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Analyzing the impacts of abortion clinic structures and processes: a qualitative analysis of women's negative experience of abortion clinics

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Abstract

Background: In the United States, the social myth that abortion clinics are unsafe, lonely places is pervasive. Little research has investigated the extent to which women's negative experiences of clinic interactions and processes confirm or contest this myth.
Study Design: Semistructured interviews with 41 women who received an abortion at a clinic were conducted and analyzed using qualitative analytical techniques in Atlas 5.0.
Results: The processes and structures of the abortion clinic necessitated by the realities of antiabortion hostilities lead some women to react negatively to the clinic experience in ways consistent with the social myth of the abortion clinic. Staff interactions can mitigate or alleviate these experiences.
Conclusions: Clinic workers and administrators should be aware that safety structures and processes may create negative experiences for some women. Policymakers should be aware of the extent to which public policies and conflict over abortion render the social myth of the clinic a reality.

Keywords: Abortion; Abortion clinic; Abortion myths; Qualitative research

1. Introduction

In the American context, abortion is provided predominately in freestanding clinics: over 70% of abortions occur in facilities where more than half of the care provided is abortion-related [1]. The emergence of the freestanding abortion clinic is a historical phenomenon, influenced by social factors, including the work of advocates and opponents [2–4]. In parallel, the abortion clinic has become a popular narrative frame in the political debate over abortion rights. Depictions of clinics in popular culture, such as in the movie *Juno* [5], cast them as lonely, depressing places devoid of compassion or human contact. Other films, such as *If These Walls Could Talk* [6], and ongoing media coverage of violent protests outside abortion clinics reinforce the idea that clinics are volatile and scary places. Other common characterizations of the abortion clinic are more extreme, labeling the clinic a "mill" or "factory" [7] and thereby asserting that clinics are highly efficient enterprises with a capitalist motivation and no concern for the women themselves. For example, a new documentary, *Blood Money* [8], professes to expose the profit Planned Parenthood makes from abortion. Collectively, these narratives of the clinical space are emotionally intense and invite identification by the general public, especially those who have not had an abortion at a clinic but believe they understand the experience.

These characterizations do not generally match the reality of the abortion clinic. Prior research documents that, overall, women are highly satisfied with the abortion care they receive in clinics [9–12]. But negative characterizations of the clinic nonetheless occupy a central place in public narratives about what abortion is. Just as narratives of illegal abortion in the 1960s introduced the rhetoric of a "back alley abortion" with its attendant connotations of victimization [13], tales of the abortion clinic in contemporary narratives of abortion can be understood as representing a social myth of abortion. While these myths may be dismissed as false or

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only partially true by those with real knowledge of an abortion clinic, they carry great weight as public narratives and thus impact public perceptions of abortion, the women who receive them and the people who provide them, as well as voter behavior and policy-making. Indeed, the impact of social myths can be very real. Abortion rights opponents have capitalized on the characterization of the clinic as interested in profit rather than women's needs in order to pass legislation that, in practice, reduces access to abortion.

Since a mythic construct of the abortion clinic as an impersonal and volatile place exists in contemporary society and can be argued to impact people's larger impressions of abortion, it is important to understand to what extent it is also a lived experience. Although likely imprecise or incomplete, social myths are often at least partially true [13]. They represent some aspects of lived experience, albeit ones that may be exaggerated or mischaracterized. The persistence of myths about the abortion clinic suggests that some experiences are confirming the myths or, at the least, failing to contest them. To date, however, research has not explored the relationship of social myths to lived experience in the abortion clinic. Our research aims to qualitatively describe some of the ways lived experience may reinforce or counter the social myths about abortion clinics using interview data from women who have had an abortion at a freestanding clinic. Through their stories, we can identify effects existing clinical spaces have on some women's experience of abortion, potentially identifying opportunities for improvements in clinical service delivery and suggesting means to contest pervasive social myths about abortion clinics.

2. Methods and materials

This analysis draws on interview data collected for two separate studies, both of which asked respondents about their negative abortion experiences. Although the two data sets drew on different interview guides, both interviewed a sample of women who were over 18 years old and had an abortion. For both studies, interviews were designed to elicit stories from women about aspects of their abortion that were difficult. The similarity of narratives about the clinic experience across both sets of interviews suggests that the differing recruitment procedures detailed below did not affect the quality of the data; the multiple recruitment processes instead speak to the generalizability of these data. Both studies were approved by the University of California, San Francisco, Institutional Review Board.

2.1. Study A

As part of a study of women's experience of abortion in the US heartland, semistructured interviews with women over 18 years old who had recently received or were planning an abortion at three abortion clinics located in the Midwest and south were conducted in 2006 and 2007. Facilities were defined as an abortion clinic if over 50% of their patient visits were for abortions. Thirty-two potential participants were informed of the study through the clinic or their doctor and referred to the researchers. Efforts were made to sample participants from diverse age and race/ethnicity groups. In-person interviews were scheduled for those women who agreed to participate in the study.

Interviews were semistructured to allow respondents to contribute what they found important. Interviewers followed-up with probing questions when appropriate to clarify or make explicit respondents' narratives. Interviews included questions about respondents' experience locating an abortion clinic and having the abortion and lasted between 45 and 60 min. All interviews were recorded and transcribed. No identifying information was collected.

2.2. Study B

As part of a study on women's emotional experiences around abortion, women over 18 years old who had received an abortion were interviewed in 2009. Respondents were located two ways: through referral from an abortion support talkline or from solicitation of participants in a separate research study of women's experience of abortion care at the authors' institution. We assumed that women calling a talkline were exhibiting help-seeking behavior that may have been caused by a negative clinical experience and could therefore speak to the question of how the clinical experience may confirm the mythic construct of the abortion clinic. Confirming our expectation that callers would be exhibiting emotional difficulty, talkline counselors judged nine callers too distraught to refer to the study. Review of these cases by study staff confirmed these judgments. The talklines do not publish demographic or other information on their callers. Thirty-one women who called a talkline were referred to the study. The help-seeking patterns of the participants solicited through the other research study were unknown; 12 women from that study were contacted. Interested potential respondents called a designated number to make an appointment for a phone interview.

As with Study A, interviews were open-ended and semistructured, allowing respondents to offer narratives of what they found salient in their experiences. Prompting questions included discussion of the respondent's emotional experience of abortion both before and after the procedure. Of relevance to this analysis, respondents were asked to describe their experience of the clinic and what they wished had been different about their abortion experience. Probing questions were asked as necessary. Interviews lasted between 30 and 150 min, averaging around 75 min, and were recorded and transcribed. No identifying information was collected.

2.3. Analysis

Drawing on both studies, we have data from 41 women (see Table 1 for demographic data). In Study A, 20 women were interviewed (response rate of 63%). These 20

Table 1
Demographic data on respondents, sorted alphabetically by pseudonym

Pseudonym	Age[a]	Race/ethnicity	Highest educational attainment	Region	Gestational age in weeks[b]
Aisha	21	American Indian	High school	South	12–16
Alicia	27	African American	College	Midwest	<12
Allison	29	White	College	Midwest	<12
Amanda	25	White	Some college	South	<12
Angela	20	African American	Some college	South	<12
Beth	39	White	Some college	South	<12
Brandy	21	African American	Some college	West Coast	<12
Cassie	25	White	College	South	<12
Cheryl	43	White	G.E.D.	South	12–16
Christina	29	Hispanic	Some college	West Coast	20+
Cynthia	36	White	Graduate school	West Coast	<12
Deb	41	White	Graduate school	South	20+
Elena	32	Hispanic	Some college	West Coast	20+
Emily	36	White	College	West Coast	20+
Erica	21	Pacific Islander	Some college	West Coast	20+
Jackie	Unknown	African American	Some college	South	<12
Jennifer	27	White	College	South	<12
Jessie	18	Mixed	High school	South	12–16
Jordan	25	African American	High school	South	<12
Joy	28	American Indian	Some graduate school	South	<12
Julie	40	White	Some graduate school	Midwest	<12
Katia	25	Mixed	Graduate school	West Coast	<12
Kelly	43	African American	College	East Coast	<12
Lana	28	Asian	College	East Coast	<12
Laura	37	White	Graduate school	East Coast	<12
Lauren	24	African American	High school	West Coast	20+
Lisa	23	White	Some college	South	<12
Lucia	30	Hispanic	Some college	West Coast	20+
Lyndsay	18	White	High school	South	<12
Makayla	27	African American	Some grad	South	<12
Maricel	24	Hispanic	Some high school	South	20+
Melinda	29	White	College	West Coast	<12
Mia	23	Asian	Some college	West Coast	20+
Michelle	39	White	College	West Coast	12–16
Nicole	38	White	Graduate school	Midwest	<12
Sonja	25	African American	College	South	<12
Susan	47	White	College	West Coast	20+
Tamara	35	White	College	West Coast	12–16
Tanya	25	African American	College	South	12–16
Tricia	19	White	Some college	South	<12
Vanessa	23	African American	College	South	<12

[a] Age at time of interview.
[b] Gestational age for most recent abortion.

respondents were interviewed within a week of their abortion. In Study B, of the women referred by talklines, we interviewed 14 (response rate of 45%). Of the 12 women contacted from the separate research study, 7 were interviewed (response rate of 58%). Eight respondents in Study B were within 3 months of their most recent abortion, 10 were interviewed 6 months to 2 years following their most recent abortion, and more than 2 years had passed since the abortion of the remaining 3 respondents.

The physical setting of the clinics varied across the sample. Some respondents received their abortion in an urban setting, some in a rural area; some in buildings that were freestanding and some in facilities nestled among office buildings; some at facilities that exclusively provided abortions and some at facilities that offered a variety of reproductive health services. Some respondents received 2-day surgical procedures due to later gestational age; most with earlier gestational ages opted for an aspiration abortion, and a few chose a medication abortion (see Table 1 for gestational ages).

Transcripts of interviews from both studies were analyzed qualitatively using Atlas.ti 5.0 for discussion of the clinic experience [14]. Relevant passages were further analyzed for themes that recurred across the combined interview sample. All names used in the following sections are pseudonyms.

Despite their varied backgrounds, respondents in both studies nonetheless converged in their narratives on several ways in which the experience of abortion is made more difficult by clinics and doctors, as well as some fairly simple ways clinics improved respondents' overall experience. The

consistent themes across interviews, especially in light of the diversity in respondents' region, age and race, suggest that these data speak broadly to women's experience of abortion in clinics. To the extent that these lived experiences mirror or fail to challenge the mythic construct of the abortion clinic, that social myth will be preserved. In the following discussion, we first report interview data on negative aspects of the clinic experience and then turn to discussions of positive aspects of the clinic experience. As with all interview data, there is the possibility that the order of the questions may have influenced subsequent responses participants gave.

3. Results

The interview data from both studies provide insights into how women experience the abortion clinic — including interactions with protesters and clinical staff, the physical design and the processes for care — in ways that serve to affirm and/or contest the social myth of the abortion clinic. Women experienced some features of the clinic experience as negative, even in cases where the features were designed to ensure their safety, and some aspects, specifically nonjudgmental staff, as positive.

3.1. Women's experience of antiabortion protesters

The atmosphere outside the clinic featured frequently in women's narratives of their abortion experience. Consistent with prior research on the negative effect of protesters [15,16], eight respondents described the presence of protesters at the clinic as negative or even traumatic, and four other respondents reported favorably that there were no protesters when they arrived at the clinic. For Allison, "the most disturbing part of the whole experience was the protestors." She experienced encountering the protesters as "very intimidating" and expressed a fear of violence based on those confrontations. Maricel explained that she was "kind of scared because, first of all, when I came in from that drive-through [driveway], there was people screaming not to have an abortion and I was kind of scared." To avoid an experience with protesters, Katia traveled far from home to ensure that she would not have to attend a clinic picketed by protesters. Respondents anticipated the presence of protesters, largely because of clinic depictions in local media coverage and popular culture, and/or personal knowledge of friends and family who regularly participate in clinic protests. Even with that anticipation, these interactions with protesters increased women's feelings of stigma, secrecy and shame, confirming aspects of the social myth of abortion.

At least one respondent was under the impression that the clinic itself permitted abortion rights opponents to stand outside. Vanessa said, "you would think they would have a say-so about whether they would allow [protesters] on their property or not." Vanessa was confused about whether the clinic itself was supportive of abortion generally and of her decision to have an abortion specifically, and understood the protester presence to be evidence that clinic workers did not care about protecting patients like her. The characterization of abortion providers as unfeeling and uncaring is part of the mythic construct of abortion. For respondents like Vanessa, the clinic experience did not dispel public myths about the abortion clinic.

3.2. Women's experience of safety procedures

Respondents also reported that the elaborate security measures in place at many abortion clinics served to increase their feelings of stigma, secrecy and isolation, consistent with the mythic construct of the clinic. As noted above, many clinics are structured and run in response to a hostile environment, implementing extensive safety measures to protect both staff and clients. Ironically, some of these very safety procedures served to make the experience more upsetting to respondents. For instance, Julie explained that the process of being buzzed into the clinic made the entire experience seem illicit and shameful: "I know they're trying to protect your rights and to keep everybody safe but it just made it even seem all the more like a secretive, shameful thing." She elaborated that although she supported the provision of abortion, the clinic experience was negative for her: "I felt like a number. You know, they just use your first name and last initial for privacy. I just felt like there was so much shame around it."

Maricel was troubled by having to pass through a metal detector when she entered the clinic. She did not know why they were there, but explained that the presence of metal detectors made her feel scared and "like someone's going to come in and rob you."

Joy said of her experience at a clinic that requested payment only in cash and buzzed her in through a secure door that "it felt like a drug deal." Unlike Maricel, Joy had a theory about why the cash-only policy came about, even as she identified the problematic consequences of these kinds of policies:

> I think they've had probably threats from antiabortionists or whatever but there's that feeling of like, okay, you know, get out of the car, cover your head, does anyone see you, go straight into the door. I mean, it's just this whole secretive kind of, just again, an experience like you're really doing something wrong.

According to these respondents' accounts, some actions by the clinics served to increase women's experience of abortion as stigmatizing rather than help them feel safe.

Another security procedure clinics have implemented is the separation of the patient from any companions, including her partner and/or parents. For several respondents, being separated from her companions made the abortion more difficult. Two women who had an abortion decades prior to their interviews, when they were teenagers, expressed a desire to have had a parent present, describing the solo

experience as lonely and scary. Another respondent wished her husband could have accompanied her for support. She explained that she wanted him present because "it just feels like such a burden to have [an abortion], [to] go through it, and then to have him physically not be there holding my hand. I just think that would've been very significantly better, I mean, a lot better to have him [present]."

The separation caused respondents' loved ones difficulty as well. Cheryl described her sister being "horrified for me the whole time that I was out of her sight because she didn't know what they was gonna do."

3.3. Women's interactions with providers and clinic staff

Broadly speaking, it is beyond the scope of the clinic to easily and swiftly eliminate the physical and emotional obstacles women articulated in the previous sections, especially given legal protections for protest. Nonetheless, there were some bright spots in respondents' experiences — specifically in their interactions with staff — that mitigated some of the emotional difficulties respondents experienced following run-ins with protesters or because of procedures required to protect patient and provider safety. In particular, the compassionate behavior by staff and providers reduced some respondents' feelings of isolation and loneliness, challenging some of the social myth of the abortion clinic.

Respondents noted that their experience was made more positive by nonjudgmental staff who conveyed genuine concern (mentioned by 14 respondents). For example, Erica identified staff behavior and support as nonjudgmental and as helping her move past her feelings of shame:

> I believe they sensed that sense of embarrassment and just shamefulness that I had within me. And, you know, they actually shared their experiences or their personal opinions to uplift me. And I felt comfortable. It sounds kind of corny, but I felt like they were friends... [They helped me realize] it's not as bad as I thought and I don't feel bad for doing this and I'm not the only one doing this.

Lyndsay expressed surprise that the nurses were so kind and nonjudgmental, treating her as they would anyone else; she fully expected them to express disapproval about her circumstances. Another woman, who had not told her family about her plan to terminate her pregnancy for fear of their judgment, explained that the friendliness of one nurse made up for the absence of her family. She said:

> She kind of reminded me of like a family member just because she was nice... It was kind of cool to have [her] there because I couldn't tell my actual family so it was nice to have somebody who was kind of supportive that kind of reminded me of them that way.

Six respondents spoke positively of the presence of a patient advocate, counselor or nurse who held their hand, explained to them exactly what was going to happen or was simply present, suggesting that having a designated advocate was extremely beneficial for some women.

Simple actions by clinic staff understood to signal concern for the patients were enough to shift negative feelings of loneliness into more positive feelings. One woman remembers being left alone after the procedure and feeling extremely lonely, until:

> [A]fter a very long time somebody brought me a little glass of Tang... I was so grateful to get it 'cause it felt like... finally someone has come back into the room and given me something... it was the first, you know, kindness might be too strong of a word, but someone was giving me something and I was so grateful to receive that, even if it was like just a tiny Dixie cup of Tang, you know?... There was just this big, empty "okay, now what?" afterwards. And I was really, really happy to get that little glass of Tang.

In respondents' narratives, too, there were stories of missed opportunities wherein a small gesture by a provider or staff member could have dramatically improved the experience. When asked what they would change or do differently about their abortion, a number of women articulated a desire that the clinic experience itself could have been more compassionate. Respondents identified the behavior of clinic staff and the formality of clinic procedures (noted above) as exacerbating the feelings of isolation and stigma they felt. Specifically, women noted that sometimes staff was impersonal (four cases), did not explain delays (two cases), made them feel rushed (three cases) or left the women alone such that they felt very lonely (three cases). Three women reported that they received no emotional support from clinic staff.

Tamara, for example, described feeling as though she was inconveniencing the doctor who provided her abortion when she was 20 years old. She found the doctor gruff and was unsure how to react to the comment that "at least you're not fat." She has gained a substantial amount of weight in the 15 years since and now finds herself returning to that comment and feeling embarrassed whenever she goes to the gynecologist. Lisa, too, had a negative experience with the doctor who provided her abortion. As the medicine to sedate her was beginning to have an effect, the doctor told her she did not want to have to be back there having an abortion ever again, suggesting that she should feel bad about being in a situation where she needed an abortion. Lisa experienced the doctor's comment as condescending and offensive.

These stories from respondents, however, must be considered in the context of scholars' findings on clinic staff's own emotional labor. Studies have found that clinic workers develop strategies to balance their sense of self with the needs of the job, often detaching or distancing themselves from clients they perceive as difficult or ambivalent [17]. In other words, staff's failure to emotionally support a patient may have complex underpinnings that preserve staff members' ability to do their jobs, even as it may have a negative effect on an individual patient.

4. Discussion

Consideration of the public narrative of the abortion clinic as an unsafe, lonely place helps provide a framework for deeper understanding of how clinical care is experienced by women obtaining abortions at specialty abortion clinics. Our data suggest that women's experience of clinical processes and interactions may serve to confirm the mythic construct of the abortion clinic as unsafe, lonely and impersonal and perpetuate the social myth. The "abortion clinic" is more than simply a location where women obtain their abortions; it is a place that contributes to social myths about abortion and the larger (negative) social meaning of abortion.

Our findings further suggest that the mythic construct may be a self-fulfilling prophecy. While abortion rights opponents often mobilize the argument that abortion is harmful to women's mental health as a justification for restricting access to abortion care [18], our findings suggest that clinic processes necessitated by the realities of antiabortion hostilities — e.g., violence, economics, specialty licensure and punitive state laws — lead some women to react negatively to the very place where they must obtain their care. Security measures designed to protect confidentiality such as first-name-only identification when inside the facility may further contribute to the isolation some women already experience in the abortion context. These experiences may be exacerbated by measures designed to keep clinic workers safe, i.e., metal detectors, bullet-proof glass pass-throughs and the physical separation of clients from their companions. Our data suggest that the negative emotional experiences abortion rights opponents ascribe to abortion may instead largely be the product of procedures necessitated by opponents' actions. However, without clarification by clinic personnel, women may inaccurately understand aspects of their experience as confirming the mythic construct of the clinic.

To that end, our findings show that staff interactions can mitigate or alleviate respondents' negative experiences. Small but meaningful interactions and gestures were positively received by women in our studies. However, just as positive interactions can be helpful to women, small, negative interactions can also have large effects. Our data suggest that abortion protesters may contribute to women's negative experiences with abortion care. Our findings build on prior research on the harms of protesters by illuminating how some women experience the abortion clinic as complicit in their negative experience, as in the case of the respondent who thought the clinic permitted the presence of hostile protesters.

Research on the relationship between other mythic constructs and lived experience, particularly in the realm of medicine, may yield similar useful findings.

We note that our data do not reflect the stories of women who experienced the clinic as a safe space and do not offer suggestions of how to reframe patients' experiences in ways that clarify, for example, the purpose of security measures. Future research should evaluate reframing strategies.

5. Conclusion

The social myth of the abortion clinic as a dangerous, impersonal place is pervasive. Yet despite this myth's persistence, the care provided by abortion clinics continually results in high overall patient satisfaction. Clinic workers and administrators should be aware that not all women who obtain abortions in these facilities understand the reasons behind clinical procedures and processes. Their lack of awareness may cause them to understand their experience as confirming the mythic construct of the abortion clinic as an unsafe, lonely place or, at the least, see their experience as an exception that does not broadly challenge the mythic construct. Our work also suggests that small positive interactions with staff can help mitigate these effects.

Additionally, it is worth emphasizing that clinics alone are not responsible for the existence, perpetuation or mitigation of the mythic construct of the abortion clinic. As noted at the outset, popular media like mainstream movies and documentaries, among other sources, have facilitated the persistence of this mythic construct.

The perpetuation of the social myth of the abortion clinic as a bad place has consequences for voter behavior, policymaking and public reaction to women who have abortions. Policymakers should be aware of the extent to which public policies and conflict over abortion are implicated in some women's negative experience with abortion, making the social myth a reality.

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