# Isolating Abortion Stigma from Women Who Have Had Abortions:

## A Look at Undergraduate Students at a Christian University

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A Senior Thesis submitted in partial fulfillment
of the requirements for graduation
in the Honors Program
Liberty University
Spring 2021

Acceptance of Senior Honors Thesis

This Senior Honors Thesis is accepted in partial
fulfillment of the requirements for graduation from the
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**Abstract**

Abortion has been subject to stigma due to violating cultural ideals of womanhood, sexism, attribution of personhood to the fetus, legal restrictions, perception as a dirty procedure, the pro-life community, being underreported, and religious beliefs. In order to cope with stigma-induced distress, individuals often resort to secrecy. Stigmatized women concealing their abortion may suppress thoughts about the abortion, leading them to suffer from obsessive and intrusive thoughts that repeatedly reappear simply because they are unwanted. Because of this harmful cycle, it is imperative that individuals understand the distinction between stigma towards abortion and post-abortive women. The current study examines the ability of undergraduate students to separate abortion stigma from the stigma of women who have had an abortion.

# Isolating Abortion Stigma from Women Who Have Had Abortions: A Look at Undergraduate Students at a Christian University

## Introduction

Since the passing of Roe v. Wade and its legalization in 1973, abortion has become a common procedure in women's healthcare. According to the Guttmacher Institute, 862,320 abortions occurred in the United States in 2017 (Jones et al., 2019). In 2016, eighty-six percent of abortions were performed on unmarried women (Jatlaoui et al., 2019). Among married and unmarried women, the percentage of pregnancies that ended in abortion were four percent and thirty-eight percent, respectively (Jatlaoui et al., 2019). The age group with the highest abortion rates was women in their twenties (Jones et al., 2019; Jatlaoui et al., 2019). This is likely due to the greater level of freedom (including sexual freedom) in college-aged young adults, as well as a future-focused mindset towards careers.

Abortion rates also vary with the number of previous live births. Forty-one percent of abortions were experienced by women who had never had a child, forty-five percent of abortions were experienced by women who had one or two children, and fourteen percent of abortions were experienced by women who had three or more children (Jatlaoui et al., 2019). Thus, the majority of women who have abortions have two or fewer (or no) children. Overall, black women were most likely to have an abortion, making up thirty-eight percent of all abortions in 2016 (Jatlaoui et al., 2019). In contrast, white women comprised thirty-five percent of abortions, and Hispanic women accounted for nineteen percent of abortions (Jatlaoui et al., 2019). The remaining eight percent of abortions were sought by women of an unspecified race (Jatlaoui et al., 2019). Among white women, 109 abortions were performed per one thousand live births; 401 abortions were performed per one thousand live births of black women (Jatlaoui et al., 2019). In regard to gestation, the majority of

abortions (91.0%) took place within the first trimester, which is defined as the first twelve weeks of pregnancy (Jatlaoui et al., 2019). Second trimester abortions, in the thirteenth through twentieth weeks of pregnancy, made up 7.7% of abortions, while third trimester abortions, after twenty-one weeks, were 1.2% of all abortions (Jatlaoui et al., 2019).

Women of various religious backgrounds also have differing tendencies to abort. Seventeen percent of abortions in 2014 were experienced by Protestants, while Evangelical Protestants made up thirteen percent of abortions of that same year (Jerman et al., 2016). Women of Catholic religious affiliation had twenty-four percent of the abortions in that year; eight percent of abortions were performed on women of an unspecified religious background (Jerman et al., 2016). Finally, women of no religion had the highest percentage of abortions: thirty-eight percent (Jerman et al., 2016). It is interesting to note, however, that Catholic women had the second highest number of abortions in 2014 despite the Catholic Church's disapproval of abortion.

The Agency for Health Care Administration in Florida (FAHCA) reports the reason for each abortion within the state every year. In 2020, over seventy-five percent of abortions were considered elective (FAHCA, 2021). Examples that could be included in such elective cases are young mothers, single mothers, unstable relationships, education or career interference, being finished having children, and inability to afford having another child (Finer et al., 2005). Other circumstances surrounding abortion are less common. Twenty percent of abortions were performed for social or economic reasons in 2020 (FAHCA, 2021). Abortions that were sought for emotional and/or psychological reasons made up 1.87% of the total abortions for that year (FAHCA, 2021). Physical health of the mother, not considered life-threatening, was 1.50% of abortions in 2020 (FAHCA, 2021). Women whose lives were in danger consisted of 0.20% of abortions; fetal genetic defect,

deformation, or abnormality were considered 0.95% of abortions (FAHCA, 2021). Abortion because of rape and incest were performed in just 0.01% and 0.15% of cases, respectively (FAHCA, 2021).

**Stigma**

In order to fully understand abortion stigma, one must first consider the concept of stigma as a whole. Stigma was first defined by Goffman (1963) as an "attribute that is deeply discrediting" and diminishes the stigmatized individual "from a whole and usual person, to a tainted, discounted one" (p. 3). This transformation occurs because of stigma's consequences. Stigmatization of many groups has been found to result in identifying and labeling differences, associating that label with a negative connotation, creating an us versus them mentality, and allowing discrimination to follow (Link & Phelan, 2006). Connection with a stigmatized group is often avoided by other people, often through a form of discrimination, as stigma is considered contagious (Das, 2001). The literature indicates that stigma of any type can affect an individual's relationship with family and friends, as well as significant others (Shellenberg & Tsui, 2012). This leads to an increased feeling of isolation, as both societal and close relationships have been compromised. Mental health and well-being can also be influenced by stigma, resulting in increased anxiety, physiological distress, avoidance, depression, and social withdrawal (Shellenberg & Tsui, 2012).

Although the experience of stigma is unique to each woman, researchers have determined the existence of three general forms of stigma: internalized stigma, enacted stigma, and felt stigma (Herek, 2009). Internalized stigma occurs when a woman begins to accept and believe the negative attitudes of people around her, which can be harmful to her mental health (Herek, 2009; Shellenberg & Tsui, 2012). A woman's experience with clear or subtle prejudiced actions is known as enacted stigma (Herek, 2009). Finally, felt stigma, also known as perceived stigma, encompasses a woman's perception of other people's negative attitudes towards her (Herek, 2009; Hanschmidt et al., 2016).

Enacted stigma is easily defined, as it can be observed clearly; however, the occurrence of internalized stigma and felt stigma is much harder to determine, as only an individual herself can determine whether or not they have been experienced. Additionally, because internalized and felt stigma are internal forms of stigma, their incidences may not occur with the same frequency of visible enacted stigma.

**Stigma and Secrecy**

Interestingly, stigma also induces an individual's behaviors and decisions regarding disclosure (Shellenberg & Tsui, 2012). Coping with the three forms of stigma is often accomplished through secrecy. Authors state that individuals keep secrets regarding significant life events, such as abortion, in an attempt to combat the fear of social disapproval (Lane & Wegner, 1995; Pennebaker, 1993; Wegner & Erber, 1993). When women anticipate stigma due to their decision to abort, they often resort to secrecy to control the level of stigma they face (Astbury-Ward et al., 2012; Shellenberg, 2010). This concealment appears to have immediate desirable effects. Disapproval and conflict, often due to stigma, can be avoided; consequently, social relationships and support can be maintained (Major & Gramzow, 1999). One study conducted by Major et al. (1990) found that women experience less distress when keeping their abortion a secret, compared to confiding in someone who is perceived as not completely supportive.

Despite the immediate benefits of concealment, secrecy regarding an abortion is correlated with delayed adverse psychological effects (Astbury-Ward et al., 2012). Disclosure is a natural technique to cope with stressful life events, and many people experience an innate need to talk to others about such stressful life events (Tait & Silver, 1989; Major & Gramzow, 1999). Therefore, there is a negative reaction to resisting disclosure. Decreased physical health and well-being are correlated with failing to disclose emotional life events (Pennebaker, 1989, 1997). Additionally,

concealed stigma is associated with lessened physical health (Cole et al., 1996). Conversely, when these individuals eventually choose to talk about their significant life events, they develop increased physical and psychological health (Major & Gramzow, 1999).

Secret-keeping has been shown to stimulate obsession about the secret, which can lead to a cycle of psychological distress (Lane & Wegner, 1995). As previously stated, women attempt to ease stigma-related distress by keeping their abortion a secret, which is often accomplished through the suppression of thoughts about the abortion (Major & Gramzow, 1999). Unfortunately, thought suppression leads to even more intrusive thoughts, as unwanted thoughts reappear in one's consciousness simply because they are unwanted (Wegner 1989, 1994; Wegner & Erber, 1992; Wegner et al., 1993). These reoccurring thoughts further the cycle of negative psychological health, as they increase abortion-related distress (Major & Gramzow, 1999). A woman's ability to fully understand and process her abortion can also be influenced by secrecy (Pennebaker, 1989, 1997). Due to this relationship, the abortion and related distress may resurface in dreams and ruminating thoughts (Major & Gramzow, 1999). With its instigation of cyclical secrecy through inhibited disclosure, physical and psychological distress, thought suppression, intrusive thoughts, and further distress, abortion stigma can be considered to cause an unofficial form of posttraumatic stress disorder (Major & Gramzow, 1999).

The psychological price of an abortion on a woman is the topic of much research and debate. Some findings suggest that there are no negative consequences for the majority of post-abortive women (Adler et al., 1990, 1992; Lodi et al., 1985; Major & Cozzarelli, 1992). However, other researchers find that the secrecy necessary for most women to avoid stigma has a negative effect on her (Cockrill & Nack, 2013); however, it should be noted that other factors can influence such negative effects. A study conducted by Kimport et al. (2011) found that women experienced more

negative feelings after their abortions when they felt the decision was primarily made by their partners or parents, rather than themselves. In addition, if women did not feel supported in their decision, they were more likely to experience negative psychological outcomes (APA, 2008). It has been confidently demonstrated that a minority of women do experience adverse consequences, such as the consequences aforementioned, because of abortion (Lodi et al., 1985; Zolese & Blacker, 1992).

**Stigma Related to Abortion**

All three types of stigma (internalized, enacted, and felt) described above can occur in relation to abortion, collectively referred to as abortion stigma. Kumar et al. (2009) describe abortion stigma as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to the ideals of womanhood" (p. 628). An example of internalized stigma related to abortion is a woman that has begun to believe the opinions of society about post-abortive women – that she is a terrible person and undeserving of love because she had an abortion. A woman experiences enacted stigma when she faces the hateful actions or speech of others due to her abortion. Her perception of disapproval from others regarding her abortion would be considered felt stigma. Abortion stigma can be experienced by various individuals included in the process: the woman, her friends and family, abortion providers, and pro-choice supporters (Cockrill & Nack, 2013; Goffman, 1963). However, abortion stigma faced by the woman who has had an abortion is the interest of the current study.

The idea of womanhood can often be heavily influenced by culture; therefore, many theories exist to explain why abortion and women who have abortions are stigmatized. Perhaps the theory that should be examined first is how abortion relates to the idea of womanhood in a culture. In western culture, fundamental ideas of womanhood are violated when a woman gets an abortion: sexual purity, motherhood, and nurturing the vulnerable (Kumar et al., 2009; Norris et al., 2011). It has long been

regarded that women should have sex only for the purpose of procreation; because of this idea, female sexuality is considered to be promiscuous, despite being permitted for males (Norris et al., 2011). Abortion removes procreation from female sexuality, complicating the concept of womanhood. Motherhood, considered a key characteristic of womanhood (Holton et al., 2009), is thought to bring completion to a woman's life (Chrisler et al., 2014). However, motherhood is abandoned, at least temporarily, when a woman seeks an abortion. Finally, according to society, women are supposed to care for the vulnerable, whether that be children, elderly parents, or another victimized group. The unborn child, a vulnerable being with no way to advocate for himself, is not considered in an abortion. The literature confirms that abortion-related attitudes are associated with attitudes regarding traditional gender roles (Barnartt & Harris, 1982; Cook et al., 1992; Ebaugh & Haney, 1980; Osborne & Davies, 2009, 2012). For these reasons, abortion appears to reject the ideals of womanhood that society has adopted.

Sexism, tied to the traditional gender roles of purity, motherhood, and nurturing tendencies, appears to impact attitudes towards abortion. Hostile sexism and benevolent sexism are subcategories of sexism that provide more insight into abortion stigma. It is considered by some researchers that a more general hostility towards women potentially leading to malicious actions is characterized as hostile sexism; likewise, benevolent sexism is reported to consist of subtle actions that are considered chivalrous at first glance but result from inferior views of women (Glick & Fiske, 1996). Glick and Fiske (1996) hold that hostile sexism punishes women who do not ascribe to traditional gender roles, while benevolent sexism praises women who do ascribe to traditional gender roles (Glick et al., 1997). It should be noted that traditional biblical views would hold a differing perspective regarding the intentions behind supposed benevolent sexism. Both forms of sexism are correlated with pro-life ideals, but each demonstrate a different relationship to abortion. Hostile and benevolent sexism

perspectives reject elective abortion, which is performed for social or economic reasons (Huang et al., 2014). In contrast, traumatic abortions (danger to the mother, rape, or incest) are only rejected by individuals with benevolent sexist ideologies (Huang et al., 2014). Because benevolent sexism reflects opposition towards both elective and traumatic abortions, it is considered the preferred predictor of abortion attitudes. A study conducted by Huang et al. (2016) found that benevolent sexism and abortion support were mediated by attitudes toward motherhood. In addition, the researchers found that benevolent and hostile sexism are positively correlated with the belief that motherhood is important to women, which is also negatively correlated with support for elective and traumatic abortions (Huang et al., 2016).

Another explanation for why abortion is stigmatized includes attributing personhood to the fetus (Norris et al., 2011). Due to recent advancements in science and medical technology, such as ultrasound, the fetus has gained the highest level of personhood in modern history. The line between fetus and infant has blurred, leading to the introduction of viability into the abortion debate. Instead of arguing whether a fetus is a human being, it is the topics of viability and dependency on the mother that pro-choice groups now focus on. For example, groups that have moderate views on abortion might support abortion before the fetus is viable – at around twenty weeks gestation – and reject it after that point. Because the fetus can be considered a life, and abortion is the end of that life, abortion is considered murder in the pro-life community. In the strongest pro-life groups, abortion is prohibited at any stage, including emergency contraceptives like Plan B. This stance may cause women who have had abortions to be viewed as murderers by certain groups (Norris et al., 2011). Understandably, post-abortive women experience negative feelings when addressed with this line of logic. The current study focuses on the ability of individuals to isolate their abortion stigma from

women who have undergone an abortion. If this ability is demonstrated to be possible and can be highlighted in pro-life communities, perhaps women will experience less distress.

Legal restrictions also contribute to the stigmatization of abortion. Requirements to obtain parental consent, gestational limits, waiting periods, and ultrasound viewings – seen as victories in the pro-life circle – make it more complicated for women to receive an abortion and reinforce the immorality of abortion. Unsafe abortions are also associated with legal restrictions on abortion, since those limitations might cause women to go about unconventional and dangerous means to procure an abortion. Because of the negative associations of legal restrictions, one might think that removing hinderances on abortion would prove helpful for women in terms of stigma; however, history shows that loosening restrictions on abortion have not lessened abortion stigma (Norris et al., 2011; Joffe, 1996).

Stigma towards abortion is affected by its perception as a dirty or unhealthy procedure (Norris et al., 2011). With its history consisting of back-alley abortions and self-initiated attempts, a mental framework of danger has been created. Although abortions have significantly lowered rates of mortality and morbidity recently, this framework has continued. As previously discussed, both sides of the abortion debate disagree on how harmful the procedure is to women. Physical consequences will not be discussed in the current study, since this research is focused on the psychology of abortion stigma; however, the reader should note that physical harm can further the propagation of stigma related to abortion.

Norris et al. (2011) discuss how the pro-life community has utilized stigma as a tool in the aim to reverse Roe v. Wade. They state that this community employs stigma deliberately to discourage women from seeking abortion and to decrease societal support. The pro-life movement should take note of this perception. Reducing the use of stigma, enacting empathy, and increasing the

warmth of efforts could make their attempts to help women seek an alternative for an unwanted pregnancy more effective. Avoiding stigma could also help decrease the negative psychological effects for women that choose to continue with their abortion. Women's health practitioners that align with pro-life ideology should also employ strategies to lessen stigma, so that they can provide better care to their patients and listen more effectively to their concerns without making their patient feel judged.

Abortion has a reputation of being an uncommon procedure and is often underreported. Just 35-60% of women who are surveyed actually report their abortion (Jagannathan, 2001). Kumar et al. (2009) discuss the prevalence paradox, in which the idea of abortion is considered rare despite being a common procedure. The cycle begins when women keep their abortion a secret, underreport their abortion, or misclassify their abortion as another procedure. Lack of disclosure leads society to believe that abortion is uncommon and abnormal, which furthers the idea that abortion is deviant. This idea creates a social norm against abortion, so women who have experienced abortion feel discriminated and stigmatized by society and experience stigmatization. The negative feelings that women face dissuade women from exposing their abortions, and the cycle is reinforced.

Finally, ascribing to a religion – especially Christianity – can also have a role in how much an individual stigmatizes abortion. Religiosity has been a consistent predictor of abortion attitudes (Gleeson et al., 2008; Steele, 2009). A Spanish study conducted by Alvargonzález (2017) found that non-religious affiliation in undergraduate students is associated with more favorable views of abortion, in comparison to Catholicism, which has the least favorable view of abortion; this finding is consistent with the literature (Abel-Aziz et al., 2004; Adebayo, 1990; Barret, 1980; Buga, 2002; Ebaugh & Haney, 1980; Espósito & Basow, 1995; Faria et al., 1985; Hess & Rueb, 2005; Hollis & Morris, 1992; Krishnan, 1991; Marshall et al., 1994; McIntosh et al., 1979; Szafran et al., 1988;

Walzer, 1994; Wright & Rogers, 1987). When church attendance was considered, the results of the study were amplified (Alvargonzález, 2017). Catholic individuals who attend church more regularly were less supportive of abortion than Catholics who attended church less regularly (Alvargonzález, 2017). This study only included non-religious, Catholic, and other as categories for religiosity, as Catholicism is the primary religion in Spain (Alvargonzález, 2017). When surveyed in 2014, Evangelical Protestants, of all Christian denominations, are the least supportive of abortion (Religious Landscape Study, 2014). The religiosity of the woman who experienced abortion herself may also shape her opinions about and psychological response to her decision to abort (APA, 2008), which may impact her perception of stigma from others, but this factor will not be examined in the current research in order to preserve simplicity.

In regard to the stereotype that Christians stigmatize abortion and women who have had abortions, it is not surprising that Christians tend to be pro-life, as personhood is attributed to the unborn throughout Scripture. The books of Job, Isaiah, Jeremiah, and Galatians speak about God forming the child in the womb and appointing him a future purpose. Perhaps the most well-known of these verses is Psalm 139:13-16 which reads:

> For you created my inmost being; you knit me together in my mother's womb. I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well. My frame was not hidden from you when I was made in the secret place, when I was woven together in the depths of the earth. Your eyes saw my unformed body; all the days ordained for me were written in your book before one of them came to be (*New International Version,* 2011).

Old Testament law in Exodus specifically gives value to a preborn baby's life in matters of assault and murder. The Bible also urges believers to stand up for those who do not have a voice,

which includes unborn children. Proverbs 31:8 commands, “Speak up for those who cannot speak for themselves, for the rights of all who are destitute” (*New International Version,* 2011). These biblical passages give explanation as to why the Christian Church disapproves of abortion. Because religiosity has an evident impact on an individual’s attitudes toward abortion, it will be included as a contributing factor in the current research; participants’ reported religious affiliation will be requested in the survey. Additionally, the ability of individuals, specifically Christians, to separate abortion stigma from stigma directed towards the woman who underwent the abortion is the focus of this study.

**Abortion Support**

As stated before, when a woman senses a lack of social support regarding her abortion, she tends to experience negative emotions, but the level to which society supports abortion differs according to the circumstances surrounding the abortion. Certain reasonings for abortion are considered by society to be acceptable; a deformed fetus, pregnancy despite contraception, pregnancy due to incest or rape, and a very young mother are considered good reasons for abortion (Norris et al., 2011). Socially unacceptable reasons for abortion include having previous abortions, an unexpected pregnancy arising without contraception use, and older mothers (Furedi, 2001). These unaccepted cases are referred to as elective abortions, while the accepted cases are coined traumatic abortions. Following this line of logic, the abortion support of the general public lies with circumstances in which contraceptive efforts have been made or the mother and/or child are victims of trauma. Overall, the profile of individuals that are most supportive of abortion include people who are “less religious, non-Catholic, older, and more knowledgeable [about abortion]” (Esposito & Basow, 1995, p. 2009).

The societal trends of abortion support tend to coincide with the abortion support of undergraduate students. What was previously defined as traumatic abortions are viewed as more acceptable by students (Carlton et al., 2000; Hill, 2004), and the majority of students do not support abortion for any situation (Carlton et al., 2000). Rather, it has been shown that most students are conditionally accepting of abortion (Bailey, 1993). Abortion as a method of birth control and abortions that take place beyond the first trimester are least supported by students (Carlton et al., 2000). To a lesser extent, students disagreed with abortion when the mother already had children or was having relationship troubles with the father (Carlton et al., 2000; Hill, 2004). Because they are the population of interest in the current study, it is helpful to further examine the level to which they support abortion. The same study conducted by Alvargonzález (2017) that determined the influence of students' religion on abortion support also examined the abortion attitudes and abortion-related knowledge of undergraduates. It was found that students with the most support for abortion were history, philosophy, and physics majors. Intermediate levels of support were correlated with law, engineering, and biology students. Students of medicine, psychology, and nursing seemed to have the lowest levels of abortion support. Interestingly, the knowledge these students encompassed about abortion suggests a role in their attitudes toward the procedure. The medicine, nursing, and law undergraduates reported more knowledge about abortion, while less knowledge was reported by students of physics, engineering, and philosophy. Therefore, the students with more knowledge about abortion (particularly medicine and nursing students) displayed lower abortion support compared to the other groups of students. This finding contrasts the previously mentioned results of Esposito & Basow (1995), which indicates a transition of abortion attitudes in recent years. Knowledge of abortion is also known to influence abortion stigma, but its exact role is complicated by the student's

perception of information, past experiences, and options (Esposito & Basow, 1995); thus, it is beyond the scope of this review.

## Current Study

As the literature was examined, the need for further research regarding undergraduate perceptions of women who have had abortions emerged. Limited research on abortion stigma has been conducted on undergraduates with samples primarily including only medicine and nursing students (Alvargonzález, 2017; Barret, 1980; Buga, 2002; Carlton et al., 2000; Finlay, 1981; Gleeson et al., 2008; Jones, 2006; Rosenblatt, 1999; Ruiz-Cantero et al., 1991; Shortorbani et al., 2004; Steele, 2009). Currently, only one measure (Shellenberg et al., 2014) was found which focused on the stigma of women who faced abortion, indicating the lack of research in this area of study. Additionally, there is a distinction between the legal right to abortion and the moral choice to abort (Hollis & Morris, 1992). Most research in the past has focused on participants' opinions of whether abortion should be legal for women in various circumstances (Adebayo, 1990; Betzig & Lombardo, 1992; Esposito & Basow, 1995; Hall & Ferree, 1986; Scott & Schuman, 1988; Szafran & Clagett, 1988). Until recently, only a small portion of the literature has examined individuals' personal opinions about the morality of abortion (Alvargonzález, 2017; Carlton et al., 2000; Esposito & Basow, 1995; Furedi, 2001; Hill, 2004; Moore & Stief, 1991; Norris et al., 2011; Westfall et al., 1991). Finally, considering the distress experienced by women who have had abortions, it is important to isolate abortion stigma from post-abortive women.

The current study aims to answer several questions regarding the ability of individuals to isolate abortion stigma from the stigma of women who have had abortions. These questions guided the measures chosen and the way in which the data are interpreted. The research questions are as follows: (1) Is there an apparent ability for individuals to separate their stigma of women who have

had abortions from the stigma of abortion itself? (2) Does this ability differ with the gender of the individual? (3) Does abortion stigma differ between men and women? (4) Does the gender of the individual influence the stigma of women who have had abortions?

## Method

### Participants

A total of thirty participants were included in the study and consisted of psychology undergraduate students over the age of eighteen who were currently attending a private southeastern Christian university. Participants were recruited through announcements made by professors in residential classes. A link to the survey was also provided on a university website listing psychology activities for academic credit. All the participants (n=30) were between eighteen and twenty-four years of age. Ten percent (3) of participants identified as male, and 90% (27) of participants identified as female. The academic classification of the participants showed 0% freshmen. Rather, 23% (7) were sophomores, 10% (3) were juniors, and 67% (20) were seniors. One hundred percent of the participating individuals reported being Christian. None of the participants selected non-religious, Muslim, Jewish, or "other" as their religious affiliation. Of the individuals who were Christians, none identified as Catholic, Methodist, Lutheran, Pentecostal, Episcopalian, or Adventist. Additionally, no individuals reported affiliating with a separate, "other" denomination. Baptists made up 37% (11) of the sample, while Presbyterians made up 7% (2) of the sample. Fifty-seven percent (17) reported being non-denominational. The demographics showed that 7% (2) of participants indicated having direct or indirect experience with abortion.

### Procedure

In a survey constructed through Qualtrics, participants completed demographic questions, including age, gender, academic level (freshman, sophomore, junior, or senior), religious affiliation,

and affiliated denomination (if Christian). If participants reported themselves to be under the age of eighteen, they were directed to the end of the survey. They were then asked to answer the following question: "Have you or someone close to you experienced abortion?" Following this question, participants completed two psychological assessments measuring abortion stigma and stigmatization of women who have had an abortion (see Appendix A).

The results of the survey were analyzed using the most recent version of SPSS, 27.0.1.0. For the purposes of analyzing the first research question, a Pearson correlation coefficient analysis was conducted to determine if an association between abortion stigma and the stigma of women who have experienced abortion existed. The remaining three research questions were tested via independent samples t-tests to determine mean differences between the two stigma scales. To determine trends between the demographic data and levels of stigma, individual statistical comparisons were made.

## Measures

### *Attitudes about Abortion Scale*

Hill (2004) created a questionnaire, called the *Attitudes about Abortion Scale*, to measure abortion stigma. This ten-item measure consisted of various circumstances surrounding a woman's abortion; seven items were commonly used in previous studies (Esposito & Basow, 1995; Hollis & Morris, 1992) and three items were original to Hill. Scenarios include health of the mother, health of the baby, rape, poverty, and disability, among others. Participants were asked to specify their level of agreement via a seven-point Likert scale, with one representing "strongly disagree" and seven represented "strongly agree." High scores indicated less stigma of abortion, while strong levels of stigma were indicated by low scores. Internal reliability is very strong with this measure, as Cronbach's alpha was 0.93 (Alvargonzález, 2017).

### *SABAS Sub-scale: Negative Stereotyping*

The *Stigmatizing Attitudes, Beliefs, and Actions Scale* (SABAS) was developed by Shellenberg et al. (2014) to analyze abortion stigma through negative stereotypes, discrimination or exclusion, and fear of contagion. It was designed to inform the public about abortion stigma, decrease societal and individual stigma, and measure the effectiveness of abortion stigma interventions. SABAS was originally tested in Ghana and Zambia; however, the items do not appear to be culturally specific. The full measure consists of eighteen questions, which are broken up into three sub-scales: negative stereotypes (8 items), discrimination and exclusion (7 items), and potential contagion (3 items). Each item is set up as a five-point Likert-scale, with five indicating strong disapproval and one indicating strong approval of each statement. High scores suggest more stigmatization of abortion, and low scores suggest less stigmatization of abortion. Responses were reverse scored to correspond with the scores of the abortion stigma measure, so high scores represent low stigmatization and low scores represent high stigmatization. This measure's internal consistency is considered high, with coefficient alphas for each sub-scale being 0.85, 0.80, and 0.80, respectively; the entire questionnaire has a coefficient alpha of 0.90 (Shellenberg et al., 2014). For reasons of simplicity in this relatively new research topic, only the negative stereotype sub-scale was included in the current survey to measure the stigma of women who have had abortions. Items within this sub-scale include statements such as, "a woman who has an abortion is committing a sin" (Shellenberg et al., 2014).

## Results and Discussion

### Limitations

The results of this study must be prefaced with its limitations, the most obvious of which is the ability to generalize the findings beyond the population studied. The chosen population is very

specific: psychology students at a private southeastern Christian university in the United States. Because the university is located in the southeast and consists of mostly Christian Caucasian females, results are most representative of this cultural, religious, and regional group. Additionally, some of the subgroups among whom the researcher had hoped to draw comparisons, sample sizes were, for any inferences, impractically small (n = 2 or 3). However difficult it may be to apply the results of this study to the general public, this population still provides interesting and helpful findings. Undergraduate students are commonly used as research populations within psychological research (Gallander Wintre et al., 2001; Roye et al., 2019; Silk-Eglit et al., 2014). Opinions of undergraduates are also thought to spread to the general population (Bailey, 1993), as they are the future members of the general public (Fadare & Tamuno, 2011). Thus, the observations of this study have the potential to spread to members of other age groups. Psychology students were selected as the discipline included in the survey due to the availability of participants to the researcher (as this research was completed within the psychology department) and the literature's lack of research conducted with psychology students. Additionally, the researcher proceeded with the study at her Christian university for its availability and its ability to offer insight into the Church's attitudes towards abortion. Another limitation of this study lies in the lack of definition given regarding abortion in the survey. Participants may have been confused as to which gestational age the abortion was taking place during, which could have contributed to abortion stigma and support for the proposed circumstances. For example, individuals might have approved of abortion at an earlier stage of gestation but disapproved of it later in the pregnancy. However, the overall stigma of abortion was of interest to the researcher, rather than stigma of abortion at a specific point. Future research should focus on potential factors that influence abortion stigma (age, religious affiliation, religiosity, knowledge of abortion, sexual orientation, previous sexual experience, and previous experience with abortion) and

its ability to be isolated from the stigma of women who have had abortions. Larger study samples, more diverse participants, and stated ages of gestation would provide better insight on this research topic.

**Ability to Separate Stigma**

The first research question asks if there is an apparent ability of individuals to separate their abortion stigma from their stigma of women who have had abortions. Students with high scores on the abortion stigma measure are considered to have low levels of stigma towards abortion, and high scores (once reverse scored) on the SABAS measure indicate low levels of stigma towards women who have had abortions. Therefore, students with higher scores overall are thought to be less stigmatizing than students with lower scores. A high score is defined in this study as a score higher than the median of each scale, meaning equal to or above 3.5 for the abortion stigma measure and equal to or above 2.5 for the SABAS measure. Seventy-seven percent (23) of individuals surveyed scored low and were more likely to stigmatize abortion, while 23% (7) scored high and were less likely to stigmatize abortion. One-hundred percent of participants scored high, indicating they were unlikely to show stigma toward women who have had abortions. A Pearson correlation coefficient was computed to determine the relationship between participant mean scores on abortion stigma and the stigma of women who have had abortions. The results indicate a non-significant negative relationship between the variables, $r(28) = -0.029$, $p = 0.878$. As abortion stigma mean scores increased, stigma towards post-abortive women mean scores decreased, but not significantly. Thus, this study suggests that there may be an ability to separate abortion stigma from the stigma of women who have had abortions. This research is potentially ground-breaking in the ability to separate abortion stigma from stigma of women who have had abortions, as no studies are able to be contrasted with these results.

**Gender on Ability to Separate Stigma**

The second research question examines the impact of gender on the ability of participants to isolate their abortion stigma from women who have had abortions. All participants, regardless of gender and previous score in abortion stigma, had low levels of stigma toward women who have had abortions. Surveyed individuals either maintained their low stigma or separated their abortion stigma from women who have had abortions. As stated above, the ability to isolate stigma has not been previously studied, so no other findings can be compared.

**Gender on Abortion Stigma**

Male and female levels of abortion stigma were compared in the current study. Of the men involved in this study, 67% (2) recorded increased levels of abortion stigma, and 33% (1) recorded decreased levels of abortion stigma. In comparison, the majority (81%; 22) of women in this study were more stigmatizing towards abortion; 19% (5) were less stigmatizing of abortion. The literature on this topic of gender is been very muddled (Esposito & Basow, 1995). Some research suggests that men have less abortion stigma (Esposito & Basow, 1995; Moore & Stief, 1991; Wright & Rogers, 1987); nonetheless, other studies suggest that women have less abortion stigma (Esposito & Basow, 1995; Westfall et al., 1991). Additionally, there is research that finds no difference in abortion stigma between men and women (Esposito & Basow, 1995; Betzig & Lombardo, 1992; Szafran & Clagett, 1988). Gender has not been considered a predictor of abortion stigma (Esposito & Basow, 1995; Hill, 2004; Bailey, 1993) and continues as such.

**Gender on Stigma Post-Abortive Women Face**

The difference between male and female students' stigma of women who have had abortions was also analyzed by the researcher with interesting results. All the participating men in this study (100%; 3) showed decreased levels of stigma towards abortive women. Likewise, 100% (27) of

surveyed women did not display stigma towards abortive women. Due to the lack of research specifically regarding stigma towards post-abortive women, comparisons to the literature cannot be made.

**Other Contributing Factors**

Due to the entirety (100%) of participants being in the same age group, age as a contributing factor – for both abortion stigma and women who have had abortions – could not be evaluated. In the past, older students have had more favorable opinions about abortion (Esposito & Basow, 1995; Faria et al., 1985; Westfall et al., 1991; Wright & Rogers, 1987). This trend is thought to be due to older students having more time to develop relationships with women who are in need of or have experienced abortion, which would allow them to be more likely to support abortion and sympathize with the pro-choice community (Esposito & Basow, 1995; Wright & Rogers, 1987). Younger students are hypothesized to have more confounding thoughts regarding their identity, leading to pliable beliefs – including abortion (Esposito & Basow, 1995; Wright & Rogers, 1987).

As previously stated, no freshmen completed the study's survey. Twenty-nine percent (2) of sophomores displayed lower levels of stigma towards abortion, while 71% (5) displayed high levels of stigma. All sophomores (100%; 7) scored high in stigma towards post-abortive women, suggesting less stigma. One hundred percent (3) of juniors indicated high stigma towards abortion; however, 100% (3) also indicated low stigma towards women who have had abortions. The majority (75%; 15) of seniors were more likely to stigmatize abortion, while only 25% (5) were likely to avoid stigmatizing abortion. In contrast, all (100%; 20) the seniors recorded less stigmatization of post-abortive women. Overall, juniors were observed to have lower stigma towards abortion when compared to other academic levels. All students, regardless of academic level, displayed low levels of stigma towards women who have had abortions. The opinions of undergraduate freshmen,

sophomores, juniors, and seniors regarding abortion have not been specifically compared in previous research.

All the participants reported affiliating with Christianity, so the effect of religion on stigma was not able to be evaluated. Denominations, however, were still able to be analyzed. In the current study, Presbyterians displayed 100% (2) tendency towards stigma of abortion but 100% (2) less stigma of women who have had abortions. Twenty-seven percent (3) of surveyed Baptists had low levels of abortion stigma, and 73% (8) had high levels of abortion stigma. All (11) Baptists who participated in the study scored high in stigma towards post-abortive women, indicating less stigmatization. Twenty-four percent (4) of surveyed individuals identifying as Non-denominational were less likely to stigmatize abortion, while 76% (13) were more likely to stigmatize abortion. One hundred percent (17) of Non-denominational participants displayed lower levels of stigma towards women who have had abortions. Of Christian respondents, Baptists scored lowest in abortion stigma, but Non-denominational individuals were not far behind. All participants, regardless of religious denomination had high scores – indicating lower stigma – towards women who had aborted. This new information regarding non-Catholic denominations is interesting to note because the literature has only established that Catholics are most disapproving of abortion (Adebayo, 1990; Esposito & Basow, 1995; Faria et al., 1985; Hollis & Morris, 1992; Krishnan, 1991; Szafran & Clagett, 1988; Wright & Rogers, 1987). Hypotheses about this pattern lie in the doctrine of Catholicism; abortion is considered a sin in all circumstances (Esposito & Basow, 1995). Individuals affiliating with Judaism and Protestant denominations, aside from Baptist, disapprove of abortion to a lesser extent (Esposito & Basow, 1995). Due to a lack of religious doctrine, those who identify as nonreligious are not bound by the beliefs of religion about abortion; thus, these individuals tend to be most approving of abortion (Esposito & Basow, 1995). Religiosity was not looked at in the current study for the purposes of

simplicity, but previous studies have observed that people who believe themselves to be very religious have more negative views of abortion (Adebayo, 1990; Esposito & Basow, 1995; Krishnan, 1991). Increased church attendance is also correlated with disapproval of abortion (Esposito & Basow, 1995; Szafran & Clagett, 1988). Thus, these factors could have influenced the participants' responses.

Finally, all (2) of those who reported having direct or indirect experience with abortion were observed to have higher levels of abortion stigma, while also displaying low levels of stigma towards women who have had abortions. In comparison, 25% (7) of those without abortion experience exhibited lower abortion stigma, and 75% (21) exhibited greater abortion stigma. All (28) individuals without abortion experience had low stigma towards women who have had abortions. However, regardless of abortion experience, all participants were less likely to stigmatize post-abortive women. The literature contrastingly shows that individuals with direct or indirect experience with abortion are more supportive of abortion than those with no previous experience (Alvargonzález, 2017; Carlton et al., 2000; Hill, 2004; Hollis & Morris, 1992; Wright & Rogers, 1987).

**Implications**

The researcher acknowledges that abortion is considered a sin within the Christian Church and is not recommending that this sin be minimized; however, the degree to which the sinner is stigmatized because of her sin is of concern. In various passages of the New Testament, Jesus shows kindness to sinners, despite the treatment of the religious culture. In Luke 19, he went back to the home of a tax collector to eat. Jesus allowed a prostitute to wash his feet in Luke 7. When he was on the cross in Luke 23:43, Jesus also extended salvation to the murderer also being crucified, saying "…Today you will be with me in paradise," (*New International Version,* 2011). Through these examples in Scripture, it is evident that women who have had abortions are not excluded from

salvation. All are offered grace if they come to Jesus in repentance. 1 John 1:9 states, “If we confess our sins, he is faithful and just and will forgive us our sins and purify us from all unrighteousness” (*New International Version*, 2011). There is also no denying that a number of women who consider abortion are facing stressful and perhaps insurmountable circumstances; God also promises to help such individuals overcome their situation, such as poverty, a future career, and trauma. If post-abortive women approach the Christian Church seeking forgiveness and help, it should be the aim of its members to show her God’s love.

This research challenges individuals to separate their disapproval of abortion from women who are facing or have experienced abortion. As evident through this study, it is possible to separate stigma of abortion from the stigmatization of women who have experienced abortion. Thus, this ability should be encouraged throughout Christian churches, perhaps through sermons, classes, or encouraged service at pregnancy care centers. Cognitive behavioral therapy within women’s studies, seminars, and counseling could also be utilized to increase the secular population’s ability to isolate abortion stigma from women who have had abortions. It is the hope of the researcher that, because of this study and any future studies it prompts, individuals develop the ability to separate their stigmatization of abortion from women who have had abortion.

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Appendix A

**Survey**

1. What is your age?
    - Under 18 *(directed to end of survey)*
    - 18-24
    - 25-31
    - 32-38
    - 39-49
    - 50+
2. What is your gender?
    - Male
    - Female
3. What is your academic status at Liberty University?
    - Freshman
    - Sophomore
    - Junior
    - Senior
4. What is your religious affiliation?
    - Non-religious
    - Christian
    - Muslim
    - Jewish
    - Other
5. Which major denomination do you affiliate with? *(this question is triggered if the previous answer is Christian*)
    - Catholic
    - Baptist
    - Methodist
    - Lutheran
    - Presbyterian
    - Pentecostal
    - Episcopalian
    - Adventist
    - Non-denominational
    - Other
6. Have you or someone close to you experienced abortion?
    - Yes
    - No

***Attitudes about Abortion Scale (Hill, 2004)***

Please indicate **your level of agreement with abortion** for each of the following circumstances with one being strongly disagree for the given circumstance and seven being strongly agree for the given circumstance.

The health of the mother is in danger

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| (strongly disagree) | | | | | | (strongly agree) |

There are significant risks for serious damage to the baby

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| (strongly disagree) | | | | | | (strongly agree) |

The woman is married and wants no more children

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| (strongly disagree) | | | | | | (strongly agree) |

The woman is a victim of rape

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| (strongly disagree) | | | | | | (strongly agree) |

The woman is not married and doesn't want to marry the man

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| (strongly disagree) | | | | | | (strongly agree) |

The woman is too poor to support a baby

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| (strongly disagree) | | | | | | (strongly agree) |

The woman has made a personal decision to abort

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| (strongly disagree) | | | | | | (strongly agree) |

The woman has had a previous abortion

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| (strongly disagree) | | | | | | (strongly agree) |

The woman is a junior in college and is hoping to go on to graduate school

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| (strongly disagree) | | | | | | (strongly agree) |

The woman is mentally handicapped

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| (strongly disagree) | | | | | | (strongly agree) |

***SABAS Sub-scale: Negative Stereotyping (Shellenburg, 2013)***

Please indicate how much you agree or disagree with the following statements.

A woman who has an abortion is committing a sin.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| (strongly disagree) | (disagree) | (unsure) | (agree) | (strongly agree) |

Once a woman has one abortion, she will make it a habit.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| (strongly disagree) | (disagree) | (unsure) | (agree) | (strongly agree) |

A woman who has had an abortion cannot be trusted.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| (strongly disagree) | (disagree) | (unsure) | (agree) | (strongly agree) |

A woman who has an abortion brings shame to her family.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| (strongly disagree) | (disagree) | (unsure) | (agree) | (strongly agree) |

The health of a woman who has an abortion is never as good as it was before the abortion.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| (strongly disagree) | (disagree) | (unsure) | (agree) | (strongly agree) |

A woman who has had an abortion might encourage other women to get abortions.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| (strongly disagree) | (disagree) | (unsure) | (agree) | (strongly agree) |

A woman who has an abortion is a bad mother.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| (strongly disagree) | (disagree) | (unsure) | (agree) | (strongly agree) |

A woman who has an abortion brings shame to her community.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| (strongly disagree) | (disagree) | (unsure) | (agree) | (strongly agree) |