Time For A Change? The Lived Experiences of Abortion Workers Who Left The Industry

Susan Marie Cole
Department of Community Care and Counseling, Liberty University

A Dissertation Presented in Partial Fulfillment
Of the Requirements for the Degree
Doctor of Education

School of Behavioral Sciences
Liberty University
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Approved By

Vasti Holstun, Ph.D., Committee Chair
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ABSTRACT

The purpose of this phenomenological study was to gain insight and understanding into the lived experiences of those who have worked in a medical facility or freestanding clinic providing abortion services and who eventually chose to leave the industry due to moral distress. Two research questions are addressed in this study: What is the lived experience of former abortion workers who left the field due to moral distress both before and after their transition from the industry? And, What were (and are) the perceived bio-psycho-social-spiritual impacts of abortion work for those who ultimately left the field due to moral distress? A comprehensive review of the literature discusses abortion, the political landscape of abortion, abortion workers, moral ideology, moral distress, moral injury, forgiveness, influence of global meaning, and spirituality. Fourteen participants who are affiliated with an organization that assists individuals exiting the abortion industry were interviewed for this study. Phenomenological hermeneutic theory was the method utilized to gather, explore and interpret the transcribed narratives given by the interviewees. Specifically, the computer software NVivo and van Manen’s six-step research paradigm were utilized to transcribe, analyze and interpret the data. Finally, themes emerging from the data that are presented in detail include Shifting View of Abortion: From Pro-Choice to Pro-Life, Memorable Experiences During Tenure in Abortion Industry, Difficult Work Environment, Bio-Psycho-Socio-Spiritual Conflict, and A Turning Point, and topics of discussion are Stigma of Abortion Work, Work Experiences and Environment, Bio-Psycho-Socio-Spiritual Effects, Aspects of Moral Distress and Moral Injury, and Steps toward Healing.

Keywords: abortion, abortion worker, bio-psycho-socio-spiritual effects, forgiveness, meaning, moral distress, moral injury, spirituality
Dedication

This dissertation is first dedicated in honor of Dr. William “Danny” Bird, 06/26/1974-08/19/2021. Dr. Bird, you ran for the prize set before you. You spoke words of wisdom, guidance and encouragement during your time as my chair. Thank you for being such an attentive mentor. I can imagine our Heavenly Father saying, “Well done, my good and faithful servant.”

I also dedicate this research to the heart, vision and tenacity of the awesome women who gave their time and shared their stories with me. I pray God’s richest blessings upon your lives Alex, Anne, Beth, Claire, Deborah, Dewy, Faith, Jean, Lena, Lily, Maria, Miriam, Rubi and Susanne. Your faith mirrors the following Bible verses:

But blessed are those who trust in the Lord and have made the Lord their hope and confidence. They are like trees planted along the riverbank, with roots that reach deep into the water. Such trees are not bothered by the heat or worried by long months of drought. Their leaves stay green, and they never stop producing fruit (Jeremiah 17:7-8).
Acknowledgements

To begin, I am very thankful for the awesome grace of God that has strengthened and guided me during this dissertation process. You, Lord, are my rock and it is for Your purposes that this research has been conducted. May You be honored! Next, I am appreciative of my family for their support and encouragement: My husband, Hank, you are such an amazing partner and a true gift from God! You enabled me to focus on writing when it was so important. My parents, Ron and Mary, who have taught me the importance of following God’s direction. You were great sounding boards when I felt stymied and a support in all times of need. And for my sons, Andrew, Tyler and Luke. You each have been a gift straight from Heaven. Your lives matter! Finally, my precious puppies, Shadow Baby and Bitsy Boo, who are pure joy and always offer unconditional love and calm.

Moreover, my dissertation committee has offered amazing insight, knowledge, direction, and encouragement. Thank you to Dr. Holstun, my chair, Dr. Milacci, my reader, and Dr. Volk for methodology overview. Additionally, the leadership at *And Then There Were None* have partnered with me to make this research possible. Thank you to the entire team of counselors and support staff at ATTWN for your effort and invaluable input.
TIME FOR A CHANGE? THE LIVED EXPERIENCES OF

Table of Contents

Abstract..........................................................................................................................3
Dedication.....................................................................................................................5
Acknowledgements......................................................................................................6
Table of Contents.........................................................................................................7
List of Tables...............................................................................................................14
List of Abbreviations...................................................................................................15
Chapter One: Introduction..........................................................................................16
  Overview.....................................................................................................................16
  Scriptural Premise......................................................................................................16
  Introduction...............................................................................................................17
  Background: History of Abortion in the United States.................................................18
  Situation to Self..........................................................................................................19
  Problem Statement....................................................................................................21
  Purpose Statement.....................................................................................................22
  Significance of the Study..........................................................................................23
  Research Questions...................................................................................................23
  Definition of Terms....................................................................................................23
  Summary....................................................................................................................25
Chapter Two: Literature Review..................................................................................26
  Overview....................................................................................................................26
  Theoretical Framework..............................................................................................27
  Related Research......................................................................................................27
TIME FOR A CHANGE? THE LIVED EXPERIENCES OF

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>28</td>
</tr>
<tr>
<td>Expanded Statistics</td>
<td>29</td>
</tr>
<tr>
<td>Complications and Clinic Oversight</td>
<td>29</td>
</tr>
<tr>
<td>Women’s Experiences with Abortion</td>
<td>31</td>
</tr>
<tr>
<td>History of Abortion in the United States</td>
<td>33</td>
</tr>
<tr>
<td>Political Landscape</td>
<td>34</td>
</tr>
<tr>
<td>Movements: Pro-Choice and Pro-Life</td>
<td>36</td>
</tr>
<tr>
<td>Viability and Personhood</td>
<td>38</td>
</tr>
<tr>
<td>Moral Ideology</td>
<td>40</td>
</tr>
<tr>
<td>Philosophical Perspective</td>
<td>41</td>
</tr>
<tr>
<td>Abortion Industry Workers</td>
<td>42</td>
</tr>
<tr>
<td>Provider Experiences</td>
<td>43</td>
</tr>
<tr>
<td>Stigma Associated with Abortion Work</td>
<td>44</td>
</tr>
<tr>
<td>Ethics of Abortion Methods</td>
<td>45</td>
</tr>
<tr>
<td>Moral Integrity</td>
<td>46</td>
</tr>
<tr>
<td>Conscience Objection</td>
<td>47</td>
</tr>
<tr>
<td>Training</td>
<td>48</td>
</tr>
<tr>
<td>Recruitment and Retention</td>
<td>48</td>
</tr>
<tr>
<td>Moral Distress</td>
<td>50</td>
</tr>
<tr>
<td>Moral Distress in Health Care Providers</td>
<td>50</td>
</tr>
<tr>
<td>Moral Injury</td>
<td>52</td>
</tr>
<tr>
<td>Key Aspects of Resolution</td>
<td>57</td>
</tr>
<tr>
<td>Influence of Global Meaning</td>
<td>58</td>
</tr>
</tbody>
</table>
Spiritual Considerations.................................................................60
Spirituality as Healing...............................................................60
Creating Space for Grace.........................................................61
Conclusion..................................................................................63

CHAPTER THREE: METHODS..........................................................64
Overview.......................................................................................64
Design.........................................................................................64
Phenomenological Design.........................................................65
Van Manen’s Six Steps for Data Analysis......................................66
Research Questions........................................................................67
Setting.........................................................................................67
Participants.................................................................................68
Procedures.................................................................................69
The Researcher’s Role.................................................................70
Data Collection............................................................................71
Interviews....................................................................................72
Data Analysis.............................................................................74
NVivo for Data Analysis............................................................76
Trustworthiness..........................................................................77
Credibility....................................................................................78
Dependability and Conformability..............................................78
Transferability............................................................................78
Ethical Concerns.........................................................................79
CHAPTER FOUR: FINDINGS

Overview

Utilization of Qualitative Computer Software

Participants

Clinic’s Focus of Care

Job Responsibilities

Modifications of Participant Quotes

Themes Related to Research Question One

Major Theme One: Shifting View of Abortion

Sub-Theme: Pro-Choice Before Working in the Industry

Sub-Theme: Shifting View While Working in the Industry

Sub-Theme: Pro-Life After Working in the Industry

Major Theme Two: Memorable Experiences During Tenure in the Industry

Sub-Theme: Meeting Quotas

Sub-Theme: Sense of Vulnerability

Sub-Theme: Stigma and Seclusion

Major Theme Three: Difficult Work Environment

Sub-Theme: Memories and Regrets

Sub-Theme: Distressing Tasks

Sub-Theme: Problematic Practices

Sub-Theme: Deception

Sub-Theme: Protestors and Prayers
Sub-Theme: Angst: Leaving the Industry..............................................106

Themes Related to Research Question Two...........................................108

Major Theme Four: Bio-Psycho-Socio-Spiritual Conflict........................109

Sub-Theme: Maladaptive Transitions....................................................109

Sub-Theme: Destructive Coping..............................................................111

Sub-Theme: Comprehensive Conflict..................................................112

Sub-Theme: Relationships.................................................................115

Sub-Theme: Dissonance, Conviction and Condemnation........................115

Sub-Theme: Pre-existing Trauma............................................................117

Sub-Theme: Depersonalization..............................................................118

Major Theme Five: A Turning Point.......................................................120

Sub-Theme: Guilt and Forgiveness.........................................................120

Sub-Theme: Healing and Camaraderie..................................................121

Summary...............................................................................................123

CHAPTER FIVE: CONCLUSION...............................................................125

Overview..............................................................................................125

Phenomenological Methodology............................................................125

Summary of Findings.............................................................................126

Synopsis of Interview Question Responses...........................................126

Discussion............................................................................................129

What This Research Adds to the Existing Literature.............................130

Major Topic One: Stigma of Abortion.................................................130

Sub-Topic: Dirty Work.................................................................132
APPENDICES

Appendix A: ATTWN Approval Letter
Appendix B: IRB Approval
Appendix C: Informed Consent
Appendix D: Recruitment E-Mail
Appendix E: Recruitment Video Transcript
Appendix F: Interview Questions
List of Tables

Table 1: Participant Demographics..............................................................................79
Table 2: Job Responsibilities.......................................................................................81
Table 3: Major Theme One: Shifting View of Abortion..............................................82
Table 4: Major Theme Two: Memorable Experiences During Tenure on Abortion Industry........................................................................................................87
Table 5: Major Theme Three: Difficult Work Environment........................................91
Table 6: Major Theme Four: Bio-Psycho-Socio-Spiritual Effects...............................103
Table 7: Major Theme Five: A Turning Point..............................................................114
List of Abbreviations

American Civil Liberties Union (ACLU)
American Psychological Association (APA)
And Then There Were None (ATTWN)
Bio-Psycho-Socio-Spiritual (BPSS)
Burnout (BRN)
Compassion Fatigue (CF)
Dirty Hands (DH)
Guttmacher Institute (GI)
Moral Distress (MD)
Moral Injury (MI)
Moral Injury Events Scale (MIES)
Moral Injury Outcomes Scale (MIOS)
National Abortion Federation (NAF)
National Right to Life Conference (NRLC)
Parts of Conception (POC)
Post-Traumatic Stress (PTSD)
Potentially Injurious Experiences (PMIEs)
Secondary Traumatic Stress (STS)
Sexually Transmitted Disease (STD)
Chapter One: Introduction

Overview

Abortion is an elective procedure that has been legal in the United States since 1973 (Guttmacher, 2020). Continued controversy and complexity has surrounded the moral, legal and emotional aspects of abortion for decades, both before and since legalization (Cleaver, 2017; Jozkoski et al., 2018). Two questions are central to the abortion argument: Is the act of ending a pregnancy the right of the woman since it is her body (American Civil Liberties Union [ACLU], 2020)? Or does the developing baby have a right to life from conception to death (National Right to Life, [NRLC] n/d)? This polemic extends into abortion facilities and clinics that employ medical professionals who serve in a variety of roles. Stigma and work-related stress have been the most studied experiences of those who work in this industry and are often influenced by this moral and political controversy (Janiak et al., 2018). Other experiences may also contribute to workplace challenges as every year a number of abortion facilities and clinics receive violations for not only performing procedures in an unsafe environment (improper of sanitation), but also for employing untrained, unqualified or unlicensed staff that engage in duties such as dispensing medications (Americans United for Life, 2016; Checkmyclinic.org, n/d; Studnicki & Fisher, 2018). Although a lack of literature exists regarding those who work in the abortion industry, even less exists about former abortion workers. This study has been conducted to fill a gap in the literature on those who have left the abortion industry and whether they experienced any negative bio-psycho-socio-spiritual effects during and after their tenure.

Scriptural Premise

Through hermeneutic phenomenological study, which is interpretive of language and focuses on the lived experiences of those belonging to a specified group, much can be observed,
heard, learned and put into practice (McLeod, 2011; Kazdin, 2003; van Manen, 2015).

Interestingly, the Bible offers wisdom associated with this type of research through words spoken by Jesus Christ in Mark 4:21-23 (The Living Bible),

> When someone lights a lamp, does he put a box over it to shut out the light? Of course not! The light couldn’t be seen or used. A lamp is placed on a stand to shine and be useful. All that is now hidden will someday come to light. If you have ears, listen! And be sure to put into practice what you hear.

Subsequently, from a bio-psycho-socio-spiritual view these thoughts offer a four-fold meaning. First, even in life’s deepest disappointments, challenges and pain, there exists hope and a light meant to shine in one’s soul (Jeremiah 29:11; Psalm 18:28). Second, sharing one’s story with another who is willing to listen may facilitate healing through empathetic connection and acknowledgement (Marich, 2014). Third, for the listening ear these experiential truths spoken from the heart and soul offer insights, understanding, and meaning that can be utilized when interacting with others who hurt or question their similar experiences (McMinn & Campbell, 2017). Finally, findings may extend into therapeutic and spiritual practice (Coe, 2019; Patton, 2015); such was the goal of this study on the lived experiences of former abortion industry workers.

**Introduction**

The following research discusses prominent topics related to those who have provided abortion services in either a medical facility or freestanding clinic and who have ultimately left the field. It also incorporates significant data pertaining to the lived experiences of these individuals through customized semi-structured interviews (Billups, 2021). To begin, research regarding abortion industry workers has not been plenteous considering abortion on demand has
been legal in the United States since 1973 (Cornell Law School, n.d.). A central concern within the literature regarding the abortion industry is the stigma attached to abortion providers and work-related stress as full-time providers often experience higher risk for burnout due to these factors (Janiak et al., 2018). Moreover, a moral and spiritual component appears to exist for those who determine they can no longer work in the field of abortion provision (And Then There Were None [ATTWN], 2020a). For instance, moral shock is a factor that might influence a person who works in this industry if exposed during one’s job to images that might be disgusting or unsettling, in turn provoking a moral reaction or conviction (Wisneski & Skitka, 2017). Thus, this study sought insight into how working in an abortion facility affects one’s bio-psycho-socio-spiritual well-being, as well as how these individual’s everyday lives may be influenced by working in an abortion environment.

**Background: History of Abortion in the United States**

Abortion on demand was legalized after the Supreme court passed Roe v Wade in 1973. Roe, an unmarried pregnant woman, and Hallford, a physician who had two pending prosecutions against him for performing illegal abortions in Texas, challenged the constitutionality of criminal abortion laws in the state of Texas that did not allow for abortion except for medical purposes limited to saving the life of the mother (Cornell Law School, n/d). Prior to this 1973 ruling, abortion was regulated by the individual states with laws that spanned from the procedure being illegal to permissible for circumstances including rape, incest or the mother’s physical well-being (Beckman, 2016).

According to the Guttmacher Institute [GI] (2020) and National Right to Life [NRLC] (2022), an estimated 62-million plus abortions have occurred in the United States since 1973. These abortions are usually performed in free-standing clinics, hospitals, and medical offices.
TIME FOR A CHANGE? THE LIVED EXPERIENCES OF

(National Abortion Federation [NAF], 2020b). In recent years, women seeking an abortion in certain parts of the country are no longer required to see a doctor in person to receive a referral for a medical abortion that entails the use of the drugs Mifepristone, which blocks hormones, and Misoprostol, that induces cramping and the emptying of the uterus (Berer, 2020; GI, 2019; Kohn et al., 2019).

In reality, even though an immense amount of research has been conducted on the rights of all women to have the legal option to abort (Cohen & Parry, 1981), the experiences of those who have either had or were denied an abortion (Foster et al., 2018; Steinberg et al., 2016; Whitney, 2017), and the ever-changing schema of abortion laws (Cartwright et al., 2018; Cleaver, 2017), a limited number of studies exist that explore the lived experiences of not only workers who are currently employed, but also those who formerly worked in the field of abortion. Subsequently, a more comprehensive understanding of current and former abortion workers’ experiences is imperative. Most research on the experiences of abortion industry workers focuses upon stigma, sense of pride or guilt regarding one’s profession and fear of impending harm (Kumar, 2018; Martin, Debbink, Hassinger, Youatt, Eagen-Torkko, & Harris, 2014; Sanger, 2016). However, a recent publication on former industry workers described traumatic encounters that occurred while engaging in job duties associated with providing abortions (Johnson & Detrow, 2016). Therefore, further inquiry into the lived experiences of individuals who have worked in abortion provision purposes to expand the breadth and depth of understanding this phenomenon.

**Situation to Self**

Within the realm of qualitative research, it is relevant to assume the researcher possesses a personal lens or worldview, which means the views and opinions of the researcher may be
compromised if prior involvement in the area of study, personal convictions, and preconceived ideologies are not identified and controlled (Fusch & Ness, 2015; Kazdin, 2003). Thus, as a researcher I have self-checked my pro-life thoughts and beliefs in light of abortion being a legal and commonly practiced medical procedure and an industry that employs numerous professionals. Applicably, my motivation during this study has been to gain insight and understanding into the lived experiences of the former abortion industry workers interviewed, which was supported through a disciplined objective stance that checked any preconceived ideas.

White (2017) proposes that character is both a person’s strongest asset and liability. Thus, I have been committed to writing at a level that meets academic and reader expectations as this study purposed to educate and challenge beyond the existing literature and expand possible considerations (Booth et al., 2016). As the research process pursued accurately investigating, researching, interviewing, analyzing data, and writing on the lived experiences of former abortion industry workers, I have been mindful of any subjective thoughts, feelings, and conclusions. Therefore, as an act of censoring potential bias or bracketing my prior understanding of abortion and its provision, key aspects of my personal stance of being prolife were identified (Bhattacharya, 2017; Billups, 2021). As a Christian, I adhere to the thought that all life has purpose and babies are not accidents despite their conception being planned or unplanned by their biological parents. My husband and I are adoptive parents, embracing three amazing baby boys as our own and raising them to cultivate their talents and find their purpose, meaning and joy in life. Although my personal view of the beginning point and purpose of life remains steadfast, a compassion to understand another person’s experience of involvement in terminating unplanned pregnancies formed my curiosity and commitment to engaging in a disciplined and impartial study.
With this said, the idea to pursue qualitative research through interviewing individuals who have chosen to leave the abortion industry came as I watched the movie “Unplanned” (Solomon & Konzelman, 2018), which was based upon Abby Johnson’s experience of working as a director at a Texas Planned Parenthood and her decision to leave the abortion industry. I had never heard of Abbey Johnson, nor the non-profit organization ATTWN, before watching this movie. Neither had I met any of the participants of this study before scheduling their interviews. The information regarding ATTWN was listed in the post-movie trailer along with the resources available for those who desire to quit their jobs in the field of abortion. Many questions surfaced as to how other individuals who have had adverse experiences decided to leave their jobs providing abortions in either a medical facility or freestanding clinic. These questions included how they found support, what type of healing has been necessary to return to a healthy equilibrium and how these workers made sense or meaning of their lived experiences, especially in the context of the current social-political environment. After discussing my thoughts on this phenomenon with my professor, I contacted ATTWN and they agreed to assist me in recruiting participants for this study through their organization.

**Problem Statement**

This study is intended for both those in academia and mental health practice and purposed to add to the literature by exploring the experiences of those who have directly worked in the area of abortion provision (Aurini et al., 2016). Much of the existing research has focused upon abortion workers’ experiences with stigma associated with their work in the abortion industry, such as being judged, isolated or discriminated against, which often results in providers being misunderstood due to a disparity between rhetoric and lived experience (Martin, Debbink, Hassinger, Youatt, & Harris, 2014; Martin et al., 2017; Martin et al., 2018). Therefore, further
research is imperative in order to comprehend these experiences and the multi-facetted needs of this specific population (Terrell, 2016).

In order to understand the relevance of this study, the essence of potential issues within the lived experiences of former abortion industry workers have been addressed via a problem statement (Peoples, 2021). Some former abortion industry workers identify negative emotional states associated with acts performed or engaged in as part of their job responsibilities, as well as perceived stigma while working at an abortion facility. Therefore, an extensive literature review served as an initial step for exploring and creating a foundation for comprehending the why’s, what’s, and how’s of former abortion workers’ experiences and addressing the gaps in the existing research, and was followed in tandem by extensive interviews with fourteen individuals who have worked in an environment that provided abortions (Andrews, 2017; Billups, 2021).

**Purpose Statement**

A purpose statement connects the identified issue or problem with the intent or focus of a study (Peoples, 2021). Hence, a practical template has been utilized to identify the purpose of this research (Creswell, 2018). The overall purpose of this phenomenological research was to understand the lived experiences of those who have worked in the abortion industry and ultimately left due to moral distress. This study explored potential medical, relational, and moral influences that working in the abortion industry had upon 14 participants who have been involved with ATTWN, an organization that assists those desiring to leave the abortion industry. Qualitative research, more specifically phenomenological hermeneutic theory, was the methodology utilized to explore and interpret the transcribed narratives given by these participants. Transcription of participant interviews and data interpretation were assisted by the
computer software NVivo (released 2020). The six-steps of van Manen’s (2015) paradigm for data analysis were also key in understanding this data.

**Significance of Study**

The significance of this study on former abortion industry workers was multi-fold. First, interviewing former abortion industry workers established a missing perspective to the existing literature on abortion workers (Audrini et al., 2016). Second, a deeper understanding of this population adds to the empirical research and may lead to improved evidence-based treatments and bio-psycho-socio-spiritual outcomes (Heppner et al., 2016). Moreover, insightful information extends understanding into abortion workers’ experiences that may assist abortion clinics in developing safeguards that promote comprehensive mental, emotional, physical and spiritual health among their employees, as well as advocacy agencies, such as ATTWN, in meeting the needs of those who endure some form of trauma or remorse leading to the person exiting the field (Bhattacharya, 2017).

**Research Questions**

Two specific questions served as the objective for this study and sought to understand the reasons or circumstances that contributed to this population’s exit from their jobs within the abortion industry. Addressing these research questions also assisted in identifying the potential effect these job responsibilities had upon their lives.

**Research Question 1:** What is the lived experiences of former abortion workers who left the field due to moral distress both before and after their transition from the industry?

**Research Question 2:** What were (and are) the perceived bio-psycho-socio-spiritual impacts of abortion work for those who ultimately left the field due to moral distress?

**Definitions**
1. *Abortion* - Abortion is the spontaneous or induced termination of pregnancy before the fetus reaches a viable age (Tabor’s Medical Dictionary, 2019).

2. *Abortion Worker* – An employee or independent contractor who has provided abortion services in either a medical facility or freestanding clinic; a robust skilled clinical workforce that provides roughly 1 million abortions in the United States annually (ATTWN, 2020a; Janiak et al., 2015).

3. *Conscience Objection* - Conscience objection (CO) on behalf of a medical provider involves the individual’s moral agency, authenticity to his or her integrity, one’s professional role and patient obligations (Harris et al., 2018).

4. *Global Meaning* - Global meaning relies upon seeing beyond a single experience to a broader focus on cumulative experiences that occur over time and requires an element of relinquishing goals, compromising beliefs and sense of meaning (Hicks & King, 2007).

5. *Meaning* - Meaning within this paradigm is developed through how one responds to unchangeable and challenging circumstances through a will to meaning, suffering, and freedom that moves a person away from the pain and toward resolve through one’s freedom of choice and reactions throughout a hardship (Frankl, 2006).

6. *Moral Distress* – Moral Distress (MD) is a phenomenon experienced by those in the medical profession when presented by a choice between alternatives that result in perceived negative outcomes or confronted by a situation that counters one’s sense of right or wrong (Fourie, 2015; Oh & Gastmans, 2015).

7. *Moral Injury* - Moral Injury (MI) is an outcome and key facet of a traumatic event (Antonelli, 2017). Intrusive symptoms include one’s mind replaying past events, imagining bad things happening such as worse-case scenario, the inability to find solutions and
uncontrollable thoughts; basically, an inability to separate oneself from troublesome thoughts and feelings (Farnsworth, 2019; Gibbons et al., 2013).

8. **Forgiveness** – Forgiveness encompasses multiple realms including the divine, from God, as well as the human aspects of extending forgiveness to self and others and receiving from another. Whether or not forgiveness is associated with a Christian theology, it possesses a restorative nature that facilitates healing (Griffin et al., 2014).

9. **Self-forgiveness** – Self-forgiveness involves asking God for divine forgiveness, making amends for offences toward others or wrongdoing, self-examination of expectations or motives, and adjusting self-perspective in order to view and accept oneself as an imperfect, yet valuable human being (Worthington & Langberg, 2012).

**Summary**

The research topic for this dissertation is the lived experiences of abortion workers who chose to leave the industry. Chapter One began by discussing the history of abortion and abortion workers as an introduction to the abortion industry. Of interest was the possibility of negative emotional and mental states associated with acts performed or engaged in, as well as perceived stigma, while working at an abortion facility. Accordingly, the overall purpose of this phenomenological research was to understand the lived experiences of those who have worked in the abortion industry and chose to leave. A multi-fold significance for this study was identified as adding perspective, improving clinical understanding, and workplace and advocacy support for current and former abortion workers. Finally, key terms were defined to improve reader comprehension.
Chapter Two: Literature Review

Overview

This chapter addressed the current body of literature on the multifaceted nature of abortion and abortion work. The bio-psycho-socio-spiritual effects experienced by a number of abortion workers is presented, as well as a discussion on some of these potential effects, such as moral distress and moral injury. Components of proposed avenues of healing include forgiveness, global meaning and spirituality. This chapter begins with an overview and a description of the study’s theoretical framework. An examination of the literature links critical and possibly significant information pertaining to research on former abortion industry workers and potential outcomes of their experiences. Finally, a summary of the information presented concludes this literature review.

There is a lack of research on the experiences of abortion workers, especially those who have exited the industry. Most research conducted over the last four decades has focused on topics such as a woman’s legal right to abortion and abortion statistics (Cohen & Parry, 1981; Jones & Jerman, 2017), women’s experiences in obtaining or being denied an abortion (Foster et al., 2017), post-abortion physical, mental and emotional outcomes (Rue & Coleman, 2007; Steinberg et al., 2016; Whitney, 2017), and abortion stigma experienced by both women who have aborted and employees who work in the industry (Frohwirth et al., 2018; Kumar, 2018). Additional studies have focused on the perceived hostility by pro-choice individuals from those who oppose abortion (NAF, 2018), the political and moral controversy surrounding abortion (Lipka & Gramlich, 2019), fetus rights (Chervenak & McCullough, 2017), conscientious objection to performing abortions by healthcare professionals (Czarnecki et al., 2019; Harris et al., 2018), the availability and safety of medical and surgical abortion (Berer, 2020; Skop, 2019),
and the legal reform of abortion laws and efforts to maintain abortion rights (Aiken, 2019; Joeffe, 2018). These themes will be discussed in relationship to those who are currently or have formerly worked as an abortion provider. Finally, manifestation of possible bio-psycho-socio-spiritual effects will also be presented with an overview of moral distress and moral injury.

**Theoretical Framework**

Foundational to effective research is a well-defined theoretic framework (Rockinson-Szapkiw & Spaulding, 2014). This qualitative research procures data through an interview process that is specific to the lived experiences of former abortion industry workers, and may be viewed as an account of “phenomenological examples” (van Manen & van Manen, 2021, p. 1077). Thus, it is critical to develop a comprehensive understanding of abortion, abortion workers, and possible outcomes of working in this industry (Billups, 2021; Leavy, 2017). Hermeneutic phenomenology reflects upon lived experiences and may be viewed as more of a method of questioning as the participant’s recollection of her experience adds insight and attaches meaning to the phenomenon being studied (van Manen, 2016). These accounts shared by the participants need to find a foundation in the existing literature describing what has been experienced and documented in the past. The pursuit of merging existing findings and the findings of this study is not simplistic and strives to add new and meaningful insight to the lived experiences of those who have worked in the abortion industry (van Manen, 2017).

**Related Literature**

Although no clear understanding prevails of why abortion workers exit the industry, previous literature offers some insight for consideration (Andrews, 2017). For example, for some workers stigma serves to increase commitment to protect abortion work and the pro-choice movement and guards against negative experiences, emotions or discussions that otherwise
might shed question upon the industry, yet for other abortion workers stigma induces fear of impending danger due to harassment directed at abortion facilities and providers (Martin et al., 2017; Pivarnik et al., 2018). Discussing reasons why some workers have left jobs in the abortion industry, Johnson and Detrow (2016) point to experiences such as watching a 16-year-old young lady hemorrhage on the table, pimps scheduling abortions for sex workers, late-term abortion, clients who had multiple abortions, the synoecism of fellow workers regarding the products of conception room (where fetal parts are pieced together to ensure complete abortion), pro-life proponents picketing in front of the clinic, promoting abortion from initial contact with clients, and the lack of staff devotion in caring about the best interest of the patient. Subsequently, at least for some, there is an emotional, mental, moral, relational and spiritual link between abortion work and the decision to leave. Thus, the purpose of this study is to explore the possibilities of why former abortion industry workers exit the industry and add pertinent data to the existing body of literature (Bhattacharya, 2017).

**Abortion**

MacNair (2018) boldly states, “The behavior surrounding abortion is changing” (p. 1). This statement is reflected in the rate of induced abortion which decreased eight percent between 2014, at 14.6 per 1000, and 2017, at 13.5 per 1000; the lowest rate since legalization in 1973 (GI, 2019). Abortion is the spontaneous or induced termination of pregnancy before the fetus reaches a viable age (Tabor’s Medical Dictionary, 2019). This definition is twofold. First, spontaneous abortion, also known as miscarriage, is the non-induced fetal death or passage of products of conception before 20-weeks’ gestation (Dulay, 2017, p.1). Second, induced abortion is the intentional or elective termination of pregnancy through a surgical or pharmaceutical procedure (Casey, 2018, p. 1; “*Journal of Midwifery & Women's Health,*” 2017). Medical abortion,
dispensed through the abortion provider before ten weeks gestation, is becoming the termination method of choice replacing surgical abortions (Raifman et al., 2018). This type of abortion which often occurs in the privacy of one’s own home, increased from 29% in 2014 to 39% in 2017, and is completed through the use of the drugs Mifepristone, which blocks hormones, and Misoprostol, that induces cramping and the emptying of the uterus (GI, 2019).

**Expanded Statistics**

The message of the pro-choice movement is that “Abortion is common, safe and effective” (Cameron et al., 2017, p. 1; Zolot, 2018). However, from legalization through 2017, 61,628,584 abortions have been completed (GI, 2020). Despite this imposing number, statistics show that from 2008 to 2014, 25% fewer women had an abortion with the most pronounced change being in the age group 15 to 19 (Jones & Jerman, 2017). According to the Guttmacher Institute (GI) (2019), the 2017 data reveals that 18% of women chose to terminate their pregnancy, with 2016 data indicating that 88% of abortions are performed in the first trimester; by the time a woman turns 45, there is a 24% chance that she will have had an abortion with half of all abortions occurring in the 20 to 29 age group. Foster (2017) suggests that this decrease may be attributed to increased use of contraceptives including long-acting forms, understanding of the conception process, infertility due to delayed or reduced intercourse, alternative sex acts, and the availability of medical abortion with limited physician oversight.

**Complications and Clinic Oversight**

Complications as a result of abortion are seldom discussed. Although abortion providers are not federally mandated to report and the data is often incomplete, the Center for Disease Control (CDC) has surveilled abortion since 1969 and includes 48 sources that have submitted information regarding occurrence, statistics, and protocols for the safety and well-being of the
patient and estimates that approximately one abortion-related death per 100,000 has occurred since legalization (GI, 2020; Jatlaoui et al., 2019). Correspondingly, the estimated rate of complications for medication abortion is about 2% and 1.3% for surgical abortions before 12 weeks, rising to 1.5% in the second and third trimester (Sajadi-Ernazarova & Martinez, 2020). Potential complications of surgical and medical abortion include incomplete abortion, allergic reaction to anesthesia, bacterial infections, hemorrhaging, severe pain, prolonged cramping, blood clots in the uterus, uterine or bowel perforation, and septic shock, which increase with gestational age, pre-existing health conditions and obesity (Allen & Goldberg, 2016; Benson et al., 2016; Gerdts et al, 2016; Giorgi & Weatherspoon, 2019).

As with other invasive medical procedures, abortion poses certain risks even when the termination is deemed a medical necessity for the mother. Thus there has been an organized move toward increased oversight of abortion facilities and providers by many states as a means to maintain the highest level of safety and patient care, such as scheduled inspections, reporting, and hospital privileges in case of emergency (Skop, 2019). Again, surveillance of abortion is tantamount not only for gathering relevant statistical information to evaluate and guide various aspects of women’s reproductive health, but also to improve education about contraceptive methods and other health resources and maintain safe abortion practice environments (Jatlaoui et al., 2018). Various regions of the United States comprise of states with stricter facility and provider restrictions that are regulated by local health departments and government administrations (Berglas, 2018; Sanger, 2016). Checkmyclinic.org (n/d) is an organization that acquires reports from the U. S. Health Resources and Services Administration and publishes the information on a website identifying abortion facilities in every state and offering data on health department violations and the providers’ level of training; remarkably, only 50% of states require
facilities to meet ambulatory surgical center regulations and frequent health code violations consist of uncertified or undertrained staff, lack of maintaining proper infection control standards and inadequate sterilization of instruments.

Additionally, procedures that involve intravenous (IV) or deep sedation, which reduces anxiety and pain during the procedure and immediate discomfort post-op, are routinely performed in ambulatory surgical centers and the offices of medical specialists. Those trained in this form of anesthesia, including certified nurse anesthetists that work in abortion clinics, require a special certification to ensure patient safety (Kim et al., 2020). Medical professionals are required to be licensed by the state where they practice, which is overseen by a state board comparable to the Department of Regulatory Agencies (DORA). Conversely, in some states, such as Colorado, abortion clinics are not licensed nor inspected (State of Colorado, 2020; Urbina & Upton, 2013). Despite the lack of regulated health oversight, Roberts and colleagues (2018) contend that facility type does not influence increased rates of mortality nor significant complications in women who have abortions in an ambulatory surgical center versus a physician’s office, abortion clinic, or non-specialized clinic. Nonetheless, the question remains as to why some abortion providers would not desire to offer women seeking abortion services the utmost safe environment for surgical procedures.

Women’s Experiences with Abortion

Numerous studies have been conducted over the years on the experiences of women who have had abortions. One inquiry found that patient expectations influenced abortion experience including level of pain, the helpfulness of the staff, clinic atmosphere, and wait time as longer delays attributed to increased anxiety (McLemore et al., 2014). Other factors that improved abortion experiences were the administration of sedation during the procedure, which decreases
both pain and awareness, and privacy that allows for discretion (Altshuler et al., 2017).

Furthermore, a three-year study conducted in the United States found that 95% of the 667 participants said having an abortion was the right choice and any negative feelings dwindled over the study’s three-year timeframe (Rocca et al., 2015). In contrast, research has also recognized that some women who have had abortions experience regret, anger, anxiety, guilt, shame, depression and self-destructive behaviors, as well as associated stress due to an unplanned pregnancy, secrecy, perceived stigma of wrongdoing and pre-existing mental health issues that potentially complicate a woman’s psychological response (Coleman et al., 2017; Curley & Johnson, 2013; Wallin Lundell et al., 2017; Steinberg et al., 2016; Whitney, 2017).

Equally important, many women think they should be given options counseling (parenting, adoption, and abortion) by the physician when told she is pregnant (French et al., 2017). However, the willingness of healthcare providers to give a referral sometimes depends upon the woman’s circumstances. In some cases, a name and phone number may be given, while in others the woman may seek a provider as many abortion facilities do not require a referral (Homaifar et al., 2017). Medical providers can influence a woman’s experience of receiving information and referral for abortion care, which may impede the process of receiving abortion services (Kimport et al., 2016). Many healthcare professionals may want to offer information without influencing a woman’s choice regarding her pregnancy, especially when their personal values, emotions, or opinions may interfere with her choice (Kjelsvik et al., 2018). Because medical abortion has become more accessible over the last several years, many women prefer this method; although some countries have stricter restrictions than others, a healthcare provider is usually directly or indirectly involved through an in-person or telemedicine appointment (Berer, 2020; Kerestes et al., 2019).
Interestingly, repeated messaging has been proposed to improve the knowledge about and acceptance of abortion. Purportedly, a lack of information and negative attitude toward abortion, particularly from a religious perspective, exists due to a deficit of values clarification including understanding, empathy, perceived barriers and openness to change (Frohwirth et al., 2018; Turner et al., 2018). Notwithstanding and perhaps unexpected by those who view pro-life advocates as ignorant regarding the dynamics of abortion or hostile toward those who have chosen abortion, the reaction by most people in which women disclose having an abortion tends to be more supportive than angry (Cowan, 2017). Also important to realize is that even though one may not support the act of abortion, they may still support and offer grace to the person who has had or contemplates an abortion; a stance that is both pro-woman and pro-life (Traina, 2018; Ukueberuwa, 2017).

Recent History of Abortion in the United States

The Supreme Court heard arguments for the Jane Roe v. Henry Wade case in 1971 with a subsequent hearing in 1972; on January 23, 1973 the court ruled 7-2 in favor of a woman’s right to abort (History.com Editors, 2020). The appellants in the case were Roe, a single woman who was prohibited from terminating her unwanted pregnancy, Doe, a couple in which the wife had a pre-existing medical condition that would be threatened by pregnancy, and a medical doctor named Hallford that had two pending prosecutions from performing illegal abortions in the state of Texas, and the appellee, Wade, a former Dallas district attorney (Cornell Law School, n/d).

The first hearing consisted of five arguments: A baby has opportunity and rights only when the mother chooses to give birth. The Hippocratic Oath is nullified in consideration of a woman’s constitutional right to abortion. The fifth and fourteenth amendments represent due process against the government inhibiting an individual’s personal life and liberty, and
personhood is only proven for the woman not the fetus. The ninth amendment declares people hold rights beyond those identified in the Bill of Rights (Library of Supreme Court, 1971). The second hearing included arguments reaffirming the fifth, ninth and fourteenth amendments advocating that a woman should not be forced to continue in an unwanted pregnancy, due to being pregnant a woman may not be a productive member of society thus leading to the baby becoming the responsibility of the state, and no protection exists for the fetus until after birth (Library of Supreme Court, 1972).

**Political Landscape**

To begin, a vast moral and political dialogue revolved around abortion for decades before legalization, a time devoid of regulation and oversight with some states restricting the procedure, and has contentiously evolved to a polarization between those who support and those who oppose the elective ending of pregnancy (Cohen & Parry, 1981; Mucciaroni et al., 2019). As legalization approaches its fifty-year anniversary, Americans are still divided on whether abortion should be legal, and if so to what extent, including many questions regarding the array of regulations that have been enacted over the years (Lipka & Gramlich, 2019). For example, in a 2014 U.S. Landscape Study by the PEW Research Center, many of the residents in Louisiana, Arkansas, Mississippi, Alabama, Tennessee, Kentucky and West Virginia think that abortion should be illegal (Diamant & Sandstrom, 2020).

Nonetheless, strong debate supporting abortion rights and freedoms persists. For instance, pro-choice advocates impugned President Trump’s administration with diminishing reproductive and abortion rights as a result of policies that revoked foreign aid to organizations that provided family planning and abortion, his appointment of two conservative justices to the Supreme Court, and restricted funding for U.S. organizations that offer abortion services (Aiken, 2019).
Moreover, the Trump administration’s stance on government funding of abortion was blamed for denying the right for immigrant women held in detention facilities and women incarcerated in jail or prison to an elective abortion, requiring a medical reason be identified in order to terminate; though this scenario deems carrying a pregnancy full-term punishment, no clear data exists regarding the statistics of abortion within penal systems (Sufrin, 2019). Attempting to counter a move in the direction of tightened restrictions, some states like Illinois, New York, Oregon, Maine, Hawaii, Massachusetts, and Virginia have either moved to repeal what is seen as unnecessary restrictions or expand abortion availability and funding (Cappello, 2020).

Hence, the legality of abortion has been met with a barrage of proposed restrictions that has stirred concern among those who support reproductive rights, late-term abortion, and government-based abortion funding (Andaya & Mishtal, 2016; Ibis Reproductive Health, 2018; The Editors et al, 2019). In 2013, 70 laws known as targeted regulations of abortion providers (TRAP) were passed by 22 states, restricting abortion and resulting in the closure of numerous clinics; as of early 2019, 58 abortion restrictions including bans on abortion were enacted by state legislatures in mostly the Midwest, Plains and the South and 93 proactive abortion provisions enacted in the West, Northwest and Illinois (Mercier et al., 2015; Nash, Mohammed et al., 2019). Moreover, Louisiana Act 620 requiring physicians who perform abortions to obtain hospital privileges to address emergencies and complications brought the abortion debate back to the U. S. Supreme Court in March of 2020; the argument against Act 620 revolved around the fact that many abortion providers are not eligible for privileges because of the scope of medicine they practice, not meeting requirements of being a surgeon, or admitting a required number of patients yearly (Library of Supreme Court, 2020). Perhaps this divide geographically in the United States may be explained in part due to the influence of a larger religious adherence in
certain states to protestant and catholic beliefs that life begins in the womb and abortion is an unacceptable means to end a pregnancy (Adamczyk & Valdimersdottir, 2018).

Movements: Pro-Choice and Pro-Life

Clifford (2019) proposes that when moral conviction is communicated as an aspect of social policy it can lead to political polarization, such as the debate that abortion is a woman’s right (Ntontis & Hopkins, 2018). Abortion remains a controversial and complex issue (Jozkowski et al., 2018). Defending abortion, Curry (2010) emphasizes Roe v. Wade carries relevance into the present era as this landmark decision protects all individuals from the government holding control over an individual’s body. Further, pro-choice advocates take to task the term and images of “murder” in connection with terminating an unwanted pregnancy, especially when associating the fetus as a baby (Ivy, 2005; Wisneski & Skitka, 2017). Ironically, the origins of illegal abortion was not government overreach but the efforts of the American Medical Association, a professional organization for physicians, who lobbied for abortion to be deemed illegal as a means of controlling who and how doctors could treat patients (Cohen & Parry, 1981; History.com Editors, 2020).

Specifically, a pro-choice perspective of abortion supports the mother’s right to choose without undue burden whether she gives birth or terminates the pregnancy, emphasizing it is the woman’s body and her goals and desires are the apex for decision-making (Borgmann & Weiss, 2003; Fetrow, 2018). Fathalla (2020) considers not offering legal and safe abortion an infringement upon a woman’s human rights; moreover, the inability of not accessing this right is viewed as possibly contributing to negative psychological states (Steinberg & Russo, 2009). Subsequently, those who identify as pro-life are sometimes defined by pro-choice advocates as being judgmental in perceived stereotyping of women who abort, infringing upon women’s
rights through anti-feminism thought, and restricting funded research (Duerkson & Lawson, 2017; Marecek et al., 2017). Again, since the fetus is in the process of developing in utero and totally dependent upon the mother, the fetus is not seen as a separate individual until birth (Ivy, 2005). In conclusion, advocates for abortion emphasize that women seek abortion for numerous reasons including school or work, relationship issues, and lack of resources; thus when heavy restrictions are enacted, a woman who is facing an unwanted pregnancy is potentially submitted to an array of stress--socially, psychologically, financially, and even geographically if the nearest clinic is a hundred miles away (Biggs et al., 2013; Greasley, 2017; Mayans & Vaca, 2018).

In contrast, pro-life proponents may begin a discussion by differentiating whether a pregnancy is unplanned or if the child is unwanted, and in some settings such as A Caring Pregnancy Center (ACPC), seek to offer medical services, counseling and options that support both the lives of mother and baby (ACPC, 2017; Moreau et al., 2014). Ultrasound and waiting periods are abortion regulations that allot a pregnant woman a reference point for the existence and the current development of her baby and offer an extended aspect of informed consent and time to consider options to avoid an impulsive choice (Friz, 2018; Upadhyay et al., 2017). Pro-life obstetricians and gynecologist acknowledge the emotional, mental and psychological challenges a woman experiences when faced with an unexpected pregnancy and support her decision options by offering referrals beyond abortion providers (Pauls & Landwehr, 2017).

Purposefully, pro-life efforts extend to upholding the baby’s right to be born (National Right to Life, 2013). Statistics show that babies born before 24 weeks have a survival rate less than 50 percent, rising to 60 to 70 percent after 24 weeks and 80-90 percent after 28 weeks (University of Utah, 2020). Additionally, limits to abortion 20 weeks and under have been a focus of regulation change since fetal pain is associated with abortion beyond this point along
with potential viability of the fetus (Grossman et al., 2014; Cohen & Sayeed, 2011). Furthermore, pro-life advocates have confronted pro-choice positions by focusing on ideology associating with a lack of differentiation of personhood between fetus and neonate and through efforts to limit the expansion of abortion, including late-term elective abortion and abortion terminating the fetus with a diagnosed medical anomaly, either before or after birth, (Francis & Silvers, 2013; Giubilini & Minerva, 2013; Tooley, 2013). Finally, a crucial piece of legislature that has garnered substantial support by medical professionals is the Born Alive Abortion Act, which addresses babies not being left to die inhumanely after surviving an abortion (Harrison et al., 2019; Terzo, 2019).

Viability and Personhood

Perhaps the only point of agreement for some on both sides of the abortion issue is that of viability and personhood of the baby, which may be the pivotal key in determining if abortion is ethically or morally permissible (Kamitsuka, 2018). Viability of the fetus has been a premise for abortion restriction, allowing for termination before this point when the fetus could survive outside the mother’s womb (Han et al., 2018). Over the decades since Roe v. Wade passed in 1973, viability of a fetus has remained at approximately 24 weeks, with an estimated 54% of surviving preterm babies born before 25 weeks sustaining mild to no disabilities and 46% moderate to severe disabilities; yet issues of subjective interpretation still exist favoring the rights of the woman due to ambiguities regarding ontological status (Eades, 2019; Marlow et al., 2005; Oehmke et al., 2019). Notwithstanding, the fetus as a patient obtains moral status independent of the mother when there is the ability to survive as a neonate with biomedical and technological capacities. Research indicates via thalamus and subplate presence, sufficient nociceptive pathways, arousability, wake time, and hormonal and behavioral indicators of pain
that a fetus in the second half of pregnancy is likely to experience pain, medically prompting analgesia for surgical procedures (Bellini, 2019; Chervenak & McCullough, 2017; Derbyshire & Bockmann, 2020).

Furthermore, evidence discloses that plasma begins being pumped in a fetus’s heart and fetal red blood cells developing around three weeks (Artal-Mittelmark, 2021). A fetus is formed by the end of the first semester with the nervous system continuing to develop throughout pregnancy, reflecting the capacity to react to visual stimuli in the third semester (Reid et al., 2017; Terzo, 2019). The technology of ultrasound allows for parents to view the developing fetus at 2D and 3D/4D perspectives, providing vivid images that may facilitate a deeper bond with the unborn baby. In fact, some parents choose to invest in Keepsake Ultrasounds which initiate a memory book beginning in-utero (de Jong-Pleij et al., 2013; Dowdy, 2016). Moreover, proud expectant parents often celebrate a gender reveal and choose a name for their unborn baby early in pregnancy. These acts indicate personhood for the fetus (Daou, 2010).

Finally, analogous to the determination of when life begins is the investiture of personhood of a fetus. The Fourteenth Amendment has been utilized as a proponent for and against the personhood of a fetus with conception being considered the point in which a human being acquires DNA sequence and thus obtains personhood (Biggers, 1981; Horne, 2007). Yet proponents of a fetus being inseparable from the mother and merely existing in a state of process suggest that it is the mother that bridges a multi-staged gap between conception, in-utero development, and personhood including post-birth development (Ivy, 2005). Regardless, in some states the death of a fetus is recognized as a homicide. In fact, 30 states have laws which attribute victimhood to an unborn person or fetus at any stage of development (NRLC, 2018). Adding to the complicated examination of the abortion debate is the significance of implantation and the
ethical dilemma of how cryopreserved embryos that were purposefully harvested should be approached when not implanted via IVF, as technically, fertilization has occurred and implantation is possible (Gilles, 2015; Sheldon, 2015).

**Moral Ideology**

Perhaps the most relevant question for many in determining the permissibility of abortion revolves around when life begins. Argument has been made stating the association of Christianity rejecting abortion is not based upon a comprehensive historical and biblical context, suggesting the Bible is God’s interaction with man and not imperatives for life via verses that have been topically chosen (Castuera, 2017). Nevertheless, a Biblical perspective does offer insight into God’s motives and acts within Scripture to convey His interaction with humankind throughout the continuum of life, which assigns value to those who are considered “the least of these.” For example, Psalm 139:13-17 establishes that not only is one formed in the womb by God’s design, but also is privy to God’s purpose during this period of unseen development, extending after birth and throughout life (Amplified Bible, 1987). In support of this point of view, an online survey of 600 people who were predominately in vitro fertilization (IVF) professionals and patients in the United States, Europe, United Kingdom and Australia/New Zealand, approximately 65% responded to three choices of when life begins: the sperm fusing with the egg, implantation, and the detection of a fetal heartbeat (Elliot et al., 2008). Yeung (2005) purports that fertilization points to the beginning of life due to a trajectory that reveals the development of a human being.

Adherence to the notion of life’s purpose influences people’s views and beliefs in human life. Roy (2018), whose work has been an influential source within nursing research, proposes spirituality founded in a philosophical focus upon the purposefulness of human life assists in
approaching and making crucial moral and ethical decisions pertaining to medical care. In the
assessment of terminating the life of a fetus, one must consider moral worth and the weightiness
of the act of abortion (Simkulet, 2019). Wisdom encourages discussion and the struggle to
delineate the moral status of a developing, yet unborn, fetus, is an ongoing deliberation that
might assume a common ground in the overall benefit of reducing the number and rate of
abortions (Gert, 2010).

**Philosophical Perspective**

Equally important as the mother’s rights to her life are those of the baby. Hendricks
(2019a) proposes through an impairment argument that if it is considered immoral to expose a
fetus to substances in utero culminating in the fetus being born with fetal alcohol syndrome,
which deprives the fetus of a future holistic well-being, then it would also be immoral to kill a
fetus via abortion. A more recent philosophical development in the contemplation of mother and
fetus rights is the theory of life after abortion through a process called ectogenesis, that is the
development of the fetus outside the womb in the form of a scientific surrogate. A two-fold
purpose could be fulfilled through ectogenesis as the life of the baby would be preserved and
adoptive parents could realize their desire to parent (Mathison & Davis, 2017). Significantly, this
paradigm theoretically points to a possible end of the abortion debate as the woman would be
allotted the opportunity to terminate her pregnancy and the fetus offered the potentiality of life;
notwithstanding the consideration of the ethics surrounding ectogenesis.

Although the prior pro-life evaluation may be true, from a pro-choice perspective
Rasanen (2017) purports genetic parents have a right to the death of a fetus, even in ectogenesis.
According to Rasanen (2017) abortion ends pregnancy, whereas ectogenesis would result in the
genetic parents being in a state of attributional parenthood, whereas they may feel some sense of
responsibility or attachment to the child even if raised by someone else; additionally, the act of ectogenesis abortion negates the parent’s genetic privacy and breaches parent’s rights to destroy their property as the fetus is viewed as belonging to them. Countering this defense is the argument that even though a child carries his or her parents’ DNA via paternal and maternal consent, once conception occurs the DNA has been given to and becomes the genetic makeup of the child, and comparatively the child to parent relationship is not equivalent to that of property to owner (Kaczor, 2018). Continuing this argument, the premise of right to property of offspring is inaccurate as an embryo might be associated as property while the fetus may not, and even if abortion is permissible, parents would not have the right to destroy their fetus; additionally, the supposition that the death of the fetus absolves all parental obligations earlier associated with attributional parenthood is misguided (Hendricks, 2018; Mathison & Davis, 2017). Finally, Blackshaw and Rodger (2019) maintain that the killing of a fetus, a viable human being even if not having complete moral status, is a weak argument.

Abortion Industry Workers

A low number of practicing OB/GYN providers, approximately 7-14%, provide abortion services with a higher percentage being female physicians; in contrast, as high as 43% of those in OB/GYN practice do not refer to abortion facilities or practitioners (Desai et al., 2018; Stulberg et al., 2011). Because of the social polarity that exists surrounding what is viewed as the necessity of abortion work and the ethical and moral acceptance of such, abortion provision may be seen as abnormal or even deviant, which may lead to a lack of disclosing one’s job due to concerns of rejection, judgment, and harassment (Harris et al., 2013; Kumar, 2013). Additionally, concern surrounds abortion facilities often being separated from other medical providers and being at risk of alienation from mainstream healthcare in a manner that not only
contributes to stigma, but also influences availability for patient care (O’Donnell et al., 2011). Finally, aspects of negative clinical experiences and conscience objection asserted by some medical professionals influence abortion provision (Czarnecki et al., 2019; Johnson & Detrow, 2016).

Provider Experiences

To begin, those who work in the abortion industry often enter the field with the intent to help women from a supportive and non-judgmental approach (Britton et al, 2017). Nurses are deemed to be caring and compassionate individuals. Those who work in abortion facilities support a woman’s right to abortion and often ethically justify professional involvement in performing these procedures by attributing difficult life circumstances as mediating a woman’s choice to terminate (Feo et al., 2018; McLemore, Kools et al., 2015). Nonetheless, even though support of abortion is unanimous among providers, some struggle maintaining a balance between abortion provision and government restraints, as well as the dichotomy between nursing as a profession purposed on saving lives and offering acts of healing and assisting with the termination of a life (Gallagher et al., 2010; Purcell et al., 2017). Finally, providers identify complying with regulations such as obtaining admitting privileges in order to perform abortions and TRAP laws as interrupting and limiting abortion provision (Joffe, 2018).

Furthermore, the comradery of a professional community is often absent in abortion work. Research estimates that 60% of terminations are performed by independent providers and 35% by Planned Parenthood (an affiliated non-profit organization), with only 5% occurring in hospitals or physician offices (Abortion Care Network, 2018). Job responsibilities and demands for those working in the abortion industry reflect higher levels of stress, especially with the rising numbers of medical abortions which require increased emotional support due to the painful and
at times traumatic process. Self-care through improved coping, supportive and intuitive supervision, staff training and development, and targeted workshops has been found to assist in managing mental and emotional pressures while facilitating support (Debbink et al., 2016; Lipp & Fothergill, 2009).

Finally, abortion workers often feel their well-being is at risk because of the services offered by their profession. Physical, mental and emotional threats toward abortion clinics and workers have been part of workplace concerns since legalization, with an increase in exposure to hate speech, picketing and obstructing in front of clinic doors (National Abortion Federation, 2018). Consequently, abortion workers who are exposed to or directly experience violence through protester aggression, including but not limited to yelling, pushing, name calling or obstruction, are at risk for mental health issues. PTSD symptoms have been identified as being linked to exposure or witnessing of offensive behaviors and violent acts associated with abortion work (Fitzpatrick & Wilson, 1999; Lowe & Hayes, 2019).

Stigma Associated with Abortion Work

Many who work in the abortion industry sense a negative characterization of their profession stemming from restrictive abortion laws and regulations, stigma of dirty work, and moral incongruence within their communities (Britton et al., 2017; Jones et al., 2018; Kumar, 2018). To begin, dirty work is associated with vocations that are often a necessity in society yet deemed as undesirable or even disgusting due to the substance of the work, such as interacting with excrement, blood or death and in some cases may reflect a lack of education or skillset (Simpson & Simpson, 2018). The connection between dirty work, stigmatization and emotional exhaustion may result in negative effects both in and outside of the workplace (Bentein et al., 2017; McMurray & Ward, 2014). Consequently, the stigma associated with dirty work suggests
that the person performing job responsibilities is tainted, inferior or even deviant as in abortion provision; nonetheless, it is proposed that managers can actively advocate for these individuals by hiring according to vocational fit indicating an affinity for the role, assisting new hires in learning how to mitigate negative connotations of work tasks, and maintaining a positive affirmation of job performance that might otherwise lack from outside the workplace (Ashforth et al., 2017; Astbury-Ward, 2018; Chiappetta-Swanson, 2005).

Interestingly, the stigma associated with abortion has been projected as being weaponized by those who are pro-life and support restrictive measures (Norris et al., 2011). Subsequently, an inability to separate abortion stigma from abortion work may negatively affect a worker’s personal and professional life in the beginning of one’s career, but eventually the stigma may dissipate as reflected by providers often scoring higher on compassion satisfaction (Harris et al., 2011; Martin, Debbink, Hassinger, Youatt, Eagon-Torkko, & Harris, 2014). The Revised Abortion Providers Stigma Scale offers insight into disclosure management, internalized states, judgment, social isolation and discrimination by quantifying the stigma experiences of those who work in abortion provision and is a positive tool for intervention (Martin et al., 2018). Finally, Janiak and Goldberg (2016) propose the term “elective abortion” be replaced with “induced abortion” as a means of reducing negative perceptions and stigma.

Ethics of Abortion Methods

Those who work in the abortion industry are faced with ethical aspects of practice. For instance, post-abortion care is often non-existent due the presumed safety of the procedure, yet more recent regulations have taken into consideration that complications still occur and suggest a need for availability of coordinated care for these patients (Dickens, 2019). Similarly, consideration for the mother’s well-being before any abortion procedure is recommended,
including performing an ultrasound to rule out ectopic and at-risk pregnancies (Detti et al., 2020; Schmidt-Hansen et al., 2020). Ultrasound technology utilizes pulsing sound waves, which interact with tissue and result in echoes when passing through electrical current, resulting in a two-dimensional image that assists with diagnosis (Powles et al., 2018). Nonetheless, advocates for limiting restrictions think that mandating ultrasound as a medical procedure is unethical and has the potential to do harm to the patient, such as seeing the developing fetus and hearing a heartbeat the day before terminating the pregnancy (Kreutzfeld, 2017).

Furthermore, ethical consideration should be given to the fetus when choosing the type of abortion procedure since evidence differentiating the type and amount of pain experienced by the fetus during evacuation is still being explored (Kluge, 2015). Beckwith (as cited by Hendricks, 2019b) reminds his readers that certain methods of surgical abortion, such as dilation and curettage and induction, do not lead to the immediate death of a fetus. The use of ultrasound in guided abortions may lead a provider in emptying the uterus of the products of conception, but also may reveal the fetus moving away from the curette, thus indicating sensation and possible pain (Johnson et al., 2014).

**Moral Integrity**

As previously mentioned, although personal values and beliefs vary among individuals working in the abortion industry, the aspect of moral integrity remains fundamental in nursing as well as an ethical standard of caregiving (Laabs, 2011). Also, the lack of quantification for the permissibility of abortion, regulated oversight, and an adequate reporting system call into question the ethics surrounding many facilities which engage in abortion provision (Studnicki & Fisher, 2018). Moreover, at times women seek an abortion due to circumstances stemming from abuse or rape, which places providers in a position of contemplating whether to proceed as
normal, offer empathetic support, or report the woman’s disclosure to legal authorities (Perry et al., 2015). In conclusion, often those who work in abortion provision do not have a broad support system such is available to general and more accepted aspects of medical practice (Jacobs, 2015).

**Conscience Objective**

Without a doubt, the abortion rights debate has been founded upon the ethical necessity of legal abortion in order to save the lives of women who would otherwise seek an illegal and potentially dangerous “back alley” abortion; nonetheless, even though abortion is legal, physicians maintain the right to refuse performing them (Faundes & Miranda, 2017). Decisions of whether to engage in certain medical procedures, such as abortion, are for some complicated and often consider aspects of work contexts, obligations and experience, personal beliefs, values and life experience, and patient circumstances (Cowley, 2019; Czarnecki, et al., 2019; Lamb et al., 2019). Interestingly, work-related moral incongruence or stress of conscience has been linked to depersonalization, where one feels as if one is merely going through the motions and not wholly present, which may lead to burn-out (Badro, 2013; Glasberg et al., 2006; Lamb, 2016).

Conscience objection (CO) on behalf of a medical provider involves the individual’s moral agency, authenticity to integrity, one’s professional role and patient obligations (Harris et al., 2018). In identifying CO as it relates to abortion, aspects of one’s beliefs about abortion seem to direct actions and may be influenced by a sense of stigma or political component (Harris et al., 2016). Although the choice to assert CO has been legal for decades, some claim that it poses a risk to individuals in need of medical attention, including those who seek to terminate a pregnancy (Morrell & Chavkin, 2015; Sepper, 2019). Notwithstanding, CO does not have to be incompatible with competent patient care as many OB/GYN organizations support a balance of
CO and fulfilling one’s professional responsibility by counseling and referring the patient to an abortion provider (Neal, 2019; Ralston, 2018).

**Training**

Research presents a need for training in order to provide competent services to clients seeking abortion. To begin, first line providers including primary care, health clinic and other social service professionals are encouraged to take advantage of organizations such as *Description Provide* that teach necessary referral skills which address aspects of unplanned pregnancy and offer accurate abortion-related-information (O’Donnell et al., 2018). Secondly, the training of medical students in abortion and family planning is important as TRAP laws have been instrumental in physicians ceasing to provide abortions as part of their practice. Thus, an increase in family practice training has been identified in areas of the country that are not under restrictive regulations (Britton et al, 2017; Gowda, 2019). Finally, improved knowledge is essential regarding procedure and process, communication and empathy, and training and experience when caring for second trimester (13-24 weeks) abortion patients, as these women may suffer higher levels of physical and emotional pain when delivering a deceased fetus through medical and surgical abortion. This may also be emotionally disturbing for providers who handle the delivered fetus (Andersson et al., 2014; Lerma & Blumenthal, 2020; Mauri et al., 2015).

**Recruitment and Retention**

A recent study of reproductive healthcare providers suggests that although a strong majority support a woman’s right to an abortion some discrepancies emerge among younger workers, such as supporting restrictions requiring counseling and ultrasounds, and may pose a future risk to adequate medical personnel within the abortion industry (Dodge et al, 2016). In
response to value-based issues, Gingrich (2017) advises that nursing students be exposed to in-depth information on contraception and abortion in a classroom setting which invites conversation and debate, allowing them to identify and address personally held values in context of their future profession, and direct attention to the patient’s need for care over personal ideology. Additionally, recruitment of clinically trained and didactically informed nurses at the educational institute level is necessary to provide the medical personal required to meet the imminent needs of abortion facilities (McLemore, Levi et al., 2015; Turk et al., 2014). Similarly, utilizing certified nurse midwives, nurse practitioners and physician assistants to perform abortions in the first trimester not only remains consistent with safety standards, but also lowers the cost of the procedure for those who lack financial means (Tillman & Levy, 2020; Weitz et al., 2013).

A key element beyond recruiting competent personnel is retaining these professionals. Understandably, job longevity and satisfaction increase with coping mechanisms that reduce stress and compassion-fatigue and bring balance between private life and professional obligations, whereas aspects of moral distress may hinder retention (Lamiani et al., 2017; Wolkomir & Powers, 2007). To begin, some cultures have stronger beliefs about life, which may lead to a nurse’s disapproval of induced abortion even if concealing their stance, which may interfere with level of care (Yang et al., 2016). Lipp (2011) suggests that self-preservation manages negative emotions and is supported by being mindful of and maintaining personal values, mitigating judgement and disapproval of repeat clients or those terminating at an advanced gestational stage, and still adequately addressing the needs of the patient. Lastly, in a more recent study, compassion satisfaction was found to increase professional fulfillment and was strengthened through positive connections with other abortion providers (Teffò et al., 2018).
Moral Distress

Stress is an undeniable aspect of working in the medical field, as one’s decisions affect patient care, recuperation and overall quality of life. To begin, burnout (BRN), an aspect of moral distress (MD), is an ever-developing phenomenon among healthcare workers and has shown evidence of being an outcome of one’s nursing role and the demands of a stress-laden job (Garcia-Sierra et al., 2016; Waddill-Goad, 2019). Among abortion providers, those who work in freestanding clinics that specialize in women’s medical and abortion services experience a higher level of BRN (Janiak et al., 2017). Next, compassion fatigue (CF), another key component of MD, has been found to result from BRN and secondary traumatic stress (STS), and develops as one deals with critical care, end of life circumstances, increased patient load, and lack of proper staffing (Austin et al., 2017; Corley et al., 2005). Finally, MD is a phenomenon experienced by those in the medical profession when presented by a choice between alternatives that result in perceived negative outcomes or confronted by a situation that counters his or her sense of right or wrong (Fourie, 2015; Oh & Gastmans, 2015).

Moral Distress in Health Care Providers

Wilson (2018) discusses a MD theory that considers those who work in the medical profession (acknowledged a moral profession) as moral agents who make decisions on behalf of patients and act according to their professional judgement. Unfortunately, even the best decisions at times end in poor outcomes and may result in mental and emotional turmoil. Medical professionals bring personal values, beliefs and attitudes to work as part of their moral agency; furthermore, nurses tend to associate relationships and connections they maintain in their personal lives with nursing encounters, which may contribute to the stress they experience in the form of occupational stress, MD, or actual traumatization (McGibbon et al., 2010). Moral and
ethical issues that construct an ethical climate mediate the progression of MD, including quality of professional life and the longevity of medical personnel (Pauly et al., 2009).

Numerous factors have been attributed to MD, which is proposed to be destructive to the moral agency and integrity of healthcare professionals, such as involvement in what may create a sense of dirty hands, possible ethical conflicts when decisions must be made choosing one patient over another, dealing with economic constraints, when patient rights to privacy interfere with communication between providers, and requirement to meet challenging or antiquated regulations (Hamric, 2012; Tigard, 2019). Additionally, the context in which a moral dilemma occurs must be considered to understand the development of MD as a multi-faceted phenomenon (Kalvemark et al, 2004; Morley et al., 2019). Research points to the benefit of organizational support from supervisors regarding ethics-related issues, along with formal training promoting self-efficacy for attending to moral and ethical circumstances (Rathert et al., 2016).

Nurses identify experiencing increased frustration and decreased work satisfaction when institutional constraints either rival or prohibit acting according to what they perceive as the right course of action (Burston & Tuckett, 2013; Zuzelo, 2007). Particularly, emotions are directly associated with one’s moral compass and thus are influenced by situations that challenge moral integrity (McCarthy & Monteverde, 2018). In a systematic study utilizing metaethnography, medical and mental health professionals who either encountered or worked directly with abused children felt moral distress or moral dilemma due to feeling inadequate to assist the child or fear of making the situation worse (Albaek et al., 2018). As such, research reflects that Tigard (2019) is correct in emphasizing that ongoing efforts need to be made to increase clarity on the nature of MD, along with the causes and how this phenomenon develops.
Since the concept of MD was introduced by Jameton in 1984, which identified MD as one not being able to pursue what seems or feels right due to employee or organizational restrictions, numerous studies have been conducted on medical professionals and have extended into organizational and sociopolitical realms that also pose ethical concerns (Jameton, 2013). Morley (2018) recommends a three-point proposal of MD with one experiencing a moral event and psychological distress with a direct and casual relationship between the two. For instance, although physicians and nurses working in neonatal, pediatric and adult intensive care units exhibit higher levels of MD due to critical care issues, healthcare personnel involved with direct patient care in various degrees demonstrate MD overall (Prentice et al., 2016; Trotochaud et al, 2015; Whitehead et al., 2015). Hanna (2005), who conducted research on moral distress as experienced by nurses required to assist with elective abortions before conscientious objection, found moral distress to be a form of internal withdraw or an inner belief that one engaged in hurting instead of helping. On the other side of this issue, there are physicians who feel that state legislature that restricts abortion procedures creates symptoms of MD as they are unable to offer certain services to patients (Berlinger, 2016).

Moral Injury

According to Antonelli (2017), MI is an outcome and key facet of a traumatic event. Such events may fall into categories influenced by organization or leadership, an unsafe environment, circumstances involving culture or relationships, and psychological contexts (Currier, McCormick et al., 2015). Even though these types of experiences often occur in a split second, the effects may either lie dormant or extend over a lengthy period (Held et al., 2019). Threat to one’s life adds to MI as one’s sense of safety is stripped by traumatic experiences and damages a person’s core morality or moral worldview (Litz et al., 2018; Yan, 2016).
Additionally, Yandell (2019) proposes MI presents within the realm of human relationships. Research has deciphered an association between acts of war and a soldier’s moral core; these attributes of moral injury should be studied and applied to other disciplines beyond military veterans and include family members and other close relationships (Haight et al., 2016; MacLeish, 2018; Wiinikka-Lydon, 2019).

An array of symptoms may be exhibited by those exposed to potentially morally injurious experiences (PMIEs) and should be approached from an aspect of clinical significance (Griffin et al., 2019, Meador & Nieuwsma, 2018). Primary symptoms of MI are noted as guilt, shame, spiritual crisis and doubts about meaning in life, whereas secondary symptoms include reexperiencing and avoidance, depression, anxiety, substance use, suicidality, and difficulties with relationships and social functioning (Bravo et al, 2019; Jinkerson, 2016). Jinkerson and Battles (2019) found that an individual’s primary or core MI symptoms mediate the relationship between the exposure to a PMIEs and secondary symptoms. Intrusive symptoms include one’s mind replaying past events, imaging bad things happening such as worse-case scenario, the inability to find solutions and uncontrollable thoughts; basically, an inability to separate oneself from troublesome thoughts and feelings (Farnsworth, 2019; Gibbons et al., 2013).

Moral Injury is not a recognized diagnosis in the DSM-5 and although there is a growing amount of research defining symptomology, there is still no formal and empirically defined definition of this phenomenon (Litz & Kerig, 2019). Research also has revealed differences in brain scan results between PTSD and MI, as well as identifying forgiveness as a key aspect of healing for MI (Barnes et al., 2019). The distinction between PTSD and MI are not clearly defined, although both reflect commonalities and associations (Davies et al, 2019; Smigelsky et al., 2019). Hodgson and Carey (2017) state that due to being a phenomenon that is complex and
multi-faceted in nature, MI remains exploratory. Gray and colleagues (2017) define moral injury as a self-handicapping syndrome that is demoralizing and dominated by shame and anger and MI is not only problematic, but also detrimental to one’s overall well-being if aspects of self-blame are not met with hope, compassion and forgiveness. Blame, as a symptom of PTSD, correlates with MI with increased intrusions and emotional distress, such as shame and guilt (Bub & Lommen, 2017).

Questions arise when diagnosing symptomology that may correspond with syndromes such as BRN, MD, PTSD, and MI. Moral injury in healthcare is considered a violation of one or more of the “four pillars of bioethics,” which includes nonmaleficence, beneficence, patient autonomy, and social justice (Heston & Pahang, 2019, p. 483). Those who have morally injurious experiences feel a sense of betrayal, which differs according to whether the individual or another person was responsible for the act, as well as whether the act was one of commission or omission (Schorr et al., 2018). Nash (2019) presents two moral injury paradigms beginning with Farnsworth’s Prescriptive, a cognitive behavioral approach that points to psychological trauma stemming from faulty beliefs of self and others, leading to damaging and exaggerated behaviors that reflect mental, emotional, and physical impairment. The other paradigm is the Stress Injury Model, founded in a bio-medical perspective that associates moral injury as a response to an actual event which violates one’s personal values, morals and beliefs of self, others, and the world, resulting in a “literal wound to the mind, brain, body, and spirit” (p. 468).

Mental health issues ranging from depression, PTSD, MI, suicidality, spiritual struggles, loss of life meaning, and substance abuse have been identified as symptomatic of wartime experiences that either inhibit a person’s daily functioning or shake one’s moral compass (Barnes et al., 2019; Battles et al., 2018; Battles et al. 2019). Whether MI is an outcome of PTSD or
contributes to PTSD, medical and mental health professions must be mindful that MI is an
unseen wound that influences assessment and treatment of symptoms such as dissociative states
or reactions, intrusive memories or distressing dreams, mood changes, fragmented core beliefs,
personality changes, identity crises, attachment or relationship disruptions, and struggles with
guilt and shame (American Psychiatric Association, 2013; Bartzak, 2015; Drozdek et al., 2020).
Due to the extensive nature of MI, considerations for management and healing of symptoms
must move beyond psychotherapy and encompass other life aspects to address and meet client
needs (Molendijk, 2018).

For those who have experienced MI, rumination is a contributing factor to persistent
mental health issues, such as intrusive memories (Bravo et al., 2019). Suicidal ideation and self-
harm, although not exclusive to moral injury, can have a profound negative effect upon veterans.
Moreover, there is evidence that betrayal of self and others is connected with not only
psychological distress, but also spiritual distress or struggles (Evans et al., 2018). Spiritual
struggles studies conducted with veterans have identified differences in psychological and
religious or spiritual aspects of spiritual struggles, and MI struggles as they correlate with one’s
premilitary spiritual or religious or cultural background (Currier et al., 2019).

Coping with moral and spiritual injuries might include substance use, since mental
challenges such as PTSD, depression and anxiety often co-exist with substance use and abuse.
Recent studies with veteran populations found wartime experiences, which are often associated
with moral injury, correlates with suicidality, substance use and other mental health issues
(Battles et al., 2018). Alcohol use abets emotional numbing and avoidance of negative affective
states, which if left unchecked leads to self-harm. Alcohol misuse interrupts relationships and
adds to an already existent depression (Battles et al., 2019). Interestingly, the difference between
male and female mental health effects associated with MI did not reveal significant variance in these outcomes (Kelley et al., 2019).

Again, MI may be described as a conflict of values that results in a compromising of circumstances and rivals one’s concept of how things “should” function or work, drawing attention to human imperfections and any discrepancy in personal values (Molendijk et al., 2018). Thus, assessment for PMIEs through the use of measurements is necessary for identifying relevant mental and emotional health variables and their relationship with PMIEs. This information not only adds to understanding, but also to treatment options and planning (Williamson et al., 2018). Assessments, such as the Moral Injury Events Scale and the Modified Moral Injury Questionnaire have been developed to identify exposure to and acknowledgement of traumatic and morally injurious events, seeking deeper insight into the dimensions and characterizations regarding experiences related to perceived transgressions by self or others that contribute to MI (Braitman et al., 2018; Bryan et al., 2017; Currier, Holland et al., 2015). The Moral Injury Event Scale (MIES) is a self-report measure associated with symptoms of MI and indicates a sense of transgression toward others and self, along with betrayal (Bryan, et al., 2016). Moral injurious events are not limited to military veterans, and research extends to other populations such as journalists, teachers and police officers exposed to significant violence (Williamson et al., 2018). The Moral Injury Outcome Scale (MIOS), which reflects both reliability and validity, addresses multiple dimensions of MI expanded to those who assist in therapeutic process, such as clinicians, as they add a much-needed perspective for treatment (Currier, Holland, & Malott, 2015; Koenig et al., 2018; Yeterian et al., 2019).

A possibility exists that abortion work may hold some commonalities with combat veterans in experiencing incidents that lead to moral injury, even if it is a result of dirty hands
TIME FOR A CHANGE? THE LIVED EXPERIENCES OF

(DH). For instance, many people find the act of killing off-putting and therefore may approach the topic with either a sense of disdain or misunderstanding (Bush, 2013). Wiinikka-Lydon (2018), sees “moral injury as the dirt of dirty hands” and the decisions they create (p. 357); both MI and DH include manifestations of guilt and shame, although MI corresponds with a choice between conflicting values in which both options lead to damaging outcomes, and DH is a choice that even though iniquitous may be supported by a law or deemed necessity. DH in its ethical complexity juxtaposes an act morally required with a moral wrong, leaving to question whether such acts are punishable (de Wijze, 2013). Sneddon (2019) determines that the term “hands” is directly correlated with the implication of personal agency.

Military veterans who indicate moral injury due to warzone experiences struggle with questions regarding global meaning and perhaps a loss of life meaning, thus resulting in mental and spiritual health challenges (Currier et al, 2019). Although MI may be linked with PTSD, a therapist should be careful to address the needs of one’s wounded soul and not just treating the apparent diagnosable mental health disorder (Dombo et al., 2013). Complicating the counseling relationship is the barrier of trust that the individual has constructed for self-protection as the morally injurious experience violated a profound trust in others and self (Shay, 2014).

**Key Aspect of Resolution**

Acts of moral injury result in emotions and cognitions that lead to a conflict and struggle for meaning and suggests a sense of being stuck in the traumatic experience connotated by emotional, mental, physical and spiritual symptomology (Kopacz et al., 2016). A critical therapeutic aspect of MI, in which loss of meaning in life is a core symptom, is addressing the need for meaning-making as part of an individual’s existential paradigm (Bremault-Phillips et al., 2019). Existential threats impact one’s sense of meaning and well-being; emotional self-
understanding and regulation is linked with increased meaning and improved management of
distressful life challenges (Abeyta et al., 2015). Positive life changes can occur when a person
has a sense of meaning in life; although a search for meaning does not automatically result in
positive change, cognitive resolution to difficulties is an aspect of finding meaning (Linley &
Joseph, 2011). Deering and Williams (2018) propose the process of recovery that subdues self-
harming behaviors requires renewing identity and building hope and meaning while facilitating
personal empowerment and connectedness with others.

Influence of Global Meaning

Two facets of meaning influence experience perception. First, situational meaning is a
relative factor in addressing disruptions or disturbances of one’s goals and direction in life, thus
often creating a negative state of being, such as anxiety, depression and lowered self-esteem that
challenge global beliefs and life goals (Park & Gutierrez, 2013). Second, global meaning relies
upon seeing beyond a single experience to a broader focus on cumulative experiences that occur
over time and requires an element of relinquishing goals, compromising beliefs and sense of
meaning (Hicks & King, 2007). Meaning systems are most functional when one’s personal life
experiences, which are associated with situational meaning, are congruent with one’s ideology of
global meaning; distinguishing the difference between the two facilitates understanding and
acceptance of stressful or traumatic life events (Park et al., 2016).

Interjecting the concept of global meaning into an existential challenge facilitates deeper
understanding and promotes renewed perspective. Park (2017) describes function meaning as a
key element of determining personal change. Components of global meaning include emotion, as
a subjective sense of meaning when experiences cause distress due to a lack of understanding or
purpose, and the compromising of one’s belief of self, God and others which is reflected through cognition and interferes with personal goals and motivation.

According to Wong (2010) there are four components of global meaning: the motivational aspect of purpose, the cognitive component of understanding, a behavioral component of responsibility, and the affective component of evaluation or self-regulation. Martela and Steger (2016) discuss what they perceive as three key facets of meaning, including coherence (ability to make sense of meaning), purpose (life goals or direction) and significance (values and substance of life). Specifically, individuals must grasp a comprehension of both self and the world, as well as an objectivity and intentionality of actions and perceived worth. Fundamentally, this shift involves an altering of how one understands the troublesome event of one’s global meaning.

Although seeking meaning amid one’s problems has been discussed through the years as therapeutically significant, a proactive approach to meaning making is linked with improved coping and holistic well-being (Miao et al., 2017; Steger, 2012). Assessment assists in identifying how a stated stressful experience or traumatic event has affected an individual through “The Global Meaning Violations Scale,” which consists of five questions comparing how one felt before and after a significant event, as well as the extent to which eight aspects of one’s life have been impaired (Park et al., 2016). As life meaning emerges and increases, people suffering with depression may find their hopelessness decrease, which often in turn lowers suicidal ideation and risk, including among those who have endured moral injurious experiences (Braden et al., 2017; Corona et al., 2019; Gross et al., 2019).

Spiritual Considerations
Frankl (2006) maintained that meaning is derived from belief and faith in God and that the search for meaning is neither pointless nor futile. God exists and thus purpose exists. Meaning within this paradigm is developed through how one responds to unchangeable and challenging circumstances via a will to meaning, suffering, and freedom that moves a person away from the pain and toward resolve through one’s freedom of choice and reactions throughout a hardship. While a perceived normal response to overwhelming circumstances would seem abnormal, instead it is perceived as an awareness and acceptance of the trauma cultivated by hope for change and healing that empowers one to move forward (Kopacz et al., 2019). Frankl (2006) advocates for living in the here and now based upon a future spiritual hope as “love is the ultimate and highest goal to which a man can aspire” (p. 37).

**Spirituality as Healing**

Spirituality is an integral facet of healing as it offers a pathway out of the wilderness experience of moral injury. For some people, religious or spiritual challenges may lead to a decline in faith as a source of strength, while for others spiritual practices facilitate improved outcomes (Wilt et al., 2019). Liebert (2019) writes that spiritual practices connect a person to God or the Divine and ignite faith. Spiritual leaders offer healing opportunities for those who grapple with the overwhelming grief, shame and hopelessness associated with MI. This healing occurs through the utilization of religious or spiritual resources and practices that acknowledge the presence of the Divine, such as scriptural readings, conversations with other believers, confession, practice of silence or meditation, journaling, music, prayer and worship (Doehring, 2019; Ramsey, 2019).

Effective therapy aimed at treating moral injury targets both psychological and spiritual symptomology; bridging the chasm in one’s spirituality interjects a renewed pillar of strength
beneficial to holistic healing (Pearce et al., 2018; Starnino et al., 2019). Pastoral counseling or intervention allots one meaning making and facilitates self-understanding, renewed identity and resilience through Biblical paradigms and insights (Grimell, 2018; Schuhmann & van der Geugten, 2017; Sullivan & Starnino, 2019). For instance, military veterans have benefitted from religiously or spiritually designed programs that concentrate on forgiveness as a healing facet, confronting self-condemnation and fostering self-acceptance as a step toward resolving wounds of moral injury (Purcell et al, 2018; Worthington & Langberg, 2012). Moreover, a Jewish perspective of healing brokenness through ancient literature is rich in spiritual value and often speaks of meaning found through experience, which cultivates forgiveness and hope through identifying one’s innate purpose and the presence of an invincible God (Geringer & Wiener, 2019).

**Creating Space for Grace**

Conflict between an immanent decision or action and one’s personal ethical stance or beliefs often leads to moral distress or injury. Spirituality, which is often linked with felt purpose in life, can offer strength to mitigate negative behavioral health symptomology (Simmons et al., 2018). Soul repair involves creating a space for grace (Antal & Winings, 2015). Programs that incorporate religious dimensions into a therapeutic protocol need to offer an environment of acceptance and mercy so those who grapple with moral injury can both make sense of and peace with painful encounters (Antal & Winings, 2015). According to Litz and colleagues (2009), key elements for treatment of moral injury include acceptance that leads to connection, educating client about moral injury, modified exposure therapy, integrating concepts of self-forgiveness and worth, connecting with a moral authority, making amends, reconnecting with other people and planning for the future.
A recent study of spirituality and en route military nurses identified spirituality as both enabling improved coping during deployment and creating inner conflict when caring for severely injured soldiers and civilian children. Nonetheless, 63% of these participants stated needing behavioral health support after returning from deployment with only 39% seeking that support (Simmons et al., 2018). Cohen (2017, 2018) discusses apology as an element of moral repair that supports self-repair in those who experience a weight of shame, guilt, or wrongdoing from an action or effect that causes a sense of regret. Another study conducted with military veterans found that forgiveness through self-compassion enables positive coping in response to traumatic or morally injurious experiences, which supports therapeutic approaches aimed at reducing shame (Forkus et al., 2019).

Forgiveness encompasses multiple realms including the divine, as well as the human aspects of extending forgiveness to self and others and receiving from another. Regardless of whether forgiveness is associated with a Christian theology, it possesses a restorative nature that facilitates healing (Griffin et al., 2014). Freedman and Zarifkar (2015) discuss forgiveness as involving effort, an active ongoing choice that neither condones nor excuses a wrong while pursuing mental and emotional healing from pain. Research indicates that forgiveness matters to veterans who feel shame and guilt surrounding their actions during war and reflects a potent avenue for addressing moral injury (Purcell et al., 2018). Forgiveness involves unconditional forgiving love that is demonstrated through God toward those who seek Him, interpersonally by releasing those who have hurt or offended another, or by self as one forgives oneself of intuited wrongfulness or injustices of omission or commission (Kim & Enright, 2014, p. 266).

Summary
In conclusion, research on the experiences of medical professionals who have exited the abortion industry is limited. Current and past literature has mostly explored experiences of those who provide abortions and often focuses upon issues of stigma and government restrictions and regulations. Abortion has been discussed in the previous pages as a controversial social, relational, and medical phenomenon. Professionals who provide abortion services encounter an array of experiences such as witnessing apathy toward patients by colleagues to handling a second trimester deceased fetus, leaving them prone to frustration, burnout, a sense of guilt and regret, and perhaps moral distress or moral injury due to their involvement in this industry. Finally, exploring global meaning and other spiritual considerations have been found to facilitate healing when traumatic outcomes have influenced those who choose to leave the field of abortion provision.
Chapter Three: Methods

Overview

To begin, two types of academic and scientific studies exist. Although both qualitative and quantitative research are empirical, they differ in methodology, design, and strategies for assessment and evaluation of data (Bloomberg & Volpe, 2019; Creswell & Creswell, 2018). Qualitative research assists in understanding the strengths, contributions and limitations of data and seeks deeper understanding of a social setting, context, or activity from the participant’s perspective (Kazdin, 2003; Moustakas, 1994; Vogt, 2016). These considerations guide the following qualitative study.

This chapter addresses two research questions focused upon the lived experiences of 14 former abortion industry workers who worked in a medical facility or freestanding clinic that provided abortions. The participants were interviewed to gain their perspectives on their work experiences, effects upon their bio-psycho-socio-spiritual well-being, and how they have made sense or meaning of these lived experience (Bhattacharya, 2017). Moreover, this chapter identifies participant demographics and discusses how data was collected, the structure of the interview process, the procedures for analyzing the collected data, and the data’s trustworthiness, credibility, dependability, confirmability and transferability, and ethical concerns (Peoples, 2021; van Manen, 2016).

Design

Foundational to effective research is a well-defined theoretic framework (Rockinson-Szapkiw, 2014). This research on former abortion industry workers extended from a qualitative framework and investigated the lived experiences of individuals who have formerly worked in a medical facility or freestanding clinic providing abortion services. Because of its proficiency in
collecting rich or thick information and isolating recurring themes, a hermeneutic phenomenological design was utilized for this study (Kazdin, 2003; Vagle, 2018). Two strengths emerge from this design, which engages individuals in an interview process as a means of collecting data (Billups, 2021). First, a personal account of one’s experience is powerful and influential. People are often intrigued by the stories of others and connect with a shared experience, enabling it to become a resource for those who are involved in a similar position (Denzin & Lincoln, 2018). Second, phenomenological research is important in both professional and personal perspectives because it moves beyond numbers into an intimate realm that offers insight and understanding beyond assessment results. It consists of not only resonate information, but also reflects emotional and mental states that are relevant for enhancing empathy within therapeutic relationships and interventions (McLeod, 2011; Neubauer et al., 2019).

**Phenomenology Design**

Qualitative research procures data through an interview process that assesses the experiences of people who have either shared common life events or encountered a specific phenomenon pertaining to life events and corresponding behaviors that may entail deep emotion (Creswell & Baez, 2021; Seidman, 2019). As such, qualitative research is both interpretive as it explores meaning and theoretic in pursuing why and how things occur (Kazdin, 2003). Moreover, qualitative research seeks to understand the “what” in how these lived experiences have impacted an individual’s everyday life, outlook, emotional health and spirituality (Bloomberg & Volpe, 2019). Qualitative research has three components including theory, method and analysis, and seeks to communicate how social experience is created and how meaning is attached to an individual’s lived experiences (Denzin & Lincoln, 2018). The
objective of qualitative research, which philosophically borrows in part from social constructivism, is to understand a phenomenon from an individual’s perspective by utilizing a methodology that expresses data through the participants’ own words and descriptions of observable behavior (Portney, 2020). Accordingly, phenomenological method is interpretive and inductively analyzes data in order to increase the amount of textual meaning about the topic being studied (Bhattacharya, 2017; Creswell & Poth, 2018). Thus, the result is a description of “what” the participants experienced and “how” they experienced it (Moustakas, 1994).

Subsequently, a well-defined theoretical framework is imperative in communicating the purpose and dynamics of the proposed qualitative study, building upon concepts and actions, and organizing data associated with the corresponding design (Goldberg & Allen, 2015). Theoretically and in line with Heidegger, this phenomenological study which confers meaning through subjective experience, is hermeneutic in process of text interpretation and enables insight and understanding of one’s personal existence (Vagle, 2018; van Manen, 2016). Language is foundational to phenomenological research as hermeneutics is interpretation; in turn, meaning is identified as developing through encountering or experiencing an impressionable event (Vis, 2008). Consciousness is said to come out of intentionality and develops as discovered through experience (van Manen, 2015).

**Van Manen’s Six Steps for Data Analysis**

The methodology utilized for this study was van Manen’s six-step research Hermeneutic paradigm. Van Manen (2015) approaches hermeneutic phenomenology from a combination of European and North American influences. These six steps include:

Step One: Turning to the nature of the lived experience.

Step Two: Investigating experience as we live it.
Step Three: Reflecting on essential themes as hermeneutic phenomenological reflection.

Step Four: Describing the phenomenon through the art of writing and re-writing.

Step Five: Maintaining a strong and oriented relation to the phenomena.

Step Six: Balancing the research context by considering parts and the whole.

Ultimately, the interplay between these six steps assisted in identifying distinctions and increasing insight that facilitated developing relevant themes (van Manen, 2015). Finally, the interviews were analyzed as a whole with a focus on the bio-psycho-socio-spiritual outcomes of each individuals’ experiences of working in and leaving the abortion industry.

**Research Questions**

Two specific questions serve as the objective for this study and seek to understand the reasons or circumstances that contributed to this population’s exit from their jobs within the abortion industry. Addressing these research questions assisted in identifying the potential effect the job positions had upon the participants’ lives.

**Research Question 1:** What is the lived experience of former abortion workers who left the field due to moral distress both before and after their transition from the industry?

**Research Question 2:** What were (and are) the perceived bio-psycho-social-spiritual impacts of abortion work for those who ultimately left the field due to moral distress?

**Setting**

This research on the lived experiences of former abortion industry workers was a hermeneutic phenomenological qualitative study, which entailed in-depth interviewing and recording the experiences and perspectives of a purposeful sample of fourteen former abortion industry workers (Billups, 2021; Leavy, 2017). The interviews were conducted via Microsoft Teams and Zoom online conferencing applications for a more comprehensive collection of
verbal communication (Aurini et al., 2016). These interviews were scheduled at the interviewee’s convenience in a quiet and stress-free atmosphere and lasted between 45 to 90 minutes (Creswell & Creswell, 2018). An advantage qualitative research offers is that data collection occurs within the natural setting of the participant’s home or office instead of a clinical or controlled setting which may induce increased stress levels (Billups, 2021).

**Participants**

The participants for the study were individuals who have been involved with and received services from And Then There Were None (ATTWN), an organization that assists abortion workers in exiting the profession by offering financial and legal assistance, employment opportunities, and emotional and spiritual support (ATTWN, 2020b). Before submitting this proposed research topic for approval by the Ed.D. faculty, the board of ATTWN discussed and verbally approved participation in the study of those willing and desirous to share their stories. After the proposal was defended and presented to ATTWN, a formal letter of approval (see Appendix A) was attained, as well as an accepted form of informed consent to submit for the participants’ knowledge (Appendix C). Both were submitted as part of the Institutional Review Board (IRB) application from the Liberty School of Behavioral Sciences (Appendix B). The required forms delineating the proposed research were submitted to and approved by the Liberty University IRB to ensure compliance with ethical guidelines for researching human participants (Cone & Foster, 2006; Creswell & Creswell, 2018; Liberty University School of Behavioral Sciences, 2019-2020). Finally, after approval, a recruitment e-mail (Appendix D), video (Appendix E), and interview questions (Appendix F) were sent to potential participants, along with the approved informed consent.
Demographics reveal a distinct diversity between the 14 participants. All of the participants were female and ranged from 40 to 71 in age. Seven women identified their race as Caucasian and seven as either Afro-Latino, Hispanic or Mexican. Eight women identified as Christian, five as Catholic and one as non-religious. Seven of the participants’ level of education was a four-year degree or higher and seven had either a two-year degree or a certificate in Medical Health Assistant or Certified Nurse Assistant. All but four interviewees were hired to work in the abortion industry between the ages of 19 and 27. Eight of the women worked in the industry three years or more with the longest tenures being 14 to 17 years. Eight participants worked for an affiliate clinic and six for a private clinic. Five interviewees left the industry within the last five years, one woman left 42 years ago, and the rest exited their positions in the 1990’s and first decade of 2000. Four of the interviewees had at least one abortion herself.

**Procedures**

Former abortion industry workers were invited to participate in the study and provided information about the study’s aims and methodology through contacts with ATTWN. Participants were prescreened by ATTWN who established inclusion criteria, namely that the participants were former abortion workers and had passed an emotional and mental health screening completed by ATTWN staff counselors. Fourteen participants were recruited from this prescreened list and contacted in order to establish a working relationship and to schedule interviews (Seidman, 2019).

These were semi-structured and recorded interviews that were transcribed and returned to interviewees for member checking to ensure the accuracy of the transcription and to invite participants to further articulate their ideas about the questions (Aurini et al., 2016; van Manen, 2016). The participants’ emotional responses were monitored, and brief breaks were taken if a
participant appeared overwhelmed with the researcher engaging in reflection and validation of any emotional triggers or feelings. All questions were addressed. However, if a participant had not been comfortable answering a specific question, a reason for suspending the question in lieu of the answer would have been noted. Moreover, participants were reminded of ATTWN psychosocial support services in the informed consent, at the conclusion of the interview, and when they were contacted for member checking.

**The Researcher’s Role**

First, the idea to pursue qualitative research through interviewing individuals who have chosen to leave the abortion industry came as I watched the movie “Unplanned” (Solomon & Konzelman, 2018), which was based upon Abby Johnson’s experience of working as a director at a Texas Planned Parenthood and her decision to leave the abortion industry. I had never heard of Abbey Johnson, nor the non-profit organization ATTWN, before watching this movie. Neither had I met any of the participants of this study before scheduling their interviews. The information regarding ATTWN was listed in the post-movie trailer along with the resources available for those who desire to quit their jobs in the field of abortion. Many questions surfaced as to how other individuals who have had adverse experiences decided to leave their jobs providing abortions in either a medical facility or freestanding clinic. These questions included how they found support, what type of healing has been necessary to return to a healthy equilibrium and how these workers made sense or meaning of their lived experiences, especially in the context of the current social-political environment.

Next, specific to qualitative design, researchers are not separated from the process (Yeh & Inman, 2007). As such, a qualitative researcher is permitted to be subjective and interactive, participating and acting as an investigator who listens, observes, and empathizes (Creswell &
Creswell, 2018; Rudenstam & Newton, 2015). A key aspect associated with qualitative design is that of relationship between the researcher and the participants, such as demonstrating empathy, intuitive insight in probing deeper when necessary, and the self-discipline to refrain from assumption or imposing personal opinion upon the shared and analyzed data (Billups, 2021). In particular, qualitative research requires the examiner to expend a significant amount of time conducting interviews, as well as analyzing data (Creswell & Poth, 2018). Ultimately, as a researcher, one must responsibly utilize perceptive and skillful questioning that cultivates rich and descriptive data, which predicates facets of meaning to another individual’s lived experience (van Manen, 2016).

**Data Collection**

After approval for this study was granted by the IRB, pertinent information was forwarded to the contact at ATTWN to begin the process of identifying and vetting participants who met the research criteria and were at minimal mental and emotional risk to participate without negative repercussions (Bell et al., 2020). Once a list of potential participants was compiled, the individuals were electronically mailed a link to the video information packet including the purpose and plan for the study (Creswell & Poth, 2018). To establish rapport with the potential participants, the primary researcher contacted participants by phone to schedule a formal interview and to answer any questions that the participants may have had (Fontana & Frey, 1998). The 14 individuals who meet the criteria set forth for this study were offered the opportunity to participate. A sample size of at least 10 was expected to offer ample data to analyze, and this goal was met through identifying 14 participants (Creswell & Creswell, 2018). Informed consent, right to privacy, and protection from harm were explained to the participants.
before obtaining signed permission to gather, analyze and publish the data for this study (Bell et al., 2020; Fontana & Frey, 1998; Kazdin, 2003).

**Interviews**

Van Manen (2016) proposes that phenomenological questioning is about opening and interrogating with respect to one’s being and must draw readers’ interest into the phenomena being studied. Phenomenological questioning is a process in which participants explore the very essence of the identified lived experience, beyond merely answering questions and reconstructing their experiences (Seidman, 2019). The interview structure of this qualitative research utilized formal semi-structured, in-depth open-ended, experience-oriented questions as a basis for active interviewing, which is an integral aspect of a descriptive approach (Bhattacharya, 2017). Therefore, an approximate 45-75-minute audio or video taped interview was scheduled with each participant at a location of her choosing and comfortability, such as a private home office (Bloomberg & Volpe, 2019; Creswell & Creswell, 2018).

Subsequently, given the Covid pandemic and geographic restrictions, interviews were completed virtually. First, a series of questions were asked to deepen the initial interviewer-participant rapport and to create a concise personal profile (Fontana & Frey, 1998). Next, multiple questions relating to the individuals’ experiences providing abortions were asked, including central and sub-questions, as well as prompts when necessitated (Creswell & Guetterman, 2018; Portney, 2020). These interviews consisted of sections that had a unique purpose, such as warm-up questions, central questions, cooldown questions, and verbal and visual exploring to gather as much pertinent information as possible (Aurini et al., 2016; Seidman, 2019).
Since qualitative research is an emerging process, open-ended questions were utilized to create options for responding and allowing participants to adequately voice their experiences and perspectives (Moustakas, 1994). Leading questions or questions that can be answered with a simple yes or no were avoided (Merriam & Tisdell, 2016). Observations were noted and prompts for further clarification were utilized, when appropriate, to enrich and deepen the narrative (Adler & Adler, 1998). Moreover, supplemental e-mails were exchanged to clarify or substantiate any ambiguity within the collected data (Creswell & Guetterman, 2018). And, as noted above, member checking was used to verify accuracy (Billups, 2021).

Van Manen (2016) proposes that phenomenology is not as much about answering as it is questioning which explores experience and seeks meaning. With this mindset, participants were asked the following questions, which implemented nondirectional language (Leavy, 2017). The stated purpose for these questions offered the reasoning behind why they are being asked (Seidman, 2019). The eight open-ended semi-structured interview questions are as follows:

1) To begin, please introduce yourself by sharing any relevant information about you and your family.

2) Tell me how you came to work in the medical field and in the abortion industry. Which position in the abortion clinic were you hired to perform?

3) Describe your personal view of abortion and abortion provision before you entered this field. How has this view changed since leaving the field?

4) Describe your job responsibilities at the facility in which you worked and any tasks that were more difficult than others to perform.

5) What interactions or encounters, with either patients or fellow workers, do you remember most? Describe what made these occurrences memorable.
6) Personnel in high stress, people-helping professions often talk about the transition from work to home on a day-to-day basis as challenging. What do you remember about your daily transitions to home routines or challenges when you worked in the abortion industry?

7) What led you to the point of leaving your job and how did you seek help in doing so if it was needed?

8) Please discuss any mental, emotional, physical or spiritual effects that you have experienced since working in the abortion industry and did you seek help in dealing with these challenges?

Each of these questions had purpose and intent in being posed to the participants of this study (Seidman, 2019). The goal of question one was to collect information about the interviewee’s personal background. Question two aimed at understanding the interviewee’s general career background. Next, question three explored the interviewee’s view of abortion and abortion provision before and after working in the industry. The following questions, four and five, sought information about working in an abortion environment and any notable patient and co-worker occurrences that influenced the interviewee’s overall experience. Question six focused upon any possible negative personal events or emotional outcomes that might have been initiated by working in a workplace providing abortions. Question seven investigated why the individual chose to leave the abortion industry and described the transition into a different type of medical provision or a job in a new career. Finally, question eight delved into any bio-psycho-socio-spiritual effects of working in the abortion industry and how these individuals’ sought assistance in pursuing improved holistic well-being.

**Data Analysis**
In a hermeneutic phenomenological study, personal expression adds to the construction of personal meaning and correlates with the Greek perspective of *Being*. Context, as well as one’s audience and the phenomenon itself, were taken into consideration by the Greeks when interpreting language (Potter, 2017). Gadamer (2006) viewed hermeneutics as ontological in nature, focusing on being as it relates to truth through self-transparency as connected with one’s experiences of an event. This line of thought is associated with the concept of qualitative research that seeks meaning through considering the encounters or lived experiences of people (van Manen, 2016). Qualitative research has been referred to as “rich” due to the quality of the data and “thick” because of the multiple layers of detail that are gleaned from the participants’ experiences (Fusch & Ness, 2015; Kazdin, 2003). Thus, in this study theoretic interpretation through data analysis extracted meaning from semi-structured interviews and developed a perspective of the phenomenon surrounding the lived experiences of 14 former abortion industry workers (Piantanida & Garman, 2009).

Whether from a profound single statement or from multiple converging statements, this analysis took a whole-parts-whole approach in uncovering the layers of data (Vagle, 2018; Vis, 2008). In order to have accurate interpretation of data gathered through phenomenological interviewing, the researcher engages in a rigorous interpretation process (Lindseth & Norberg, 2004). Hermeneutic qualitative data analysis is renowned for its back and forth, part to whole to part process that begins as early as the first interview (Davidsen, 2013; Frechette et al., 2020). As such, video-taped interviews were transcribed verbatim to allow for a phenomenological approach to analysis that led to a point of data saturation where no new information was being gathered (Creswell & Guetterman, 2018; Leavy, 2017). Next, the data were coded into different categories of meaning according to participants’ answers, statements and behaviors with
significant statements clustered using the participants’ own words, which identified themes and led to data analysis according to the consistency and depth of participants’ statements (Bloomberg & Volpe, 2008; Creswell & Poth, 2018). Data were organized through identifying distinct individual experiences that fit together with the experiences and ideas of other participants to form a supportable theme (Nowell et al., 2017). Finally, the goal of this research was to develop a strong methodology and precise process that would allow the information to be published for the consideration of both academics and practitioners (Ponterotto & Grieger, 2007).

**NVivo for Data Analysis**

The computer software NVivo (released 2020) was utilized to analyze data for this study. Before any analysis occurred, the drafts of the interviews were submitted to interviewees for their review. After the participants affirmed the veracity of the information collected and any identified modifications or correction of errors were made, the final data were submitted into the NVivo software (released 2020) to assist the researcher with organizing, coding and analysis (Creswell & Creswell, 2018). Computer assisted qualitative data analysis software (CAQDAS) offers researchers a reliable means for data management with increased speed and efficiency, which grants insight into results (Merriam & Tisdell, 2016; Moylan et al., 2015). Palys and Atchison (2012) acknowledge advantages of using NVivo software for data analysis as including internet-based interactive techniques, automated transcription, coding and analysis. Subsequently, the use of NVivo for this study supported improved validity through its rigor, organization, advanced coding capabilities, and matrix queries which provided depth and richness in understanding the data (Edhlund & McDougall, 2020; Siccama et al., 2008). Finally,
ethics associated with the use of digital tools were considered during data analysis, foremost the protection of the participants’ privacy (Davidson et al., 2016; Paulus et al., 2017).

**Trustworthiness**

The assurance of accuracy within the researcher’s results is fundamental. Threats to trustworthiness in qualitative design, defined as inaccuracies in method or interpretation, include data that are interpreted according to the researcher’s personal bias or data collected in a setting or process that compromises interaction with participants (Aurini et al., 2016). Five distinct types of validity are associated with qualitative research: Descriptive validity deals with factual accuracy; interpretive validity indicates the implied meaning is accurately represented; theoretic validity supports the reasoning of the phenomenon or experience; internal validity seeks to verify that there are not alternative explanations for the findings; and external validity accounts for the generalization of the findings across people, settings, time and situations (Kazdin, 2003). Accordingly, trustworthiness in the data relies heavily upon the extent of ethical application and practice during execution of the study’s methods (Merriam & Tisdell, 2016).

Moreover, triangulation was attained through cross-checking the data collected from the multiple participants and corroborating evidence that denoted themes or a theory and served to verify validity (Rudestam & Newton, 2014; Vagle, 2018). Peer debriefing and member checking supported the triangulation process and determining the accuracy of the data findings. Thus, each of the participants involved in this study was given their transcribed interview to review to verify the information and prevent interviewer bias (Creswell & Creswell, 2018). Denzin and Lincoln (2012) proposed that constructionist theory, which is a paradigm associated with phenomenological design, requires researchers to ensure their collected data meets acceptable
levels of trustworthiness, credibility, transferability and confirmability. The following paragraphs describe the criteria that set these standards.

**Credibility**

Credibility focuses on the extent to which a study’s findings are truthful and plausible (Billups, 2021). To begin, an utmost focus on spending extensive time with the study’s participants exploring their experiences and perspectives assisted the researcher in averting personal bias and misinterpretation (van Manen, 2016). Next, utilizing auxiliary personnel associated with ATTWN assisted in collecting the data and computer software in analyzing the data, which supported credibility (McLeod, 2011). Finally, an abundance of detail was garnered from video and audio tapes, which also allotted for verifying the accuracy of the information shared by participants during the interview process (Rudestam & Newton, 2015).

**Dependability and Confirmability**

Dependability in qualitative research may be linked with reliability in quantitative research and purposes to ensure data meets the standards of dependability; therefore, a step-by-step outline of the process of data collection with correlating documents was documented (Merriam & Tisdell, 2016). Meticulous documentation demands that the interviewer keep comprehensive notes and video or audio tapes throughout the interview process, protect the raw data for accurate analysis, conduct peer debriefing and member checking, and procure data triangulation and saturation (Swezey, 2014). In addition, confirmability was established by journaling interactions and any ethical issues that surface during data analysis and incorporated feedback from those who engaged in data collection, analysis and overview (Forero et al., 2018).

**Transferability**
Transferability deals with whether the results of a study can be applicable to other research conducted in a similar setting, participants, and context (Anderson, 2017). Researchers improve the validity of their findings when reporting data that is both thick and rich in description, thus increasing potential generalization to other participants in varying settings (Rudestam & Newton, 2015). Kazdin (2003) correlates transferability with assessing the characteristics of the participants and the context of the data. As such, this study was conducted in a manner that would allow for duplication.

**Ethical Considerations**

Consideration must be given to three aspects of ethics that include core professional principles and virtue ethics, procedural ethics associated with conducting, interpreting, writing and publishing scholarly research, and the ethical issues imperative to safeguarding study participants (Heppner et al., 2016; McLeod, 2011). Moreover, researchers are expected to properly cite all information and data used during a study to avoid plagiarism, such as using or mentioning the academic work of other individuals and acknowledging contributions of those who have assisted with the development and advancement of the research (American Counseling Association [ACA], 2014). Subsequently, departments assign chairs and committee members to guide students through the dissertation process and universities appoint an Institutional Review Board (IRB) to assess proposed research to affirm ethical acceptability, risk of potential harm to potential participants, and appropriate informed consent (Bell et al., 2020; White, 2017).

Ethical considerations adhere to professional and academic codes of ethics, which offer participants informed consent, avoids any possible deception, maintains personal privacy and confidentiality, and ensures accuracy when interpreting and presenting data (Christians, 2013). Ethical safeguards when developing the proposal and organizing a research plan are also
imperative (Bell et al., 2020). Thus, the informed consent for this research consisted of not only comprehensive information regarding the study, such as the purpose and proposed outcomes of the research, but also the participants’ capacity to understand the process, their voluntary involvement and rights that included confidentiality and personal well-being (Leavy, 2017; Seidman, 2019).

Again, ethical protections to do no harm were fundamental for the 14 participants during the research and beyond, ensuring that appropriate mental health supports were in place (ACA, 2014). Furthermore, because of the use of technology, data has been discussed in a manner that protects personal identification through autonomy, is securely stored and will be appropriately deleted after two years (Aurini et al, 2016; Moylan et al, 2015). Finally, adhering to the ethical principles of the American Association of Christian Counselors (AACC; 2014), this research assimilated faith and values which included an attitude of servanthood and actions that embraced excellence, integrity, trustworthiness, dignity, soundness, and accountability which fortified professional interactions and decision-making with the participants.

In conclusion, this researcher purposed to follow the previously discussed ethical imperatives. Institutional Review Board (IRB) permission was sought, and the IRB approved conducting the study in compliance with ethical standards. Participants were pre-screened by ATTWN to mitigate any harm occurring as a result of the interview process and from participating in the study. ATTWN made counseling services available to these clients and the participants were encouraged to either continue or reengage these services in the event they were needed at any time after their interview. All data are stored on password protected computers in password protected files. The identities of all participants have been protected throughout the processes in which data were collected, used and reported (Billups, 2021).
Summary

This research is a qualitative study that investigated the lived experiences of individuals who formerly worked in a medical facility or freestanding clinic providing abortion services. Chapter Three: Methods discussed the hermeneutic phenomenological design for this study including the research questions, web-conference setting, 14 participants associated with ATTWN, procedures used in conducting the research, the researcher’s role, how data were collected, how the data were analyzed, and the attention given to assuring the trustworthiness of the results and ethical considerations. In conclusion, the results and discussion of this research are presented in Chapters Four and Five.
Chapter Four: Findings

Overview

This chapter discusses the results of the data collected from interviewing 14 former abortion industry workers, who are named by pseudonyms throughout this study to protect their identities. These interviews were transcribed through NVivo (released 2020), which is a computer software designed for qualitative research and serves as a flexible tool to assist in transcribing, coding, organizing and analyzing collected data. Two research questions (RQ) will be addressed in conjunction with a presentation of the data results. RQ1: What is the lived experience of former abortion workers who left the field due to moral distress both before and after their transition from the industry? RQ2: What were (and are) the perceived bio-psycho-socio-spiritual impacts of abortion work for those who ultimately left the field due to moral distress? Finally, a summary concludes this chapter by highlighting key themes and findings.

To begin, an introduction presents the 14 participants who are associated with the organization And Then There Were None (ATTWN). Two charts, prepared by and imported from Nvivo (released 2020), delineate pertinent demographic information and data regarding job responsibilities pertaining to the participants. Next, theme development through data analysis is discussed in context of how identified themes were generated from the data collected during participant interviews. These themes are substantiated by participant quotes and presented in relation to the two research questions that explore both these former workers’ lived experiences and any notable bio-psycho-social-spiritual effects. Themes related to RQ1 include Shifting View of Abortion: From Pro-Choice to Pro-Life; Memorable Experiences During Tenure in Abortion Work; and Difficult Work Environment. Themes related to RQ2 consist of Bio-Psycho-Socio-Spiritual Conflicts and A Turning Point. Themes are expounded upon in context to the unique
lived experiences of former abortion industry workers and aspects of moral distress, which led to minimal to severe life-changing symptomology. Moral distress in this research is viewed as an aspect of working in the medical field that may lead to burnout from job demands, compassion fatigue, secondary traumatic stress, decreased work satisfaction, or a belief that one is harming more than helping (Burston & Tucket, 2013; Garcia-Sierra et al., 2016; Hanna, 2005; Janiak et al., 2017).

**Utilization of Qualitative Computer Software**

Theme development was assisted by NVivo (released 2020), a computer software for qualitative research. The transcribed participant interviews were imported into NVivo (released 2020) as data files, organized into potential themes, and coded by highlighting statements from the participants’ transcripts and moving them to a corresponding node, which is an efficient type of file or container used to store data (Creswell & Creswell, 2018; Edhlund & McDougall, 2019). Nodes were reviewed for accurate interpretation and placement to ensure accuracy of data analysis. Exploration of the data files and codes involved running word frequencies, various queries, and creating visuals to identify demographics and detail results. Furthermore, van Manen’s (2015) six research steps were engaged to substantiate theme development stemming from the interview questions and additional findings, and guided in writing the results.

**Participants**

Fourteen participants, who are identified by pseudonyms and involved with the organization ATTWN, were interviewed over the course of four weeks. These ladies reside in various parts of the United States and have in some cases worked in abortion clinics located in a different state than they currently reside. All but one participant was married at the time of the interview and 13 out of 14 interviewees are mothers either by birth, adoption, or both. One
participant was retired when interviewed and the other 13 employed in various occupations, with approximately half still working in the medical field in an environment other than the abortion industry. Below is a chart that was prepared and imported from the computer software, NVivo (released 2020), describing the demographic characteristics of each participant including gender, current age, age hired, length at job, year left, clinic type, race, education level, religious or spiritual affiliation, and number of personal abortions.

Table 1

Participant Demographics

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Current Age</th>
<th>Age Hired</th>
<th>Length at Job</th>
<th>Year Left</th>
<th>Clinic Type</th>
<th>Race</th>
<th>Education</th>
<th>Religion</th>
<th>Abortions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alex</td>
<td>Female</td>
<td>43</td>
<td>38</td>
<td>0.75</td>
<td>2016</td>
<td>Affiliate</td>
<td>Afro-Latino</td>
<td>Doc Candidate</td>
<td>Christian</td>
<td>0</td>
</tr>
<tr>
<td>Anne</td>
<td>Female</td>
<td>71</td>
<td>27</td>
<td>3</td>
<td>1979</td>
<td>Private</td>
<td>Caucasian</td>
<td>MHA</td>
<td>Christian</td>
<td>2</td>
</tr>
<tr>
<td>Beth</td>
<td>Female</td>
<td>53</td>
<td>22</td>
<td>3.5</td>
<td>1993</td>
<td>Private</td>
<td>Caucasian</td>
<td>2-years College</td>
<td>Christian</td>
<td>1</td>
</tr>
<tr>
<td>Claire</td>
<td>Female</td>
<td>40</td>
<td>21</td>
<td>8</td>
<td>2009</td>
<td>Affiliate</td>
<td>Caucasian</td>
<td>MA</td>
<td>Catholic</td>
<td>2</td>
</tr>
<tr>
<td>Deborah</td>
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<td>45</td>
<td>23</td>
<td>17</td>
<td>2017</td>
<td>Affiliate</td>
<td>Hispanic-Latino</td>
<td>4-years College</td>
<td>Catholic</td>
<td>0</td>
</tr>
<tr>
<td>Dewy</td>
<td>Female</td>
<td>53</td>
<td>19</td>
<td>1.5</td>
<td>1989</td>
<td>Private</td>
<td>Caucasian</td>
<td>AND</td>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>Faith</td>
<td>Female</td>
<td>45</td>
<td>38</td>
<td>1</td>
<td>2014</td>
<td>Affiliate</td>
<td>Hispanic</td>
<td>RMA</td>
<td>Catholic</td>
<td>0</td>
</tr>
<tr>
<td>Jean</td>
<td>Female</td>
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<td>23</td>
<td>14</td>
<td>2014</td>
<td>Affiliate</td>
<td>Caucasian</td>
<td>MA</td>
<td>Christian</td>
<td>0</td>
</tr>
<tr>
<td>Lena</td>
<td>Female</td>
<td>62</td>
<td>24</td>
<td>2.5</td>
<td>1986</td>
<td>Private</td>
<td>Caucasian</td>
<td>BSN</td>
<td>Christian</td>
<td>0</td>
</tr>
<tr>
<td>Lily</td>
<td>Female</td>
<td>50</td>
<td>42</td>
<td>4</td>
<td>2017</td>
<td>Private</td>
<td>Afro-Latino</td>
<td>BSN</td>
<td>Christian</td>
<td>1</td>
</tr>
<tr>
<td>Maria</td>
<td>Female</td>
<td>38</td>
<td>23</td>
<td>5</td>
<td>2011</td>
<td>Affiliate</td>
<td>Mexican</td>
<td>MHA</td>
<td>Catholic</td>
<td>0</td>
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<tr>
<td>Miriam</td>
<td>Female</td>
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<td>2008</td>
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<td>Caucasian</td>
<td>2-years College</td>
<td>Christian</td>
<td>0</td>
</tr>
<tr>
<td>Rubi</td>
<td>Female</td>
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<td>2009</td>
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<td>Hispanic</td>
<td>HSD</td>
<td>Catholic</td>
<td>0</td>
</tr>
<tr>
<td>Susanne</td>
<td>Female</td>
<td>47</td>
<td>19</td>
<td>6</td>
<td>1999</td>
<td>Private</td>
<td>Mexican</td>
<td>CNA</td>
<td>Christian</td>
<td>0</td>
</tr>
</tbody>
</table>

*Participant Demographics* chart prepared by and imported from NVivo (released 2020).
Clinic’s Focus of Care

Although assisting with abortions or working with parts of conception (POC) did not fall directly into the job responsibilities of a few of the study’s participants, all interviewees were exposed to at least one abortion procedure or the POC room during their tenure at the clinic in which they worked. Jean worked at two facilities, the first being an abortion clinic and the second more of a family planning clinic. The clinic in which Deborah, Miriam and Rubi worked provided pap smears, breast exams, comprehensive exams, sexually transmitted infection (STD) screening and treatment, birth control, pregnancy tests, as well as abortion referrals or surgical and medical abortion services. Both surgical and medication abortions were offered at Alex and Claire’s clinics. Anne, Beth and Susanne’s clinics scheduled surgical abortions multiple times a week. Finally, late-term abortions through the second trimester were performed at the clinics in which Dewy, Lena and Lily were employed.

Job Responsibilities

Participants’ reasons for working in the abortion industry varied from wanting to work in the medical field providing women’s healthcare to just needing a job. Each participant was hired for a specific job such as, “I was hired to be the health center manager” (Alex), “I was hired as an outreach and education person” (Anne), “I was procedure room and parts of conception” (Beth), “I got hired as a medical assistant” (Claire and Dewy), “I was hired as a reproductive health assistant” (Maria), “I was hired to do counseling” (Faith), “I was hired as a receptionist or front office” (Rubi and Susanne), “I was hired to do contraceptive education” (Deborah & Miriam), and “I was hired as a Registered Nurse” (Lena, Lily and Jean). However, all these women ended up with additional job responsibilities and received on-the-job training at the
facility in which they worked. The chart below identifies the job responsibilities each of the participants engaged in during their time working in the abortion industry.

Table 2

Job Responsibilities

<table>
<thead>
<tr>
<th></th>
<th>Assisted with Abortions</th>
<th>Clinic Director/Manager</th>
<th>Contraception Education</th>
<th>Counseling</th>
<th>Front Desk/ Billing</th>
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Job Responsibilities chart prepared by and imported from NVivo (released 2020)

Modifications of Participant Quotes

Qualitative research consists of contextual details and phenomenological studies utilize direct participant quotes to communicate research results (Bhattacharya, 2017). Often these direct quotes are modified in order to abridge and clarify the citation (Eldh et al., 2020). As
such, this protocol has been followed in writing the results of this study. Quotes have been modified by removing filler (“uhm”, “like”, “so”, “you know”) or repeat words, correcting slang and tense, using brackets around words for clarification and ellipses to shorten quotes and connect pertinent thoughts. Utmost attention has been given to make sure modifications honor the participants’ original statements and maintain the intended meaning. Moreover, the results are communicated in a manner that identifies varying aspects of experience (Daly, 2009). Charts have been provided documenting how participants responded to each theme, followed by information on theme development through direct responses (Goldberg & Allen, 2015). Major themes were identified by responses predicated from eight or more participants. Themes related to RQ1 include *Shifting View of Abortion; Memorable Experiences During Tenure in Abortion Work*; and *Difficult Work Environment*. Themes related to RQ2 consist of *Bio-Psycho-Socio-Spiritual Conflicts* and *A Turning Point*.

**Themes Related to Research Question One**

Three major themes emerged from RQ1: What is the lived experience of former abortion workers who left the field due to moral distress both before and after their transition from the industry? The first major theme is *Shifting View of Abortion: From Pro-Choice to Pro-Life*, which includes sub-themes of *Pro-Choice Before Working in the Industry*, *Shift While Working in the Industry*, and *Pro-Life After Working in the Industry*. *Memorable Experiences During Tenure in Abortion Work* is the second major theme and includes sub-themes of *Meeting Quotas*, *Sense of Vulnerability*, and *Stigma and Seclusion*. The third major theme, *Difficult Work Environment*, discusses sub-themes of *Memories and Regrets*, *Distressing Tasks*, *Problematic Practices*, *Deception*, *Problematic Protesters*, and *Angst*.

**Major Theme One: Shifting View of Abortion**
An evident theme that emerged from the interviews was a distinct shift in the participants’ views of abortion. All 14 interviewees were pro-choice when they began working in the industry. Thirteen participants stated being adamantly pro-life after leaving, with one still maintaining early abortion should be allowed in specific circumstances. Ten women identified experiences while employed that were instrumental in their views shifting from pro-choice to pro-life. Interestingly, four interviewees commented on the insouciance of even talking about abortion and labeling it an avoided topic. Anne stated, “Nobody wants to really talk about abortion. But [especially] if you're triggered by it, you're just going to put a stop sign out.” Lily proposed, “This topic is such a taboo. Such a let's not talk about, don't see it, it doesn't exist.” Moreover, two of these women felt as though the topic is one that the Christian community attempts to avoid. Miriam suggests, “There's so many churches that are truly afraid to take a stand, [to] speak up for life.” And Lena acknowledged that “We left our beloved church because nobody would talk about pro-life…ever.”

### Table 3

**Major Theme One: Shifting View of Abortion**

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**Sub-Theme: Pro-Choice Before Working in the Industry**

The participants identified varying perspectives of abortion prior to working in the industry. Some interviewees did not have a strong opinion about abortion, such as “I grew up in
TIME FOR A CHANGE? THE LIVED EXPERIENCES OF

a home that was secular. We didn't talk about abortion, so I didn't have much of an opinion” (Miriam) and “Before [working] at Planned Parenthood I didn't have an opinion” (Alex). Anne’s perspective was, “I didn't have a moral dilemma with it because it wasn't taught [to] me.” Jean professed, “I met my husband when I was 18 [in] college and we just kind of lived life as heathens.” And Dewy alluded to not considering the multiple aspects associated with the abortion procedure, “I don't think I had any concept of [the] baby in the womb…I never thought about it.”

Many participants equated their pre-industry view of abortion as a woman’s right and her choice to make. For instance, “I'd grown up in a liberal family, pro-choice family, I was not put off” (Lena). Interestingly, four participants voiced that even though they were pro-choice at the time of employment, they would not personally have had an abortion. Deborah felt, “Well, I will never have one, but if someone else does, her problems, her body and her choice.” Faith conferred the same stance, “So I myself would never have an abortion. But…it's not my place to tell another woman what to do with her body.” Additional comments included: “Because even though I didn't choose it for myself, I thought I couldn't stop others from choosing. Making their own choice” (Maria). “If I haven't had an abortion and if I don't have an abortion, I'm OK. All I knew was that it ended a pregnancy” (Rubi). And Susanne emphasized that her sentiment at the time was women’s rights, “We were Catholic, but that never really was spoken of at my house…I was [like] women's rights.”

In contrast, a few women had undergone the procedure themselves and their thoughts about abortion were connected to their life experiences. “I was OK with the abortion thing. I was like, oh, this is just one more aspect of nursing that I can just make sure everybody is super safe and super amazing” (Lily). Beth said, “I’d gone to apply for the abortion clinic where I had my
abortion a few years prior. I was one of those diehard pro-choice people that was very radical.”

And finally, Claire offered insight into her mindset, “When I got involved with Planned Parenthood, I had actually had an abortion. I wasn't raised that way. I was raised prolife and to believe that abortion was wrong.”

**Sub-Theme: Shifting View While Working in Industry**

Although the participants felt as though they were doing something to help women through an unplanned pregnancy, doubts began to surface during their tenure as to whether abortion was the best means of support. Claire was convinced that abortion was the answer for most of her time working in the abortion industry, “[Clients] were, ‘I'm thinking about having an abortion.’ I was, ‘Great! Let's do it!’ There was no ‘Let's talk about your options today.’” In the beginning Lily felt her job offered “provision to other women in need. I really did think that I was doing the best thing that I [could] for these women.” Anne attributed her view as being influenced by the messaging about abortion, “Truth is…it would be killing her baby and we couldn't say that in the abortion clinic. I was still kind of blinded by the very effective marketing of abortion in our country.”

Four interviewees spoke directly to a change in mindset and of heart that began taking place while working in the industry, such as “Even like a year before I got out, my heart was changing and softening” (Miriam) and “I was secretly becoming pro-life, but I didn't know anybody to talk to about that…I felt really alone with it “(Lena). At the same time, a shift occurred in client care priorities. Deborah explained, “And even though I had nothing to do with the rooms, I was like…going to work on the contraceptive half so hard that women wouldn’t need abortion.” And Dewy reminisced, “I was young…I had to pay bills [so] I didn't have the option. If I would have been at home, I probably would have immediately quit.”
Finally, an awakening in a few participants’ faith was instrumental in a changing view of abortion as Jean experienced, “And then I became a mother and then I became a Christian. And that's when God started having little whispers and then made himself a lot more obvious.” Maria actively sought God as she began to question working in the industry, “So I started reading my Bible and started praying and asking God to show me what was wrong with abortion…He does answer prayers.” And in retrospect, Rubi concluded that “When I was working in the abortion industry, I wasn't really much of a believer. I think that's what allowed me to work [there] because I didn't see the evil side.”

**Sub-Theme: Pro-Life After Working in the Industry**

To begin, all but one participant professes an unequivocal pro-life stance since leaving the abortion industry. This participant, who still thinks abortion may continue to be an option, expressed her view as “Now I feel really strongly about there being a point in which there can be no abortion unless it's really severe like anencephaly…or if the mother's life is completely at risk” (Dewy). For some the shift of opinion occurred over time after leaving the job, “I still wasn't 100 percent pro-life. I just knew that I couldn't work there anymore…but [not] long after leaving, I became pro-life from the womb to the tomb” (Alex). Most of the participants now have strong thoughts and beliefs about abortion and the industry. Claire stated, “I’ve had a 180-degree shift on that…I don't believe abortion is right in any circumstance or situation.” Deborah expressed, “I'm against abortion. There's no excuse for it…it's a business to me.” And Jean articulated that “Now being pro-life, any genetically unique human deserves protection in my brain.”
Looking back, several of the interviewees had strong feelings regarding working in the abortion industry. Beth professed, “You know, it makes me sad that people don't value life. But I was one of those people. I didn't value anybody's life.” Lena attributes staying to her coworkers, despite the fact what they did was evil, it was a very warm and supportive woman friendly environment. Which may be why I stayed there as long as I did. It was antithetical for me to work in an environment that was strictly about death. That's what it was.

Lily still struggles with the guilt, “Like for four years I was not a nurse. I was labeled a nurse, but I was everything against my oath.” Anne stressed, “You could call it products of conception or a blob of tissue, but now we can see in a sonogram that there's a beating heart. There's a backbone and brain.” Susanne concurred, “It's not of this world...from what I saw...it's [just] horrific. I wouldn't want anybody to go through that or see that.” Finally, Rubi attributes God for her exit and current view, “If it wasn't for God, I don't think I would be here...This allowed me to see that what I was doing in there was not OK.”

Moreover, this change of perspective has led the way for involvement on the pro-life side of the abortion platform. For instance, Faith looks forward to working with a local center that assists women who are dealing with an unplanned pregnancy, “A pregnancy resource center bought [the] building next door to that abortion clinic...they'll be opening soon, so I cannot wait.” Maria also volunteers, “I was praying outside the clinic I used to work for and volunteering at a local pregnancy center.” Addressing the need for abortion awareness and local pregnancy center support, Miriam stated, “It's sad for me to think that there's so many churches that are truly afraid to take a stand, [to] speak up for life.”

Major Theme Two: Memorable Experiences During Tenure in Abortion Industry
The second major theme that developed from the data associated with RQ1 is *Memorable Experiences During Tenure in Abortion Industry*. Three themes pertaining to participants’ memorable experiences include *Meeting Quotas*, *Sense of Vulnerability*, and *Stigma and Seclusion*. Additionally, one minor theme is included in this section due to the significance it held to three participants and the likelihood that others might have benefited from increased pay and did not mention since it was not directly related to the questions asked during the interviews.

**Table 4**

*Major Theme Two: Memorable Experiences During Tenure in Abortion Industry*

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*Sub-Theme: Meeting Quotas*

Ten out of the 14 interviewees mentioned quotas, meeting numbers, or abortion as their clinic’s money-maker as troublesome. To begin, Lena emphasized that “Abortion has literally become an accepted part of health care.” Because this procedure has become commonplace, the rate of occurrence is often not questioned by both those inside and outside of the industry. However, most of the participants in this study eventually found this dynamic unethical. Claire points out that “I was told that we were going to be doubling our abortion quota, which was just insanity to me. The whole talking point at that time was safe, legal and rare.” Rubi disclosed, “We were pushing for abortion, so many of [the women] left the clinic with an abortion appointment.” Faith struggled with the fact that “The questions were opposite of what I would ask [women], like they were selling the abortion.”
Both pressure and reward seemed to be aspects of abortion quotas and the clinics’ meeting their numbers. Deborah felt stress from the demand of quotas, “The pressure of meeting the quota...how do they expect me to find women to have abortions? They make you feel like you're going to lose your job.” Miriam recounted the possible rewards for meeting numbers, “We worked diligently to hit our numbers and our goals because if we hit the goal, we would either get a couple hours of PTO, a bump in staffing hours, or a pizza party for the staff.”

Concomitantly, Jean recalls a conversation with her former manager about abortion quotas, “I said, ‘Isn't our goal to put ourselves out of business...provide contraceptive services so [there’s no] need for abortion?’ And she said, ‘Jean, this is how we make our money.’” Anne was disturbed by abortion for profit, “Abortion, when we didn't have a big abortion clinic...was the money maker.” Alex shared her assessment of priorities, “But it's all about money.” And Dewy addressed the disregard for gestational boundaries by saying, “At that point [abortion] was legal to 24 weeks, but I know that he went beyond 24 weeks regularly. For the [women], for the money.”

Sub-Theme: Sense of Vulnerability

Participants voiced vulnerability as evidenced in complying to others’ desires, economic need, and the demands of the industry. To begin, Anne related vulnerability to her experience, “After working in the abortion clinic, many women are like me...they go along to get along because somebody else is influencing that decision.” Beth admitted, “So if you don't really have any kind of beliefs, then I think it's very easy to be manipulated into thinking that you're doing the right thing.” Maria conferred with these thoughts as she stated, “I guess [I was] naïve too, because I was not grounded in my faith. I was not grounded in my cultural values.”
Moreover, economic needs appeared to play a role in workers being hesitant to leave the industry even when they desired to quit. Rubi expressed her reason for working in the industry, “We are all in there to make money and to bring that money home because we have kids to feed.” Alex said, “Eighteen dollars an hour is amazing for someone who's a health care tech and wants to stay in the health care field.” Claire expounded upon the higher pay offered by the industry, “I would say that a lot of single moms were hired…at a higher pay than they would get paid anywhere else. [This] sort of made them feel trapped into that pay grade so they felt they couldn’t leave.”

Finally, vulnerability was also expressed through the industry hiring people according to its own needs, which placed workers in a challenging situation. Deborah recounts that she was just happy at first to have a job as “Who else will give me that opportunity to work in the medical field, undocumented.” Faith followed up by saying, “They knew a lot about me. I think they hire the wounded.” Lily recounted that “Hiring people was really hard. You'd have your people that just once they found out what we did, they absolutely said no. We hired unlicensed people.” And finally, Dewy stressed the nature of the work as, “That's hard stuff, especially for a 19-year-old.”

Sub-Theme: Stigma and Seclusion

A couple participants mentioned not wanting to either be in the public eye or interact with those not associated with the abortion industry. Lily said, “We only interacted with each other…if we ever had to celebrate a birthday, it was just us that went out to a secluded room at a secluded table…nobody wanted to be seen by other people.” Alex felt as though, “You can't talk to anyone else about what you've seen and what you've done. People look at you like you're insane.” Beth attributes not interacting with people outside her clinic due to uncomfortable
reactions of previous acquaintances, “There were a couple of girls in our group that were just like, ‘That's horrible! I could never have an abortion. How could you do that?’”

Isolation and loneliness dovetailed with this sense of seclusion. For instance, Miriam was mortified when in front of her family a woman told her, “You helped me get my abortion.” Faith confessed, “I'd never been so lonely.” Claire had similar experiences, “I kept seeing people that had abortions at my clinic.” She added, “I just felt like I couldn't trust anybody…I felt very alone.”

Additionally, shame was not only a presence while working in the industry, but also after quitting. Lena said, “I was ashamed enough that I didn't share with anybody where I worked.” Maria echoed this sentiment, “I wasn’t proud to say that I worked in the abortion industry so I wouldn't really talk about my job.” Dewy continues to struggle with her work-related experiences, “I've never talked to anybody about it because it's too shocking and I feel like I'm exposing the babies…for shock purposes. I can't talk about it to people unless they get it.” And Susanne also finds it difficult to disclose she worked in the industry, “I've worked at the [Christian] school for six years, but I'm not going to tell them because they're going to say, ‘Oh, I can't believe you worked there!’”

**Major Theme Three: Difficult Work Environment**

The third major theme that emerged from the data associated with RQ1 is *Difficult Work Environment*. Five sub-themes associated with *Difficult Work Environment* are discussed in this section and include *Memories and Regrets, Distressing Tasks, Problematic Practices, Deception, Protesters and Prayers*, and *Angst: Leaving the Industry*. These sub-themes are presented within *Table 5* and expounded upon in the following paragraphs.
Major Theme Three: Difficult Work Environment

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As mentioned previously, participants were each hired for a specific position and then often trained to assist with other duties. Some of these tasks were stated to be more difficult than others to perform. Moreover, all interviews discussed vivid memories and regrets they have regarding the time they worked in the abortion industry. Some participants found the work environment itself challenging, such as Dewy, “We would be in the room and whether or not we were hearing babies cry that were there with their mothers, who knows? But then we would say that we heard the ghosts of babies, like everybody said it was haunted there.” This section presents actual experiences with patients and coworkers.

Sub-Theme One: Memories and Regrets

To begin, memorable experiences and regrets begin with patient care. Alex relays, “We had two instances while I was there where the provider just could not get it [bleeding] under control. We ended up having to call the EMS.” Anne shared her encounter, “There was one situation where a woman was pretty sick after [her abortion] and she came back. Sadly, I think she had an incomplete abortion.” Claire expresses empathy, “We had harmed her during an
abortion and we had left part of the baby in her…She looked so sick. She was in the hospital for days.”

Next, some interviewees voiced concern for the fact that abortion might have been a cover-up for either an incestuous relationship or human trafficking. Beth remembers an incident with a young girl at her clinic, “She's 12 and she's literally screaming…a nervous wreck. Now, [I am] pretty certain that was an incestuous relationship that she got pregnant from and her grandmother [was] trying to hide it…it just it breaks my heart.” Claire said, “We had a prostitute that came in over and over again. Now I realize she was being trafficked. Every time she came in she had an STD. We never called the cops. We never offered to help her.” Maria questioned,

This patient that was 14 came to get an abortion. I tried to get her on birth control, she didn't want birth control. She [came back] six months later [for an abortion]. How is it we're covering up for possible sexual assault, incest, human trafficking? She could have been any of those.

Participants perceived that many young women chose late-term abortion due to a perceived inability or lack of desire to care for the baby or a medical recommendation to abort. Jean shared, “In my experience, which is a year if not a little more, in the abortion clinic there was just the one woman [whose] child had Down syndrome and she did not want to continue the pregnancy to term.” Lena recollects, “This couple wanted to have a baby, but they discovered she was carrying twins. They were about 17 weeks then and aborted the twins because it didn't fit their lifestyle.” Lily remembers,

I got a call from them one day saying, ‘they're telling me that my baby's not going to make it and that I have no choice but to terminate.’ Every ounce of my being, my instinct said ‘get medical records, don't do this today.’ And there was no fetal anomaly.
In addition, patient responses remain in the minds of a few of the participants. Faith will never forget the woman’s response who was pregnant with four babies after she saw her ultrasound, “She jumps up and looks at that screen and sees her four babies and started to cry and she called her boyfriend and told him, ‘It's not one baby, it's four.’ She didn't want to do one.” Faith continues,

I'm in the POC room with the baby in the pan. I'm holding on to this baby and crying. I looked at my coworker and [said], ‘I don't want to hear that this is tissue. This is a baby. Those are babies.’

Jean recalls a patient who could not make up her mind as to whether to abort or not,

She came in and had the procedure and was 19 weeks along. I remember seeing the child…you can't deny this is a genetically unique human that's fully formed, but immature. That young lady felt the kicks and the life within her. That was a tough one, because so often you, when you're in the industry, it's so much easier to let go of something small and very underdeveloped versus life in its fullness.”

For Rubi it was the pain the women felt, “They were having that abortion procedure and were crying. It makes my heart [hurt]…how my heart was so hard that I never saw the brokenness.”

Furthermore, some participants experiences involved parents on both the side of not wanting their child to have any interaction with an abortion clinic to those who brought their daughter to the clinic. First, Miriam recalls parents who were appalled that their daughter was receiving services, “There were...moms or dads, that would find birth control pills for their teenage daughter and call and be angry.” Dewy recalls “girls coming in that were in maternity clothes, you know, their mothers, most of them their mothers, would be dragging them in there.”
Susanne added, “And then there were memorable people that you end up knowing that go there and they had no idea that you worked there.”

Finally, a couple interviewees stated memories involving superiors where they worked. Dewy shared, “I do remember knocking on this doctor's door to tell him somebody was on the phone or something and him screaming at me and throwing something at the door. I remember thinking he's completely insane.” Maria recalls her supervisor, “I realized it was very, very toxic. The manager was rude. She was mean. She was a bully.” Both Deborah and Lily had physical repercussions associated with their experiences. Deborah was observing an abortion,

I was on the side of the bed next to the patient and I had an asthma attack because of the anxiety it caused me. I had to leave the room…the doctor got mad at me because he had to move the aspiration machine.

Lily stressed,

I did get hurt on the job, we had no insurance. A patient woke up in the middle of the procedure. She kicked out, my knee went backwards…I was expected to be back at work the next day…I need a total knee replacement now.

Sub-Theme: Distressing Tasks

Interview question four asked the participants to describe their job responsibilities at the facility in which they worked, which was discussed in the beginning pages of this chapter, and any tasks that were more difficult than others to perform. Thirteen of the 14 interviewees identified job tasks they found difficult. Jean pointed out that the lack of quick patient care was troubling to her, “One young lady hemorrhaged, and we needed to get her to the hospital. There was that, just that momentary pause. But unfortunately, there is a desire to not bring any attention to an abortion clinic.” Miriam summed up the most common responses, “It's the whole
set of issues, it's the noise, the sound of it is bad, seeing the baby in the jar. You know, we'd strain it through a colander and then rinse it.”

Foremost, late-term abortions were voiced by four participants as being associated with difficult job tasks. Lena emphasized, “I would say that the late cases were harder.” Alex described her most challenging experiences, “When I assisted in the day two ultrasounds for second trimester abortions, that was the hardest because you actually could see everything on the ultrasound machine.” For Dewy and Deborah, it was the handling of the late term baby parts. “I had to put the late term body parts in buckets, and these were big babies. They were viable babies” (Dewy). And “The Stericycle would come and pick up above twenty-one weeks, I had to make those death certificates” (Deborah).

Likewise, the parts of conception lab was stated as troublesome. Anne said, “Seeing the little feet in the containers…that had to be one of the harder things.” Susanne remembered, “When [the doctor] was [almost] done with the procedure, he would bring that in so I could sort it out and make sure that every little piece of tissue is there and sometimes body parts were in there” (Susanne). Faith was taken back, “What got me was when I was asked to go into the POC room… it was a 13-weeker and I had to piece that baby back together. That was a baby with actual legs, arms, everything.”

Beth continued the conversation on difficult tasks, “In the POC room. And it was also hard not to tell the patients if it was a multiple abortion or when you could very clearly tell that they had an STD. But that wasn't our responsibility.” Rubi expounded, “Hard to believe that I felt more uncomfortable doing phlebotomy than rinsing and placing the baby in a bread bag” (Rubi). Lily shifted the thought to clinic sterilization, “Like, why do I have to fight to get somebody who's competent to clean a medical facility?” Finally, Maria was often upset that “I
got in trouble because I was taking too long to counsel [the patient]. I was trying to educate her about the different birth controls and trying to convince her to [choose] one.”

*Sub-Theme: Problematic Practices*

Over the course of their tenure in the abortion industry, participants were involved in procedures or practices they deemed problematic. Two main areas of conflict were the babies and the women. To begin, the reality of life in the form of the developing fetus created question as to the denial of an immature, yet fully developed baby. Five interviewees shared vivid memories of interactions with what they deemed as actual babies and not just a fetus. Alex recounts assisting with abortions, “You see tools being inserted into the mother, pass the cervix into the womb and the baby being crushed…the skull is crushed and then each limb is literally ripped and the baby is pulled out.” Dewy said, “I remember seeing a baby pull its leg back, because they would just reach in and pull it out, pull the baby out in pieces.” She continued, I was traumatized by seeing a little piece of [mucus] on the tray. It was a tiny arm torn off at the shoulder…tiny fingernails and creases in the hand. I remember thinking, ‘Oh, my God, even when they're this little they're tiny humans.’

Moreover, these parts of conception were viewed as being handled with disrespect. Jean discussed the difficulty of seeing the parts of conception, “Some women wanted to see the baby, and the clinic I worked for allowed this. I would accompany them to view their child, which was an undeniable, torn apart human.” For Lena it was the later cases that were challenging, “[The doctor] instilled the urea into the uterus to kill them, it starts to break down the placenta. It’s a highly concentrated salt solution and it burns the baby's skin.” And Rubi sadly remembers, I was working in the POC lab that day and this baby, he was 16 weeks. When this baby was passed to me from the door and I emptied it, everything was very visible…his little
arms, his legs. And the head...you could see every detail on that little face and his little hands. I rinsed it off...the doctor came in to look at the baby. I put it in the freaking red bag and just threw it in the freezer.

Equally relevant, eight participants mentioned memories of interactions with the women who came into the clinics as troublesome. Beth remembered, “I'm passing the instruments, turning on the suction machine, and I'm seeing all of the blood and fetal tissue, everything going through, and the patient's grimacing in pain.” For Miriam and Faith, the recovery room was difficult. “You know, women were either, like angry or crying. Some were relieved, but still kind of angry” (Miriam). “What got me every time was the blank stare in these women's faces after this procedure and they were in recovery. They all had the same blank stare with tears rolling out of their eyes” (Faith). Deborah noticed, “The women on birth control were having abortions just as frequent or even more frequent than the women without birth control, and that is the business of abortion.”

Other interviewees felt the treatment of these women who were seeking assistance was disrespectful. Alex confesses,

Talking over women when they kind of expressed that they really weren't sure of the decision. Talking over them and basically...encouraging them to do it, ‘Oh, this is the best thing for you right now. You'll be able to have kids again in the future.’ We lied to these women.

Anne added, “Women would ask questions, which obviously indicated they were struggling with the decision morally and they were just kind of glossed over.” Faith disliked that she was expected to encourage abortion, “And I'm like, but aren't you supposed to ask them? What if they
don't want to have an abortion? What if they have doubts? What if there's a reason why they're here? But we weren't allowed to ask that.” Rubi concurred,

My view has changed a lot because there was no empowerment. I [was] telling a woman that she's not able to be a mom, that she's not able to be a mom of four, five or six. What gives me the right to tell them that they are not capable of this?

Claire feels like, “We should have protected the women that were coming to us for help. But instead, over and over again, we protected their abuser.” And finally, Anne’s appraisal was for many women, “They go along to get along because somebody else is influencing that decision.”

Sub-Theme: Deception

Deception is a theme that developed on both sides of the participants’ experiences with management-employee interactions and patient care. To begin, Anne sees the industry as propagating duplicity, “The deception and the outright lies of an industry that proudly states that they are for women. The authority by which they ran that place, you had to follow certain rules, and the effective marketing of abortion in our country.” Beth recounts the philosophy, “It was just tissue. And we're getting rid of it and that's it.” Miriam expounded upon this thought, “And the regional director who was interviewing me said, ‘Well, it's not murder unless the fetus is viable.’” Faith shared that after she and other workers at the clinic experienced a traumatic occurrence, a grief counselor was hired to speak with them, “I realized that she was just there to make sure that we were still with the program. That we were for abortion, that it didn't matter the gestational age…it's just tissue.” And Dewy added, “People think that late term abortions are very rare. They're not!”

Patient interactions and care also was an aspect of the deception the participants’ identified. For instance, the doctor Susanne worked for “would advertise himself as a
gynecologist, in obstetrics and gynecology, but was all abortion and birth control.” Lena commented on what she deemed the questionable motives of the doctor she worked for,

> He really did not like doing pain relief or sedation except under extreme circumstances because he didn't want to deal with any side effects of somebody being sick or taking a while to wake up. As I look back, I realize how little he really cared for the women.

Along the same line, Deborah was disturbed by, “But to hear them lie about what happened in the room with that girl and other things the abortionist was doing, it was heartbreaking.” Alex discussed the behavior of those she worked with on abortion days,

> We would go to a bar or a local restaurant and we would all just get obliterated and we would laugh and talk about the women and call them frequent fliers for the ones who were coming in multiple times…just totally degrade them.

She connected this bad behavior as “what we had to do to continue doing what we were doing. To be able to wake up and do it again the next day.” Finally, Claire found it dichotomous that “we all thought we were so enlightened…so tolerant when we were at the clinic. [But] all these people who claimed tolerance, were the least tolerant.”

**Sub-Theme: Protesters and Prayers**

Some of the individuals who stood outside the abortion clinics protesting added stress to the participants’ workday. “When I went to the clinic for the first time, there were all of these crazy people out there…with bloody pictures and stuff” (Claire). Faith remembered, “Protesters telling me God hated me. He was never going to forgive me. I was a baby killer.” Rubi was often taken back by “The people that we had protesting outside, they were really mean and nasty. They would [say] ‘baby killers, don't work in there.’” Susanne recalls, “We had the bomb threats…people calling and cursing at you.”
Yet not all individuals who stood in front of the clinics were hostile. Many quietly prayed and others kindly interacted with workers when going into or leaving work and even assisted participants’ in leaving the abortion industry. Rubi was influenced by, “The quiet people that were out there praying, they were across the street. They weren't even near the clinic.” Beth asserted, “The lady I had arrested, she and I'll pray on the sidewalk together now.” Claire and Lily are thankful for those who prayed for them, “These people who had been praying outside the clinic, who I thought were totally intolerant, they were the ones who embraced me” (Claire). “I had prayer warriors on the site. I found this out later…for me, it was a set of three faces that I saw all the time” (Lily). Faith would walk up to one of the prayers at her clinic and ask, “Hey, can you pray for me today? So that's what started my transformation. It was like I felt different.” One prayer reached out to Deborah to help her when she left her job, “That lady had been praying outside for 20 years. When she didn't see me come back, she got worried. She called me and said, ‘What can we do for you? Let us help you.’” And Miriam found support, “We call them picketers…outside of the clinic. And that's where I ended up going to church. And they just accepted me as I was.”

Sub-Theme: Angst: Leaving the Industry

Some interesting facets developed in association with why and how the participants left their jobs at the clinics in which they worked. Most participants had experienced some form of angst while performing their job responsibilities whether from personal conviction, burn-out, or challenges with co-workers or supervision. Only one participant left due to a family-related circumstance and was satisfied with her job at the clinic when she resigned, “My husband said…let's just get out of the place we're at and let's start somewhere new” (Rubi). Conversely, two participants decided to pursue different jobs due to dissatisfaction with supervision or
desiring a change. Beth offered, “I was like, ‘I don't have to work here.’ So I quit.” Lena said, “I was just ready to go on to something else and my next job was newborn intensive care.”

Three of the participants were let go even though they intended to quit if a specified issue, such as unsupervised medical abortion or negligence in patient care, was not addressed. Participant responses indicated deep emotions linked with that apex: “I had one of the senior leadership tell me, ‘you know, maybe you just can't do this job, maybe you're not cut out for this’” (Alex). “And I was vocal about that, shared my opinion and ended up getting fired” (Miriam). “It's a tragedy that did it for me that day” (Deborah).

For many of the participants, leaving was directly linked to an experience either in the abortion room or the POC lab and mostly involved a second or third term abortion: “Once I saw that, I knew that I could no longer work there” (Claire). “And that was my breaking point, because this was a baby. Oh, my God. I mean, this was a baby that would have lived” (Dewy). “Those were babies. I didn't even put [in] a resignation letter. I just never came back” (Faith). “I'm like, this is not helping them. This is not empowering them. This is just allowing them to be used…I gave my two-week notice and I left” (Maria). “Looking at the women in the waiting room I'm seeing generations of people that are going to be eliminated…what I saw was very much a business transaction” (Jean).

Lastly, three participants identified God as the conduit for leaving the abortion clinic in which they were employed. Anne stated, “God just really took me out of that circumstance and placed me into this very remote but very real environment.” Lily struggled and finally found a release, “Sometimes I'd just be outside [in my car] praying and it just became heavier and heavier for me to go in… I got the sign today, today I quit.” And Susanne shared, “So that's
when I started going to church, and eventually I ended up accepting Christ…that's how I ended up leaving.”

In summary, the previous section discussed three major themes related to RQ1: What is the lived experience of former abortion workers who left the field due to moral distress both before and after their transition from the industry? These themes include *Shifting View of Abortion: From Pro-Choice to Pro-Life*, *Memorable Experiences During Tenure in Abortion Work*, and *Difficult Work Environment*. Sub-themes were presented within the context of the major themes and supported by direct participant quotes. The following section addresses themes related to RQ 2: What were (and are) the perceived bio-psycho-social-spiritual impacts of abortion work for those who ultimately left the field due to moral distress?

**Themes Related to Research Question Two**

Two major themes emerged from RQ2: What were (and are) the perceived bio-psycho-social-spiritual impacts of abortion work for those who ultimately left the field due to moral distress? These major themes include *Bio-Psycho-Socio-Spiritual Effects*, and *A Turning Point*. Almost all the women who took part in the interviews voiced a dissonance between their personal well-being and performing job tasks required by the abortion clinic in which they worked, indicating aspects of moral distress. All participants vocalized experiencing some type of bio-psycho-social-spiritual challenges or effects while working in the abortion industry.

As far as leaving the industry, some interviewees vocalized that their decision to quit developed over time. For others, it was a specific event that verified the need to leave. Alex, for example, referred to her sense of uneasiness working in an abortion facility by saying, “But I never quit, even though my mind, my psyche, my soul, everything was telling me, ‘You don't need to be here.’” Additionally, and of interest, participants who suffered pre-existing trauma
indicated more significant distress. These experiences are discussed in relationship to the emerging themes. Participant quotes offer insight into the development and perceived relevance of these themes.

**Major Theme Four: Bio-Psycho-Socio-Spiritual Effects**

Major theme one is *Bio-Psycho-Socio-Spiritual Effects*. Seven sub-themes emerged from this major theme. These sub-themes include *Maladaptive Transitions, Destructive Coping, Comprehensive Conflict, Relationships, Dissonance, Conviction and Condemnation, Pre-existing Trauma, and Depersonalization*. These sub-themes are presented within *Table 6* and are expounded upon in the following paragraphs.

**Table 6**

*Major Theme Four: Bio-Psycho-Socio-Spiritual Effects*

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*Sub-Theme: Maladaptive Transitions*
To begin, work to home transitions proved to be challenging on multiple levels for all but three participants. Only Anne, Jean and Lena stated that coming home from their job at the abortion clinic did not affect their overall well-being or home life. These women attribute this lack of conflict with their former worldview. Anne said, “I don't really think there was much conflict because we both [she and her boyfriend] had the same mindset about things at that time.” Jean reflected the same thoughts about work to home transitions, “So I really didn't have work stress as my husband and I were content with where we were at the time.”

Conversely, the other 11 interviewees experienced maladaptive transitions from work to home life. Substance use was indicated as part of three participants’ work to home transitions. Alex disclosed, “So my outlet before I got home was to get drunk with my coworkers and then come home and crash…then wake up the next day and do it all over again.” For Dewy, “It wasn't any sort of good transition from work to home. I would take pills or whatever at home.” Beth stated,

But as far as day to day, the friends that I hung out with…we all just were big into drugs. You can't go call your best girlfriend and go, ‘oh, let me tell you what a day I had today.’ They don't wanna hear it. They're just like, ‘no, this is disgusting.’

Similarly, the complexity of talking about work with spouses had a profound affect upon a couple of participants. Claire disclosed, “My husband was pro-life and so I would deal with these difficult things at work, and I couldn’t talk about them at home.” And Faith’s husband thought she should quit. “He could see the toll it was taking. I was telling him about stuff that you’re not supposed to do. I’m killing babies and he’s like ‘then leave.’” Rubi and Lily disclosed the dissonance it created with their families and personal lives.
I think it didn’t allow me to be close to the kids. I was just there. My mom had already fed them. I just had to worry about doing homework, showers and putting them to sleep.

So it was like a routine, a boring routine (Rubi).

“Seclusion, isolation. I always refer to those years as the ‘cult years’. It’s definitely a cult mentality and that just becomes your every thought processes. I have to stay in this box by myself” (Lily).

Other interviewees tried to move on with their day and leave work behind. Deborah remembered her struggle, “I [was] waking up at 2:00 in the morning to make sure my phone was not disconnected or had lost battery.” Maria stressed “I didn't talk about it. I left work at work. That's how I dealt with it…by not dealing with it.” Miriam used her drive home to sort out her day: “It gave me time to decompress and ponder what I had seen. Thinking, does anybody know about this? Does anybody care? What in the world do I do with this information?” Finally, Susanne could not relax,

So I was not used to being relaxed and not doing anything. I was used to working, making sure everything was clean. I wouldn't be able to go to sleep until every single thing in the house was clean. I was just so obsessed.

**Sub-Theme: Destructive Coping**

Three women mentioned that the inability to sleep negatively influenced their lives during the period they worked in the abortion industry. Alex said not sleeping was a challenge: “So physically I was not sleeping…and I didn't eat properly because we would work 10, 11 hour shifts with no breaks.” Deborah also had issues sleeping because of needing to be available if an emergency arose, “I couldn't sleep.” And Susanne sought help falling asleep, “I would not be able to sleep. I would take Tylenol p.m. often so I could fall asleep.”
Nevertheless, the coping mechanism most cited was the use of substances or food. Again, Alex expounded, “The only time I would really sleep was if I was intoxicated. And that's not healthy sleep. I basically was passed out…my coping mechanism was alcohol.” Claire shared, “There was a time (after I left) I did a lot of binge drinking. A lot. You know, to the point where my husband was ‘OK, you need to cool it.’” Faith was thankful that “I'm not drinking that bottle of wine anymore to numb myself. I'm actually talking to God now.”

The use of substances was also attributed to affecting relationships that the participants had while working in the abortion industry. Anne noticed she was becoming dissatisfied with her life, “After my brother got killed, it changed my perspective. I knew that I was becoming increasingly dissatisfied with my boyfriend, he was just not healthy. We would go to parties and they'd have drugs and drinking.” Beth said that most of her friends were from work, “But the friends that I hung out with outside of work, we all were big into drugs. I could call somebody, get stoned…do acid or whatever.” Dewy voiced using substances to cope. “I coped by doing a lot of drugs. I was never clean. I would take pills or whatever at home, mostly Valium, which I still have an issue with… anything to escape.” Moreover, for Lily, “Food became my addiction…I gained over 130 pounds in the span of two years. Then when I finally quit, I was still dealing with tormenting thoughts…I think I probably gained another 50 pounds.”

**Sub-Theme: Comprehensive Conflict**

Comprehensive conflict was denoted in several ways and grouped into four basic categories. First was ongoing conflict with family and friends, which not only led to deteriorating relationships, but also depression. Alex recollects,
Me coming home telling my husband I was actually involved in the abortion procedures, that's when things started kind of going downhill. He noticed the demise in my personality and my humor. My humor became dark. I was very depressed.

Lily confessed,

I was a recluse at this point, I'm not working there anymore, but I was a recluse…I just didn't want to deal with the world. I would literally sink into my dark place for weeks and months at a time. I felt that I wasn't worthy of anybody's love or interaction.

The second form of conflict was questioning what one was doing working in the abortion industry. Beth remembers,

I just kept washing my hands over and over again and I just kept seeing blood. And I remember looking in the mirror going, ‘What have you done?’ But I still went back a couple of days later and I kept going back for three and a half years.

Claire recalls,

But every time I would try to make it OK in my head, I just like, [would] see what I had on that ultrasound. For me to come to grips with it…there were times in the beginning where I contemplated suicide.

Next, many participants experienced inner conflict that affected her overall well-being. Alex said, “It was really getting to me where I was having dreams and nightmares about it.” Claire shared her nightmares, “It would be very graphic…bloody parts of late term abortion. And I was being forced to participate. I was the one who had to put the baby back together.” Dewy expounded,

I was having massive nightmares…there were dead babies all over my bed. I’d just wake up screaming. I’d have these horrible dreams after I quit of running with the baby,
rescuing the baby … It was awful. I couldn't eat anything with tomato sauce. I couldn't eat spaghetti.

Nonetheless, Deborah’s inner conflict revolved around not having the paperwork to stay in the United States, “They had me as undocumented so they could have deported me…I always had that paranoia.”

Memories also contribute to inner conflict stemming from job duties engaged in at the abortion clinic. Jean’s memories are precise,

It doesn’t sound right that you feel like you're in a vacuum, like you're losing yourself, because a vacuum is involved in the abortion procedure. It literally feels like life is removed, which it is. There are smells…sounds. It affects every sense.

Whereas Dewy seems to have partial memories, “[I can] still see their faces floating in the blood. I don't remember some of the abortion stuff, I'm pretty [sure it's] suppressed,” Maria foremost remembers her breakdown,

I had to be hospitalized. I think it had a lot to do with the fact that I worked in the abortion industry. Some of my memories are that I realized that I killed babies. I have times that I have this rush of memories or flashbacks that are really hard to deal with.

Rubi still has vivid memories of the POC room, “I was just so focused on rinsing it off, but that little face just stayed in my head. It was like it was bothering me…that little baby was there.”

Faith thinks she may always remember, “But abortion will still haunt me. As far as just the images of the women. All I can do it is pray for them.”

Finally, a couple interviewees attempted to avoid the negative influence their work was having upon their lives through avoidance. “And I had determined that I was just going to not have anything whatsoever to do with abortion and just try to live a normal life and forget about
it” (Miriam). And, “You still have baggage that you kind of carry around, in my situation I usually just have to put it in a box… it's so weird, you can block stuff” (Lena).

**Sub-Theme: Relationships**

Relationships seemed to suffer, and in some cases are still impaired, as a result of the participants’ work in the abortion industry. Claire’s and Alex’s marriages both experienced negative consequences: “[My husband] hated what I did…everybody in my life pretty much was pro-life, my whole family, like everybody. I couldn’t talk to them about my work” (Claire). “It just really destroyed a part of my marriage. I would come home drunk. I would get scolded by my husband for driving home intoxicated” (Alex). Jean added, “I think they (family) probably were praying for me behind the scenes versus saying much to me.” Deborah recognized her children were unhappy, “My kids hated my job because I was always stressed out and I was always in a bad mood.” Other forms of unhealthy relationships were also stated. Beth stressed that while working in the industry, “It angered me if you didn't agree with what I agreed with.” Dewy expressed that she engaged in unhealthy relationships when she was younger and that “I still pick unhealthy men, I still get in abusive relationships.”

Deception and avoidance also sabotaged interactions with family members. For instance, Rubi never told her mom about the different roles she had at the abortion clinic, “All this time she thought I was just a receptionist. I've never talked about what I was doing at work, the only thing was ‘how was work today?’” Lily came from a large family, “We did a lot of family dinners. I started to pull away from all of that because it meant interacting with people who might ask a question, might make a comment.”

**Sub-Theme: Dissonance, Conviction and Condemnation**
A few of the ladies signified faith as being a part of their lives before working in the abortion industry and struggled to make sense of the dissonance they felt between Bible-based values and their work-related responsibilities. Lily shared, “I've always had a strong love and respect for God. I lied to myself. I was like, ‘God would not have brought me to this place if…’ I still had not come to terms with my participation in it.” She continued, “I never attended church because I didn't want anybody to see me or recognize me. I felt dirty and unworthy.” Faith disclosed,

I did what I had to do to support my children. I was so angry at God that even when I felt in my heart, “this is not what I want for you,” I ignored that voice. I felt like God hated me… *Thou Shalt Not Kill*, right?

Alex had to come to terms with seeing members of her church coming into the clinic where she worked,

I was tormented spiritually… I'm thinking you're the same people that chastised me for working here, but yet here you are. Bringing someone for a procedure. So I was torn… why am I here? Am I really pro-choice? Is this really health care?

And Beth professed, “I was so far away from church when I was starting. Me and some of my friends, we dabbled in black magic… we learned how to read cards and Ouija boards. I always felt these horrible spirits.”

Concomitantly, other participant’s spoke about aspects of conviction. Lena remembered, “I think I was already starting to feel guilty… and I remember her asking me, ‘So you work in a woman's clinic? Oh, it must be so much fun being around those mommies and babies.’ And that was uncomfortable.” Dewy shared,
I was sitting there thinking about karma and it hit me like a ton of bricks. It's the babies…I realized that I've been part of this murder industry. I don't know if there's a God that… how can you pick up dead baby heads and put them in buckets…How can you not be judged for that?

Miriam added,

To plot to kill the babies is probably one of the worst things any living person could ever do…I do still struggle with that somewhat in my own heart. But it is only through the grace of Jesus Christ that I have been saved.

Some interviewees still struggle with the fear of condemnation regarding their work in the abortion industry. Maria uttered, “Just the shame of it. I was afraid of how the church was going to judge me or I didn't even know how to talk about it.” Susanne was apprehensive to share her past profession thinking,

Even though I left, I wasn't able to really talk to anybody about it. Because even though they were Christian, they would still kind of condemn me for what I did, or didn't see me the same. They saw me as if I had not quit.

Finally, Claire took her sense of condemnation to a very personal level, “There was a point where my husband and I had dealt with some infertility. There was definitely a sense during that time, like, well, God's punishing me. I've definitely been through some dark places because of my work.”

**Sub-Theme: Pre-existing Trauma**

Although previous trauma was not an element of the eight questions asked during the interviews, it was mentioned by eight of the fourteen participants. Two types of trauma were predominant: abusive or toxic relationships and loss and grief. Being exposed to violent
relationships appeared to have a negative effect with Lily finding a way “to leave the toxic environment that I was raised in. It was a very abusive home.” Maria, in thinking about her responses stated, “I also grew up in a lot of domestic violence.” Rubi reasoned the job was important to keep because, “My husband and I, we weren't doing OK. [He was] drinking.” Finally, Dewy painfully confessed,

I had a traumatic upbringing. I was already a mess. So there was that and then the abortion [work] where it seems to just get buried in my mind. I've had depression and anxiety and bad relationships. I feel like I’ve triggered PTSD by facing this.

Two of the participants had husbands that had died prior to them working in the abortion industry. Alex shared, “my oldest child’s father is deceased from my first marriage.” Faith stated her entire life changed within a year’s time,

I lost him to a car accident. So I had to stop going to school. I didn't just lose my husband. I lost my whole support system that year. My husband, my mother-in-law, my father-in-law and my dad months apart.

For Deborah it was a previous miscarriage, “The doctor refers to the head of the baby going into the trash and it took me back to my miscarriage, because I was 14 weeks.” And Anne struggled with the fact that “I am a survivor of an attempted abortion…my life was defined for many years in terms of how I was treated because I wasn't supposed to be here.”

**Sub-Theme: Depersonalization**

Finally, depersonalization emerged from the data as a form of bio-psycho-socio-spiritual conflict. Depersonalization divests someone or something of human characteristics, which may include a sense of something not being real or of one not being present in a situation (Merriam-Webster, n.d.). Both forms of depersonalization mentioned in this definition were identified by
the interviewees, including the depersonalization of the fetus and client through language and how the fetal remains were handled, as well as some participants not feeling present while performing certain job duties.

The first aspect that will be discussed is that of depersonalization through language as various terminology was substituted for baby or fetus. Lena asserted,

You depersonalize the unborn baby…we compared it to fruit. [One] that was around eight weeks…it was a tangerine. The next size up was an orange and the next size was a grapefruit…then you're getting into the boundaries of the later cases.

Anne acknowledged that “We were not allowed to use the word baby. Products of conception. It's just a blob of tissue.” Lily confirmed the use of this type of verbiage, “That's not a fetus…it's just a clump of cells.” Moreover, the women having abortions also were given nicknames. Alex recollects, “[We would] call them frequent fliers for the ones who were coming in multiple times to just totally degrade them.”

Second, participants detailed fetal parts being handled in a manner that indicated depersonalization, such as, “We'd strain it through a colander and then rinse it…and in the early days, we'd flush it down a big toilet” (Miriam). “What they call the POC room…[you put it] in a Ziploc bag” (Susanne). Deborah expounded, “If under 16 weeks, it’s going in one Ziploc at the end of the day.” If the fetus was over sixteen weeks, Dewy said she “had to put [the] late term body parts [into] buckets…you would have to put a head and two arms, two legs and a torso in each bucket.” With regret Maria shared, “[I] remember making fun of the baby body parts.”

Moreover, the workers themselves experienced aspects of depersonalization with statements like “I was like in someone else's body. I was like the shadow and I was just existing” (Faith) and “I was very good at putting on a front, to building up walls around me” (Beth). Claire
remembered, “I had to pretend like I hadn’t been working inside of an abortion clinic all day.” And Rubi quantified her experience, “To stop and see what these women were really thinking and coworkers…I say that we were just like working robots…no one was talking. We were just moving and moving and moving like we had a role to do.”

**Major Theme Five: A Turning Point**

A major theme that surfaced as the participants shared their stories was that of a turning point. At first many of the women seemed plagued by guilt, only to then experience forgiveness. Next, it was through interacting with others who had common experiences working in the abortion industry that a sense of felt understanding led to new relationships offering strength and facilitating further healing. The two sub-themes associated with this major theme are *Guilt and Forgiveness* and *Healing and Camaraderie*.

**Table 7**

*Major Theme Five: A Turning Point*

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**Sub-Theme: Guilt and Forgiveness**

Foremost, guilt was a predominant feeling vocalized by several interviewees. Jean proposed, “It's not until I started transitioning more pro-life when I started having a little more difficulty… because there was so much uncertainty around it.” Deborah shared, “Well, I think the biggest one is guilt.” Maria said, “It's really hard to be OK with the kind of work that I used to do.” Others add, “I didn't know how to really carry this burden, you know. Women I
manipulated or coerced or talked into having an abortion. It was just too emotional for me. I just
felt too much guilt about it” (Claire). “And it still hurts me. You know, it still affects me…how
did I allow myself [to work] there?” (Rubi). “So I wouldn't really share with anybody and then
also [the] guilt because of what I did” (Susanne).

Simultaneously, forgiveness was identified by many participants as coming from God. A
couple of the participants still wrestled with separating God’s forgiveness and the sense of guilt
they still carried, stating “I accepted before anything that He had forgiven me, but it took me
longer to forgive myself. That was a big struggle because I'm the one with demons, I'm the one
that has to deal with this” (Lily). And, “To this day, I mean, I know I'm forgiven by God, but I
have a hard time reconciling all that I did…the thing that saved me [is]coming to know Jesus
Christ as my savior” (Miriam). Others have felt a release from the heaviness of what they
deemed as wrong and harmful. Beth professed, “God cleansed all of that…I'm not going to
forget things, but that doesn't mean that I have to live in it. I have no guilt anymore.” Maria
concurred, “But when we experience God's grace, we understand and we just appreciate it so
much because we know that His love and His ability to forgive is just amazing.” Lena added,
“I've made my peace with God about it. I know I'm forgiven.” Rubi asserted, “As soon as I came
out from our first retreat, I felt forgiven. I felt like this pressure, this guilt just washed off me.”
And Susanne summarized, “I've been forgiven.”

Sub-Theme: Healing and Camaraderie

Many of the participants voiced a need for healing after leaving their jobs in the abortion
industry. Their personal faith, local church, and ATTWN were credited by these women as
supporting them during their struggle to reconcile job-related adverse experiences and behaviors
and facilitating both spiritual and emotional healing. Deborah said, “My church has helped me a
lot with the spiritual healing.” Faith emphasized, “But when I found that church…and And Then There Were None, I realized there are still really good people…that really do care.” Healing was also discussed in context of growing closer to God. Rubi acknowledged, “So I feel that I'm healing every day…since I became close to my faith and now I love God more than anything.” Still others viewed healing had occurred in light of not forgetting and maintaining the hope of Heaven. Lena shared, “I visualize them (babies) in Heaven and I visualize one day meeting them.” Lily stressed, “You heal, but you never forget.”

As an organization focused on assisting those exiting the abortion industry, ATTWN offers frequent retreats that address the comprehensive needs associated with past abortion work. Jean attributes her healing to, “God just kind of set people in place to help me heal along the way. And…being a part of And Then There Were None and the healing retreats has been really helpful.” Maria associated the need for healing in reference to pulling a band-aid off a wound, “When I went to the retreat, that's when I realized it was a tremendous help, even though it hurt a lot because it was just like I had this huge Band-Aid on it and I was ripping it off.”

Furthermore, a meaningful comradery developed among many participants through cultivating relationships with others who experienced similar work responsibilities. Deborah set a strong foundation for understanding this phenomenon by saying, “It's hard when you have not been in those shoes, to say you understand what those women are going through or what we are going through as former abortion workers.” Alex expounded upon this thought, “And so there's only us, our small group, that we can talk to and share and understand one another. Like when I tell people, ‘Abortion has a smell.’” Rubi added, “You are able to describe what you were doing, the smell, the sound of that machine…you get like [no] judgment. Everyone understands what you're talking about. Everybody knows that feeling.”
This non-judgmental connection of understanding and acceptance was described as a sisterhood among interviewees. Lena recounts, “And so it was a good thing in the sense that I was able to meet four other people that wouldn't have that flicker in their eyes when I told them what I used to do.” Susanne stated, “But now there [are] people like me that I'm not going to be judged for what I did.” Claire expressed, “To be able to share without judgement, and with others that [understood] because they worked there too.” Faith described *And Then There Were None* as “Still a big part of my life…from someone I just contacted to get resources and now they have become my sisters.” Finally, Jean affirmed the bond by saying, “So then now you have a whole sisterhood.

In summary, this section presented findings related to RQ 2: What were (and are) the perceived bio-psycho-social-spiritual impacts of abortion work for those who ultimately left the field due to moral distress? These major themes include *Bio-Psycho-Socio-Spiritual Effects*, and *A Turning Point*. Sub-themes were identified through *Table 6* and *Table 7*. These sub-themes were supported through direct quotes from the participants.

**Summary**

This chapter discussed the results of the data collected through interviewing 14 former abortion industry workers. These participants were introduced, and a chart provided outlining their demographics. Theme development was explained in tandem with the use of Nvivo (released 2020) qualitative computer software. These themes were substantiated by participant quotes and presented in relation to the two research questions that explore both these former workers’ lived experiences and any notable bio-psycho-social-spiritual effects. Finally, five major themes were expounded upon in context to the unique lived experiences of these former abortion industry workers and the aspects of moral distress they experienced, including *Shifting*
View of Abortion: From Pro-Choice to Pro-Life; Memorable Experiences During Tenure in Abortion Work; Difficult Work Environment; Bio-Psycho-Socio-Spiritual Conflicts and A Turning Point.
Chapter Five: Conclusion

Overview

The purpose of this study was to uncover and explore the lived experiences of former abortion industry workers. Two research questions guided this study and sought to provide an understanding of the reasons or circumstances that contributed to this population’s exit from their jobs within the abortion industry. These research questions also assisted in identifying the potential effects the job responsibilities had upon the participants’ lives.

Research Question 1: What is the lived experiences of former abortion workers who left the field due to moral distress both before and after their transition from the industry?

Research Question 2: What were (and are) the perceived bio-psycho-social-spiritual impacts of abortion work for those who ultimately left the field due to moral distress?

The following chapter discusses the 14 participants’ thoughts and feelings associated with problematic incidents with patients and coworkers, protesters and prayers outside their place of employment, and the challenges they faced in relation to their jobs at the abortion clinics where they were employed. Additionally, BPSS effects disclosed in relationship to these events are examined pertaining to the data collected and the existing literature. As such, this chapter identifies and discusses the findings of the research, as well as the relevance it holds considering the existing research. Implications are presented regarding the results, along with the limitations and recommendations for future research.

Phenomenological Methodology

Chapter Five discusses significant findings of the data collected and analyzed as part of this study. Van Manen (2016) offers insightful information about phenomenological discourse, which he says brings clarity to experience as it examines the ordinary life. Words, through rich
and rigorous language, identify meaning through experience that is raw and involves naming, not telling about or giving one’s opinion, but life as actually experienced by the person (van Manen, 2016). His discourse continues to highlight that shared experience presents how the participant describes the “now” as a reflection of the past, as well as an awareness that the “now” is also challenged by the past (van Manen, 2016). These findings are discussed in terms of relevancy with the existing literature and influence for future considerations for identifying and meeting the needs of abortion workers who have left the industry. Finally, in sharing their stories and disclosing their experiences the participants of this study often uncovered deep and at times dormant emotions and a sense of vulnerability, an act of personal strength and bravery which deserves respect.

**Summary of Findings**

The following synopsis presents interview questions one through eight. Each question is introduced along with its purpose for collecting data. Additionally, a concise description of the findings is provided.

**Synopsis of Interview Question (IQ) Responses**

**IQ One**

*To begin, please introduce yourself by sharing any relevant information about you and your family.* This question, which involved several prompts regarding specific timeframes, ages, and religious affiliation gathered a substantial amount of information that allowed for a strong demographic profile to be developed for each participant. Additional information was disclosed later in the interview through answers to the other questions, which also strengthened the demographic composition of this group of participants.

**IQ Two**
Tell me how you came to work in the medical field and in the abortion industry. Which position in the abortion clinic were you hired to perform? Interviewees offered a history that enabled a foundation for gaining insight into their realms of professional experience both before and while working in the abortion industry. A few participants stated that a positive of working in the abortion industry was higher pay overall and extra pay for being bilingual, which they did not receive at previous places of employment. Job responsibilities encompassed 12 different stated positions and in-house cross-training was common. A few interviewees stated engaging in job duties for which they were not certified or properly trained.

**IQ Three**

Describe your personal view of abortion and abortion provision before you entered this field. How has this view changed since leaving the field? An interesting trend was revealed through this question. All participants entered the abortion industry with a pro-choice view of abortion, although half of the interviewees said they would not have one themselves. After working in the abortion industry, however, only one participant out of 14 stated abortion should remain legal for situations of abuse or rape and only in early pregnancy. The consensus among all former abortion industry workers interviewed was that the result of abortion was not evacuated tissue, but a baby with identifiable parts and facial features.

**IQ Four**

Describe your job responsibilities at the facility in which you worked and any tasks that were more difficult than others to perform. The interviewees’ responses identified on-the-job training and the multiple tasks most of the participants engaged in as beyond the position they were hired to perform, which were sometimes beyond their skillset or professional certifications. Furthermore, many tasks were challenging for these women such as participating in the abortion
procedure, working in POC piecing back baby body parts to confirm a complete abortion, having patients refuse birth control, and pre-abortion counseling that did not offer options beyond abortion. Participants all recognized through their work experiences that there exists personhood aside from viability.

**IQ Five**

What interactions or encounters, with either patients or fellow workers, do you remember most? Describe what made these occurrences memorable. The most mentioned memorable experiences involved some form of patient complication such as an incomplete abortion or excessive bleeding and working in the POC lab. The interviewees questioned whether abortion really served the greater good for the women who sought help at their clinics. In hindsight, the issue of women who came in multiple times for abortions has raised concern with many of the participants since quitting. Many now wonder if these women could have been in an abusive environment or trafficked, especially since they often tested positive for at least one STD. Additionally, negatives regarding the industry were expressed concerning clinic operations, supervision, work environment, stress, patient care and stigma.

**IQ Six**

Personnel in high stress, people-helping professions often talk about the transition from work to home on a day-to-day basis as challenging. What do you remember about your daily transitions to home routines or challenges when you worked in the abortion industry? Two women stated that they did not experience any challenges with work to home transitions, mostly due to their lifestyle and worldview at that time in their lives. However, most of the interviewees did state some trouble with the shift from work to home in areas of not being able to relax or sleep, strain on family relationships, and substance use.
IQ Seven

What led you to the point of leaving your job and how did you seek help in doing so if it was needed? A few of the women interviewed were fired from their positions in the abortion industry. One interviewee left due to a move to another city and otherwise would have continued working at the clinic where she was employed. The remaining participants all left due to tension with supervision, a traumatic experience with a patient, burnout, or personal conflict either performing or being involved with abortions.

IQ Eight

Please discuss any mental, emotional, physical or spiritual effects that you have experienced since working in the abortion industry and did you seek help in dealing with these challenges? Interviewees candidly answered this question which addressed the holistic effects that abortion work had upon their lives and those of their loved ones. BPSS consequences, including mental and emotional symptoms, physical symptoms, relationship conflicts, spiritual struggles and substance use, were identified through documented statements made throughout the interviews. An unexpected theme emerged from these interviews as eight of the women disclosed previous trauma, which became a consideration for possible increased negative BPSS outcomes.

Discussion

The purpose of this phenomenological research was to understand the lived experiences of those who have worked in the abortion industry and ultimately left due to moral distress and to expand the existing body of literature pertaining to abortion work (Bhattacharya, 2017). As such, this research correlates with and supports several facets of the existing literature and adds new perspectives on the lived experiences of abortion industry workers. Topics presented in this
section connect the experiences of the former abortion workers interviewed for this study with pertinent findings of previous research. In some accounts, the participants’ experiences confirmed these existing findings and in others substantially differed and offered new insights. Thus the findings of this research offer the relevance of affirming or adding to the existing body of literature. Each of the participants in this study worked in a freestanding clinic or facility, which concurs with literature as the predominate source for abortion provision (Abortion Care Network, 2018).

**What this Research Adds to Existing Literature**

Previous research has indicated that many who work in the abortion industry sense a negative characterization of their vocation stemming from restrictive abortion laws and regulations, the stigma of dirty work, and moral incongruence within their communities (Britton et al., 2017; Jones et al., 2017; Kumar, 2018). Thus, areas of interest associated with past findings will be part of this discussion. Relevant topics include *Stigma of Abortion Work, Work Experiences and Environment, Bio-Psycho-Socio-Spiritual Effects, Aspects of Moral Distress and Moral Injury*, and *Steps toward Healing*. These major topics contain sub-topics that identify and discuss specific experiences of this study’s participants as related to the literature. Additionally, the *Major Themes (MT)* from chapter four associated with these topics will be identified, as well as the correlating *RQ* and *IQ*.

**Major Topic One: Stigma of Abortion Work**

Participants offered numerous responses identifying stigma for *IQ Five: What interactions or encounters, with either patients or fellow workers, do you remember most? Describe what made these occurrences memorable.* This topic connects to *Major Theme Two: Memorable Experiences During Tenure in Abortion Industry. Major Theme Three: Difficult*
Work Environment, is also addressed by participants’ responses that highlight pertinent information regarding lived experiences associated with abortion work. Furthermore, the sub-topic of CO correlates with IQ Three: Describe your personal view of abortion and abortion provision before you entered this field. How has this view changed since leaving the field? and Major Theme One: Shifting View of Abortion: From Pro-Choice to Pro-Life. Responses from both of these questions correspond directly with RQ1 as work experiences and also add to RQ2 as BPSS effect was indicated.

To begin, those who work in the abortion industry have been found to not receive the same support or respite as other medical professionals who work in a more generalized or acceptable field of medicine (Jacobs, 2015). Areas of challenge for these workers include working in an aspect of medicine that is often segregated from mainstream medical specialties and practices, partaking in what may be deemed as dirty work, working in a field that is politically polarized between pro-life and pro-choice and often involves protesters, and being confronted by the emotional and relational disconnect with family and friends (Astbury-Ward, 2018; Britton et al., 2017; Jones et al., 2017; Kumar, 2018; O’Donnell et al., 2011). This study affirms the existence of stigma, which has been one of the most researched facets of abortion work. Ten participants indicated experiencing aspects of stigma. Interviewees made statements denoting a sense of either feeling stigmatized or secluded that resulted in isolating themselves due to feeling uncomfortable with others knowing what they did at their job in the abortion clinic or to avoid being recognized by those who had seen them in their work environment. In line with the existing literature, most felt uncomfortable disclosing to people, even to their own families, where they worked and their job responsibilities (Harris et al., 2013; Kumar, 2013). The
following paragraphs discuss the influences of the stigma of dirty work and issues of conscientious objection.

**Sub-Topic: Dirty Work**

First, abortion work is engaging in what might be considered by many as dirty work, which is often associated with vocations that may seem undesirable or disgusting to others due to the type of work, contact with human excrement like blood, or dealing with death (Simpson & Simpson, 2018). This type of job often possesses an element of stigma that may lead to negative effects both at work and outside of work (Bentein et al., 2017; Gallagher et al., 2010; McMurray & Ward, 2014). Participants in this study corroborated the findings of past studies regarding stigma as far as not being able to share where they worked or what they did because “people look at you like you’re insane” (Alex) or make statements like “That’s horrible...How could you do that?” (Beth). Moreover, loneliness was acknowledged as an aspect of stigma not only because others did not understand or approve, but because running into those treated at the clinic was uncomfortable or embarrassing. In front of her children, Miriam had a woman exclaim, “you helped me get my abortion!” Claire stated that she “kept seeing people that had abortions at her clinic.” Faith summed this experience up saying, “I’d never been so lonely.” In this study, stigma presented as a component that added to the more traumatic aspects of abortion work that are discussed in later topics and sense of shame and guilt.

**Sub-Topic: Conscientious Objection**

Conscientious Objection (CO) is a consideration not just of medical personnel who choose not to engage in abortion work, but the changing attitude and conviction of the interviewees over time working in the industry. All interviewees stated they were pro-choice before working in the abortion clinic and thought they would be able to help women, which is in
line with past findings (Britton et al., 2017). However, due to the type of duties they engaged in, these women had adverse experiences that triggered a metamorphosis to a pro-life conviction and the inability to be involved in the termination of pregnancies. These responses align with literature that has found abortion work involves aspects of health care that may generate moral challenges for medical personnel (Berlinger, 2016).

Conscientious objection gives those in the medical field the ability to refuse to engage in certain procedures, such as abortion (Faundes & Miranda, 2017). Nonetheless, due to complications of a woman who either has aborted or is in process of aborting, medical assistance outside of the clinic may be necessary and thus involve individuals who might otherwise choose not to perform or be involved in abortion procedures. From this perspective, Lena pointed out that sometimes a patient would require emergency care at the hospital across the street from the clinic where she worked, “I've often wondered [about] the E.R. doctors [who had] to deal with [abortion patient]…because at that point, regardless of what their personal conviction would be, they would be drawn into it.” Of course, this is one perspective and a patient would be given the medical care needed regardless of their circumstances.

Moral agency and integrity are attributes of CO and foundational to one’s professional role (Harris et al., 2018). It has been found that some in the medical field, even those who are “pro-choice,” find certain aspects of abortion uncomfortable and decide to abstain from certain procedures (Czarnecki et al., 2019). Thus, another consideration of this research is that of changing attitudes and beliefs about one’s work at the abortion facility over the course of one’s tenure. These type of concerns became instrumental in the participants’ of this study choosing to quit. Such was Faith’s pivotal experience, “it was a 13-weeker and I had to piece that baby back together. That was a baby with actual legs, arms, everything.” Jean recalled walking into a
waiting room, “I’m seeing generations of people that are going to be eliminated…what I saw was a business transaction.” Lily found herself not wanting to go to work, “it just became heavier and heavier for me to go in.” And for Miriam it centered around a life ended, “To plot to kill babies…I do still struggle with that somewhat in my own heart.” The reality of a fully developed human being treated so inhumanely was pivotal in a shift from pro-choice to pro-life and formed CO to abortion for those who were active in abortion provision.

Major Topic Two: Work Experiences and Environment

Participants offered numerous responses to IQ Four: Describe your job responsibilities at the facility in which you worked and any tasks that were more difficult than others to perform and IQ Five: What interactions or encounters, with either patients or fellow workers, do you remember most? Describe what made these occurrences memorable. This major discussion topic connects with RQ1 and Major Theme Two: Memorable Experiences During Tenure in Abortion Industry and Major Theme Three: Difficult Work Environment, and interacts with participants’ responses to highlight pertinent information regarding lived experiences associated with abortion work. Sub-topics include Greater Good for the Women, In the Midst of Turmoil, and Protesters and Prayers.

Sub-Topic: Greater Good for the Women

All of the participants in this study have questioned whether abortion served the greater good for all the women who came to the clinics where they worked. Two specific factors dominate this query and focus on the overall wellbeing of the woman. First, incidents occurred that required further medical intervention, some quite serious, and had a profound effect upon these former workers. Second, other instances brought to light the distinct possibilities that a
form of abuse or trafficking was occurring in the woman’s life and nothing was done on behalf of the clinic to assist the victim.

Data supports the view that complications associated with abortion are rare with early termination and slightly increase with gestational age (Gedts et al., 2016; Sajadi-Ernazarova & Martinez, 2020). However, when complications do occur they not only affect the patient, but potentially those who work in the abortion clinic and nearby medical facilities, as indicated by the results of this study. Participants stated feeling an array of feelings and thoughts regarding critical situations involving complications as they recounted their experiences. Alex added, “But we did have two instances while I was there where the provider just could not get it under control. And we ended up having to call the EMS.” Beth remembered telling a young patient who was bleeding, “OK, even if you don't want to do this here, you need to go to the hospital.” Claire told of a patient, “She was in the hospital…she had become septic because we left part of the baby.” Jean recounted that “one young lady hemorrhaged and had to go to the hospital.” All participants who mentioned complications identified negative feelings and regret associated with patient outcomes, especially when a form of negligence was involved.

Next, unanswered questions surrounded some of the women and teen girls who sought abortion and whether their decision was an act of reproductive control by another person (Rowlands & Walker, 2019). Claire, looking back at her years in the abortion clinic remembered a prostitute that came in numerous times and always had an STD. Claire stated “Now I realize she was being trafficked…We should have protected the women that were coming to us for help. But instead, over and over again, we protected their abuser.” Other participants questioned, either at the time of service or in hindsight, the circumstances surrounding a client’s pregnancy. Maria was still disturbed by an incident with a 14-year-old client she tried to get on birth control,
“She didn’t want birth control. She [came back] six months later [for an abortion]. How is it we’re covering up for possible sexual assault, incest, human trafficking? She could have been any of those.” Anne emphasized her thoughts that many of the women “Go along to get along because someone else is influencing that decision.”

Research suggests that reporting is complicated by issues such as a lack of screening and reporting due to patient privacy or clinic policy (McDow & Dols, 2021; Perry et al., 2015). Perhaps one issue of oversight is only about 5% of abortion provision occurs in a medical center or office, the other 95% at freestanding clinics separated from other medical facilities that do not benefit from multi-provider patient screening and oversight (Abortion Care Network, 2018). Unfortunately, primary care providers may not refer for abortion procedures and many of these clinics do not require a referral, in turn impeding communication between providers (Homaifer, 2017; Kimport et al., 2016).

**Sub-Topic: In the Midst of Turmoil**

First, although hired to perform specific duties, workers were often asked to engage in other jobs for which they were either not qualified or certified to perform. Alex ended up assisting in abortion procedures and in recovery, even though she is not a nurse. Claire, who did not have proper training or certification, fulfilled responsibilities of a medical assistant. Susanne was unaware that she was legally not allowed to be involved with medication until a patient complication occurred. Beth, a nursing student, was assisting with abortions her first day on the job. Nineteen-year-old Dewy assisted the doctor with abortions even though she had no previous experience. These accounts point to the importance of regulated oversight by local health departments and government administrations, especially since some states do not require
provider regulations, facility licensure or inspections (Berglas, 2018; Sanger, 2016; Urbina & Upton, 2013).

Second, a number of participants described undesirable practices and adverse encounters with clinic leadership. This topic is discussed in literature in regard to the challenges posed by poor communication and interpersonal conflict (McLemore, Levi et al., 2015). Issues that arose in the data included differing goals, lack of relatability, hostile interactions, and disparity of attitudes. To many of the participants a main goal of the clinic where they worked was to perform abortions, which resulted in some feeling as though they were supposed to “sell” the abortion instead of offering options such as referrals for support or adoption. Jean’s manager told her, “This is how we make our money.” Deborah felt a lack of relatability as her job was contraception education, yet she noticed that the women on birth control were having abortions just as frequently as women who weren’t on birth control. Dewy tired of hostile attitudes, especially with the doctor she worked for who yelled at her when she attempted to relay a message to him. As far as a disparity of attitudes, Faith remembers a counselor being called in to talk with the staff after a traumatic experience with a patient, “I realized that she was just there to make sure that we were still with the program. That we were for abortion, that it didn’t matter the gestational age…it’s just tissue.” These accounts were not the exception as all participants stated undesirable experiences in at least one of these four areas.

Sub-Topic: Protesters and Prayers

Participants corroborate the negative influences of hostile protesters while affirming the positive impact of those who quietly stood outside and prayed. First, hostile protesters exhibited behaviors such as picketing with disturbing signs, distributing flyers deemed as pro-life propaganda, yelling, calling names such as “baby killer,” and even threatening abortion workers
with harm, which has been linked with negative mental and emotional effects including increased stigma (Fitzpatrick & Wilson, 1999; Norris et al., 2011). Existing literature has mostly discussed protesters in a negative perspective, such as acting in a threatening and obstructive manner, and often associates religious zealotry and even gender-related bigotry with these demonstrators (Lowe & Hayes, 2019; National Abortion Federation, 2018). Participants abhorred these actions as they recounted their experiences of “protesters telling me God hated me” (Faith) or saying “baby killer, don’t work there” (Rubi). Claire remembered her first day going to the clinic, “there were all these crazy people out there…with bloody pictures and stuff.” Susanne recalled the phone calls of bomb threats and cursing. None of these practices are acceptable and are ineffective in delivering a caring message of hope that furthers the pro-life conversation or facilitates change.

On the other hand, in stark contrast to hostile protesters is the positive impact of peaceful protesters, which adds to the body of literature. This research identified that respectful and peaceful protesters who encouraged life also offered positive support to many of the abortion workers interviewed for this study. These positive protesters are often called “prayers” and showed genuine concern for both the workers and the clients by praying instead of overtly protesting, and were supportive of workers leaving the industry through offering acceptance, strength and resources. These civil individuals and groups counter those who are hostile and are effective in communicating their message of hope and life instead of one of hate and condemnation (40 Days for Life, 2021). Claire and Miriam summate their experiences, “these people who had been praying outside the clinic, who I thought were intolerant, they were the ones who embraced me” (Claire) and “that’s where I ended up going to church. And they just accepted me as I was” (Miriam).
Major Topic Three: Bio-Psycho-Socio-Spiritual Effects

Major Topic Three: Bio-Psycho-Socio-Spiritual Effects discusses data collected via IQ Six: Personnel in high stress, people-helping professions often talk about the transition from work to home on a day-to-day basis as challenging. What do you remember about your daily transitions to home routines or challenges when you worked in the abortion industry? and IQ Eight: Please discuss any mental, emotional, physical or spiritual effects that you have experienced since working in the abortion industry and did you seek help in dealing with these challenges? These IQ’s are associated with RQ2: What were (and are) the perceived bio-psycho-social-spiritual impacts of abortion work for those who ultimately left the field due to moral distress? All 14 participants indicated experiencing aspects that fall under the umbrella of BPSS effects and will be discussed in the following paragraphs.

To begin, the influence of stigma associated with abortion work as dirty work was discussed in a previous section as affecting many interviewees in the realm of relationships. However, participants identified that the actual work itself imposed the most negative BPSS effects. This data correlates with previous research finding that work-related moral incongruence or stress of conscience was linked to depersonalization (where one feels as if she is merely going through the motions and not wholly present), emotional exhaustion, and negative effect upon one’s personal life contributing to burnout (Badro, 2013; Glasberg et al, 2006; Lamb, 2016). Interestingly, depersonalization was indicated by 13 of the 14 participants in terms of not feeling present while performing certain job duties, of the fetuses and clients through the use of language and how the fetuses’ were handled. “I was like in someone else’s body. I was like a shadow and I was just existing” (Faith). “You feel like you are in a vacuum, like you’re losing yourself…it literally feels like life is removed” (Jean). “He said, ‘go find the head in the trash…referring to
the baby as trash” (Deborah). “Frequent fliers was the term used for (women) who were coming in multiple times” (Alex). Depersonalization seemed to be a means of coping for most of the former abortion industry workers interviewed for this study.

Additionally, literature indicates that as gestational age advances so do the possible negative effects of working with these fetuses, such as piecing back body parts to ensure complete abortion or handling after delivery, as well as tending to the women whose pain may increase with later-term abortion and extend the length of the procedure (Andersson et al., 2014; Lerma & Blumenthal, 2020; Mauri et al., 2015). These previous findings were verified through the findings of this study. Participants who worked in the POC lab stated deep sadness at how baby parts were treated. Rubi recalls that after all parts were accounted for they would be put in a red bag, tied up and thrown in the freezer, “Twenty…25 bags at the end of the day and in the freezer.” Still visible in Anne’s mind are the shelves with “little feet in the containers.” Five participants who worked with later abortions articulated adverse experiences and negative mental and emotional outcomes associated with them. For instance, Dewy lives with the memories of having to “put a head and two arms, two legs and a torso in each bucket.” Lena realized that it “didn’t register with me how much their skin was being burned and how incredibly painful it had to be…I had to go in with a doppler and listen for fetal heart tones because he didn’t want live babies born.” Lily grieved over a late-term abortion of a baby that was “not going to make it” and ended up being born “with no fetal anomaly.” And Deborah abhorred that “the Stericycle will come and pick up anyone above 21 weeks. I had to make those death certificates.”

According to the data of this study, these type of occurrences are not rare and inflict a lasting BPSS impact.
Bio-psycho-socio-spiritual effects mentioned in the data comprised of numerous narratives and multiple outcomes. Substance abuse was mentioned as a means of coping with work issues and stress by seven participants with three specifying alcohol, three identifying drugs and alcohol, and one naming food. Mental health issues identified in connection with abortion work were expressed as depression by two, the inability to sleep by four, PTSD by one, and a mental breakdown by two participants. Intrusive episodes were affirmed by several participants with nightmares experienced by three, memories by four, and feelings of guilt and shame by a majority of participants. Relationship issues with their nuclear family were identified by 11 participants. Finally, spiritual challenges were acknowledged by nine participants. Comprehensively, an array of symptomology was experienced by all of the participants while engaging in abortion work. Thus, the holistic well-being of those working in the abortion industry should be monitored to protect employees. Opportunities should also be offered to develop communication skills and support among coworkers, which may increase job satisfaction and longevity and develop and maintain a more productive work environment (Debbink et al, 2016; Lipp & Fothergill, 2009).

**Major Topic Four: Aspects of Moral Distress and Moral Injury**

*Major Topic Four: Aspects of Moral Distress (MD) and Moral Injury (MI)* discusses data collected via *IQ Six: Personnel in high stress, people-helping professions often talk about the transition from work to home on a day-to-day basis as challenging. What do you remember about your daily transitions to home routines or challenges when you worked in the abortion industry? and IQ Eight: Please discuss any mental, emotional, physical or spiritual effects that you have experienced since working in the abortion industry and did you seek help in dealing with these challenges?* These IQ’s are associated with *RQ2: What were (and are) the perceived*
bio-psycho-social-spiritual impacts of abortion work for those who ultimately left the field due to moral distress? All 14 participants indicated experiencing symptomology that falls under the umbrella of BPSS effects and were discussed in the previous paragraphs. Discussion on the development of MD and MI is outlined in the following paragraphs. The existing literature includes data regarding MD among healthcare providers with a few references to abortion workers. However, a lack of research exists on MI among abortion workers, so information is used from research on other populations who engage in what might be considered dirty work, such as those who serve in the military.

Sub-Topic: Moral Distress

First, stress is an undeniable aspect of working in the medical field (Waddill-Goad, 2019). Moral Distress is a phenomenon among healthcare workers that involves components such as burnout (BRN), compassion fatigue (CF), and secondary traumatic stress (STS), which often develop in circumstances necessitating end-of-life care, critical care, and increased patient load due to a lack of proper staffing (Austin et al., 2017; Corley et al., 2005). BRN is often associated with work or organization issues, whereas CF is more emotional exhaustion and vicarious trauma, which can be similar to STS (Cavanagh et al., 2020). CF is a risk for those in the abortion industry since it can be difficult and distressing work (Sorenson et al., 2016). Because medical personnel are considered members of a moral profession that acts on behalf of patients, decisions regarding care often have positive outcomes (Wilson, 2017). However, at times the result of proposed treatments may be adverse and lead to mental and emotional turmoil, especially if the situation counters the professional’s sense of right or wrong, and either adds to stress, MD or even traumatization (Deschenes et al., 2020; Fourie, 2015; Gastmans, 2015; McGibbon et al., 2010; Oelhafen et al., 2019).
Numerous participants in this study mentioned feeling like the actions they were taking at their jobs in the abortion clinic were not right, whether it was the treatment of the women (clients), the aborted fetuses, or the moral issue of abortion itself. Later-term abortions created a complexity of emotion for the participants, which is supported in literature as being associated with the “gray zone of periviability” (Eves et al., 2015, p. 173). Such were the circumstances participants were distressed by as Rubi accounts piecing back together a 16-week-old, “But it was like it was bothering me…that little face was there, that little baby was there.” Lena struggled with, “They were about 17 weeks then and aborted the twins because it didn’t fit their lifestyle” (Lena).

Offering the first definition in 1984, Jameton identified MD as one not being able to pursue what seems or feels right due to employee or organizational restrictions, which since have expanded into sociopolitical realms that also pose ethical concerns (Jameton, 2013). A three-point proposal on the development of MD involves an individual experiencing a moral event and psychological distress with a direct and unintentional relationship between the two (Morley, 2018). Although the research on MD and abortion workers is limited, Hanna (2005) found MD associated with elective abortions to present in the form of internal withdraw or an inner belief that one engaged in hurting instead of helping. This proposal of MD is fitting with the experiences several of the participants shared and the accompanying BPSS effects, such as “I just kept washing my hands over and over again and I just kept seeing blood. And I remember looking at myself in the mirror going, ‘what have you done?’” (Beth). Alex admitted, “And it just really destroyed a part of my marriage.”

*Sub-Topic: Moral Injury*
Sometimes the concept of dirty hands is linked to professions where an individual engages in what may seem morally wrong, often denoted as a choice or implication of personal agency to be involved in iniquitous acts that are legal or deemed necessary, and hold a negative moral connotation (de Wijze, 2013; Sneddon, 2019). Moral Injury (MI) is an outcome and key facet of a traumatic event (Antonelli, 2017). Within the realm of healthcare, MI is considered a violation of one or more of the “four pillars of bioethics,” which includes nonmaleficence (do no harm), beneficence (do good), patient autonomy (freedom to choose) and social justice (fairness) (Heston & Pahang, 2019, p. 483). An example of one who has a morally injurious experience and feeling a sense of betrayal by leadership is Faith’s traumatic experience with the client who was in the process of aborting quadruplets due to pressure from her boyfriend which significantly countered these pillars of bioethics and then was met with counseling to “make sure we were still with the program” (Schorr et al., 2018). Deborah also felt a personal breach of these pillars and betrayal of leadership from the doctor she thought had not completed an abortion, “I can’t believe it when he said ‘go find the head in the trash’ referring to a baby as trash.” Many participants stated they regret what they did in the abortion industry and felt their actions were not a true reflection of who they were as a person and countered their beliefs.

Furthermore, Nash’s (2019) MI paradigm, the Stress Injury Model, founded in a bio-medical perspective that associates moral injury as a response to an actual event which violates one’s personal values, morals, and beliefs of self, others and the world gives insight into several of the participants BPSS outcomes. Many of the traumatic events disclosed during the interviews occurred during the use of ultrasound. The technological advances in ultrasound have led to increased utilization in both pre-abortion examination to rule out ectopic pregnancy and determine gestational age and in abortion counseling (Anger et al., 2021; Detti et al., 2020;
Wang et al., 2021). Research indicates that a woman who views an ultrasound may be affected by seeing images and hearing the fetal heartbeat of her baby and thus should have a choice as to view the images or not; nonetheless, some women still choose to abort after seeing the images, while others reconsider pursuing the procedure (Kjelsvik et al., 2021; Kreutzfeld, 2017; Upadhyay et al., 2017). However, research does not speak of the experiences participants had in seeing that “his ultrasound machine was really antique looking…easier for him to manipulate that machine, to make it look like it was a smaller pregnancy” (Susanne). Or, “we measure the cranium of the baby, which is the head and the gestational age… to see which size we needed to use for the suction or if they were going to get a medical” (Faith). For Rubi it was a miscalculated gestational age that changed her thinking, “She did the ultrasound wrong, she sized the baby wrong…he was 16 weeks.”

The use of intra-procedural ultrasonography during abortion procedures, usually during second trimester abortions, guides the doctor in emptying the uterus and reduces complications like retained products of conception (Klein et al., 2007; Larish et al., 2021; NAS, 2020a). Participants found assisting in ultrasound-guided abortions difficult in that “The day two ultrasounds for second semester abortions were hardest…she’s grabbing onto my arm in pain and I’m using my other arm to hold the ultrasound while this provider basically rips a human being apart limb by limb” (Alex). Claire said she could no longer work at the clinic “When I witnessed a live ultrasound-guided abortion procedure and I saw a 13-week-old baby fight and struggle for his life against the abortion instruments.” Seeing a developed fetus move away from the instruments initiated a sense of personhood for the baby whose future was terminated and challenged the workers assessment of their moral actions.
The DSM-5 offers information on the development and identification of PTSD and other stressor-related disorders linked to traumatic experiences, but symptomology indicative of MD or MI are not included as part of this section (APA, 2013). In fact, there is still not a formal and empirically defined definition of MI (Farnsworth, 2019; Litz & Kerig, 2019). The relationship between PTSD and MI is not fully understood, but they do share similar symptoms, commonalities and associations (Davies et al., 2019; Smigelsky et al., 2019). Participants in this study described BPSS effects, such as deep and persistent guilt and shame, spiritual crisis, and doubts about the meaning of life that are primary symptoms of MI with secondary symptoms which include reexperiencing and avoidance, depression, anxiety, substance use, suicidality and difficulties with relationships and social functioning (Bravo et al., 2019; Jinkerson, 2016). Dewy is an example of a participant who could be considered for experiencing MI as she has shared, “I was having massive nightmares and waking up and…there were dead babies all over my bed.” She also struggled with physical symptoms, “I couldn’t eat anything with tomato sauce. I couldn’t eat spaghetti” and substance use, “I coped by doing a lot of drugs…I was never clean.” Her relationships have been complicated as well, “I still pick unhealthy men, I still got in abusive relationships” and spirituality questioned, “I’m like karma’s bullshit.” Finally, the possibility that former abortion workers have experienced MI through their work should be considered as it may increase understanding their symptoms and change the approach to therapy.

**Major Topic Five: Steps Toward Healing Through Forgiveness and Meaning-Making**

*Major Topic Five: Steps Toward Healing Through Forgiveness and Meaning-Making* discusses data collected via *IQ Seven: What led you to the point of leaving your job and how did you seek help in doing so if it was needed?* and *IQ Eight: Please discuss any mental, emotional, physical or spiritual effects that you have experienced since working in the abortion industry and*
did you seek help in dealing with these challenges? These IQ’s are associated with RQ2: What were (and are) the perceived bio-psycho-social-spiritual impacts of abortion work for those who ultimately left the field due to moral distress? The three sub-topics discussing facets of soul repair include Spiritual Aspect, The Need for Resources and Support System, and Meaning-Making Through Action.

Soul repair involves creating a space for grace (Antal & Winings, 2015). The healing retreats that are offered through ATTWN create a safe environment for former abortion industry workers to meet other former workers, find a place of peace and reprieve, and supportive counselors to meet with to work through trauma and BPSS effects. Forgiveness is a central theme in healing and includes accepting forgiveness from God who models unconditional forgiving love, forgiving self and extending forgiveness to others (Kim & Enright, 2014). Forgiveness through self-compassion enables positive coping, which is a need of many who exit the industry (Forkus et al., 2019). Spirituality, having multi-faceted needs met, and meaning-making are also integral to moving forward and cultivating holistic well-being.

**Sub-Topic: Spiritual Aspect**

A spiritual encounter with God was instrumental in initiating a healing process for 13 participants. One participant came to a point where she felt all the bad things that happened in her life was karma due to “being part of this murder industry. How can you pick up dead baby heads and put them in buckets…How can you not be judged for that?” (Dewy). Guilt and shame have been core of the participants’ struggle of coming to terms with their involvement in the abortion industry. Because constructs like guilt and shame may lead to self-loathing and numerous other destructive symptomology, intervention is needed on multiple levels and cannot be simply reduced to a single antidote. However, a person’s spirituality can serve as a foundation
that regulates the healing process mentally and emotionally, as what was noted in many of these participants’ accounts. Although mental health interventions are deemed necessary to regain healthy equilibrium and function and are beneficial to quality of life, spirituality attends to the wounded soul and offers connection with an ever-present, forgiving and benevolent God through practices such as scriptural readings, interactions with other believers, confession, meditation, journaling, music, prayer and worship (Doehring, 2019; Ramsey, 2019). Previous research on treating MI state that therapies are most effective with both psychological and spiritual goals that allow for the strength and renewal of one’s spirituality (Pearce et al., 2018; Starnino et al., 2019).

**Sub-Topic: Need for Resources and Support System**

Quitting a job and making a career change is not only intimidating, but also can be overwhelming when resources are scarce. Often individuals who are changing jobs need supports in place to move forward into either a less stressful or demanding occupation or a career that requires additional education or training. Sometimes financial assistance is needed to replace lost income or counseling support is needed to heal negative work experiences and facilitate increased confidence. The participants in this study credit the non-profit, ATTWN, with assisting them in these areas of need that provided the opportunity for change. “They provided me financial assistance until I found a new job. They provided a resume writer who rebuilt my resume and helped me with job searches. They flew me down to Texas several times for spiritual healing retreats” (Alex). “They helped me with like a month of wages that I had lost. They helped me with my resume. They helped me find another job” (Faith). “It was like this discovery of this pocket of just the worst trauma and pain that had never, ever even been looked at. I opened it. And so I’ve been getting help with them, ATTWN” (Dewy).
For many of the participants in this study leaving their jobs at the abortion clinic was made possible because of ATTWN. Moreover, a healing and restorative process has occurred through the healing retreats and camaraderie with others who also have left the industry. Opportunities for interaction and relationship building among others who have worked in the same industry and endured similar experiences were discussed as beneficial, as Rubi and Alex quantified, “abortion has a smell…the sound of that machine.” Participants hail the non-judgmental atmosphere that facilitates felt understanding, acceptance and hope for healing and a future. Lena supports this reality by saying “it was a good thing in the sense that I was able to meet four other people that wouldn’t have that flicker in their eyes when I told them what I used to do.” Susanne was relieved that she was able to interact with “people like me, that I’m not going to be judged for what I did.” Finally, Jean summed up the experience with ATTWN, “So then now you have a whole sisterhood.”

Sub-Topic: Meaning-Making through Action

Participants in this study identified taking action to create positive and meaningful change as an integral part of their healing process. Literature affirms that meaning-making is linked to improved coping and holistic wellbeing (Miao et al., 2017; Steger, 2012). These participants engaged in three components of action which involved reaching out to others in need including both abortion workers and women who contemplate aborting, speaking out about their experiences, working to advance constructive legal and societal changes, and serving women who encounter unplanned pregnancies through non-profit organizations. Faith was looking forward to volunteering at a new non-profit, “A pregnancy resource center bought the building next door to that building, that abortion clinic, and should open soon.” Rubi shared her passion for helping pregnant women, “We've had many women contact us (at Loveline) because they
want to leave a domestic violence home and they don't know how, they are not able to pay the rent and that's what's pushing them to have an abortion.” And Jean affirmed the relevance of outreach, “They're meeting their immediate needs and providing them with emotional support. That's what I have seen from the pro-life movement.” In a humble, yet powerful way, investing their time and energy, sharing their experiences, and promoting life have become actions of meaning that facilitates healing in the participants’ daily lives.

**Implications**

This section discusses the implications of the findings gleaned from this research. Main topics that merit consideration for future action include work environment, outreach to abortion workers who have persistent BPSS effects, and pro-life focus, advocacy, and activism. As such, suggestions are made for those in the mental health and Christian communities, abortion industry, pro-life organizations and individuals who choose to protest abortion in support for life.

**Suggestions for the Abortion Industry**

The findings of this research support the following suggestions for clinics who either dispense prescriptions for medical abortion or perform abortion procedures. First, they should hire employees who are qualified for the available position and offer continuing education to expand critical understanding and competencies. Job satisfaction often increased through reduced stress and confidence in one’s abilities to proficiently engage in her job duties. Next, the applicants should be screened for potential previous trauma or mental and emotional vulnerabilities with the consideration of how the work environment and duties might trigger pre-existing trauma and exacerbate mental and emotion symptomology. There is a need to recognize the potential for moral distress, address and acknowledge occurrences that impact workers. Finally, it is important to affirm commitment to patient care by exploring issues such as potential
abuse, human trafficking and client mental health and develop a rapport with agencies that offer supports needed by women who chose to carry their baby to either parent themselves, or place for adoption.

**Suggestions for Professional Helpers**

Professional helpers may include clergy, counselors, and other mental health workers. Many who have worked in the abortion industry have encountered traumatic events during their efforts to provide client care. The participants of this study revealed symptoms of PTSD, MD and MI. Symptomology of MI may be exhibited by those who have been exposed to potentially morally injurious experiences (PMIEs) and should be approached from an aspect of clinical significance (Griffin et al., 2019; Meador & Nieuwsma, 2018). For example, soul care is indicated in research to address not only MD, but deeper needs of MI. Thus, therapy should focus on addressing the needs of the wounded soul and not just treat the apparent diagnosable mental health disorder (Dombo et al., 2013). Next, integrating spirituality into therapy is encouraged as forgiveness is a key anchor for healing. Hope, purpose and meaning are established in faith. Moreover, partnering with organizations like ATTWN expands therapeutic reach and offers potential relationships with others with similar experiences to interact and find camaraderie. Finally, seeking further information specific to this populations’ needs supports comprehensive care.

**Suggestions for Christians**

Christians should expect strong beliefs on both side of the abortion issue. Diversity of thought should be considered as people do not have to agree or think the same in order to respect one another’s thoughts or beliefs. In fact, a depth of understanding and learning is facilitated by listening. Next, Christians should recognize the reason why the abortion worker may be working
in the industry. Seven participants wanted to work in women’s health and stated being pro-choice, whereas the other seven, even though pro-choice, just needed a job to live on their own or to support children. “I did what I did to support my children” (Faith). Also, it is important to recognize the challenges these workers face who engage in what might be considered dirty work and how this may negatively affect them at the core of who they are as an individual and even intensify past life experiences and negative beliefs about self.

Therefore, it is important to keep in mind that as believers in Christ, we are saved by grace and by grace we find our destiny in God’s purposes, and though one was once blind, through Christ one sees (Ephesians 2:8-9; John 9:25). The example given by ATTWN in connecting with the person is an encouragement of the possibilities that may follow when engaging in relationship building. This is important as Rubi shared her experience with ATTWN, “Many of us are afraid to speak up…many of us are embarrassed. I felt I was seen…Just to see abortion workers as normal people.” Without a doubt, a message of hope and change is more powerful than one of condemnation. The results from the mission and message of ATTWN, which focuses on abstaining from judgment and instead offering unconditional regard, have cultivated change through redemption, restoration and vision for a future. Most important, healing is based upon God’s forgiveness and awareness of purpose and providence.

**Suggestions for Pro-Life Demonstration**

It is important to purposefully plan demonstrations or pro-life vigils with wisdom and then abide by identified priorities and stay on point with the plan. Many pro-life organizations exist that run campaigns throughout the year to advocate for life and offer training for volunteers. Next, demonstrators should be intentional in communicating in a respectful manner with potential patients coming to the clinic and with the workers. They should keep in mind that
although the philosophical underpinning of the pro-choice movement may contradict the values of sanctity of life and may initiate actions that propagate the ending of life, people are not the enemy and each individual is created in the image of God and meant for a relationship with Him. Finally, all demonstration and outreach should be immersed in prayer so as to effectively offer assistance instead of condemnation, keeping in mind that there are others like Lily, “I never attended church because I didn’t want anybody to see me or recognize me. I felt dirty and unworthy.”

Assumptions, Limitations, and Delimitations

Research studies are susceptible to assumptions, limitations, and delimitations (Terrell, 2016). As such, these considerations are presented according to how they might influence this study. To begin, it was assumed that the interviewees were honest and forthright in discussing their experiences and any associated emotional, mental, physical, relational and spiritual outcomes. Next, as with all studies, this one had limitations that had the potential to weaken this qualitative study, such as the information collected in this study being unique to the participants interviewed and perhaps not correlating with the experiences of other abortion industry workers. Finally, only individuals over 21 years of age who had actively and legally worked in the abortion industry within the United States for a period greater than three months participated in this study.

Limitations

Limitations are discussed in greater length as they have the potential to weaken a qualitative study based upon the lived experiences of a specific group of individuals (Creswell & Creswell, 2018; Rudestam & Newton, 2007). This study has four identifiable limitations. First, although all the individuals interviewed for this research project have worked in the abortion
industry, their experiences varied as far as emotional, mental, physical, relational and spiritual effects and may not represent all workers who have left the field. Second, since the participants have been assisted in various ways by ATTWN, a Christian organization, a spiritual component is an integral aspect of the results. Third, because participation was voluntary, the participants’ ethnicity, age, cultural backgrounds, socioeconomic status, or stage of life in association to their professional experiences may influence the diversity of the norm or sample. Finally, only six of the participants have worked in the industry within the last ten years, three within the last 15 years, and five left between 25 and 40 years ago. This lapse in time between leaving the industry and recounting their experiences might be viewed as a significant limitation. However, considerations of why this gap may exist include effects of trauma mediating one’s desire or ability to share and the fact this research was unique and utilized participants who have been involved with an organization that focuses upon the needs of both former abortion workers and those who want to exit the industry.

**Recommendations for Future Research**

Additional studies are recommended on this topic as there is a lack of data regarding former abortion industry workers in peer-reviewed literature. Due to the documentation on these workers’ experiences that led to BPSS effects, and for some MD and even MI, further studies on associations with abortion workers’ experiences and MD and MI are advised. Moreover, exploration on empirically based therapeutic interventions that addresses trauma and MD and MI associated with work in the abortion industry could support the portion of this population that lives with such states. Along the same vein, studies on abortion workers who enter the industry having experienced pre-existing trauma might offer insight to abortion industry leadership in meeting these workers’ needs and avoiding further traumatic experiences. Finally, quantitative
studies identifying influences of abortion work on BPSS outcomes could identify key factors and corresponding outcomes.

Summary

This research was a qualitative study that investigated the lived experiences of individuals who formerly worked in a medical facility or freestanding clinic providing abortion services. Hermeneutic phenomenological design was utilized for this study, which was based upon two research questions: What is the lived experience of former abortion workers who left the field due to moral distress both before and after their transition from the industry? And, What were (and are) the perceived bio-psycho-social-spiritual impacts of abortion work for those who ultimately left the field due to moral distress? Methods included semi-structured questions for web-conference interviews with 14 participants associated with ATTWN. Van Manen’s Six-Step Research Paradigm directed analysis, along with the use of NVivo qualitative software (released 2020). Five major themes were expounded upon in context to the unique lived experiences of these former abortion industry workers and the aspects of moral distress they experienced, including *Shifting View of Abortion: From Pro-Choice to Pro-Life; Memorable Experiences During Tenure in Abortion Work; Difficult Work Environment; Bio-Psycho-Socio-Spiritual Conflicts* and *A Turning Point*. Five relevant topics discussed were *Stigma of Abortion Work, Work Experiences and Environment, Bio-Psycho-Socio-Spiritual Effects, Aspects of Moral Distress and Moral Injury, and Steps toward Healing*. Finally, implications consisted of suggestions for the Abortion Industry, Professional Helpers, the Christian Community and Pro-Life Demonstrators.
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TIME FOR A CHANGE? THE LIVED EXPERIENCES OF


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Appendix A: ATTWN Permission Letter

Susan M. Cole
Doctoral Candidate, Liberty University

December 8, 2020

Clinical Therapist
And Then There Were None

Dear Susan Cole,

After careful review of your research proposal entitled Time for a change? The lived experiences of abortion workers who left the industry, we have decided to grant you permission to access our client contacts at And Then There Were None (ATTWN) and invite them to participate in your qualitative study. We understand that we will prescreen potential interviewees and offer information about the study to possible participants that we deem mentally and emotionally stable as a means to mitigate potential harm. Counseling services have been offered to these potential participants in the past through ATTWN and will be available if the need arises at any time during the interview process. Basic data about potential participants including job positions, gender, age and contact information will be given to Susan Cole so she can discuss study details including objectives, interview procedures, time commitment, and informed consent.

Please check the following boxes, as applicable:

☐ The requested data WILL BE STRIPPED of all identifying information before it is provided to the researcher.

☐ The requested data WILL NOT BE STRIPPED of identifying information before it is provided to the researcher.

☐ Participants’ names will be changed so as no identifying information is published in the data and the study’s results.

☐ We are requesting a copy of the results upon study completion and/or publication.
Sincerely,

Clinical Therapist
And Then There Were None
Appendix B: IRB Approval

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<td>Status:</td>
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<tr>
<td>Principal Investigator:</td>
<td>Susan Cole</td>
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<td>Review Board:</td>
<td>Research Ethics Office</td>
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**Study History**

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**Key Study Contacts**

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<tr>
<td>William Bird</td>
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<td>Susan Cole</td>
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<td></td>
</tr>
<tr>
<td>Susan Cole</td>
<td>Primary Contact</td>
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Appendix C: Informed Consent

Title of the Project: Time for a Change? The Lived Experiences of Abortion Workers Who Left the Industry
Principal Investigator: Susan Marie Cole, ORDM, Doctoral Candidate, Liberty University

**Invitation to be Part of a Research Study**

You are invited to participate in a research study. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

**What is the study about and why is it being done?**

The purpose of this phenomenological research is to understand the lived experiences of those who have worked in the abortion industry and have chosen to leave. This study will explore the perceived emotional, relational, moral and spiritual impact that working in the abortion industry had upon the participants who decided to leave the abortion industry.

**What will happen if you take part in this study?**

If you agree to be in this study, I would ask you to do the following things:

1. Participate in a 60 to 90 minute video-recorded interview.
2. Review your interview transcript for accuracy. The transcript will be emailed to you one week after the interview and should take approximately 30-60 minutes to review. The transcript needs to be emailed back to the researcher within one week of receipt.
3. A brief follow-up phone call may be requested, if necessary, for clarification on your transcript or to substantiate ambiguity of the collected data.

**How could you or others benefit from this study?**

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include establishing a missing perspective of this population, adding to the existing literature on abortion workers and gleaning a deeper understanding in order to expand the empirical research, which will assist in clinics developing safeguards for workers and advocacy groups addressing needs of former workers, including potential trauma.

**What risks might you experience from being in this study?**

The risks involved in this study are minimal, which means they are equal to the risks you would take in everyday life.

Liberty University will not provide psychological treatment or financial compensation if you experience a mental health relapse as a result of participating in this research project. This does not waive any of your legal rights nor release any claim you might have based on negligence.
How will personal information be protected?
The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be confidential through the use of pseudonyms. Interviews will be conducted using an online video conferencing application. The interviewer will be in a private location and participants are also encouraged to choose a private space for the interview.
- Data will be stored on a password-locked computer and de-identified information may be used in future presentations. After three years, all electronic records will be deleted.
- Interviews will be recorded via Webex and transcribed. Recordings will be stored on Webex, which is password-protected, and accessed through a password-locked computer. Transcripts will be stored in a password-protected file on a password-protected computer.

Is study participation voluntary?
Participation in this study is voluntary. Your decision to participate (or not) will not affect your current or future relations with Liberty University or And Then There Were None. If you decide to participate, you are free to not answer specific questions or to withdraw from the study at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?
If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?
The researcher conducting this study is Susan Cole. You may ask any questions you have now. If you have questions later, you are encouraged to contact her at xxx-xxx-xxxx or at xxxxxx@liberty.edu. You may also contact the researcher’s faculty sponsor, Dr. William Bird, at xxxxx@liberty.edu.

Whom do you contact if you have questions about your rights as a research participant?
If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, you are encouraged to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Your Consent
By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the researcher using the information provided above.
I have read and understand the above information. I have asked questions and have received answers. I consent to participate in the study.

The researcher has my participation to video-record me as part of their participation in this study.

Printed Subject Name  Signature & Date
Appendix D: Recruitment Email

Good morning!

My name is Susan Cole and I am a doctoral candidate at Liberty University. Xxxx, as my contact at ATTWN, has introduced you to this research project and recommended you to me as a potential participant. The purpose of this study, *Time for a change? The lived experiences of abortion workers who left the industry*, is to gain insight and understanding into the experiences of former abortion industry workers and the bio-psycho-socio-spiritual outcomes they may potentially encounter. I have attached a video to this e-mail that explains the details of this study and what you as a participant might expect if involved in the interview process. The consent form and interview questions are also attached for your review. This study is voluntary.

Thank you for your interest and consideration. Please feel free to contact me if you have any questions, would like further information, or if you choose to participate in the study to schedule an interview and return the consent form. Your time is valuable and I appreciate you sharing it with me.

Respectfully,

Susan M. Cole
Doctoral Candidate
xxx-xxx-xxxx
xxxxxx@liberty.edu
Appendix E: Recruitment Video Transcript

Hi, my name is Susan Cole! As a doctoral candidate in the school of Behavioral Health Sciences at Liberty University, I am conducting this research as part of the requirements for a Doctor of Education degree in Community Care and Counseling with an emphasis in Traumatology. The title of my research project is, “Time for a change: The lived experiences of abortion workers who left the industry.” The overall purpose of my research is to understand the lived experiences of those who have worked in the abortion industry and why they chose to leave. Two research questions are central to this study: What is the lived experience of former abortion workers who left the field due to moral distress both before and after their transition from the industry? What were (and are) the perceived bio-psycho-social-spiritual impacts of abortion work for those who ultimately left the field due to moral distress?

Stress is a formable aspect of working in the medical field and may lead to burnout from demands of the job, compassion fatigue, secondary traumatic stress, and decreased work satisfaction. All of these outcomes may lead to moral distress and may result in an inner belief that one is harming more than helping. I have posted this video explaining the study to you, along with the attached interview questions and consent form, so that you may consider participating in this study. To be a participant you must be 18 years of age or older and have worked at least three months in the abortion industry, either directly providing or assisting with abortions or with parts of conception. Participants must also have experience some form of moral distress associated with performing their job duties and this distress must have led them to leave their job in the industry. Moral distress is defined as perceived discomfort between one actions and one’s beliefs of right or wrong.
Participants if willing, will be asked to engage in an interview that will be video recorded through a secure video conferencing platform. A time commitment of 60 to 90 minutes is requested for video recorded interviews. Additionally, participants will be asked to review the interview transcript and make any changes or additions to the transcript. This should take approximately 30 to 60 minutes to complete. A phone call may be requested, if necessary, for clarification or to substantiate any ambiguity in the collected data. Participants’ identities will be protected and remain confidential. As a participant, you will be asked to specify a pseudonym of your choice before the data is collected, and it will be used during the interview process, data analysis, in writing the results, and any publications.

In order to participate, please respond to this email. A consent document, which was previously mentioned, is attached to this email. This consent document contains additional information about my research, how personal information is protected and how the collected data will be stored. If you decide to participate, please type your name and the date on the consent form and return it by email prior to participating in the interview. Participation is voluntary. Thank you for watching this video and reviewing the interview questions and consent form. Please feel free to contact me with questions at xxx-xxx-xxxx or at xxxxxx@liberty.edu. This contact information is also included in the email. Again, thank you for taking time to watch this video. I appreciate your consideration. God bless!
Appendix F: Interview Questions

Interview Questions:

1) To begin, please introduce yourself by sharing any relevant information about you and your family.

2) Tell me how you came about working in the medical field and in the abortion industry. What position in the abortion clinic were you hired to perform?

3) Describe your personal view of abortion and abortion provision before you entered this field. How has this view changed since leaving the field?

4) Describe your job responsibilities at the facility in which you worked and any tasks that were more difficult than others to perform.

5) What interactions or encounters with either patients or fellow workers do you remember most? Describe what made these occurrences memorable.

6) Personnel in high stress people-helping professions often talk about the transition from work to home on a day-to-day basis as challenging. What do you remember about your daily transitions to home routines or challenges when you worked in the abortion industry?

7) What led you to the point of leaving your job and how did you seek help in doing so if needed?

8) Please discuss any mental, emotional, physical or spiritual effects that you have experienced since working in the abortion industry and did you seek help in dealing with these challenges?