she'd be more welcomed at home ... I've experienced the tragedies. Really important illustrations of our culture related to women and pregnancy. I've worked with women who have given up babies for adoption, with people who have been adopted, with women who grieve for their infertility. My counter-transference is with all this progress, it is so hard to be born a woman into this country.*

Mia described carrying the historical trauma of experiences with women from the past who faced the oppression women presently in Ireland must carry from abortion stigma. To wish for a terminal illness over being pregnant out of marriage and not having an option to abort. Mia highlighted how difficult it is to be both Irish and a woman, and the historical trauma this group of women bear.

Beyond sadness and grief for generations past and present, Riley expressed anger and resentment towards the broader Irish government for continuing to choose not to lift the legal restrictions on abortion and the lack of change that has occurred despite previous generations of women having worked to modify these laws and attitudes:

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[1] Magdalene laundries in Ireland were asylums of confinement operated by the Roman Catholic church from the 18th to the late 20th centuries. They housed unwed pregnant women (commonly referred to as "fallen women"), operated orphanages for the babies

I kind of marched over [to this interview] with anger and that sense of purpose. I could say it's from my clients. It's because... Sorry. Because I'm so annoyed, you know. Well, it's not annoyed. I'm angry. I've had enough. Like, my mom's been fighting for this shit from the 70s, you know.

And I think I've been brought up with that conversation, and they've got some small changes throughout her lifetime. And I'm still sitting here today, and they're still talking about having fucking debates. Um, where is- where is the referendum, you know?

I'm still sitting here, 50 years after my own mother marched for reproductive rights, and we still have nothing. And yeah, I'm getting more and more angry about it… I think before, it was kind of like, "Alright, I feel passionate about this stuff." And you know, that passion was tolerable.

It just feels as though women are being ignored. So as much as I want change for my clients, I want change for me, and I think it's important to talk about this.[Begins to cry] Sorry. This is the stuff that we need to do, you know. This is the stuff. We need to talk about experiences. We need to mobilize change and, sometimes, like I said earlier on, I do feel impotent.

Riley shared the historical anger and oppression that permeates clinical experiences when working with women who have experienced abortion stigma, as well as the need for systemic change for clients who experience abortion stigma, the generations of female

family members who have fought for reproductive rights, and for one's self. This practitioner acknowledged the direct influence of political structures on the clinical work with women who elect for abortions, and how Riley experienced these clients.

A perspective that was not widely represented in this sample was a male perspective, particularly from a clinical perspective. The male participant, Sean, spoke of the unique perspective Irish men bring to this discussion and acknowledged that his identity as a man when working with women who have experienced abortion stigma can become more present for him in the therapy room:

> *One of the things that happened with some of the clients - well, one client was quite...um, angry one day about feeling that she was judged by others for having an abortion. She didn't want to feel like this, and so, she was quite angry, particularly towards men. I kind of felt like...I was very aware. It would be one thing if I might be judging her, my views around it. She assumed that I'd be harsher towards her than another woman. And I wasn't sure myself, but I was aware that sometimes I feel, I don't know if a man [can] really even have the same kind of voice in this. I have been a little bit ambivalent...this is something for women to maybe...well, why don't you go off and leave the man out of this and actually take ownership around this. I don't think it's that straightforward really. Men are part of this decision as well. And yet, ultimately it's the woman's body.*

Sean spoke to the internalized self-blame he experienced when working with one particular client who was experiencing abortion stigma. This experience provided him with a lens through which to view abortion stigma that he had never considered previously; what might male partners be experiencing whose female partners are opting for abortions and experience abortion stigma? He acknowledged a silencing that male partners may feel in this discourse. Yet he was also curious about the complexity of abortion ultimately being a woman's decision as it is her physical body, but it also involves a male experience. He highlighted an aspect of abortion stigma that may not be readily discussed, particularly within Irish culture.

Figure 1. Themes and Subthemes

Theme 1: Secrecy
Theme 2: Cultural Barriers: Breathing in Irish Culture and the Irish Identity
Theme 3: Systems Working Against Women
- Subtheme 3a: Political/Governmental
- Subtheme 3b: Religious
- Subtheme 3c: Interlinkage of Religion and Politics

Theme 4: Personal is Professional

Discussion

The hermeneutic phenomenological analysis of in-depth interview data from nine Irish psychotherapists who spoke to the lived experiences of how Irish women experience abortion stigma provided a dramatic portrait of the "shadowed" experiences. The following discussion demonstrates the various ways abortion stigma is understood, the factors that support abortion stigma, and the two relate to one another. Major research findings are discussed, followed by study strengths and limitations, practice and training implications, and research recommendations.

Framework of Abortion Stigma

When examining the data that arose from the narratives gathered for this research, various types of stigma surfaced. These forms of stigma are most akin to Earnshaw and Chaudoir's (2009) framework for understanding societal stigma and how it is internalized by individuals. Earnshaw and Chaudoir (2009) developed a framework for considering the relationship an individual's internalized stigma has with societal and individual factors. They categorize into three components: Anticipated, Enacted, and Internalized. They theorize that how individuals internalize or experience stigma is dependent on whether they possess an attribute that society devalues (e.g., being pro-choice). They further assert that stigma serves as a tool of power; if an individual possesses the devalued attribute, then s/he is at a level of subordination; conversely if the person does not possess the attribute then s/he hold a relative position of power within society. Earnshaw and Chaudoir initially created this framework for examining HIV stigma; however, it has been used by researchers examining other forms of stigma and the effects of stigma on an individual's mental health (e.g., Bogart, Revenson, Whitfield, & France, 2014; Dako-Gyeke & Baffour, 2016; Earnshaw & Quinn, 2012; Elkingoton, Hackler, McKinnon, Borges, Wright, & Wainberg, 2012; Hall, 2014; Sharp et al., 2015; Silke, 2016; Vogt et al., 2014).

In this study, first, participants spoke about how, to varying degrees, their female clients expected to be rejected socially by Irish culture because of their abortion (i.e., Anticipated Stigma). Second, they spoke about how their female clients shared with them narratives of situations in which they had experienced discrimination in their daily lives

from Irish people or structures around them (i.e., Enacted Stigma). Third and lastly, participants spoke about the internalization process regarding how clients felt stigma against themselves for choosing to have abortions and returning to Ireland post-procedure (i.e., Internalized Stigma). All three forms of stigma were prominent throughout the narratives and themes that emerged from the present data. The three forms of stigma when combined have been associated with decreased mental health wellbeing in other studies (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Mak, Poon, Pun, & Cheung, 2007; Pascoe & Smart Richman, 2009; Quinn & Chaudoir, 2009).

Enacted stigma.

Participants discussed the prominent control exerted by the legal and political structures in Ireland and how this control impacted their clients (and themselves). They highlighted the "antiquated" ideologies that influence the daily lives of Irish women and how the governmental stance on keeping abortion illegal influences women to view themselves negatively. The government is the legal oppressor of Irish women and a primary barrier to access to choice in reproductive health care. This oppression was evident in the therapeutic space as well, as vocalized by participants and the heightened political opinions they shared during the in-depth interviews.

Participants had difficulty only sharing their client's lived experiences and how their clients experience stigma. They often spoke to their personal opinions regarding abortion and a woman's right to reproductive healthcare. Several participants discussed how their pro-choice opinions may sometimes lead them to feel stigmatized within both their identities as psychotherapists and being Irish. Previous research supports

practitioners' internal struggle to come to terms with their personal thoughts on abortion and the potential stigma associated with their pro-choice opinions (Lipp, 2011). Often participants would transition into how they personally experienced the enacted stigma of the Irish legal systems and its legal requirement that they make female clients aware of all reproductive options when they disclose they are pregnant and uncertain of what they should do. The enacted stigma by the legal structures led to secrecy and an inability to access assistance for Irish women post-abortion, resulting in a great deal of stress. The enacted stigma also created stress for Irish psychotherapists who served these women by limiting what and how they may discuss abortion.

Beyond the legal and governmental structures, Irish culture and its prominent interconnectedness with the Catholic Church fueled a system of enacted stigma. The Catholic Church has a long-standing history of prohibiting abortion and denouncing any woman who chooses to have an abortion. According to The Canon Law of the Catholic Church ("Code of Canon Law", The Vatican City State), "A person who procures a completed abortion incurs a latae sententiae excommunication" (Can. 1398). This stance continues to the present day and permeates Irish government and its legal interpretation of a woman's right to choose. The Catholic Church's presence in Ireland is deeply embedded in all structures (e.g., education, government, political institutions, familial values, etc.). In 1937, Eamon deValera, a prominent Irish politician, modified the fifth amendment in the Irish constitution to state that the Catholic Church held "a special position" and acted "as the guardian of the faith professed by the great majority of the citizens of Ireland" (The Republic of Ireland Const. amend. V). Although this statement

was eventually deleted in 1973, the cultural interlinkage between the law of Ireland and the Catholic Church was quickly reinforced and breathed in by the broader Irish people. This deep connection between church and state precipitates the relational pressure that continues to oppress and cause enacted stigma upon Irish women. These findings are consistent with previous research demonstrating that women in a predominantly Catholic country may experience women many fears of religious punishment (Sorhaindo et al., 2014).

Anticipated stigma.

Participants shared narratives highlighting various mechanisms that cause Irish women to expect discrimination or social rejection after their abortion procedures. The mechanisms inform one another and have a reciprocal effect of oppressing and silencing Irish women. Participants spoke about the "Irish Psyche," that is, a shared identity that elicits judgments against and shame upon women who choose to have abortions. The practitioners viewed the "Irish Psyche" as an unconscious connection between the long history and sociocultural context of the linkage between Church and government that is "breathed in" by the Irish collective. They emphasized how difficult it is after an abortion for Irish women to gain even the slightest awareness of the centrality of the "Irish Psyche" in causing their silence and isolation. Participants theorized that the "Irish Psyche" has been created, shaped, and continually passed on by the Catholic Church and its ever-present influence on everything from daily functioning to the moralistic ideal that all women must "live up to." These results are supported by prior research showing that

women's experience of abortion may be influenced by their perceptions of negative societal attitudes (Astbury-Ward, Parry, & Carnwell, 2012).

Expectations of what it means to be an Irish woman also contributed to the anticipated social rejection participants perceived Irish women to experience after their abortion. Several practitioners stressed that the Catholic Church's ideal female – "Madonna," "The Virgin Mary," "The Blessed Virgin" is the literal expectation for all Irish women to strive to embody. The very act of choosing to have an abortion and return to a country and culture that considers this persona as the ideal may lead to increased shame, silencing, and fear of what one's role as an Irish woman now means. This is ideal female image has had detrimental effects on their clients' mental health post abortion.

Internalized stigma.

Participants spoke to the internalization of the systems and mechanisms policing women's right to choose. Characterized by patriarchy/misogyny, these systems and mechanisms include the Catholic Church, the Irish government, the cultural frameworks that define the female ideal, and the historical trauma Irish women carry in silence regarding reproductive healthcare. According to Earnshaw & Chaudoir's (2009) framework, internalization stigma is informed equally by both anticipated and enacted stigmas, and it determines the degree to which a person feels shame or self-loathing. The internalization process the participants described as present in both themselves and their clients created a detailed picture of the secrecy and shame that was evident in their narratives. Every practitioner shared the momentous effect of secrecy in Ireland concerning abortions, particularly when a woman returns from another country after

having an abortion. Various structures (e.g., church, government, the "Irish Psyche") reinforce this secrecy; however secrecy may also serve as a way to survive within a culture that continually informs Irish women they are violating legal, moral, and ethical social standards by electing for an abortion. The fears of judgment that lead to eventual negative feelings towards themselves is supported in previous research (Cockrill & Nack, 2013).

Participants also discussed the isolation women experienced after traveling abroad. The isolation occurred when planning the trip and saving money to cover expenses, during the medical procedure, while in another country (and having no one or minimal people back in Ireland knowing of their reason for travel), and upon their return. Previous research support the present findings that women who felt stigmatized by negative societal beliefs about abortion were more likely to keep their procedure secret from those closest to them and to refrain from disclosing abortion-related emotions to individuals in their support systems (Major & Gramzow, 1999). Furthermore, prior studies have demonstrated that women who are religious have a greater tendency to experience isolation post-abortion procedure compared to non-religious women (Cockrill, Upadhyay, Turan, & Foster, 2013). Isolation is one of the detrimental effects of internalized stigma that may lead to a variety of mental health concerns (Cockrill & Nack, 2013; Cockrill, Upadhyay, Turan, & Foster, 2013; Major & Gramzow, 1999).

Phenomenon of Shared Narratives

Hermeneutic phenomenology attempts to pull the unique lived experience from each narrative shared (van Manen 1990; 2014); however the findings of the present study

reflect a generally shared narrative amongst all of the participants. Everyone expressed their opinions regarding the abortion issue in Ireland from political, religious, and personal experience perspectives. Moreover, all of the participants essentially supported a woman's right to choose. There may be several reasons for this occurrence.

First, self-selection into this study may have accounted for similar perspectives gathered. The nature of the study was examining how stigma is experienced by Irish women. Due to the nature of this study (i.e., bringing to light a lived perspective that historically and systematically has been oppressed or silenced in Ireland), individuals who held the perspective that pregnant women who are pregnant should have a right to choose may have opted to participate.

Second, similarities in the narratives may have occurred due to countertransference. Indeed, every participant actively discussed the notion of countertransference, and several stated that their personal experiences with abortion had directly affected how they hear their clients' lived experiences. Lipp (2011) argues that no matter the distancing that occurs between practitioners and their patients, the practitioners' lived experience enters the clinical space and potentially influences how they operate within the space. Furthermore, all nine participants discussed how their personal opinions affect how they hear their clients' narratives. Thus, their opinions may have influenced how they discussed the stigma their clients experienced.

Study Strengths and Limitations

The present study represents an initial step towards understanding the unique lived narrative of how Irish women experience post-abortion stigma in Ireland as reported

by Irish psychotherapists. The hermeneutic methodology and data analysis were guided by philosophical foundations, assumptions, and research paradigms (van Manen, 1990; 2016). The interviews provided in-depth data regarding both the participant's and Irish women's experiences with post-abortion stigma. The narratives of nine individuals do not reflect the entirety of the Irish women's lived experiences with stigma post-abortion. They do, however, reflect the research philosophy of hermeneutic phenomenology that multiple realities exist and that each narrative provides an equally imperative component to the themes emerging from the data (van Manen 1990; 2003; 2016).

Additionally, this was the first study to examine the lived experience of Irish women and the stigma they experience post-abortion procedure. Abortion and reproductive rights constitute a major human rights issue currently being discussed and debated broadly; the findings of the may contribute to the current conversation. Another strength is my intentionality of to maintaining confidentiality of Irish women who have had abortions. Due to the illegal nature of this act in Ireland, speaking with psychotherapists who serve these women in confidential settings allowed them to act as proxies on behalf of their clients, thereby protecting these women from harm.

Despite these strengths, there are several study limitations. First, the present study did not gather the narratives of Irish women and their experiences of abortion stigma directly, but rather the perceptions of a second party (i.e., their psychotherapists). The use of "shadowed data" (cf. Creswell, 2002) may not accurately reflect the lived experience of Irish women in how they experience stigma post-abortion procedure and the various systems that may cause them to experience stigma. The narratives of Irish women who

had abortions but did not pursue psychotherapy are not part of the collected data; it is unknown how their narratives would compare to those obtained in the present study.

A second limitation is that during the data collection process, increased public conversations and events related to abortion, reproductive rights, and historical trauma regarding abortion restrictions were occurring in Ireland. These activities may have influenced how participants spoke to the lived experiences of their clients and their own experiences. In Hermeneutic phenomenology, however, van Manen (2016) argues that the sociocultural context of what is occurring when research is being collected is not a limitation; rather, it is gravely important in obtaining accurate data. Lastly, van Manen (1990; 2016) notes the bracketing process is essential for researchers to name their lived experiences and potential biases that may influence how the data are collected and interpreted. All attempts to ensure an extensive and ethical bracketing process occurred. Nevertheless, pure bracketing it difficult if not impossible to achieve and therefore may have interfered with the interpretation of the data.

Finally, this study may have produced data that are narrow in the perspectives gathered. The objective of Hermeneutic Phenomenology research is to gather unique lived experiences of participants (van Manen, 2016); however, this study may have provided limited views. No participants spoke of the various Irish systems in regards to a woman's right to choose (i.e., government, laws, church, societal norms, etc.) with moderate or positive viewpoints. This may be a potential limitation of the data due to the self-selected sample who were asked to address specific questions that narrowly focused upon stigma directly and/or indirectly.

Practice and Training Implications

The narratives of Irish women's stigma post-abortion procedure shared via Irish psychotherapists have potentially significant implications for mental health professionals. They demonstrate the importance of cultural awareness when considering sociocultural factors that may influence how clients experience abortion stigma. For example, the presence of the Catholic Church in Irish culture is so interwoven into the "Irish psyche" that lack of awareness of this symbiotic relationship and how it consciously and unconsciously affects clients may cause further harm to harm. Mental health professionals should invest time in developing awareness and knowledge of historical and current sociocultural issues when working within a culture where abortion stigma exists.

The theme of secrecy emerged strongly in the narratives; every participant highlighted a unique experience of how secrecy lead to internalized shame. Practitioners should be mindful of the unique experience and motivations for secrecy regarding abortion procedures in an Irish woman population in order to ensure the accurate reflection of empathy and compassion. Training programs in Ireland (and perhaps in other cultures where there are strong sanctions against abortion) should emphasize the potential barriers in the broader sociocultural system and how these influences may greatly influence female clients' secrecy and shame.

Systemic barriers concerning reproductive health within the Irish government and the Catholic Church were present in all nine narratives and denote the strong influence these barriers directly have on some women's mental health. It is recommended that

mental health professionals increase their own awareness of legal and institutional barriers regarding reproductive health in order to more fully understand their clients' experience and how their experience impacts their daily mental health. Training programs should specifically address how working with female clients who reside in countries where abortion is illegal may impact clinicians' mental health and countertransference. Programs could also encourage the use of self-care activities to help mental health professionals avoid burnout and manage compassion fatigue potentially experienced when working with a stigmatized female population due to government and institutional barriers.

This study's results also provided a new context for Earnshaw and Chaudoir's (2009) stigma framework. Although, as mentioned earlier, the model was originally created for understanding the phenomenon of HIV stigma (Earnshaw & Chaudoir, 2009), the framework corresponded well to the experience of abortion stigma and provided a foundational context for the unique lived experiences vocalized by every participant. Practitioners may wish to consider applying this model to their work with clients who experience stigma related to their abortion procedures.

All of the participants discussed the difficulty separating their personal political opinions from their client's opinions, narratives, and lived experiences. Training programs should expand curricula on countertransference to include material and activities regarding the ways in which therapists' own cultural identity (whether similar to or different from their clients) may consciously and unconsciously affect their provision of services to women who have had abortions. These findings also suggest a

need for peer consultation/supervision, specifically when working with clients who possess highly stigmatized attributes to help practitioners recognize and manage countertransference.

Lastly, this study indicates the potential role mental health practitioners could play in working for systemic change, particularly in countries such as Ireland where abortion stigma may be more active due to sociocultural factors. The themes obtained in this study reflect a broader social justice call for mental health practitioner's to become active change agents in decreasing shame and increasing a culture of support regarding a woman's right to choose. To facilitate this role, training programs should continue to connect social justice issues (e.g., a woman's right to access reproductive healthcare) to their clinical training models. For instance, they could emphasize the potentially devastating impact abortion stigma has on clients, and openly discuss systemic ways to decrease this stigma (e.g., through politics, legislation, and professional organizations). Additionally, training programs should emphasize the importance and necessary role of mental health professionals acting as active agents of social change in order to decrease harm to historically marginalized groups (e.g., women accessing reproductive health). It is common practice among various mental health professionals (e.g., counselors, social workers, psychotherapists, psychologists, etc.) to have codes of ethics that emphasize the foundational themes of beneficence and justice for clients. Therefore training programs might emphasize to trainees the importance of acting in accordance with these principles, which includes working for social change.

Research Recommendations

This is the first study to examine the unique lived experiences of Irish women and their stigma post-abortion procedure via their psychotherapists. Additional research is needed to increase understanding of their experiences. Despite the challenges in recruiting participants, future researchers should attempt to directly interview Irish women who have had abortions and returned to Ireland post-procedure. Studies of this sort may more fully depict how this population experiences abortion stigma and the various systems that influence their experiences. Future research could examine the difference between the constructs of stigma and shame. Several participants utilized both constructs when being interviewed and struggled to denote the difference between the two, yet felt it necessary to utilize both. Another research endeavor could involve an exploration of the Irish male perspective of abortion stigma in Ireland (e.g., using samples of psychotherapists and male partners of women who have had abortions). The experience of Irish men and women in regards to abortion stigma may be quite distinct. Thus, the Irish male perspective may produce unique findings about how abortion stigma has been created and perpetuated, as well as provide insight into possible stigma that males experience.

Additional research on psychotherapists who serve Irish women who have experienced abortion stigma are also warranted. Studies could be done to better understand how they recognize and manage their personal reactions to their clients as well as to assess the interventions they use to address their clients' stigma. Finally, studies could be done in other countries and populations in which there are strong sanctions against abortion in order to further characterize women's experience of stigma.

The present study findings highlight Ireland and its unique cultural factors that may influence abortion stigma. Future investigations, conducted with other cultures and/or countries where abortion stigma is present due to religious influence may bring to light cultural similarities and difference, thus helping to inform future research, training, practice, and policies.

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Appendices

Appendix A[2]

Review of the Literature and Rationale for the Present Study

The counseling field is built upon a belief that our work provides a fundamental space where individuals may seek services that are confidential and safe. This space ideally provides an environment in which individuals who have experienced systematic oppression, such as women, may feel heard without judgment or retribution (Bohan, 1993). The international community has become increasingly accepting of a woman's right to elect for an abortion in times of unintended pregnancy (Amnesty International, 2016). An abortion is the deliberate choice a woman makes to terminate her pregnancy (Webster Dictionary, 2014). That said, however there are 19 countries around the world that do not support a woman's right to elect for an abortion, as evidenced by governmental, sociocultural, and/or religious restrictions (Amnesty International, 2016; Buchanan, 2015). Women who receive abortions in countries where abortion is illegal have a higher rate of anxiety, generalized depression, and post-traumatic stress (Charles, Polis, Sridhara, & Blum; 2008). Additionally, countries where abortion is illegal or virtually inaccessible, often have religious ties, most being predominantly Roman Catholic (Faundes & Barzelatto, 2006). Women who live in predominantly religiously conservative countries may experience stigma related to abortion (Saroglou & Cohen, 2013). The Republic of Ireland is one of several countries where abortion continues to be

[2] This literature review was completed as a portion of the Oral Preliminary Paper completed in partial fulfillment of the requirements for the Degree of Doctor of Philosophy, August 2016.

illegal, and has a strong cultural identity with Catholicism. Given that women who receive illegal abortions have a higher risk of mental health concerns and self-stigma, it is imperative to examine the impact stigma has on women who reside in and anti-abortion

The United Nations (UN) has consistently taken a strong lead in the past 20-30 years in advocating for increased access to abortion services for women around the world (Gutmacher Institute, 2014), however there remain countries around the world (such as the Republic of Ireland) where abortion continues to be illegal. The ramifications of such laws are extremely impactful on the health and well-being of women who reside in these highly regulated countries (Bellieni & Buonocore, 2013). The UN considers any nation where abortion is illegal as an anti-abortion country and one that violates a woman's basic fundamental right to control her physical body (Guttmacher Institute, 2014).

Historical and Cultural Background

The practice of abortion is an ancient procedure predating any legal institutions that currently regulate it, and practices vary depending on cultural norms (Weitz & Weitz, 2015). The first major institution to provide legal sanctions is the Roman Catholic Church; the Church implemented the Code of Canon Law in the 12th century which ruled for excommunication from the Church for any woman who receives an abortion or to anyone who assists a woman in receiving an abortion (Weitz & Weitz). By the late 19th century, the Pope had declared abortion to be punishable by banishment from the church and as criminally punishable (Weitz & Weitz).

The Republic of Ireland is located in an area of the world considered to be generally more liberal in sociopolitical views and legislation regarding women's

reproductive healthcare (Levels, Sluiter, & Need, 2014). These views are not representative of Ireland, however. Historically, the Republic of Ireland has been a predominantly Roman Catholic nation with a strong link to conservative views about family planning (Coakley, 2011). Even when the Republic of Ireland was under the legal jurisdiction of the U.K., the government passed sections 58 and 59 of the Offences Against the Person Act of 1861 (Bloomer & O'Dowd, 2014). This act stated that procuring a miscarriage was a criminal offense and all parties involved would be charged accordingly and punished (Bloomer & O'Dowd, 2014). The Republic of Ireland gained independence from the U.K. in 1919, yet the Irish government continued to uphold the strong Roman Catholic conservative beliefs regarding family planning and abortion (Hug, 2016). Meanwhile, the U.K. began to decrease governmental control over a woman's right to elect for an abortion (Hug). Prior to World War II, a large number of Irish women traveled to the U.K. to receive abortion services (Bloomer & O'Dowd). In the 1930's, over 100 women were dying annually from illegal abortion services in Ireland (McCormick, 2013). For the next 40-50 years, much of the Irish legislation regarding abortion would neither be addressed nor modified.

In 1983, legislators amended the Eight Amendment of the Constitution of Ireland by stating that the life of the mother is just as important as the "right to life of the unborn" (Hug, 2016). Although this ruling created some gray area, the courts continued to rule in favor of the "life of the unborn" in all cases (Hug). Furthermore, the Irish government in 1992 passed the Fourteenth Amendment which stated that no agencies in Ireland are allowed to assist women with traveling abroad to receive abortions (Hug). The

Irish government also created and passed the Regulation of Information Act in 1995 which gives the Irish government the right to regulate what information is provided to women who want to travel abroad to receive abortions (McCormick, 2013). In 2013, the Protection of Life During Pregnancy Act passed, and it states that abortion is illegal unless performed in order to save the life of the mother (Hug). It is estimated that about 160,000 Irish women have traveled to Great Britain to receive abortions over the past 33 years (Gentleman, 2015). This number only includes women who provided an Irish home address; most women choose not to disclose this information (Gentleman).

The Irish government continues to receive severe scrutiny from multiple international human rights organizations. In 2016, the UN Human Rights Committee declared Ireland's abortion law violates the UN's International Covenant on Civil and Political Rights (Amnesty International, 2016). The UN Council called on the Irish government to decrease governmental control of a woman's right to receive an abortion (Amnesty International). In 2016, Amnesty International released a report highly critical of the Irish government's control over a woman's right to choose and for their harsh punishment towards Irish healthcare providers who help women receive abortions and/or abortion-related health care services in other countries.

According to the U.K. Department of Health, about nine Irish women each day travel to the U.K. for access to abortion services. In 2009, 1,200 abortion pills were seized by Irish customs (Bloom & O'Dowd, 2014) and according to the UK Department of Health (2008), abortion is the most common gynecological procedure for Irish women,

with an estimated 1 in 10-15 Irish women of reproductive age having received an abortion.

Descriptions of these three unique countries and cultural groups portray intense social, religious, and governmental stigma regarding abortion. This socialized and politicized stigma may be linked to a series of mental health issues for girls and women who pursue abortion.

Stigma Associated with Abortion

Mueller and Major (1989) conducted one of the earliest studies examining the relationship between self-blame and abortion. They investigated the differential effectiveness of two, 7-minute counseling interventions for decreasing women's internalized self-blame post-abortion. The interventions were intended to alter attributions for an unwanted pregnancy and raise expectations for coping with an abortion. The researchers also examined the impact of individual differences in pre-abortion blame for an unwanted pregnancy and self-efficacy for coping with an abortion on post-abortion adjustment.

The authors recruited 283 women from a large urban area in the U.S. who had undergone first-trimester abortions at private abortion clinics. The participants were a generally diverse sample demographically. Forty percent of the subjects were employed, 16% were unemployed, 34% were students, and 10% were housewives. Most were either white (78%) or Black/African American (21%); 58% were Catholic, and 38% Protestant. They ranged in age from 14 to 40 years (mean = 22). Eighty percent were single, 66% had no children, 66% had never previously received an abortion while 34% had prior

abortion(s). Participants completed a pre-procedure survey that included two measures assessing blame (Major et al., 1985) and perceived self-efficacy (Bandura & Adams, 1977). For the blame scale, women were asked to indicate the extent to which they blamed each of the following categories for their pregnancy: self-character, self-behavior, other person, the situation, and chance. Each of the five items on the blame scale was rated separately (Scale: 1 = *not at all,* to 7 = *very much*). The Self-efficacy Scale measured self-efficacy for coping with abortion via a 10-item scale of post-abortion coping behaviors (Scale: 0 = couldn't do it at all, to 10 = completely sure I could do it).

Participants were then randomly assigned to one of three groups (an attributional intervention group, a coping expectation intervention group, or a control group) right before undergoing the abortion. The attributional intervention (ATT-INT) consisted of a psychoeducation workshop designed to minimize blaming their pregnancy on their personality or characteristics. The development of this intervention was based on suggestions outlined by Abramson et al. (1978). The coping expectation intervention (EXP-INT) consisted of a psychoeducation workshop with the goal to increase expectations that they could cope healthily and successfully with their abortion. The methods used in this intervention were based on the verbal persuasion techniques alluded to in Bandura's research on perceived self-efficacy (cf. (Bandura, 1977). The control intervention consisted of a presentation on general information about abortion procedures and clinic services. After their abortion procedure, participants were given 30 minutes to rest. Then they completed a series of measures assessing physical complaints, mood, anticipation of negative consequences, and depression. These measures were “almost

identical" (p.1062) to measures included in Major et al.'s (1985) study. Depression was assessed via the Beck Depression Inventory, Short Form (BDI; Beck & Beck, 1972). These measures operationalized the "adjustment" variable.

Results indicated that at pre-abortion, self-blame (behavior plus character) was significantly higher than general external blame (chance, situation, and others), $t(282) = 10.64$, $p < .001$. Most participants reported moderately high self-efficacy for coping with their abortion ($M = 7.14$). Furthermore, self-efficacy was positively related to self-behavior blame ($r = .20$, $p < .001$) and situation blame ($r = .11$, $p < .05$), but negatively related to self-character blame ($r = -.14$, $p < .05$), other-person blame ($r = -.20$, $p < .001$), and chance blame ($r = -.11$, $p < .05$). The authors did a 3-week follow-up and found a generally positive level of adjustment; however the range of responses may be due to participants having poor adjustment both pre- and post-abortion. Most women had adequate adjustment immediately after the abortion and even better adjustment 3 weeks later. Comparisons of adjustment at pre- and post-abortion revealed that this improvement was statistically significant for measures of mood, $t(80) = 4.79$, $p < .01$); anticipated negative consequences, $t(80) = 3.22$, $p < .01$; and depression, $t(80) = 3.81$, $p < .01$.Three individual difference variables were related to an overall better adjustment post-abortion: high self-efficacy $F(4,227) = 17.50$, $p < .0001$), low self-character blame ($F = 5.21$, $< .001$), and low other-blame ($F = 3.54$, $< .001$).

With respect to effects of interventions on post-abortion adjustment, women in both the ATT-INT and EXP-INT groups reported significantly better post-abortion adjustment than women in the control group. Additionally, participants in the EXP-INT

group reported less depression compared to the ATT-INT group. Despite the impact of intervention on immediate adjustment, analyses of adjustment 3 weeks post-abortion revealed no significant differences.

Mueller and Major's (1989) findings demonstrate the importance of individual differences in how women cope with abortion and how they adjust following an abortion, as well as the potential effectiveness of therapeutic interventions in helping women cope post-abortion. One strength of the study is the authors drew upon previous research examining the theoretical link between low self-efficacy and self-character blame with women who had received abortions (Major et al., 1985). Additional strengths include a large sample size, and randomization of participants to groups.

The study does have limitations, however. First, the authors did not measure participants' adjustment prior to their abortion procedures. Given the lack of data regarding their pre-abortion adjustment, no conclusions can be drawn about changes in levels post-abortion. Other major life events may have significantly affected how each participant viewed her self-efficacy and overall mood going into the abortion procedure, therefore impacting the effects of the interventions in unknown ways. Long-term effects of abortion are indeterminate. Prior research has shown that immediate follow-up post-abortion assessment does not provide a reliable assessment of distress level (Adler, 1982; Wilmoth, 1988). Although the authors conducted a three week follow up, they randomly selected their time frame. Also, the authors should have examined the effects due to a variety of demographic variables on major study variables to discern how these variables might impact responses on the outcome measures. No psychometric information was

provided for either the blame measure or the self-efficacy measure. Although these measures have been previously utilized, this information is pertinent to the the reliability and validity of data gathered in the current study. Additionally, the control group was not strictly a no-treatment group, as participants received information regarding abortion services and the clinic. Lastly, the interventions were created by the researchers who did not indicate any assessment of their validity.

Major and Gramzow (1999) examined the concept of stigma as related to abortion and the potential psychological impact concealment has on women two years post-abortion. They tested a hypothesized model based upon a secrecy model (Lane and Wegner, 1995). Specifically, the authors predicted that the more women felt motivated to keep their abortion a secret and suppress their thoughts about the abortion, the more intrusive the thoughts of their abortion would be, which would lead to higher rates of psychological distress. Additionally, they predicted that the more women felt the need to keep their abortions a secret, the less likely they would disclose their abortion-related emotions and feelings to others.

The sample consisted of 442 women who were already participating in a women's adjustment to abortion study (Cozzarelli, Sumner, & Major, 1998; Major, Richards, Cooper, Cozzarelli, & Zubeck, 1998; Major et al., 1997). All women were being seen at one of three abortion clinics in a large urban area in the Northeastern U.S. Participants were randomly selected from each clinic, and follow-up interviews occurred 1 month *(N* = 615) and 2 years *(N* = 442) post- abortion. The authors reported only on the 442 women who participated at both time points. The sample was moderately diverse, with

82% identifying as single, 66% as white, 32% as African American, 37% as Catholic, 43% as Protestant, and 14% having no religious affiliation. Women who agreed to participate were younger (M = 23.68) than those who declined (M = 25.92), $F(1,1042) = 21.16$, $p < .001$.

The authors did initial screenings, consisting of pre-abortion questionnaires, along with follow-up questionnaires and interviews occurring at 1 month and at 2 years post-abortion. The authors only analyzed data obtained from the pre-abortion and 2 year post-abortion questionnaires. In the Pre-abortion phase, they measured residualized distress and various control variables (e.g., religion, history of previous psychological counseling, etc.). In the two year post-abortion phase, they measured residualized stress, stigma, secrecy, intrusive thoughts, thought suppression, and emotional disclosure. Participants filled out a pre-abortion questionnaire that included *control variables*, namely, religion, number of living children, number of children previously placed for adoption, and history of prior psychological counseling. Other demographic information was gathered via clinical records. The authors also assessed predispositions to experience positive affect and negative affect prior to the abortion, using the Positive and Negative Affectivity Scales (PANAS; Watson, Clark, & Tellegen, 1988). The PANAS includes 10 positive adjectives and 10 negative adjectives. Respondents rate the extent to which the adjectives described how they usually feel (Scale: 1 = “You usually do not feel this way at all,” to 5 = “You usually feel this way a great deal”). Internal consistency reliabilities for both the Positive Affect Scale (Cronbach's alpha = .91) and the Negative Affect Scale (Cronbach's alpha = .91) were high.

Stigma was measured during the 2-year follow-up from a measure adapted from Tourangeau, Rasinski, and D'Andrade (1991). This measured asked participants how much they agreed with the following statement: "I have felt that I would be stigmatized (looked down on) by others if they knew that I had an abortion" (Scale: 1 = “strongly disagree,” to 5 = “strongly agree”). Secrecy was assessed in the 2-year follow-up by asking participants to what extent they felt the need to keep the abortion a secret from other people: (a) "I felt that I had to keep my abortion a secret from my family" and (b) "I felt that I had to keep my abortion a secret from my friends." (Scale: 1 = “strongly disagree,” to 5 = “strongly agree”). A composite score for secrecy, based on responses to the two items, had a Cronbach's alpha of .66. Intrusive thoughts were assessed at the 2-year follow-up by four items measuring the frequency or degree that participants experienced unwanted abortion-specific thoughts. Two of these items were adapted from Horowitz, Wilner, and Alvarez (1979): "Since the abortion, how much have you" (a) "had thoughts about the abortion when you didn't want to?" and (b) "found that any reminder brought back memories of the abortion?" The other two items were adapted from a measure of PTSD developed by Watson, Juba, Manifold, Kucala, and Anderson (1991): "In the past month . . . (c) have upsetting memories of the abortion pushed themselves into your mind?" and (d) "have you had recurring unpleasant dreams about the abortion?" The scale for all four items was 1 (“Not at all”) to 5 (“A great deal”). A composite score for intrusive thoughts, based on responses to the four items, had a Cronbach's alpha of .81.

Thought suppression was assessed at the 2-year follow-up via a five-item measure

examining the frequency or degree that participants suppressed thoughts about the abortion. Items were created based upon the control strategies described by Purdon and Clark (1994): "How much did you do this to help you deal with the abortion?" (a) "I distracted myself from thoughts about the abortion by thinking about something more pleasant," (b) "I distracted myself from thoughts about the abortion by doing something," and (c) "I said 'stop' to myself when I thought about the abortion." Two additional items were from the PTSD measure developed by Watson et al. (1991). "In the past month . . . (d) have you tried to avoid thinking about the abortion or feelings you associate with it?" and (e) "have you avoided activities or situations that remind you of the abortion?" All five items were measured on a scale ranging from 1 ("Not at all)" to 5 ("A great deal"). A composite score for secrecy, based on responses to the five items, had a Cronbach's alpha of .79. Emotional disclosure was measured at the 2-year follow-up and included two items assessing the degree to which participants disclosed their abortion-specific emotional reactions to others. Items were adapted via Herold and Way (1988). Participants were asked: "How much did you do this to help you deal with the abortion?" (a) "I told someone my deepest emotions about the abortion," and (b) "I talked with at least one other person about how the abortion made me feel." (Scale: 1 = "Not at all," to 5 = "A great deal"). A composite score for secrecy, based on responses to the five items, had a Cronbach's alpha of *.16*. Residualized distress was measured pre-abortion and during the 2-year follow-up via the Depression, Anxiety, and Hostility subscales of the Brief Symptom Inventory (BSI; Derogatis, 1993). Participants indicated via 5-point scales (0 = "Not at all*"* to 4 = *"*A great deal*"*), the extent to which each of 17 symptoms

bothered them in the past month (for the pre-abortion questionnaire) or in the past 2 weeks (for the follow-up). Item responses were averaged for the three BSI subscales into composite measures of pre-abortion distress (Cronbach's alpha = .90) and post-abortion distress (Cronbach's alpha = .93). A residualized index of psychological distress was calculated to assess changes in post-abortion distress from the pre-abortion levels of distress. The authors also examined the degree of personal conflict with the kind of person participants thought they were, the kind of person they ideally wanted to be, and the kind of person they thought they should be. Extent to which the abortion conflicted with their attitudes toward abortion, religious beliefs, and moral beliefs was also assessed via a six-item measure (Scale: 1 = "Not at all," to 5 = "A great deal"). A composite score for secrecy, based on responses to the five items, had a Cronbach's alpha of .81.

At the two-year follow-up, personal conflict related positively and significantly to feelings of stigma 2 years post-abortion ($r = .34$, $p < .001$). Findings also revealed that participants who felt stigmatized by abortion were more likely to keep their procedure secret from those closest to them ($r = —.14$, $p < .01$). Furthermore, secrecy was positively related to suppressing thoughts regarding their abortions *(*($r = .31$, $p < .001$) and negatively related to disclosure of abortion-related emotions to those closest to them ($r = .26$, $p < .001$). Additionally, intrusive thoughts related to the abortion ($r=.21$, $p< .001$) and suppression of thoughts ($r=.27$, $p< .001$) were positively related to increases in psychological distress over the two years.

The authors also utilized Structural Equation Modeling (SEM) to further examine the relationships among the variables. They found that emotional disclosure significantly

decreased psychological distress and moderated the relationship between intrusive thoughts and distress (χ^2 (15, N = 439) = 32.21, p = .006; CFI = .95; RMSEA = 0.051, p = .430). Lastly, they found that disclosure was associated with decreases in distress among women experiencing intrusive thoughts of their abortion, but was unrelated to distress among women not experiencing intrusive thoughts (χ^2(15, N = 439) = 25.68, p = .042; CFI = .97; RMSEA = 0.040, p = .070).

This study comprises a critical examination of the unique relationship between factors of stigma associated with pre- and post-abortion procedures. Another strength is its use of multiple variable statistical analysis. There are, however, several methodological issues. First, the authors did not account for the one-month follow-up measures theorizing that any major changes in these data would occur in the two-year follow up. The one-month follow-up measures may have provided critical information accounting for the changes that occurred for participants in regards to how they coped with their psychological distress and how their distress related to their self-stigma. Also, the reliability for a key variable, secrecy, is extremely low. Attrition of approximately 1/3 of the initial sample limits external validity. Lastly, the authors only studied one type of stigma (i.e., interpersonal stigma) and did not account for possible differential effects of stigma as a function of ethnicity, sexual orientation, religion, socioeconomic status, etc.

In the early to mid-2000's, the American Psychological Association developed a Task Force to examine the politically contentious relationship between mental health distress and abortion (APA, 2008). After the report released from the Task Force, the literature shifted to focus predominantly on the impact the larger sociopolitical cultures

had on the self-stigma and mental health distress experienced by women who have abortions. Littman, Zarcadoolas, and Jacobs (2009) pilot tested an intervention designed to provide a supportive and affirmative post-abortion culture (countering the lack of any centralized supportive intervention for women who had had abortions). They developed a three-part multi-modal intervention based upon previous research examining the unique stress associated with abortions (Adler et al. 1992; Lazarus and Folkman 1984; Major et al. 1998, 2008; Major et al. 1985, 1990, 1997; Major and Gramzow 1999). The intervention includes a brochure with referral information for support groups in the area, a DVD presentation of women sharing their experiences of stigma post-abortion, and provides a space to discuss potentially harmful sociocultural messages that they may experience after having an abortion. Qualitative data were obtained at 3 weeks post-abortion via interviews with 22 women patients from an abortion clinic in a large urban area within the U.S. Participants ranged in age from18 to 42 years (M = 29), a majority identified as Hispanic (12/22), 8/22 had two prior births, and 9/22 had one prior abortion. Insurance information was gathered from participants, and had public insurance, 6 had private insurance, and 1 woman had no insurance. Marital status was not collected in this study.

The interviews, conducted by the first author, included multiple choice items, Likert items (0 = strongly disagree to 4 = strongly agree), and open-ended questions. The data were gathered in order to assess participant agreement with the strengths-based frames and messages provided in the intervention. All participants reported believing the intervention had an overall positive impact on how they coped post-abortion and they

found it personally helpful in their emotional recovery post-abortion. Everyone also expressed a belief that the program could help other women combat internalizing harmful judgments received from anti-abortion messages. Two prevalent themes pertaining to participants' reactions to the brochure created and provided by the research team, were "It's the truth!" and "feeling understood." All of the participants described at least one portion of the brochure that was meaningful. In terms of the DVD, 18 interviewees reported feeling comfortable and supported, and 21 reported that they would recommend the video be shown to all women who receive abortions. The authors concluded that the DVD does an effective job in decreasing stigma experienced by women by providing them with a visual aid demonstrating how one may share their feelings and experiences post-abortion. Lastly, the authors wanted to examine the impact of the frames and messages of the intervention materials on participants. All but one interviewee expressed that: they regard abortions as necessary at times when taking into consideration their own well-being; they believe some groups and people shame women and make them feel worse about their abortions; and they felt higher self-efficacy after the intervention, so others' opinions would not affect them.

After the interviews, participants completed a set of questions concerning how they received the intervention. The majority (15/20) endorsed all of the following as factors that made the intervention a positive experience: 1) Being able to talk about the issues related to abortion in a comfortable setting; 2) Feeling that what I experienced has been experienced by other women, too; 3) Being treated with respect about a hard decision that I made; and 4) Feeling that my opinion will be used to help other women.

Although this pilot study is helpful in implementing and evaluating an initial intervention, there are several limitations. First, the authors limited the demographic information they collected to avoid increasing the participants' self-stigma. Further demographic information such as religion/spirituality and marital status may have provided richer information, especially concerning the relationship between larger sociocultural factors and how they impacted the efficacy of the intervention. Additionally, the authors did not evaluate long-term effects of their intervention; therefore its potential benefits and risks are unknown. Also, the intervention was provided by members of the research team which may have resulted in demanded characteristics with respect to participants' responses to the interview questions. Lastly, the first author conducted all of the interviews and transcribed the data. The use of multiple interviewers may have increased the credibility of the qualitative data (Matteson & Lincoln, 2009).

Astbury-Ward, Parry, and Carnwell (2012) conducted a qualitative study exploring participants' perceptions of stigma in relation to disclosure of abortion. The data were collected via semi-structured phone interviews in the U.K. by semi-structured interviews. The sample consisted of 17 women between 22 and 57 years (M = 24); seven of the women had one abortion previously, slightly higher than the UK national average (34%). Time elapsed since abortion ranged between 2 weeks and 37 years at the time of the interview. Participants were recruited from 12 community contraception and sexual health clinics associated with the National Health Services (NHS) in England and Wales. The interviews focused upon aspects of the abortion process, exploring the participant's

meaning and gaining their individual perspectives. The researchers used content analysis methods based in grounded theory (Glasser and Strauss, 1994). Participants were encouraged to identify and discuss issues, not readily identified in the interview schedule, which they perceived as important.

Four themes emerged from the interviews: (a) "Bottom Drawer Stuff and the Imperative to Conceal, (b) Secrecy, (c) Perceived Stigmatization in Abortion Services, and (d) Stigmatization Through Self-Blame. All four themes included direct quotes from participants to support the creation of the four themes. Results indicated that women found abortion to be a highly taboo subject in their lives and that it has caused them a personal stigmatization. Bottom Drawer Stuff and the Imperative to Conceal captured the idea that abortion is socially unacceptable. Secrecy captured the link between the objectionable nature of abortion and the need to keep it a secret, causing participants to feel silenced. Perceived Stigmatization in Abortion Services captured the experiences of women who had experienced psychological and emotional distress during their procedure, paying particular attention to the health professional attitudes and behaviors. Stigmatization Through Self-Blame captured the experiences of women who experience guilt and developed negative self-perceptions after their procedures. Participants spoke of the self-stigma and how it decreased their disclosure to others after their abortions, affecting their perceptions of the responses by society, significant others, and health professionals. Overall, the authors found that self-stigma was a dominant factor in the decreased disclosure to others that women experience post-abortion. They also concluded that women's experience of abortion maybe influenced by their perceptions of negative

societal attitudes.

This study comprises an important international qualitative inquiry into the effects of self-stigma on the disclosure of women who have experienced abortions. Despite the richness of the data, there are a number of methodological concerns. First, the authors stated that they gathered a sample group that is "a mixture of socioeconomic, educational, and marital status" (p. 3139), however they never report this demographic information in entirety. This demographic information would be important to take note because of the potential impact it would have on the coding of the data. It would also be potentially helpful to consider how women experience abortion differently depending on these demographic variables. Relatedly, no information was gathered regarding ethnicity, religion, or socioeconomic status. Other studies have found these to be salient factors when discussing stigma and abortion (Littman et al., 2009; Major & Gramzow, 1999; Mueller & Major, 1989). Relatedly, homogeneous samples are typically recommended in qualitative studies given the usual small sample size that precludes identification of thematic differences (MacFarlane, McCarthy Veach, & LeRoy, 2015).

Second, there was no control over how much time had passed between when participants had experienced their abortion and when they were interviewed. Retrospective memory might have a large effect on how accurately the women recalled their experience of self-stigma and disclosure. The wide range in time since the abortion raises issues regarding possible cohort effects – the sociopolitical context 37 years ago is quite different from contemporary times. Moreover, the sample included women who only recently had an abortion which is too soon to determine longer range impact.

Therefore the accuracy and credibility of the narratives are compromised. Third, the authors do not report the specific coding information for each of the four general themes provided. It is unknown how many portions of the participants' interviews fit into the four general themes, thus the prevalence of themes is unknown. The likelihood that all four general themes were equally represented across all interviews is small.

Stigma up until this point had only been researched from the perspective of the women receiving abortion services. Lipp (2011) demonstrated the broader stigmatized impact abortion has on others besides the women receiving abortions by studying medical providers, specifically nurses and midwives, who assist in abortion procedures. In this qualitative study, 27 participants who worked in abortion care in the NHS in Wales, U.K. were recruited via the National Health Service (NHS) mailing list. The sample had 10-30 years of medical experience in abortion care, were female, and had either nurse or midwife credentialing. They participated in individual interviews guided by questions based in grounded theory and informed by Goffman's (1963) previous theoretical work examining the effects of societal stigma. Goffman (1963) defined stigma as an attribute or act that is discrediting to an individual based upon a broader societal belief or expectation.

Lipp (2011) used constant comparative analysis in order to build upon subsequent interviews and overall found the medical providers experienced an internal struggle with coming to terms with their personal thoughts on abortion and the stigma associated with their opinion. Also, some medical providers commented on the direct impact that policy has on their overall well-being and how broader policy discussions can

lead them to feel internalized stigma. That being said, however, participants also commented on how they feel the medical services they provide are important and necessary to their patients.

Although this article contains the first published data on medical professionals who provide abortion services and how they experience stigma in their work, there are major design issues. First, the demographic information gained from the participants is extremely limited, consisting only of occupation, years of experience, and gender. Other demographic information may have a large impact on the participants' views and experiences. For example, a participant who is a practicing Catholic versus a participant who identifies as Agnostic may view her or his internalized stigma quite differently. Another issue is that the author did not use a set of standardized questions in the interviews, stating that she used constant comparative analysis. Although an unstructured interview is a legitimate approach in qualitative research, the credibility of the findings may be in greater question, as no two participants were asked the same questions. Moreover, because the interview questions were not standardized, the author potentially missed important information from earlier interviews, making it impossible to gain a sense of prevalence of themes. Lastly, the author did not provide a detailed summary of the qualitative information gained from the interviews; the inclusion of more quotations from interviews would lend credibility to the themes identified.

Around the time of the Lipp (2011) and Astbury-Ward et al. (2012) studies, researchers in the U.S. began to conduct investigations of internal stigma on minoritized women who have had abortions. Shellenberg and Tsui (2012) theorized that the

experience of various ethnicities, particularly Hispanic individuals would differ in terms of internal stigma during the abortion process. They assessed the associations between perceived stigma [e.g., how an individual imagines other's perceiving them and/or their decision(s)) and internalized stigma (e.g., how an individual views themselves and/or their decision(s)] and women's sociodemographic, reproductive, and situation characteristics by race/ethnicity. The researchers used the Guttmacher Institute's 2008 Abortion Patients Survey (APS) to obtain cross-sectional reproductive and sociodemographic information from a large national sample of abortion patients residing in the U.S. (N = 4,188). This survey has two parts (Modules A and B), with Module B focusing upon perceived and internalized stigma; the researchers only examined Module B. Potential participants were invited by medical facilities to fill out the survey, which was offered in both English and Spanish. There were 95 participating facilities (10 hospitals, 85 nonhospital facilities) that reported 12,866 abortions occurred during the 13 month sampling period. Valid questionnaires were obtained from 4,188 patients. Facility staff supplied information about age, race/ethnicity, and insurance coverage for 1,082 of the 3,293 women who declined to participate. This was done to assess whether this group differed significantly from survey participants. No information was available for the remaining 2,211 women who also declined. To correct for any bias, the authors utilized a 3-stage weighting process.

The APS survey includes measures for assessing internalized and perceived stigma (Module B). The authors focused upon these measures in their data analysis, excluding 9% of the Module B sample who identified as non- Hispanic Asian, South

Asian, Native Hawaiian, Pacific Islander, or Native American (n = 425). Participants were non-Hispanic black women (33%), non-Hispanic white women (40%), and Hispanic women (27%). Also, participants were majority Protestant (59%), with the remaining identifying as Not Religious (24%), Catholic (6%), and Other (6%). Most participants were between the ages of 20-24 (M = 34.5%), over half were Protestant (59%), and the largest percentage were from the southern region of the United States (39%). Extensive sociodemographic data were also collected.

Participants responded to a measure adapted from Major and Gramzow (1999) which examined perceived stigma and included 3 Likert-type statements (Scale: "strongly agree" to "strongly disagree"): (1) "I would be looked down on by some people if they knew I'd had this abortion"; (2) "My friends and family would think less of me if they knew about this abortion"; and (3) "My regular health care provider(s) would treat me differently if they knew I'd had this abortion." Responses to the following statements were used as proxy measures for internalized stigma: "I need to keep this abortion a secret from my close friends and family," and "What other people think or feel about my decision to have an abortion doesn't matter to me." Independent variables measured were participant's sociodemographic information (age, race/ethnicity, union status, educational attainment, poverty status, religious affiliation, immigrant status, insurance status at the time of the abortion, and region of residence); reproductive history (parity, number of previous abortions, gestational age of pregnancy, if self-induced abortions had occurred in their health history, and use of emergency contraception to try to prevent the current pregnancy); and situational characteristics (whether a participant had decided to have an

abortion before making her appointment, whether the participant wanted to have a child in the future, and how supportive the male involved with the pregnancy has been to the participant).

The authors used univariate analyses to examine the prevalence of perceived and internalized stigma. The authors also used multivariate logistic regression analysis stratified by race/ethnicity to assess the relationship between independent and dependent variables. All independent variables were used in the analysis regardless of whether or not they were found to be significantly associated with the outcome variable at the bivariate level. Among their numerous results, particularly relevant to this paper are the findings regarding ethnicity and religion. Results indicated that 66% of women reported some people would look down on them if they knew about the abortion, and 58% reported needing to keep their abortion a secret from friends and family. Additionally, Hispanic women had increased likelihood of perceiving stigma from others or from friends and family if they were Catholic (OR 1.48) and were foreign born (OR 1.83). In comparison, white women who identified as Protestant were more likely to perceive stigma (OR 1.41 for others and OR 1.54 for friends and family). Based on their results, the authors proposed that the anti-abortion stigma of the Evangelical Christian pro-life movement in the U.S. is comparable to the anti-abortion stigma experienced by conservative Catholic populations outside the U.S. Overall, the most notable associations between women's characteristics and abortion stigma varied by race/ethnicity.

Strengths of this study include the large sample size, high response rate, and use of multiple variable analyses stratified by race/ethnicity. The findings illustrate the

importance of various sociodemographic contextualizing factors associated with stigma among women who have had an abortion. There are, however, some limitations. The study was cross-sectional and correlational, and thus does not provide insight into changes in perceived and internalized stigma over time nor does it allow for causal connections between variables. The collection of information occurred on the day of each participant's abortion procedures and did not measure actual experienced stigma (rather how the women believed the experienced stigma would occur over time). Participants' experience of stigma may vary over time, therefore measuring stigma at different time points post-abortion would provide a clearer and more accurate picture. Finally, completion of questionnaires at the time of the procedures (presumably before the procedure) likely is affected by the participants' heightened emotional state (feelings about the decision to have an abortion, nervousness about the medical procedures, etc.).

Minimal research up to this point had examined the social-psychological framework of the stigma experienced by women who have abortions, paying particular attention to the management strategies they implement in order to cope with their stigma. Cockrill and Nack (2013) qualitatively examined the unique strategies U.S. women use to mitigate negative intrapersonal and interpersonal consequences of abortion stigma. They used Herek's (2009) framework depicting three ways that sexual stigma is manifested in order to inform their understanding of women's abortion experiences: (1) Internalized Stigma, a woman's acceptance of negative cultural valuations of abortion; (2) Felt Stigma, the assessment of other's abortion attitudes and expectations; and (3) Enacted Abortion Stigma, a woman's experience of subtle or clear actions that reveal prejudice

against those who have abortions. Cockril and Nack asserted that these three manifestations are related but distinguishable facets of individual-level of abortion stigma and they impact how women who have abortions manage their stigma.

The authors conducted two consecutive studies ($N = 34$) and combined both samples when reporting demographic data. For religious or spiritual identity, 23% identified as Protestant, 9% identified as Catholic, 24% identified as broadly Christian, and 44% identified as no religious or spiritual practice at this time. Participants ages ranged from 18-47 ($M = 28.5$), predominantly identified as white (52.9%), and had obtained an undergraduate degree (38.2%). The first study explored the experience and attitudes of women who had abortions in states that heavily regulated abortion access. The second study built upon the first study by focusing on the women's feelings about their abortions. Both studies consisted of confidential, in-depth, one-on-one, semi-structured interviews with women who were in the process of obtaining an abortion or who had previously had at least one abortion. All interviews were conducted by the authors.

The sample in the first study ($n = 20$) were recruited from three abortion clinics in the Midwest and South. Medical staff at the abortion clinics recruited 17 of the women, and three women were recruited via an abortion provider recommendation. The authors used purposive sampling to insure diversity in age, race, and socioeconomic status. Eighteen of the participants had received an abortion within two weeks of being interviewed, while two participants had received an abortion within six months of being interviewed. Interview questions explored participants' social and emotional experiences

of decision making, interactions with significant others regarding their abortion, and seeking care. The second study (n = 14) involved phone interviews with women who were recruited from pro-choice abortion support "talklines" (p.5). Talkline counselors were trained by the authors to recruit participants. Eligibililty criteria for both studies were: 18 years of age or older, spoke English, and were seeking post-abortion support. Participants were asked about their emotional experiences related to abortion and pregnancy, how abortion and pregnancy affected their personal relationships, what they knew about abortion pre-procedures, their perception of attitudes about abortion in their families and communities, and their experiences of talking about their abortion(s) with others.

The authors used grounded theory and used constant comparative analysis to code interview responses. For the first study, the authors also coded women's experiences of abortion stigma to assess the validity of Herek's (2009) 3-part model of stigma manifestations. For Internalized Stigma, the authors found that most of the participants had learned negative stereotypes about women who receive abortions. Six participants used the words "irresponsible" or "careless" when asked to describe women who receive abortions. The authors found that self-stigma manifested when a woman who had been exposed to negative discourses around women and abortion, believed this discourse to be true, and that it applied to her. Eight women spoke about the strong feelings of guilt and it's associated with their abortion. The authors postulated there is a strong relationship between religion and self-stigma since half of the sample identified as Christians, Protestant, or Catholic, and 65% of participants revealed self-stigma. For Felt Stigma, all

women in the sample told someone else about their abortion. They described weighing the risk and benefits of disclosing to others, and several voiced fear of questioning from others. The stigmatizing interactions women expected varied widely and depended upon multiple cultural variables (e.g., socioeconomic status, religious background, familial values). For Enacted Stigma, 14 participants discussed witnessing the confrontations between patients entering and protesters outside the abortion clinics. Other subtle interactions of enacted stigma were discussed, including loss of status when seeking an abortion and disclosing an abortion experience to a significant other or family member. Several participants discussed judgment and abandonment as motivations for women to keep their abortions secret and as reinforcement for negative feelings about themselves.

In the second study, the authors examined how women manage stigma after having an abortion. Some women managed internalized stigma by accepting that stigma about abortion exists, while simultaneously challenging this truth to their experience. Several rationalized their choice to have an abortion by accepting why it was a legitimate behavior. This rationalization focused upon two themes that emerged from the interviews: excuses and justifications. Excuses allowed the women to refute the label of irresponsibility (e.g. the sexual act that lead to pregnancy was nonconsensual), and justifications (e.g. meeting the gendered expectations set forth by other people) helped women accept responsibility for their abortions by denying the wrongfulness of abortion. Some women also managed their internalized stigma by transferring their blame onto something or someone else, for example medical providers at the abortion clinic. Ten women spoke of actively choosing to blame others who they felt “deserved” it.

Participants also spoke of striving to maintain a good reputation after their abortion. Participants often tried to reduce negative outcomes related to their reputation by not sharing their abortion with others, with three participants describing their fictional explanations to others to explain where they were when they had their abortions.

The authors found, however that individual stigma management strategies that reduce likelihoods of enacted stigma also increased other stressors (e.g., intrusive thoughts, suppressive thoughts). Participants also spoke of episodes of internalized, felt, and enacted stigma. Enacted stigma often occurred around social interactions involving talk about abortions, disclosing to others, interacting with protesters, and attending clinic appointments. Felt stigma often occurred around the time of the abortion, but after the procedure as well. Internalized stigma was experienced by participants most strongly during the time of their abortion procedure. Stigma management skills were developed over time and became less salient as time progressed. The authors did, however note that stigma-related abortions may decrease connection among women who have also had abortions and may decrease the potentially positive impact that social connection could have on them and the various types of stigma they may be experiencing.

These two studies provide a strong framework for comparing various types of stigma experienced by women who had recently had abortions, but their are limitations. First, the responses of small, convenience samples of women cannot be generalized to a broader population. Participants who were contacted via the talkline recruitment may have been experiencing higher levels of stigma than women who participated in person due to the higher level of anonymity of seeking mental health support via a talkline.

Further research is needed to explore the stigma experienced by a larger and broader sample of women. Furthermore, additional research is needed to explore differences between stigma of women who choose to call in for mental health support versus those who seek face-to-face mental health support. Another limitation is the authors' combining the demographic data when reporting the two studies. This approach precludes consideration of potentially salient differences. For example, women who attend abortion clinics for mental health support versus women who utilize talklines may differ in their socioeconomic status.

Most of the research done up until this point on sigma and abortion utilized various mental health and/or stigma measures. Cockrill, Upadhyay, Turan, and Foster (2013) argued that a specific measure must be developed to capture the unique type of stigma (social, political) experienced by women experience who have had abortions. They further noted the lack of measures that examine the abortion stigma that women experience. The authors created an initial item pool by examining previous qualitative interviews (Cockrill and Nack, 2013) focusing upon the sexual and social stigma experienced by women post-abortion. Sixty-six items assessed: internalized stigma (seven items), enacted stigma (28 items), felt stigma (14 items), and stigma management strategies (17 items). Internalized stigma included items examining women's feelings toward themselves following their abortion and their attitudes and beliefs about abortion. Felt stigma items explored a woman's concerns about damage to her reputation or receiving poor treatment by others if her abortion were to become known to others. Enacted stigma items explored a woman's interactions with key people in her life who

would have influence on her (e.g., partners, parents, friends, healthcare providers). Stigma management strategy items created from Cockrill & Nack (2013) examined how often women disclosed their abortions and how they experienced emotional support.

To assess content validity, cognitive interviews were conducted with 14 women at three family planning clinics in the U.S. Participants were 19–44 years old and differed by race (nine were white, three black, one American Indian, one mixed- race), ethnicity (three were Latina) and monthly income ($800–4,000). The first 11 completed a paper survey that included all 66 items and then answered open-ended questions determining validity of the measure. Also, the women reported whether they believed the items assessed the full range of experiences related to abortion stigma. A final set of cognitive interviews with all 14 women was performed to finalize the measure. From this feedback, the authors revised the measure to 61 items.

Next the researchers attempted to validate their scale in a sample of 437 women recruited from local family planning clinics. Their racial/ethnic breakdown was 39% White, 30% African American/Black, 20% Hispanic; 5% Asian or Pacific Islander, and 6% "other." The majority of participants (58.7%) were between 19 and 29 years old, had "some college experience (53%), and identify as Christian (58%). Half were already mothers, one- third had experienced more than one abortion, and one- fifth had experienced at least one miscarriage. Sixty-two percent of participants had their most recent abortion in the previous four years.

The researchers administered their 61-item scale to the sample. Twenty-one items were measured by five-level bidirectional Likert scale scale (0 = "strongly agree" to 4 =

"strongly disagree), 18 items were measured by frequent of the experience on four-level unidirectional scale (0 = "never" to 3 = "many times"), 11 items were measured on a four-level unidirectional scale (0 = "not at all worried" to 3 = "extremely worried"), seven items measuring community attitudes used a five-level unidirectional scale (0 = "not one" to 4 = "most people"), and each of the remaining for items had a unique set of 3-4 possible responses. The items were organized into eight sections: (a) Telling the People I Am Closest To, (b) How I Was Treated, (c) The Man Involved in My Pregnancy, (d) My Mother (Or the Woman Who Raised Me), (e) Things I Worried About, (f) How I Felt About Myself, (g) My Community's Attitudes and Beliefs, and (h) My Attitudes and Beliefs. Factor analysis revealed a four-factor model for individual-level abortion stigma: worries about judgment, isolation, self-judgment and community condemnation (Cronbach's alphas, 0.8–0.9). Construct validity for the full and sub-scales was done by examining the association between the scales and an independent measure of secrecy. A logistic regression was performed and revealed a strong association between the full scale and withholding information from someone at least once (odds ratio, 3.3; 95% confidence interval [CI], 2.7–4.1).

The authors noted that religious denomination was associated with perceptions of stigma, with both Protestant and Catholic women scoring higher on the isolation subscale than women who were not religious. Also, Catholic women scored higher on the community condemnation subscale than women who were not religious. Catholic and Protestant women experienced higher levels of stigma than nonreligious women.

The authors developed a scale that has some empirically demonstrated validity

with respect to the unique stigma experienced by women who have had abortions. There are some limitations. First, additional validation studies with other samples would help to further establish validity. Test-retest reliability should also be studied in order to determine the temporal stability of the measure. Second, their sample likely is not exhaustive in including a diverse group of women. The authors stated that their sample was diverse enough to be reflective of the U.S., but the basic demographic variables they reported do not capture the sociopolitical nuances that may be exist in other geographic regions.

Cockrill et al. (2013) provided an initial scale to capture the unique stigma that women may experience in the abortion process. Additionally, they found that Catholic women had higher scores on a community condemnation subscale, supporting previous research that identifies Catholic women at a higher risk for internalized stigma pre- and post-abortion. Sorhaindo et al. (2014) studied the unique stigma experienced by women in Mexico City and five different states in Mexico (a predominantly Catholic country). Abortion is legal in Mexico City; however abortion is restricted in the five states selected (Chihuahua, Chiapas, Jalisco, Oaxaca, and Yucatan). The researchers examined the sources, experiences, and consequences of stigma during focus group interviews comprised of women who had abortions, male partners of the women who had abortions, and members of the general community.

The authors conducted semi-structured face-to-face interviews with a total of 12 women who had received abortions and 12 men who were partners of women who had previously experienced an abortion. The men and women interviewed were not partners

with one another. The authors then held 18 focus groups with 65 women and 36 men (*N* = 101) across the five states and Mexico City. Each focus group had between five to eight participants. The groups were comprised of men ages 24–40 years (*n* = 36), women 25–40 years (*n* = 37), and young women ages 18–24 years (*n* = 28). The authors limited the focus group to individuals with a junior high education level or lower in order to accurately reflect the general population, as only 19% of Mexicans hold a higher education degree. Focus groups were used to gain more informal sentiments about abortion. From these broader community focus groups, the authors conducted in-depth interviews with women who had had an abortion and men whose partners who had had abortions within the previous 2 years. Recruitment focused on self-identified Catholics because previous research has found abortion stigma in a Mexican population is largely influenced by Catholic doctrine (McMurtrie et al., 2012). The authors analyzed the data manually using discourse analysis with microanalysis (Wetherell & Potter, 1996).

The authors first conducted the in-depth interviews (length = 1 to 1.5 hours). Of the 12 women interviewed who had undergone abortion, eight were not in a union at the time of the interviews, and seven had at least one child. For four of the 12 women, this was their second abortion. Of the 12 men interviewed, two were married and four had children. Nine of the women and 10 of the men self-identified as Catholic. All women had elected abortions, with five of the 12 women receiving illegal abortions, three of the 12 women having legal terminations in Mexico City, and the remaining four taking an over-the-counter drug found to induce abortions (Lara et al., 2006, 2011).

Upon completion of the in-depth interviews, the authors convened the focus

groups in the five different regions. Focus groups ranged between 1.5 to 2 hours. The authors found that abortion stigma was influenced by social norms that placed a high precedent on conservative Catholic discourse and motherhood. All focus group participants in all states spoke of the stigma and judgment that women receive after having an abortion. Several participants described abortion as an irremovable mark on a woman's identity once she has it, and that due to their predominantly Catholic culture, women experience a fear of religious punishment. The authors also noted the difference between the narratives heard in the five states compared to Mexico City, where in the five states the Catholic rhetoric was more apparent and the possibility of abortion was limited. Only participants in Mexico City spoke of the importance of a woman's right to make her own choices when it comes to her fertility. Several women in the five states spoke of the cultural belief that women who receive abortions will experience fertility issues due, a belief that is propagated in the rural areas of Mexico. All participants spoke of the shame and guilt they experienced after an abortion, with no participants speaking of regret in choosing to have an abortion. Few participants discussed their abortion with family or close friends out of fear of their loved ones' response.

This study is the first to qualitatively examine the stigma experienced by women in a predominantly Catholic country, but this study has methodological limitations. First, qualitative data are not intended to be generalized to the population of interest. Second the interview questions were created by the authors and do not appear to be grounded in a specific theory or prior research. The focus were mixed gender and included broader community participation. The mixed gender audience in these focus groups may have

decreased the honesty and authenticity in responses by female participants when around their male counterparts (and vice-versa), although data analysis yielded no major thematic differences between the in-depth interviews and the focus groups. Due to the sensitive nature of abortion coupled with the conservative Catholic cultural context, the information from the individual interviews and focus groups may not have been accurately captured the experience of stigma. Lastly, none of the interview questions were reported in the paper.

Summary of Research Findings Regarding Stigma and Abortion

When the studies reviewed herein are considered together, several patterns emerge that describe the stigma experiences of women who have received abortions. One common finding is that society has a large influence on the well-being of women who receive abortions (Astbury-Ward et al., 2012; Cockrill & Nack, 2013; Cockrill et al., 2013; Littman et al., 2011; Major & Gramzow, 1999; Mueller & Major, 1989; Shellenberg & Tsui, 2012; Sorhaindo et al., 2014). Specifically, the political landscape and broader discourse around abortions has an impact on how women perceive themselves and how they believe others view them (Astbury-Ward et al., 2012; Cockrill & Nack, 2013; Littman et al., 2011; Major & Gramzow, 1999; Shellenberg & Tsui, 2012; Sorhaindo et al., 2014). Sociopolitical forces may be important to consider when working with women who experience internalized stigma pre- and/or post-abortion.

Another consistent finding is that religion/spirituality has a notable relationship with the stigma that women experience pre- and/or post-abortion (Cockrill & Nack, 2013; Cockrill et al., 2013; Littman et al., 2011; Shellenberg & Tsui, 2012; Sorhaindo et al.,

2014). Therefore, future research examining stigma should assess the potential influence of religion has on a woman's experience related to her abortion. This finding was obtained both in U.S. culture (Cockrill & Nack, 2013; Cockrill et al., 2013; Littman et al., 2011; Shellenberg & Tsui, 2012) and in international studies (Astbury-Ward et al., 2012; Sorhaindo et al., 2014). That being said, however, each nation and culture are unique in how they relate religious perspectives to larger governmental regulation of women's reproductive rights. Catholicism appears to be a religion that has a unique and notable relationship to governmental regulation and the phenomenon of stigma experienced by women who have had abortions.

Lastly, there is a major gap in research examining the mental health of women post-elected termination who live in countries where abortion is illegal or highly regulated. In 2008, 41% of pregnancies were unintended and/or unplanned, and nearly nine out of ten unintended pregnancies occurred in countries in the poorest and least developed countries (Russo et al., 2014). Latin America alone accounts for 12% of the world's unplanned pregnancies, and 9% of the world's abortions (Sing et al., 2009). Research on the mental health concerns associated with abortion are largely based upon research performed in countries where abortion is legal (Sing et al., 2009). For this reason, generalizing research results from countries where abortion is legal to countries/cultures where abortion is illegal is risky, such as Ireland. More research specific to particular countries/cultures is necessary to accurately depict the mental health experiences of women who receive abortions.

The area of research regarding abortion stigma in countries where abortion is illegal is minimal, and non-existent regarding Irish women's experiences of abortion stigma.

The purpose of this study was to examine therapists' perceptions of the experience of women who live in the Republic of Ireland who have abortions, specifically how they experience abortion stigma in a country where abortion is illegal. I used qualitative research methodology and interviewed therapists who serve women who have received abortions in order to gain an in depth understanding of their experiences while minimizing risk to the women themselves.

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Appendix B

Supplementary Methods and Definitions

Research Paradigm

The qualitative paradigm is a broad research study design. A paradigm is seen as a worldview and a holistic framework of methods, values, and beliefs within the area being researched (Lincoln, Lynham, & Guba, 2011). Phenomenology describes how an individual orients to a lived experience, and hermeneutics describes how an individual interprets the "texts" of her or his life (van Manen, 1990). The paradigm of Hermeneutic Phenomenology is a loose collection of logically related concepts or assumptions that orient research and thoughts (Kafle, 2011). van Manen (1990, 2016) argues that to *do* hermeneutic phenomenology is to accomplish the unaccomplishable, meaning the very construct of interpreting in full the lived experience is impossible. Completed reduction of a lived experience can never fully occur, and therefore should not even be attempted. Hermeneutic phenomenology therefore aims to construct an evocative description via written text by the researcher that elicits the unique lived experience/view point of each participant (Creswell, 2013; Merleauu-Ponty, 1962; van Manen 2016).

Larkin, Watts, & Clifton (2006) describe themes between psychology and a Hermeneutic phenomenological approach by emphasizing the importance of the relationship between researcher and participant,

> Any discoveries that we make must necessarily be a function of the relationship that pertains between researcher and subject-matter (person and world, subject and object, etc.) / a dilemma of reflexivity familiar to

> most qualitative researchers. Indeed, this function is precisely what we would expect, given that we must identify the researcher as an inclusive part of the world they are describing. The emergent 'reality' (i.e., the resultant explanation and/or understanding of the nature of the subject-matter) can thus be seen to be dependent upon the processes of intellectual construction that shaped the 'structure of encounter.' (p. 107)

Human beings are consistently interpreting their worlds through their individual contexts. Humans engage in a natural state of "hermeneutical process of interpretation" when attempting to make sense of the world around them within the individual contexts of their own lives (Sandage, Cook, Hill, Strawn, & Reimer, 2008, p. 344). Hermeneutic phenomenology is how one views the world through her or his experiences in a pre-reflective state, meaning the day-to-day experiences that one lives in and through (van Manen, 2016). Furthermore, this method forces the researcher to approach the research with an attitude of reflection upon the experiences of participants which aims to rid the research of theoretical and emotional fallacies (van Manen, 2016). The distinction between relativism and objectivism is essential when discussing Hermeneutic phenomenological approaches.

Lifeworld

The investigator within hermeneutic phenomenology is consistently interacting with the construct of the lifeworld; the world of a lived experience which is both the source and object of phenomenological research. In this study, the lifeworld is Irish culture, specifically through the lens of the female-identified experience. It was my

purpose then to purposefully connect with Irish female-identified lived experience by staying in regular contact with this population, consistently interacting with Irish news sources concerning abortion rights for Irish women, and accessing her own Irish feminist heritage. van Manen (1990; 2016) states that an investigator must use her or his personal experiences as a starting point to interacting with the research. I am of Irish descent and strongly identify with this identity, as well as my female identity. This cultural influence acts as a natural lived experience that therefore helped me feel connected to the possible human experience (i.e.,. the intersubjective universal character between the phenomenon being studied and the investigator) (van Manen 1990; 2016).

Data Analysis and Phenomenological Structure

This study used a hermeneutic phenomenological data analysis method that emphasizes the contextualized approach of phenomenological work. The investigator, may, however modify the hermeneutic phenomenology data analysis in order to fit the data gathered (van Manen, 2016). van Manen further explains that the investigator tailors the data analysis by engaging in the writing and rewriting process, and further attempting to have the data accurately reflect the lifeworld it is depicting (2016). I took this contextual data analysis into account when allowing the themes to emerge from the data and by allowing the themes to interact with the findings of previous stigma research.

***Thematic analysis*.**

Theme analysis was utilized in this study. Theme analysis is "the process of recovering the theme or themes that are embodied and dramatized in the evolving meanings and imagery of the work" (van Manen, 1990, p. 78). Theme analysis is

common in many forms of qualitative research; however, within hermeneutic phenomenology, theme analysis serves to provide structures of experience, while acknowledging that themes will never fully capture the essence of the lifeworld. Themes are the experience of meaning, at best a simplification of a lived experience, the capturing of a phenomenon one is attempting to understand, and always intransitive (van Manen, 2016). For the purpose of this study, I approached working with the text by using a relativist foundational ontological structure that worked best with a thematic analysis approach. The themes were not exhaustive of the phenomenon, yet they allowed a systematic investigation of abortion stigma (van Manen, 2016).

Anecdotes as Methods.

A common device within phenomenological research, particularly important in hermeneutic research, is the use of stories or anecdotes. Anecdotes are methodological devices that make concepts or experiences that easily elude us more comprehensible (van Manen, 1990; 2016). Hermeneutic phenomenology aims to include descriptions that are exclusive of one another, meaning that the data should be an example composed of examples (van Manen, 2016).

I paid particular attention to the unique anecdotes that emerged from the data. I took care in attending to each narrative as a unique account that provided a distinctive lived experience. Anecdotes were selected by making sure they attempted to capture the exclusive nature of the experiences being described by participants.

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Appendix C

Recruitment Letter

Hello,
My name is Meredith Martyr and I am a Ph.D. student in Counseling Psychology at the University of Minnesota-Twin Cities in Minneapolis, Minnesota, United States of America. I am contacting you regarding a research inquiry that I believe to be important, impactful, and helpful to Irish counselors and/or psychotherapists and the larger psychotherapy community.

Goal:
My goal is to identify psychotherapists who have worked with Irish women who have had abortions, and the unique stigma these women may experience post-abortion procedure in Ireland. For this study, stigma may be defined "as negative views or potential stereotypes that are attributed to a person or groups of people when their behaviors or characteristics are viewed as different from or inferior to societal norms (Dudley, 2000).

Eligibility:
Eligible participants will have formal education and/or training (Level 8 or above) as a counselor and/or psychotherapist in Ireland, are part of an accredited Irish counseling and/or psychotherapy association, must have been practicing for at least three years post-training, and who have worked with at least one client who had an abortion before she engaged in counseling or psychotherapy. Participants must be willing to speak about their perceptions of the stigma their clients may have experienced due to their abortion; however **no** demographic information regarding clients will be collected. Lastly, it will also be required that potential participants be born in Ireland and have spent the majority of their lives residing in Ireland.

I am planning to conduct confidential, in-person interviews during March 2nd-17th, 2017 throughout Ireland. If transportation is an issue, Skype interviews may be offered by request. If you are potentially interested in participating in a 45-60 minute audio-recorded interview conducted in a confidential space in a location that is convenient for you, please follow this link that will gather contact and demographic information: https://umn.qualtrics.com/SE/?SID=SV_2nKgTI8Jnd6eZNz

Your responses recorded on this link will be kept completely confidential. Participation is completely voluntary and may be redacted at any time during or after the data collection process. I will get in touch with you after you fill out information on the above link. Thank you for taking the time to participate in this study. Your input will contribute to providing an honest portrait of the unique experiences these women experience and hopefully will inform psychotherapists of the unique forms of stigma to attend to in psychotherapy with this population. **Please contact me if you are interested in**

participating or have any questions at marty031@umn.edu. You may also contact my advisors, Drs. Patricia McCarthy Veach or Caroline Burke, by email at veach001@umn.edu or burke290@umn.edu. Thank you for your consideration,

Sincerely,

Meredith Martyr, M.A.
Doctoral Candidate Educational Psychology: Counseling and Student Personnel Psychology University of Minnesota-Twin Cities 250 Education Sciences Building 56 East River Road Minneapolis, MN 55455 651-246-0721, marty031@umn.edu

Reference:

Dudley, J. R. (2000). Confronting stigma within the services system. *Social Work*, *45*(5), 449.

Appendix D

Consent Form

Therapists' Perceptions of the Stigma Experienced by Women Residing in Ireland Who Have Abortions

You are invited to participate in an interview regarding stigma experienced by Irish women who have had abortions. Stigma may be defined as negative views or potential stereotypes that are attributed to a person or groups of people when their behaviors or characteristics are viewed as different from or inferior to societal norms (Dudley, 2000). You were selected as a possible participant because you emailed the principal investigator. We ask that you read this form and ask any questions you may have before agreeing to complete the interview.

This study is being conducted by Meredith Martyr, M.A. for her doctoral dissertation in the department of Educational Psychology at the University of Minnesota. She is advised by Drs. Patricia McCarthy Veach and Caroline Burke at the University of Minnesota.

Background Information
The goal of this study is to identify how therapists Irish female clients who have had abortions (whether in Ireland or in another country) experience abortion stigma and what perceived barriers and supports these women experience after they have received an abortion. Your input will help us provide guidance to psychotherapists in their work with women who have had abortions and reside in a country where abortion is illegal.

Procedures
If you agree to participate, you will be asked to schedule a semi-structured, in-person interview or Skype interview and respond to a brief demographic questionnaire. The interview consists of open-ended questions and is expected to take approximately 45-60 minutes. The interview will be audio-recorded and transcribed.

Risks and Benefits of Participating
Potential risks: This study has minimal risks. Participants will be asked to provide basic demographic information as well as potentially sensitive information about challenges they may encounter in their work settings and how they approach work with a minority population. A potential risk includes the possibility of a breach of confidentiality.
Benefits to participation: There are no direct benefits to participating in the study.

Confidentiality
The interview and records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a participant. All identifying information will be removed from the transcript of the

interview and audio recordings will be destroyed at the conclusion of the study. Research records and materials will be stored securely and only researchers will have access to the transcripts and audio recordings.

Voluntary Nature of the Study
Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

Contacts and Questions
The researcher conducting this study is Meredith Martyr, M.A. You may ask any 651-246-0721 marty031@umn.edu or her advisors Dr. Patricia McCarthy Veach at veach001@umn.edu or Dr. Caroline Burke at burke290@umn.edu.

If you have any questions or concerns regarding the study and would like to talk to someone other than the researchers, you are encouraged to contact the Research Subjects' Advocate line, D528 Mayo, 420 Delaware Street S.E., Minneapolis, Minnesota 55455, U.S.A.; telephone 612- 625-1650.

You will be given a copy of this information to keep for your records the day of the scheduled interview. You will be required to sign this document the day of the interview.

Statement of Consent
I have read the above information. I have had the opportunity to ask, and I have received answers to, any questions I had regarding the study. I understand that if I have any additional questions about my rights as a research participant, I may call 1-651-246-0721 or email Meredith Martyr, marty031@umn.edu.

By completing the survey, I agree to take part in this study as a research participant. In doing so, I affirm that I am at least 18 years old and that I have received a copy of this Consent and Authorization form.

Researcher Contact Information:
Meredith Martyr, M.A.
Doctoral Candidate Educational Psychology: Counseling and Student Personnel Psychology University of Minnesota-Twin Cities 250 Education Sciences Building 56 East River Road Minneapolis, MN 55455 651-246-0721, marty031@umn.edu

Reference:
Dudley, J. R. (2000). Confronting stigma within the services system. *Social Work*, *45*(5), 449.

_____	_____
Participant Signature and Date	**Researcher Signature and Date**

Appendix E

Screening Form via Qualtrics

1) Please provide your initials:

2) Please provide an email and/or phone number that you would prefer to be contacted at:

Email:

Phone Number:

3) With your training in mind, what is your title:

- Psychotherapist
- Counselor
- I do not want to state

4) What is your gender?

- Female
- Male
- Gender Nonconforming
- I do not want to state

5) How many total years of post-degree clinical experience do you have:

- 3-5 years
- 6-10 years
- 11-15 years
- 15+ years
- I do not want to state

6) What is the estimated number of Irish women you have worked with who have

disclosed having an abortion in their lifetime:

- 1-3 women
- 4-6 women
- 7-10 women
- 10+ women
- I do not want to state

7) What is your primary work setting (Check one):

- Private practice
- Agency
- University/college
- I do not want to state

8) Where would be the most convenient town/city for you to participate in an interview?

_____

9) Please provide days and times between March 2nd-19th, 2017 that would be most convenient for you to schedule a 45-60 minute, in-person interview:

_____

Appendix F

Interview Guide

The PI will provide a written copy of the definition of stigma (see Appendices C and D):

1) Did you want to add or modify this definition at all?
2) Generally speaking, is this a lens (i.e., abortion stigma does occur in Ireland) that you do understand your clients through? To what extent?
3) Tell me about the most memorable client you have worked with who has experienced stigma related to her abortion and why did you pick this woman?
4) How have your clients defined in their own words the stigma they have experienced related to their abortion?
5) What outside systems have affected or had an influence on their self-stigma
6) What other factors might play into their abortion-related stigma experiences that are not accounted for by the outside systems you just described?
7) What do you hypothesize drives the kind of stigma that is present for women who have had abortions?
8) What was it like for you working with these women who experienced stigma related to their abortions?
9) Can you tell me why you decided to participate in this study?
10) Is there anything else you would like to add that we have not discussed?

Appendix G

Historical Context for Timing of Study

During the time I was in Ireland collecting data, several noteworthy events occurred that had an apparent effect on how participants responded during the interviews. These events, described briefly below, relate to the issue of abortion regulation in Ireland. These events took place during data collection which occurred between March 2nd, 2017 and March 16th, 2017.

Taum Laundry

On March 3rd, 2017 the media published a story that gained international attention. The story reported a mass grave containing the skeletons of an estimated 800 babies and young women was found outside of Galway, Ireland. The site where the bodies were found was the site of a former Magdalene Laundry by the name of *Bon Secours Mother and Baby Home*. This home was run by a Catholic religious order of nuns who housed unmarried pregnant women; as soon as the women gave birth, they were separated from their baby. The babies supposedly were either raised by the nuns or placed for adoption as soon as possible. Dr. Catherine Corless, a Taum historian, suspected a mass grave was present on the site, and the Irish government formed a commission in 2014 to investigate her suspicions further. Katherine Zappone, the Commissioner for Children, ordered the rumored mass grave to be investigated and excavated despite the advice of Irish government officials to not disturb the site.

International Women's Day/Strike 4 Repeal

International Women's Day occurred on March 9th, 2014. This day is slated as a day for recognizing the various forms of oppression that occur against women across the world, as well as the progress made in women's equality and equity. In Ireland, however, there was a layered context. A national campaign called for International Women's Day to also be named "Strike 4 Repeal Day," where women across Ireland would not show up for work and instead engage in economic protest against the Irish government for their continual criminalization of abortion against women and medical providers. A series of protests took place across Ireland in Counties Dublin, Cork, Mayo, Kilkenny, Meath, and Wexford; they drew thousands of Irish citizens protesting against the Irish government. Several of the participants in the present study mentioned or eluded to this event before, during, or after their interviews.