Abortion Stigma Among Low-Income Women Obtaining Abortions in Western Pennsylvania: A Qualitative Assessment

CONTEXT: *Abortion stigma may cause psychological distress in women who are considering having an abortion or have had one. This phenomenon has been relatively underexplored in low-income women, who may already be at an increased risk for poor abortion-related outcomes because of difficulties accessing timely and safe abortion services.*

METHODS: *A qualitative study conducted between 2010 and 2013 used semistructured interviews to explore pregnancy intentions among low-income women recruited from six reproductive health clinics in Western Pennsylvania. Transcripts from interviews with 19 participants who were planning to terminate a pregnancy or had had an abortion in the last two weeks were examined through content analysis to identify the range of attitudes they encountered that could contribute to or reflect abortion stigma, the sources of these attitudes and women's responses to them.*

RESULTS: *Women commonly reported that partners, family members and they themselves held antiabortion attitudes. Such attitudes communicated that abortion is morally reprehensible, a rejection of motherhood, rare and thus potentially deviant, detrimental to future fertility and an irresponsible choice. Women reacted to external and internal negative attitudes by distinguishing themselves from other women who obtain abortions, experiencing negative emotions, and concealing or delaying their abortions.*

CONCLUSIONS: *Women's reactions to antiabortion attitudes may perpetuate abortion stigma. Further research is needed to inform interventions to address abortion stigma and improve women's abortion experiences.*

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Nearly one-third of U.S. women have at least one abortion.[1] Nonetheless, abortion remains highly stigmatized. Specifically, women having abortions are commonly devalued and marginalized, often because of perceptions that they are violating social norms, including cultural constructs of femininity, such as women's expected role as mothers.[2] Abortion stigma has been widely identified across populations with varying religious preferences, gender norms and abortion regulations,[3,4] and it manifests in individuals, communities, organizations, governments (by way of policies and laws) and the broader social discourse.[2,5,6] Thus, not surprisingly, it affects many women undergoing abortion.[2,3,7–19] Abortion stigma has been described as occurring across three domains: felt stigma (women's perception of others' negative attitudes toward abortion), enacted stigma (women's experience of acts of abortion-related violence or prejudice) and internalized stigma (women's own negative attitudes toward abortion).[8]

Abortion stigma can have negative emotional, physical, financial and social consequences. Although having an abortion itself is not associated with long-term mental health sequelae,[20] experiencing abortion stigma has been linked to regret, anger, sadness, guilt and stress.[14,15] Additionally, stigmatizing abortion views may contribute to uncertainty regarding the decision to pursue an abortion.[21] Difficulty with decision making is associated with delays in obtaining an abortion,[18,22,23] and having an abortion at a later stage of gestation is associated with higher costs[24] and increased complications (including higher rates of maternal mortality).[25,26] Moreover, women who present at later stages may be denied abortion services, and this may lead to the continuation to term of unwanted pregnancies.[27] Finally, women's responses to abortion stigma may perpetuate abortion stigma.[2,16] Specifically, women may draw distinctions between their own "acceptable" abortions and other women's abortions, a strategy that can involve denouncing other women;[8,10] or they may conceal their abortions,[4,7–10,17] potentially contributing to the misperception that abortion is uncommon or deviant (an important step in the production of abortion stigma).[2,4,28]

Few studies have examined abortion stigma in subpopulations who may experience abortion and abortion stigma in distinctive ways.[3,4,11] A group that warrants particular attention is low-income women in the United States. Low-income women are more likely than those who are economically better off to encounter difficulties in accessing timely and safe abortion services,[22,29] and appear to often rely on social support to mitigate barriers to abortion access.[19] Abortion stigma could compound barriers to obtaining abortions—for instance, by impeding social support. Additionally, contextual factors may affect how women in this population experience abortion stigma.

Specifically, because low-income women have disproportionately high rates of abortion,[30] the procedure could be expected to be less stigmatized than it is in populations for whom it is less common. Furthermore, because low-income women may be particularly attuned to barriers in obtaining both timely abortions and contraceptives to prevent unintended pregnancy,[10,19,22,31] they could be expected to be supportive of other women and the circumstances surrounding their abortions.

However, the limited studies assessing abortion stigma in this population suggest otherwise. In the only published study that we know of that has focused on identifying abortion stigma in an entirely low-income sample of U.S. women having abortions, Nickerson et al. found internalized stigma prevalent: Many Medicaid-eligible women who had undergone abortion endorsed negative stereotypes of other women obtaining abortions when they described why some abortions should not be covered under Medicaid.[10] The authors did not describe other negative attitudes toward abortion or investigate enacted and felt abortion stigma in women's social networks. Other studies have briefly touched on these domains of abortion stigma in low-income populations. In a study assessing broader attitudes surrounding childbearing among low-income, nonpregnant women in Birmingham, Alabama, who had not necessarily had abortions, abortion was viewed as an unacceptable, immoral and irresponsible act, whereas parenthood was considered "an act of selflessness, strength and responsibility."[32(p. 77)] And a study of low-income women presenting to an abortion clinic in Oregon found that fear of harassment by antiabortion protesters and lack of social support were significant obstacles to obtaining abortions in this population.[19]

Together, available findings suggest that low-income women likely experience abortion stigma across multiple domains. However, a more thorough understanding of the sources and range of attitudes that could reflect or contribute to abortion stigma among low-income women and their social networks is still needed to help inform strategies designed to improve women's abortion experiences. We conducted a qualitative study among low-income women obtaining abortions in Western Pennsylvania as a step toward achieving that goal.

METHODS

Sample

Data were drawn from the Contraceptive Use and Pregnancy Study, which explored how sociocultural and structural factors shape pregnancy intention and contraceptive decision making among 66 low-income women in Western Pennsylvania.[33] Participants were recruited from six reproductive health clinics that provide prenatal, gynecologic and family planning services to the uninsured and underinsured. These clinics (one clinic located in a hospital, four clinics affiliated with a hospital but located in community sites and one Planned Parenthood clinic) are located in various low-income neighborhoods in the greater Pittsburgh area and serve large numbers of low-income women and women of color.

From June 2010 until January 2013, flyers were posted in clinic waiting rooms advertising a study designed "to better understand women's views on contraceptive use, family planning, and pregnancy." The flyers contained tear-off tabs with a telephone number that women could call if they were interested in participating. Women responding to advertisements were screened for eligibility via telephone and were considered eligible if they were aged 18–45; self-identified as black, African American, white or Caucasian; were fluent in English; had an annual income that was no more than 200% of the federal poverty level; and either had a current pregnancy of less than 24 weeks' gestation, had had an abortion within the prior two weeks, or met neither of these conditions but had been sexually active with a man in the previous 12 months. The restrictions regarding gestation of a current pregnancy and elapsed time since an abortion were intended to optimize recall of events surrounding conception and of factors affecting abortion decision making. Recruitment continued until we had, per a sampling matrix, a sample of participants who varied with respect to race; age; parity; and, among pregnant women, whether they planned to continue their pregnancy. As is customary in qualitative research, we continued data collection until we reached thematic saturation, the point at which no new themes were emerging in interviews.[34]

For this analysis, we restricted our sample to the 19 women who were planning to terminate a current pregnancy or had had an abortion within the prior two weeks.

Data Collection

Semistructured interviews were conducted between June 2010 and January 2013 by the third author, a skilled interviewer with extensive experience collecting qualitative data on sensitive topics in diverse populations. Interviews were conducted in a private office space located on the University of Pittsburgh campus that was accessible by bus from all recruitment sites. Participants were asked about the circumstances surrounding their current or recent pregnancy, including whom they had talked to about the pregnancy and the abortion decision, why they had told these individuals, the responses they had received and how they had ultimately arrived at the decision to obtain an abortion. Women were also asked to share any perceived "pluses and minuses" of pregnancy and motherhood. To assess norms regarding abortion in women's social networks, we asked participants, "Among your friends, family and the community in general, what do other people think about abortion?" Women's own attitudes toward abortion were assessed by a series of open-ended questions, including "What are your thoughts about abortion?" "Do you think it's common for women to have an abortion?" "What do you think are the reasons that women have abortions?" and "Do you think it's different to have one abortion versus multiple abortions?"

All sessions were audio-recorded and transcribed verbatim, with identifiers removed. Interviews lasted an average of 43 minutes (range, 23–79). Each participant also completed a paper-based sociodemographic questionnaire and received $50 as compensation for her time. This study was approved by the University of Pittsburgh institutional review board.

Analysis

Transcripts were analyzed using content analysis. This method involves the breakdown of interview text into "units," which are formulated into thematic categories. These categories represented both an exploration of predefined areas of study inquiry and new themes that emerged during interviews. A codebook, reflecting primary categories and subcategories, was developed and refined as new themes emerged. Two coders independently coded 50% of the transcripts using Atlas.ti qualitative coding software and compared their coding; any inconsistencies were resolved through discussion. The principal investigator (the sixth author) was available to adjudicate any differences in interpretation between the coders and to review the coding scheme. One coder (the third author) then coded the remaining transcripts.

For this analysis, all codes that related to abortion and motherhood were examined for antiabortion attitudes—that is, attitudes that either directly denounced abortion or have been posited in previous studies of abortion stigma to undermine the acceptability of abortion. Although some women reported positive or neutral attitudes toward abortion in themselves or their social networks, we limited our assessment to negative attitudes, given that our primary goal was identifying targets for intervention.

RESULTS

Sample Characteristics

Of the 19 women in the sample, 10 were planning to terminate their current pregnancy, and nine had undergone an abortion in the preceding two weeks. The majority of women either had had an abortion in the first trimester or were in their first trimester of pregnancy (Table 1). Most were aged 18–24. Nearly 60% of women were black, and the rest were white, except for one woman, who was biracial. All participants had a yearly income of less than $50,000, and most had a yearly income of less than $20,000. The majority of women had at least a high school education, had public insurance, and were dating the man involved in the pregnancy but were not living with him. Most of the women did not identify with a religion, had children and had not had a previous abortion.

TABLE 1. Percentage distribution of participants in a study of abortion stigma among women having abortions, by selected characteristics, Western Pennsylvania, 2010–2013

Characteristic	% (N=19)
Abortion status	
Had first-trimester abortion*	31.6
Had second-trimester abortion*	15.8
Planning abortion/in first trimester	42.1
Planning abortion/in second trimester	10.5
Age	
18–24	68.4
25–45	31.6
Race	
Black	57.9
White	36.8
Biracial	5.3
Yearly income	
$0–9,999	52.6
$10,000–19,999	26.3
$20,000–29,000	15.8
$30,000–49,999	5.3
Education	
<high school	10.5
High school/equivalent	52.6
Some college	15.8
≥college	21.1
Insurance	
None	10.5
Public	68.4
Private	21.1
Relationship with the man involved in the pregnancy	
Not in a relationship	26.3
Dating	63.2
Engaged	10.5
Living with the man involved in the pregnancy	
No	63.2
Yes	36.8
Religion	
None	63.2
Baptist	15.8
Catholic	10.5
Jewish	5.3
Other	5.3
Parity	
0	42.1
1	21.1
2	26.3
≥3	10.5
Previous abortion	
No	68.4
Yes	31.6
Total	100.0

*In past two weeks. *Note:* Percentages may not add to 100.0 because of rounding.

Sources of Antiabortion Attitudes

Women's reports indicated that antiabortion attitudes were pervasive within their social networks. The majority described specific members of their social networks who held antiabortion views.

The men with whom women got pregnant were one of the most common sources of negativity toward abortion as per women's reports; many participants expressed that their partners did not want them to pursue abortions. A 22-year-old pregnant participant said that when her boyfriend found out that she wanted to have an abortion, "he just keep begging me, 'Please don't do this.'" However, most partners who initially expressed disapproval were eventually convinced that abortion was the best option or, at least, an acceptable one, but this process required time and persistence. For

example, a 23-year-old pregnant participant said, "I kept pushing it to him. … So right now he's okay with [the abortion]." Participants also described negative views in partners with whom they did not discuss the abortion. A 41-year-old woman who had had an abortion explained why she had not discussed the decision with her partner: "He don't believe in [abortion]. There's no way he would've went for that."

Participants also frequently reported that family members—both ones with whom they had discussed abortion and ones with whom they had not—had antiabortion views. Most commonly, women described their mothers' disapproval of abortion. For example, a 22-year-old pregnant participant said, "I didn't tell my mom because my mom wouldn't even let me do it." Other family members were also mentioned. A 41-year-old who had had an abortion said, "As I got further along, … two of my cousins was trying to get me to keep [the pregnancy]."

Many women perceived their broader social networks to be disapproving of abortion. A 24-year-old participant anticipated that if members of her community discovered that she had had an abortion, "I would probably be tarred, feathered and run out of town with pitchforks." Several women indicated that others were "mad" at them, including a 22-year-old pregnant participant, who explained, "Everybody's mad at me." Direct exposure to "prolife" and "antiabortion" propaganda was infrequently mentioned as participants spoke about abortion views in their wider communities.

Notably, participants themselves were the most common source of disapproving attitudes toward abortion. Although participants were not asked specifically to classify themselves as prolife or prochoice, about a third of them reported being opposed to abortion. A 23-year-old pregnant woman explained, "I never really believed in [abortion]." A 24-year-old pregnant participant shared this view, stating, "I don't believe in abortions at all. … And now I have to do something that I really don't believe in." Similarly, a 38-year-old who had had an abortion reported, "I was [against abortion] myself until I ended up having to have one." Another third of participants were ambivalent about abortion. For example, a 33-year-old woman who had had an abortion said, "I've never been proabortion, you know. I've never been that kind of person. Neither am I antiabortion."

Range of Antiabortion Attitudes

Abortion was commonly framed as an immoral act and frequently depicted as "murder." An 18-year-old who had had an abortion explained how members of her social network view abortion: "They look down on it because you're killing a life." A pregnant 19-year-old described how her fiancé's mother had reacted to her decision to pursue an abortion: "She said … 'You can't kill my grandbaby. That wouldn't be right.'" She then explained her own view prior to this pregnancy: "I was so against abortion … 'cause it's wrong, it's wrong. Before I got pregnant, I thought of it as murder." Similarly, 22-year-old pregnant participant said, "Before, it was like … 'Why is she killing a kid that's innocent?'"

Participants also said that certain circumstances could make an abortion particularly objectionable. A 27-year-old pregnant woman, who was generally supportive of abortion, said that the timing of an abortion was important in determining whether it was morally acceptable:

"As long as you're not five, six months pregnant, you should be able to get [an abortion]. … Other than that, you might as well keep [the pregnancy]. The baby's grown. It has fingers and stuff like that. Don't kill it, of course. But before that, I think it's okay with me."

Some participants explained that abortion specifically violated their own or their family members' religious beliefs. A 22-year-old participant, who had terminated a pregnancy because the fetus had terminal anomalies, said that her Catholic family members had wanted her to continue the pregnancy "even knowing the health problems." She explained that because of religious beliefs, her grandmother had kept "hoping that they could help and do something, because she did not want me to have an abortion." Similarly, a 23-year-old participant who had had an abortion said, "My mom pretty much told me it's a sin. She's a Christian, and she goes to church."

Another common message was that abortion represented a rejection of motherhood; having a baby was considered the expected, natural and appropriate response to a pregnancy in participants' social circles. A 24-year-old who had had an abortion summarized her community's viewpoint in these words: "If you are pregnant, you have the baby. That's it." This description was similar to the one a 21-year-old pregnant woman gave of views in her social network: "Why don't you just accept it and be that mother that you already are?" A 22-year-old participant who had had an abortion explained that her friends, who are "all young moms," were "content having a baby so young [and] never thought about having an abortion or anything." Similarly, abortion was framed as shirking one's responsibility, as opposed to rising to the challenges of motherhood. A 23-year-old pregnant participant explained: "All my family got kids, like seven to eight. They just [think], 'If we did it, then you can do it.'"

Participants also frequently described their own positive orientation toward pregnancy and family formation, which could make the decision to obtain an abortion more difficult. An 18-year-old who had had an abortion explained why she had initially hesitated to go to her abortion appointment: "Because it was our baby, and we're just gonna go get rid of it. And what if we do decide to have kids later, and they could have had an older sister or brother." Similarly, another 18-year-old who had had an abortion explained that although she had initially "wanted to get rid of [the pregnancy] right away," her feelings had changed as her pregnancy continued: "I didn't want to get rid of it, because I was pregnant for like 14 weeks, and then it started getting a little bit exciting, so I almost changed my mind." Like most of the other participants, when asked about the pluses of pregnancy and motherhood, she listed several advantages of having children, including this: "Just

having someone there … to take care of. Just always having someone with you, you never have to be lonely." Women also shared other advantages of having children. A 24-year-old pregnant participant, for example, remarked, "Maybe [having a baby] could … push me to have a new start. You know, find work and things like that."

Misconceptions that framed abortion in a negative manner were also common. First, abortion was perceived as a rare and thus potentially deviant event. Although most participants knew of other women in their social networks who had had an abortion, almost half did not perceive abortion to be common or did not know whether it was. Three had discovered that abortion was common only as they prepared for their own abortion. An 18-year-old who had had an abortion explained, "I thought [abortion] was that kind of like, every once in a while kind of thing. But when I was looking into it, … I was pretty wowed, 'cause that's a lot of people." A 24-year-old who had had an abortion recalled having a similar realization at the abortion clinic: "Before, I didn't think it was so common, but when I was at the clinic, there were a decent number of other people. ... I just thought it would be me and maybe like one or two other people."

Second, some women voiced misperceptions about abortion's jeopardizing their future fertility. A 22-year-old pregnant participant said, "I wouldn't do it again just for the simple fact that they say it messes up a woman's insides. If I ever do decide that I want to have a baby, I probably already damaged everything in there." Similarly, a 19-year-old pregnant participant said that she thought it was unsafe to have multiple abortions and that women who do so are "not able to have kids [and have] complications with their pregnancies." A 21-year-old pregnant participant also shared these concerns, commenting, "[When] you've had so many abortions, it messes up your body."

Finally, many participants viewed women who have abortions, particularly multiple abortions, as irresponsible and selfish. One 24-year-old pregnant woman remarked: "I think it's disgusting to keep on, keep on and keep on aborting babies. I think it's disgusting. If you don't want to have children, you should make that choice." A 19-year-old pregnant participant said, "If you have multiple abortions you're cruel. … You don't care." And another participant, also 19 and pregnant, remarked, "Some people are selfish. Like my cousin. My cousin had like seven abortions."

Responses to Antiabortion Attitudes

Women responded to antiabortion attitudes in a variety of ways. One common response, especially when women themselves personally held antiabortion views, was to distinguish the circumstances of their abortions from those of other women's abortions. For example, many women indicated that they were using their "one pass," in contrast to women who had more than one abortion. A 24-year-old pregnant participant reflected this view, acknowledging that one abortion might result from "an accident or whatever." She went on to say, "This [abortion] was my 'oops.' … When you have two, three, four, I don't think that's right. I really don't." Similarly, several participants classified their own reasons for abortion as valid or acceptable, while criticizing women who use "abortion as birth control" or have abortions "because they feel like it." A 33-year-old who had had an abortion, and who reported that her pregnancy had been the result of a condom's breaking, distanced herself from women whose abortions were attributable to "just outright carelessness." She continued, "I'm not proabortion. But in my case, I tried to avoid pregnancy, and it happened anyway."

Along these lines, participants with antiabortion views explained that although they did not favor abortion, there was a valid reason they pursued one. A 24-year-old pregnant participant, for instance, said:

"I don't really agree with abortion, because I personally do feel somewhat like it's slight murder. But on the other hand, you have people who, you know, it might come in handy for. ... You have people like me. I just had a baby, and I just can't do another one right now."

Women also described keeping their abortion decision from certain individuals to avoid exposing themselves to antiabortion messages. Indeed, almost half of participants reported not telling someone in their social circle about their abortion specifically to avoid arguments, social isolation or damage to their reputation. A 24-year-old who had had an abortion said, "I don't really know how [people in my circle] feel about that issue, and I don't really want to cause any unnecessary hard feelings or something like that." In other cases, participants wanted to avoid attempts, most commonly by their partners, to dissuade or prevent them from pursuing an abortion. A 41-year-old participant explained why she did not tell her partner about her abortion: "'Cause I didn't want him to try to give me any kind of inclination that I should keep it."

Women also sometimes delayed their abortions while trying to reconcile the discrepancy between internalized negative abortion attitudes and their imminent behavior. A 23-year-old, who was 17 weeks pregnant and planning on undergoing an abortion the following week, explained why she had made and canceled multiple appointments for her procedure since learning that she was pregnant at six weeks' gestation:

Participant: "I'm still a little shaky about it. It's been just like up and down ever since I found out."

Interviewer: "What kinds of things make it up and down? What are you feeling?"

Participant: "Everybody, like my mom, is telling me not to do it. And I really don't believe in it, but I know if you're not ready, you know, then that's the only option."

A 21-year-old who was six weeks pregnant explained that her cousin had encouraged her to think more about her decision and specifically warned her of the risk of depression if she had an abortion. The participant reported, "I told her I would wait it out … probably like in another couple weeks, and then I'll call."

In grappling with the internal conflict resulting from the inconsistency between their antiabortion views and their behavior, several women described negative emotions. A 24-year-old pregnant woman, who said that she does not believe in abortion, explained, "I'm really upset at myself. … I'm mad at myself." A 38-year-old described herself as "very against abortion" and explained that she feels "sad, regret, guilt" about her recent abortion. A 41-year-old participant, who said that she had "really regretted" her first abortion many years ago, explained how she viewed her second abortion, which she had at a later gestational age: "I was further gone than I wanted. I felt like I was killing a kid this time." A 33-year-old participant shared how her religious beliefs shape her perspective of her recent abortion as shameful: "Because I have a very strong faith in God, I am ashamed. … And that's something that I have to deal with forever. That's my biggest fear and regret."

DISCUSSION

In this qualitative assessment of a sample of low-income women undergoing abortions in Western Pennsylvania, we found that women encounter a wide range of attitudes that could contribute to or reflect abortion stigma—attitudes suggesting that abortion is morally reprehensible, a rejection of motherhood, rare and thus potentially deviant, detrimental to future fertility and an irresponsible choice. Furthermore, we found that there may be multiple sources of these attitudes: women's partners, families and larger social networks, as well as women themselves. Women reacted to these negative attitudes by distinguishing themselves from others who obtain abortions, experiencing negative emotions, and concealing and delaying their abortions.

The pervasiveness of negative attitudes in our sample was unanticipated. We had expected that susceptibility to abortion stigma would be low (and that awareness of the prevalence of abortion would be high), given relatively high rates of abortion among low-income women.[30] Additionally, we had expected these women to express little judgment toward other women and the circumstances surrounding their abortions, given that low-income women report barriers to obtaining both contraceptives and abortions.[10,19,22,31] Finally, because the perception of abortion as being immoral is more common among individuals who identify with a religion and attend services regularly than among those with less religious involvement,[35] we were somewhat surprised by the degree of moral objection expressed in our relatively nonreligious sample. The presence of these attitudes in our sample is thus perhaps a testament to the saliency of abortion stigma in the United States.

One factor that may reinforce (or even accentuate) negative abortion attitudes in low-income communities is the value placed on motherhood.[36] Perceptions (or the reality) of limited upward socioeconomic mobility in marginalized populations may reduce the costs of childbearing in terms of sacrificed educational or career opportunities, and may elevate the value of motherhood.[37,38] Edin and Kefalas wrote in their seminal work on family formation in low-income communities: "Children offer a tangible source of meaning, while other avenues for gaining social esteem and personal satisfaction appear vague and tenuous."[36(p. 49)] Given that abortion stigma may emerge from the transgression of cultural constructs of womanhood, including the idea that "women are not 'real women' until they are mothers,"[39(p. e329)] the negative valuation assigned to women who choose not to become mothers may be particularly robust in low-income settings.

However, aborting a pregnancy to better take care of existing or future children in the setting of limited resources, as several participants in our study described doing, may protect women against stigma. Indeed, like 58% of participants in our study, most women who undergo abortions already have children,[30] and many cite the need to focus on their other children as the reason for pursuing abortion.[40] Further research is needed to determine how the value placed on motherhood in low-income settings contributes to or mitigates the effect of abortion stigma.

Given widespread antiabortion sentiments in social networks, women frequently described negative reactions and strained relationships, findings echoed in other qualitative studies assessing women's abortion experiences.[8,17,19] However, in several large survey-based studies, most women described partners and parents as supporting their decision to obtain abortions.[21,41] Our divergent findings could reflect higher levels of enacted stigma in our sample. Alternatively, binary measures of supportiveness used in surveys may fail to capture the complexity of responses to abortion in women's social networks; for example, a survey that categorizes a confidant as supportive or not would not capture that the confidant may be ambivalent about abortion. Indeed, we found that although most partners with whom women discussed abortion were eventually supportive, many initially expressed a desire for the woman to continue the pregnancy. Men's antiabortion attitudes, as described by the women in our study, may reflect the value placed on fatherhood in low-income settings[42] or a manifestation of male partner reproductive coercion—that is, behavior used to control female partners' reproductive outcomes[43,44]—rather than negative attitudes or abortion stigma per se. Further studies are needed to assess the causes and impact of conflict surrounding abortion among low-income women, who may rely on social support to mitigate systematic barriers to abortion.[19]

The ways in which women in our sample managed antiabortion attitudes suggest that some women experiencing stigma may be faced with scenarios in which negative outcomes are inevitable. For example, many women experienced an uncomfortable discrepancy between their antiabortion attitudes and their behavior. Some acknowledged this cognitive dissonance and described regret and self-hatred as a result. Others attempted to reduce their discomfort by rationalizing their own abortion, explaining why their choice, in contrast to others' irresponsible behavior, was acceptable. However, while vilifying other women

is potentially adaptive for the individual, it ultimately may perpetuate abortion stigma more broadly.[8,10]

Similarly, participants who confided in family members with antiabortion attitudes sometimes encountered opposition and outright anger, which could lead to strained relationships or delays in pregnancy termination. Alternatively, many women attempted to avoid conflict or judgment by keeping their abortion decision from others, a phenomenon that has been described in other studies.[4,7–10,17] Given that both concealing an abortion and experiencing conflict with confidants have been linked to psychological distress, being selective about whom to tell may be the best strategy for minimizing women's mental distress postabortion.[9,45] However, although potentially beneficial for individual women, concealing an abortion may perpetuate misperceptions at the societal level about how common abortion is and may thus contribute to a cycle of secrecy surrounding abortion.[2,4,28]

Limitations

This study has some limitations. First, our study included women who had had abortions within the last two weeks and women who were planning to have abortions; these populations may be different, although our sample size was too small to allow meaningful comparisons. Along these lines, we did not verify that women who were planning on having abortions actually had them. Further research is needed to determine whether interventions for destigmatizing abortion should be tailored to women's abortion status. Second, we did not ask women to list all sources of stigma in their community. Abortion stigma circulates in a variety of ways, including through state-sponsored abortion counseling materials containing misinformation about abortion; decontextualized fetal images used by antiabortion groups; and popular culture, including movies and television shows portraying abortions as deadly or dangerous.[16,46,47] Determining the most influential sources of abortion stigma among low-income women requires further research, which may also guide intervention strategies. Third, we did not analyze positive attitudes toward abortion; an understanding of attitudes that make abortion an acceptable option for low-income women could also be helpful when designing interventions to destigmatize abortion. Finally, our findings may be biased because we learned about women's social networks from women themselves. Interviews with other members of low-income communities would allow for a more comprehensive assessment of the social milieu in which women obtain abortions.

Conclusion

Despite the limitations of our work and the need for further research, our study points to several potential targets for improving abortion experiences and outcomes among low-income women. One pilot study showed that providing materials that normalize the difficulties surrounding abortion decision making, framing women having abortions in a positive light and addressing the true prevalence and risks of abortion are beneficial to women;[48] a similar intervention may also be helpful in our population, given widespread negative attitudes, stereotypes about women having abortions and misinformation about abortion. Additionally, providing resources or support for women undergoing abortion who are unable to identify anyone in their social network who they anticipate will be supportive could decrease feelings of isolation. Further research is needed to determine what helps diverse populations of low-income women feel best supported. Our study also supports the notion that interventions may need to address community-level attitudes and beliefs. Specifically, reinforcing the potential role of abortion in helping men and women better parent existing or future children may allow abortion to be seen as promoting, rather than negating, community values in populations such as ours with strong positive orientations toward parenthood. However, these interventions should be mindful of not further stigmatizing women who do not have or plan to have children.

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