

**EXAMINATION OF THE SANCTUARY: USES OF A MEDITATIVE SPACE IN A
WOMEN'S HEALTH CLINIC**

by

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BA, University of Pittsburgh, 2006

Submitted to the Graduate Faculty of
the Graduate School of Public Health in partial fulfillment
of the requirements for the degree of
Master of Public Health

University of Pittsburgh

2010

UNIVERSITY OF PITTSBURGH

Graduate School of Public Health

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Abortion, much like pregnancy, can play a significant role in the course of a woman's life. Even so, abortion is complicated by a number of barriers – legal, financial, emotional, spiritual, religious, and physical -- with which women and men struggle beyond the mere complexity of undergoing a surgical procedure. Although abortion can be pivotal in a woman's life, every individual is remarkably different, and for that reason so is every abortion experience. For over 30 years, Allegheny Reproductive Health Center (ARHC) has embraced a holistic approach that seeks to understand and address the needs of women and men seeking termination services. In 2008, ARHC erected a space, the *Sanctuary*, designed specifically to encourage personal reflection and quiet meditation among patients and abortion providers coping with the complex issues surrounding abortion. Thus, in order to understand the impact of the *Sanctuary*, this exploratory study investigates the various uses of the meditative space. Qualitative research was conducted through the use of semi-structured interviews with clinic workers and by asking visitors to the meditative space to respond to a short questionnaire, which upon completion was placed in a secure box installed within the *Sanctuary*. From the results, four overarching themes were identified: 1. To work within the abortion field is both complex and important; 2. The next step in abortion care is a holistic approach that addresses a patient's specific needs; 3. The development of the *Sanctuary* is a step toward advancing abortion care for women and men; and

4. To establish an understanding of how the space is used by patients and clinic workers. These results imply that applying a holistic approach in abortion care, through the use of a space such as the *Sanctuary*, is respectful of the variability in women's and men's experiences related to pregnancy termination. Moreover, the findings indicate that participants support the placement and use of the *Sanctuary*, for themselves as well as patients. In terms of public health relevance, professionals within the field can utilize this research to advance the understanding of how to assist women and men in managing the complexities of abortion.

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PREFACE

Foremost, this thesis would not have been possible without my chair, Dr. Martha Ann Terry, whose support and encouragement guided me from beginning to end. I would also like to thank my committee members, whose willingness to provide perspective was sincerely appreciated.

I would like to offer my gratitude to all of my friends and family, who supported me during the process of this project, in particular, Dr. Kenneth Jaros, Tammy Thomas, Natalie Arnold Blais, Katherine Buchman and my partner, Benjamin Adams. My sincere thanks to my colleagues in the MSW/MPH program for providing an extraordinary social network of support, you know who you are, and I am indebted to assist each of you with your future thesis drafts.

I would like to express my deepest appreciation to the staff of Allegheny Reproductive Health Center, for your enthusiasm in assisting with my thesis work, in particular, those who took the time to be interviewed. Specifically, Pamela Wilson, whose vision for discussing the *Sanctuary* helped develop my own. In addition, a gracious thank you to Claire Keyes, who introduced me to abortion work, for designing the *Sanctuary*, and whose enthusiasm for helping women and men to cope with abortion had a lasting effect on my direction in life.

Above all, I would like to acknowledge the women and men coping with the complexities surrounding abortion, today, tomorrow and in future days to come. The courage you demonstrate was the impetus behind this thesis, and I hope this research will help others to understand how to help you.

1.0 INTRODUCTION

The 1973 decision of *Roe v. Wade* granted women and men the personal liberty to choose whether or not to terminate a pregnancy (Donohue, 2004). Since then, more than 30 million women in the United States have exercised their fundamental right to obtain an abortion. Today, the abortion procedure is recognized as one of the safest and most common procedures available for women.

For most women and men, the dilemma over abortion stems from the discovery of an unplanned pregnancy, in many instances the result of failed or improperly utilized contraception, unexpected sexual intercourse, or forced sexual activity. Therefore, it is imperative that abortion be understood in terms of the context, challenges, and desires experienced throughout a woman's life (Boonstra, Gold, Richards, & Finer, 2006). The foundation for understanding abortion is extraordinarily abstract. All of the constructs of abortion---the social implications, the strategic complexity of its politics, and the general public discourse---are intimately linked. For many, coping with abortion is exacerbated by an exhaustive list of additional complications: legal, financial, emotional, physical, spiritual and religious (Finer, et al. 2006). Beyond any doubt, deciding to have an abortion is a complex experience.

For generations, abortion has been a part of women's life cycles, irrespective of restrictive laws, religious prohibitions or social determinants (Grimes et al., 2006). Politically, the decision to choose abortion is often regarded as the centerpiece of a woman's sexual behavior rather than as an incomprehensible last resort (Boonstra, Gold, Richards, & Finer, 2006). Recent trends in the abortion field have placed greater value on women's varied

experiences with abortion, by incorporating the circumstances that surround a woman's decision as an essential part of maternal care. Therefore, it has become crucial for clinics that provide termination services, to adopt practices that embrace centralized care as a means of providing a safe, comfortable and peaceful place for women to cope with abortion.

For over 30 years, Allegheny Reproductive Health Center (ARHC) has had the mission of providing individualized care for its patients (ARHC, 2010). In 2008, the Center was one of the first clinical sites in the country to propose and implement a space, the *Sanctuary*, designed specifically to encourage personal reflection and quiet meditation among patients and clinic workers coping with the complex issues surrounding abortion^{1,2}. In many ways the *Sanctuary* embodies the intense dedication of its clinic workers to provide a holistic approach that addresses the various complexities of abortion.

The concept behind the creation of the *Sanctuary* was to meet the needs of women and men coping with abortion. In particular, specific attributes contribute to the unique quality of the space, explicit in how the aesthetic appearance supports its multipurpose nature. Each element of the *Sanctuary*, the color of its walls and the use of lighting, as well as the additional items placed within the space, were chosen with particular care. (See Appendix A. for photographs.) The walls of the *Sanctuary* were intentionally left bare of pictures or religious icons to provide patients the option of using the space for a multitude of personal needs. The light structure within the space is simplistic and can be controlled by the visitor based on personal preference. In the

¹ During the writing of this thesis, Carole Joffe published Dispatches from the Abortion Wars: The Costs of Fanaticism to Doctors, Patients, and the Rest of Us (2010), which dedicated a section to meditative spaces in abortion clinics. However, due to time constraints, I was unable to access or incorporate the content of the literature.

² I would like to acknowledge that several other abortion clinics have created and erected a meditative space within the past few years.

room there are a few practical items, such as a small wooden bench, a box of tissues, a vase of holy water, and most interesting, on the far wall a space has been cut into a box design, on the ledge of which is a bowl of stones. Moreover, upon its dedication, the *Sanctuary* was blessed by three Pittsburgh clergy members; therefore, opening use of the space to people of all denominations, faiths and belief systems (ARHC, 2010). This attention to detail provides a sense of quiet calm for women and men visiting the space, while also supporting the concept of allowing individuals to determine their personal use for the space. Although, the purpose of the *Sanctuary* is to accommodate women and men's real emotional needs related to abortion, the reasons individuals choose to utilize the space remain unclear.

This study aims to examine the impact of the *Sanctuary* on the women and men struggling to grapple with the experiences of abortion. In order to fulfill this objective, research was conducted through the use of semi-structured interviews with clinic workers of ARHC, and by asking visitors to the space to respond to a brief questionnaire, which upon completion would be placed into a secure box within the *Sanctuary*. Although the original intent of the research was to examine the various uses of the *Sanctuary*, components relevant to providing a holistic approach to abortion care emerged from the interviews. In particular, four overarching themes were identified: working within the abortion field is both complex and important, the next step in abortion care is adopting a holistic approach that addresses a patient's specific needs, the development of the *Sanctuary* is a step toward advancing abortion care for women and men, and to establish an understanding of how the space is used by patients and clinic workers.

This thesis will (1) provide a critical review of the current literature regarding abortion to provide a framework for the research; (2) examine the research methodology conducted to explore the use of the *Sanctuary*; (3) analyze and assess themes that emerged in the application

of thematic analysis, with elements of grounded theory; (4) discuss the domains related to creating a space such as the *Sanctuary*, thereby, offering abortion providers guidance on the process of implementing a similar space within their own facility; and (5) offer recommendations for future research.

2.0 THE FRAMEWORK FOR ABORTION

For decades, the practice of abortion has been defined by terms of life and death. Today, the controversy that galvanizes the public debate over termination manifests from a simple misunderstanding of the framework for abortion. Despite the simplicity of one of the safest, most common and routine procedures today, women and men endure a number of barriers-- financial, emotional, physical, spiritual, legal and religious--as they struggle with the processes involved with seeking an abortion (Finer, et al. 2006). Thus, the multi-layered dimensions of the abortion environment need to be viewed within a vast social and historical context: the demographics of women seeking termination; barriers and accessibility to abortions and contraceptive services; the abortion law, health system policies, political support or opposition to improved abortion care; and religious influences, societal attitudes towards abortion, and the perspectives of men and women (Healy, 2006).

2.1 A BRIEF HISTORY OF ABORTION

A full decade prior to the 1973 legalization of abortion in the United States (US), only 44 states permitted abortion when the woman's life was at risk; in Alabama, Colorado, New Mexico, Massachusetts and the District of Columbia, allowed abortion if the life or physical health of the woman was compromised; in Mississippi, in cases of life endangerment or rape; and lastly, the

state of Pennsylvania outright banned all abortions regardless of reason (Boonstra, Gold, Richards, & Finer, 2006).

Historically, the criminalization of abortion dates to the mid-1800s, as a consequence of physician concern regarding unlicensed midwives performing risky terminations (Boonstra, Gold, Richards, & Finer, 2006). The state of Massachusetts was the first state to enact restrictive legislation, and by 1900, almost all states had followed suit (Gold, 2003). State abortion laws prior to *Roe v. Wade* threatened severe legal repercussions, negatively impacting patients seeking abortions, as well as individuals who provided assistance in any capacity, including physicians (Gold, 2003). Although women were rarely convicted for undergoing termination, physicians were often susceptible to incarceration or penalty (Gold, 2003).

In 1962, the American Law Institute (ALI), under the guidance of a panel of experts, published the “Model Penal Code on Abortion,” which declared that ethically, women should be granted the right to abortion when life, physical or mental health were jeopardized, as well as in circumstances of rape, incest, or fetal anomaly (Boonstra, Gold, Richards, & Finer, 2006). Based on the American Law Institute (ALI) recommendations, Colorado was the first state to reform legislation in accordance with its guidelines in 1967 (Gold, 2003). By 1972, 13 more states had followed; an additional four states repealed anti-abortion laws in order to defer all decisions to the judgment of the physician, leaving five states yet to comply with the sweeping reform, thus setting the stage for *Roe v. Wade*, a decision that would alter the history of reproductive rights within the United States (Gold, 2003).

2.2 ABORTION: WHO, WHAT, WHERE AND HOW

2.2.1 The Characteristics of Women Obtaining Abortions

Abortion, much like pregnancy, can play a significant role in the course of a woman's life. Since the landmark *Roe v. Wade* case, more than 30 million women in the United States have had abortions (Donohoe, 2004). Currently, there are 62 million women of reproductive age living within the United States (Reich and Brindis, 2006). Of six million pregnancies per year, approximately half are unintended (Donohoe, 2004), and nearly 40% of those (1.3 million) end in termination (Shochet & Trussell, 2008). Accordingly, the Guttmacher Institute determined the characteristics of women obtaining abortions: 56% are in their 20s, 61% have at least one child, 67% have never married, 57% are economically disadvantaged, 88% live in a metropolitan area, and 78% claim a religious affiliation (Guttmacher Institute, 2010). Despite evidence of a recent decline in the incidence of abortion, an annual estimated 2% of women continue to seek services that will terminate their pregnancies (Shochet & Trussell, 2008). Moreover, it is anticipated that by the age of 45 most women will have 1.4 unintended pregnancies and nearly 43% will have made the decision to terminate (Donohoe, 2004).

In 2005, Harper, Henderson and Darney examined demographic data relating to abortion collected in a national survey. The authors identified several key characteristics of individuals, such as socioeconomic status (SES), race and ethnicity, as well as age associated with abortion. In terms of SES, the authors infer that low-income women have more abortions as a direct result of a higher incidence of unintended pregnancies. For instance, in the year 2000, the abortion rate was 44 per 1000 low-income women compared to 10 per 1000 women with higher income, a decrease from the mid-1990s to 2000 for high income women, and an increase

among low-income women (Harper, Henderson, & Darney, 2005). Moreover, women living below the federal poverty level have an abortion rate more than four times of women who are living at 300% above the poverty level (Boonstra, Gold, Richards, & Finer, 2006).

In terms of health disparities, the more vulnerable populations--women of color, the young, poor and unmarried---that have less access to contraceptive options experience higher numbers of abortions (Boonstra, Gold, Richards, & Finer, 2006). In 2005, the rate of abortion for racial/ethnic groups were 49 per 1000 for African Americans, 33 per 1000 for Hispanics, 31 per 1000 for Asians, and 13 per 1000 for Caucasian (Harper, Henderson, & Darney, 2005). Harper, Henderson and Darney (2005), propose that African American females, due to a high rate of unplanned pregnancies compared to other racial/ethnic groups, are more likely to have an abortion. Additionally, a 2005 Centers for Disease Control and Prevention (CDC) abortion surveillance report indicated that the rate for African American women is 3.1 times the rate for Caucasian women, with a higher number of “late” term abortions (up to 18 weeks gestational age) in comparison to women of other ethnicities (Major et al., 2009). Moreover, evidence indicates that there are higher rates of abortion for women aged 18-24 due to lower utilization of effective contraception in comparison to older women, as well as a generally higher fertility (Harper, Henderson, & Darney, 2005). As such, abortion rates for adolescents and young adults are as follows: 15 per 1000 for ages 15-17 years, 25 per 1000 women for ages 15-19 years, and 39 per 1000 for ages 18-19 years, and 47 per 1000 for ages 20-24 years (Harper, Henderson, & Darney, 2005).

2.2.2 The Constructs of Unintentional Pregnancy

For most women, prevention of an unintentional pregnancy is not always as simple as identifying the correct type of birth control. On average, women dedicate five years of their lives attempting to conceive, being pregnant or experiencing post-partum, and roughly an additional 30 years struggling to prevent pregnancy (Boonstra, Gold, Richards, & Finer, 2006).

At some point in their lives, 98% of women choose to utilize some type of contraception (Boonstra, Gold, Richards, & Finer, 2006). The contraceptive failure rate is 21% for periodic abstinence (rhythm method), 7% for oral contraceptives pills, and roughly 1% to 2% for the intrauterine device (Donohoe, 2004). Of the three million annual pregnancies that are unplanned, at the time of conception, 58% of women were utilizing a form of birth control (Donohoe, 2004). Furthermore, a majority of women can attribute unintended pregnancy to limited access to family planning services as well as incorrect or inadequate reproductive education (Donohoe, 2004).

Forty-six percent of women who have had an abortion were not using a contraceptive method in the month they became pregnant (Boonstra, Gold, Richards, & Finer, 2006). Of those women, 33% perceived themselves at low risk of becoming pregnant, 32% were concerned about utilizing contraception, 26% had unexpected sex, and 1% were forced to have sex (Boonstra, Gold, Richards, & Finer, 2006). In particular, the lack of contraceptive use is most prevalent among women who are young, poor, African-American, Hispanic or poorly educated (Boonstra, Gold, Richards, & Finer, 2006).

Currently, the debate over the use of abstinence-only-until-marriage in place of comprehensive sex education programs has had a significant impact on the most vulnerable populations, in particular, adolescents. Research on comprehensive sex education programs indicates that among attending teens there is a delay in onset of sexual intercourse, a reduction in

the number of sexual partners, increase in the use of condoms and contraceptives, a lower rate of STDs and, most significantly, a decrease in the number of unwanted pregnancies (Donohoe, 2004). Alternatively, abstinence-only-until-marriage programs encourage teenagers to refrain from sexual intercourse until marriage, or to become “secondary virgins” by foregoing any sexual activity until marriage (Boonstra, Gold, Richards, & Finer, 2006). Teen participation in elements of abstinence-only education such as “virginity pledging” has been linked to a diminished probability of utilizing contraception or condoms at the first instance of intercourse (Boonstra, Gold, Richards, & Finer, 2006). In addition, Harper, Henderson, & Darney (2005) stress a linkage between the increased emphasis on abstinence as contraception, and an increased demand for abortion services. An emphasis on abstinence-only education combined with the removal of information regarding utilization of contraceptives and increased rates of sexual activity among youth has led to a greater likelihood of unprotected sex and an increased risk for unplanned pregnancy among adolescents and young people (Fine & McClelland, 2006). Thus, it is unsurprising, that in the United States, nearly 750,000 teenagers become pregnant each year (Masters et al., 2008).

Between 1997 and 2007, federal support of abstinence programs expanded from \$9 million to \$176 million (Masters et al., 2008). Moreover, in the past 25 years, Congress has distributed nearly \$1.5 billion, with all states except California accepting some form of abstinence-only funding (Fine & McClelland, 2006; Donohoe, 2004). Most often, the promise of federal monies encourages economically disadvantaged areas to accept this type of funding, disproportionately impacting low-income and rural sections of the country (Fine & McClelland, 2006). Despite substantial differences in effectiveness, comprehensive sex education has in many instances been replaced by curricula that focuses on the tenets of abstinence-only-until-

marriage education, thus failing to fully prepare young people to properly manage the realities of sexual activity, thus increasing their likelihood of enduring, among other consequences, an unintended pregnancy (Fine & McClelland, 2006).

2.2.3 Accessibility to Abortion

The incidence of abortion is largely dependent upon access to and availability of abortion providers, in terms of distance, limitations of gestational age and cost and coverage of the procedure (Jones, Zolna, Henshaw, & Finer, 2008). The sparse map of abortion providers scattered across the nation plays a significant role in the capacity of women to identify safe, secure and affordable termination services. In the United States, 87% of counties lack an abortion provider (Donohoe, 2004). Twenty-four percent of women seeking abortions travel 50 miles or more to acquire services (Harper, Henderson, & Darney, 2005). Moreover, since abortion providers are more likely to be located in urban settings, women living in rural areas may have to travel up to 100 miles to locate a capable physician (Donohoe, 2004).

The availability of willing or trained physicians has substantially shifted over the last few decades. In 1992, approximately 2400 physicians were offering abortions services to women decreasing to 1800 physicians in 2004, with 57% of available providers at 50 years or older (Donohoe, 2004). The decline can be attributed to a variety of factors, including harassment and violence directed at physicians, social stigma, strict legal policies, and exorbitant insurance premiums for obstetricians (Yanda, Smith, & Rosenfield, 2003).

The steady decline in the number of available physicians is only one obstacle facing women. Some women have difficulty finding an abortion provider due to gestational age limits in obtaining a procedure (Jones, Zolna, Henshaw, & Finer, 2008). In 2005, approximately 40%

of providers offered abortion at less than four weeks, with 96% providing them at eight weeks (Jones, Zolna, Henshaw, & Finer, 2008). However, the further along a woman is in her pregnancy, the more difficult it is to locate a physician who will provide an abortion, as only 67% provide services from 13 weeks to 20 weeks, 20% from 20-23 weeks, and only 8% at 24 weeks (Jones, Zolna, Henshaw, & Finer, 2008).

The cost and coverage of an abortion procedure are significantly dependent on the gestational age of the fetus and type of facility, as well as the insurance utilized by the patient. As the majority of abortions are conducted prior to 10 weeks, most providers charge a standard fee for termination (Jones, Zolna, Henshaw, & Finer, 2008). As noted by these authors, the mean charge for a procedure is \$523, though this fee can vary by provider. Gestational age also impacts the cost and length of the procedure; for later abortions the mean charge was \$1339 at 20 weeks, since the procedure requires more provider skill and time (Jones, Zolna, Henshaw, & Finer, 2008). Insurance is often not considered a payment option as most individuals experience anxiety related to patient confidentiality (Donohoe, 2004). In general, only 26% of patients will choose to bill their private or public insurance (Donohoe, 2004). Nevertheless, though a number of health plans today cover most types of contraception, more often there is no coverage for abortion (Donohoe, 2004).

2.2.4 The Abortion Procedure

Today, abortion is considered one of the safest surgical procedures available to women within the United States (Donohue, 2004). The risk of death associated with childbirth is 11 times greater than the risk of death related with termination before 18 weeks gestational age (Donohue, 2004; Harper, Henderson, & Darney, 2005). Moreover, the risk of complications with abortion

is less than 1%, with no evidence indicating that future pregnancies or childbirths are jeopardized by the procedure (Harper, Henderson, & Darney, 2005).

Approximately 90% of abortions occur in a woman's first-trimester (less than 12 weeks gestational age), and more than 98% are performed prior to 20 weeks gestational age (Harper, Henderson, & Darney, 2005). The "early" abortion surgical procedure, within the first trimester (less than eight weeks gestational age), is viewed as a safe alternative to the dilation and evacuation method (used at 12 weeks gestational age), and is performed through the use of the electric vacuum aspiration method (Major et al., 2009). At 12 weeks gestational age, most abortion procedures are executed utilizing the dilation and evacuation method with some supplemental induction of labor (Major et al., 2009). Most "late" trimester abortions (up to 18 weeks gestational age) are conducted with the discovery of fetal anomaly or risk to the mother's health (Major et al., 2009). In recent years, the success of "early" surgical and medical procedures has substantially improved with technological advances in vaginal ultrasonography and highly sensitive pregnancy tests (Harper, Henderson, & Darney, 2005).

In 2000, the United States Food and Drug Administration (FDA) introduced the medical abortion as an alternative termination method, administered through the ingestion of mifepristone (Harper, Henderson, & Darney, 2005). Though the FDA has outlined strict guidelines for usage, this "pill" can be dispensed in any physician's office or medical facility since no surgical training is required for administration (Harper, Henderson, & Darney, 2005). The advent of the medical abortion option is considered a significant breakthrough in the abortion field due to easy dissemination and widespread availability for women. In the first half of 2001, an estimated 37,000 medical abortions were performed, approximately 6% of the total abortions executed that year (Harper, Henderson, & Darney, 2005).

Today, abortion research and technology have significantly advanced the range of where abortion services are provided for women. In 2000, 93% of abortions were executed in clinics, 71% in specialized abortion clinics, 5% in hospitals, and 2% in physicians' offices (Harper, Henderson, & Darney, 2005). As one of the most common medical procedures in the United States, the protocols involved with termination have improved to provide more safety, convenience and efficiency for women seeking abortions (Harper, Henderson, & Darney, 2005).

2.3 A TIMELINE OF ABORTION LEGISLATION

Nearly 35 years after the passage of *Roe vs. Wade*, women and men are still engaged in the politics, passions and misunderstandings that define abortion (Winikoff, 2007). Over the decades, abortion has become highly politicized, disregarding the fact that it is a safe, routine surgical procedure for women (Yanda, Smith, & Rosenfield, 2003). Today, the debate over abortion is at the forefront of current health reform legislation. Although this study does not focus on analyzing the politics of choice, a timeline of abortion legislation will provide a context for the research. The socio-political consequences of the debate over abortion are reflected in the expanding list of restrictive laws against abortion, the "loop-hole" health policies, as well as the consistently underfunded maternal and child health services (Yanda, Smith, & Rosenfield, 2003).

Since its approval, *Roe v. Wade* has resulted in questions regarding cost and insurance coverage, and state-mandated legislation as well as directed violence and harassment. That federal and state law does not incorporate abortion, as a component of maternal health has been a barrier for women. Consequently, this set of loopholes denies women state aid, permits states to

design laws that narrow access to abortion and threatens the safety of patients, doctors as well as the staff.

2.3.1 Federal Funding of Abortion

For decades, the relationship between abortion and the government has been under extensive scrutiny by legislators and the public. Today, very few federal programs provide any type of coverage for the procedure. In 1977, the Hyde Amendment was adopted as a means of separating government from involvement with abortion. The regulation required that Medicaid pay for abortion only in cases of rape, incest or when the life of the mother was in danger, although as of 2002, 18 state Medicaid programs cover abortion beyond these limitations (Harper, Henderson, & Darney, 2005). Prior to the implementation of the Hyde Amendment, Medicaid funded an estimated 300,000 abortions for low-income women (Cates, Grimes, & Schulz, 2000).

Within two years of adoption of the Hyde amendment, the number of federally financed abortions dropped to 3000 per year, only 1% of procedures compared to previous years (Cates, Grimes, & Schulz, 2000). During the 1980s, 90% of women were able to obtain an abortion despite the Hyde amendment; of these, seven of ten were financed by state revenues and the rest through other sources, such as personal monies, provider fees, and private contributions (Cates, Grimes, & Schulz, 2000). Of low-income women who would have previously relied on Medicaid funding, 7% opted to continue their pregnancy to term, less than 1% resorted to illegal means for attainment of termination, leaving 92% forced to acquire funding elsewhere (Cates, Grimes, & Schulz, 2000). Contrary to legislative intention, the Hyde amendment did not reduce the number of abortions, as low-income women still sought abortions.

2.3.2 Abortion Restrictions in the States

Today, the legal status of abortion in the United States is increasingly challenged at the state level. Most state laws target abortion in the form of legal or regulatory restrictions. In the 1992 Supreme Court verdict reached in *Planned Parenthood v. Casey*, states were granted the right to enforce these restrictions (Harper, Henderson, & Darney, 2005). Although guidelines were set within the resolution to prevent creation of law that would generate “undue burden” for women, it is highly debatable whether it did that (Harper et al., 2005). Specifically, the decision legalized regulations such as:

- (1) requirement of written informed consent for an abortion, including certain scripted information that must be presented by a physician;
- (2) requirement of waiting period between the time of the request and time of abortion;
- (3) limitations on emergency conditions that would bypass the restrictions;
- (4) abortion providers must report abortions and maintain records about them (Cates, Grimes, & Schulz, 2000).

Although there is a downward trend in abortion rates, prevalence remains high among the poor, young and minority women, further exacerbated by limitations enacted in state legislation (Harper, Henderson, & Darney, 2005). From 1995 to 2003, various state governments have enacted 335 “anti-choice” laws (Stewart, Shields, & Hwang, 2003). In particular, 22 states have mandated waiting periods (up to 24 hours) for women; 21 states require parental permission for teenagers, while 14 states require parental notification; and more than 20 states have instituted “women’s right to know” laws that mandate reading of abortion-related complications (Donohoe, 2004). Although a number of states, currently 33, require that a minor obtain parental consent or notification to obtain an abortion, many have the option of acquiring a court-ordered exemption

(Harper, Henderson, & Darney, 2005). In addition, many states require some form of counseling services, though the type varies by state. For instance, Louisiana, Mississippi, Utah, Wisconsin and Indiana have certain restrictions that mandate in-person counseling at least 18 hours prior to termination (Harper, Henderson, & Darney, 2005). Such restrictions can increase the burden for women by requiring two visits to the office or clinic, especially the majority who need to travel (Harper, Henderson, & Darney, 2005).

Several state laws also specifically impact on abortion providers, for example the Targeted Regulation of Abortion Providers (TRAP), designed to impose extra costs and regulations on abortion clinics (Donohoe, 2004). Such laws can result in the dismantling of abortion clinics, effectively decreasing women's access to services while increasing the cost of the abortion procedure (Donohoe, 2004). Additional laws pertaining to medical professionals include the passage of "refusal clauses." Currently 45 states have enacted such legislation, which permits rights to employers to refuse contraceptive coverage, pharmacist to refuse to provide or dispense contraceptives, and providers to deny patient requests for information on or referral to family planning (Donohoe, 2004).

Contrary to popular belief, the rate of abortion is not lower in areas that restrict abortion in comparison to areas in which abortion is legal (Adamczyk, 2008; Yanda, Smith, & Rosenfield, 2003). As such, the statement of "undue burden" on women is sharply brought into question by the passage of such state laws.

2.3.3 Anti-Abortion Violence

Since 1973, violence directed toward abortion clinics, patients, staff doctors and nurses has been a palpable risk. In three decades of legalized abortion, there have been 80,000 acts of violence

reported, including seven murders, 17 attempted murders, 41 bombings, 166 arsons, 125 assaults, and 654 anthrax threats (Donohoe, 2004). To contend with overt acts of harassment, Congress passed the Freedom of Access to Clinic Entrances (FACE) Act in 1994, as a means of “prohibiting property damage, use of force or threat of force, or obstruction of someone entering a clinic” (Harper, Henderson, & Darney, 2005 p. 503). Nevertheless, in 2000, 80% of 440 abortion providers reported harassment, 28% detailed picketing with physical contact, 18% recorded vandalism, 14% experienced picketing at homes of staff, and 15% received bomb threats (Harper, Henderson, & Darney, 2005). Violence directed toward providers, staff and clinics that assist women in obtaining abortions only cultivates society’s negative attitudes and perspectives related to termination.

2.4 UNDERSTANDING ABORTION

Although abortion can play a significant role in a woman’s life, every individual is remarkably different, and for that reason so is every abortion experience. In 2006, the American Psychological Association created a Task Force on Mental Health and Abortion, designed to evaluate “the relative risks associated with abortion compared with risks associated with its alternatives and sources of variability in women’s responses following abortions” (Major et al., 2009, p. 863). In 2008, the Task Force updated its initial reported findings, emphasizing the importance that “women’s varied experiences of abortion be recognized, validated, and understood” (Major et al., 2009, p. 863). As such, it is imperative to understand abortion’s relationship to religion, and the societal messages related to abortion, as well as the perspectives

of men and women seeking abortions, all as a means to better comprehend the complexity of abortion.

2.4.1 Religious Discourse

Today, in the midst of the abortion debate, there is a clearly defined relationship between religion and abortion attitudes (Adamczyk, 2008). Religion, in terms of membership, beliefs and practices, is considered to be one of the strongest determinants of abortion attitude (Jelen and Wilcox, 2003). For many women, it is respectful to understand their decision about abortion in relation to their religious preference. Despite ongoing public dialogue and debate there is a limited and incomplete body of research surrounding the intersection of abortion and religion. Nevertheless, it is important to highlight positions advocated by religious denominations, as their teachings directly influence the attitudes of abortion.

Personal religiosity can have a significant influence on whether or not a woman is subjected to circumstances, such as a high number of partners or an increased likelihood of pre-marital pregnancy, which may result in a need to seek termination services, (Adamczyk. 2009). Research has indicated that women who are surrounded by a more conservative religious community will be more exposed to anti-abortion attitudes, have less contact with pro-choice opinions and uphold family traditions that support values of motherhood over academic or career oriented pursuits (Adamczyk, 2008). Despite descriptions of several anti-abortion religious teachings, many of the women who identify with a religion are having abortions. Of women seeking termination, 43% identify themselves as Protestant, while 27% distinguish themselves as Catholics; rate of abortion for Protestants is 18 per 1,000, for Catholics 22 per 1,000, for other

types of religions is 31 per 1,000, and for those who do not identify with a religion is 30 per 1,000 (Boonstra, Gold, Richards, & Finer, 2006).

In an article entitled, “Religious Perspectives on Abortion and a Secular Response,” the authors sought to understand how seven major religious traditions (Roman Catholic, Lutheran, Jewish, Islamic, Buddhist, Confucian, and Hindu) addressed abortion within a clinical setting (Stephens, Jordens, Kerridge, & Ankeny, 2009). Many of the religious commentaries examined abortion from two perspectives: the moral status of the fetus, and the value of the pregnant woman (Stephens, Jordens, Kerridge, & Ankeny, 2009).

Of the most commonly practiced religions, Catholicism, Lutheranism, Judaism, and Islam hold diverse beliefs relating to abortion. Historically, the Catholic perspective has opposed abortion at all stages of pregnancy, regardless of circumstances. This stance is primarily due to the conviction that “any living human individual has both a human soul and human rights, including the right not to have one’s life unjustly targeted by others” (Stephens, Jordens, Kerridge, & Ankeny, 2009, p. 3). Alternatively, the crux of the Jewish position views the fetus as sacred but consider termination if there is a significant risk to the mother’s health or life. The course of action is based on a case-by-case examination to determine whether the circumstances are justifiable for choosing termination. In comparison, Lutheran doctrine involves two components: backing a stance against the termination of pregnancy while simultaneously tolerating the necessity of laws supporting abortion. The Lutheran perspective is endorsed by the ideal that there are “life situations” which force a moral decision of choosing the “lesser evil” (Stephens, Jordens, Kerridge, & Ankeny, 2009).

From the Islamic perspective, scholars interpret the Qur’anic position in terms of the moral standing of embryonic and fetal life. Although all Muslim jurists prohibit abortion once

the fetus has been in the womb for 120 days, there is a division about which situations are considered acceptable for a woman to have an abortion. A majority of jurists view the life of the fetus as more important than the life of the mother. However, recent scholars have debated this point of view, advocating on behalf of preserving the mother's life. Nevertheless, the central argument remains that the closer the fetus is to birth, the closer it is to being human, and thus, has the potential rights of a human being (Stephens, Jordens, Kerridge, & Ankeny, 2009).

Confucian, Buddhist and Hindu practices offer a vastly different perspective from other religious views. The moral complexity of the Confucian tradition regarding human life, virtue and common good of the family does not view abortion as a single pro-life or pro-choice issue. Nevertheless, Confucian principles teach that abortion should not be performed for personal reasons, such as financial hardship, although it is acceptable in situations of rape, incest, or threat to the mother's life. Traditional Buddhist beliefs embrace the idea that "where the abortion brought about the death of the child as intended, the judicial decision was that the offense fell into the category of 'depriving a human being of life'" (Stephens, Jordens, Kerridge, & Ankeny, 2009, p. 11). A more liberal Western Buddhist perspective understands abortion as "allowable where the intention is compassionate and the act achieves the best outcome for all concerned" (Stephens, Jordens, Kerridge, & Ankeny, 2009, p. 12). In contrast, Hinduism describes the act of abortion as "morally reprehensible," since upon conception the fetus is regarded as a human person (Stephens, Jordens, Kerridge, & Ankeny, 2009). Thus, abortion is ethically considered to be terminating a human life, generating negative *karma*. Despite the traditional perspective that abortion is considered wrong, modern law in India has made termination legal without significant religious intolerance (Stephens, Jordens, Kerridge, & Ankeny, 2009).

The religious discourses discussed by authors Stephens, Jordens, Kerridge, and Ankeny (2009) offers a unique insight into the moral grounding of religious teachings associated with abortion. Many of the commentaries focus on the degree of “moral leeway” for women who choose abortion. This “moral leeway” brings into question whether or not there is a right choice for abortion, or if it should be assessed based on individual circumstances. As such, Stephens, Jordens, Kerridge, and Ankeny (2009) noted instances of religious practices that assist women through the abortion process. For instance, in Judaism, a woman may need to be counseled in accordance with how rooted her values are in traditional principles (Stephens, Jordens, Kerridge, & Ankeny, 2009). Women who practice Buddhism will often perform honorable deeds to counterbalance negative *karma* caused by an abortion (Stephens, Jordens, Kerridge, & Ankeny, 2009). The Lutheran religion suggests that a woman should be informed about potential psychological and negative effects of abortion and should sign an informed consent form after three days of deep deliberation (Stephens, Jordens, Kerridge, & Ankeny, 2009). Today, many clinics seek to incorporate religion and spirituality into abortion counseling as an important step in understanding and validating the experiences of many different women and men who are seeking termination services.

2.4.2 Social Context

For decades, society has condemned certain types of women who become pregnant (Major et al., 2009), grouping struggling single mothers into the category of lazy, selfish “welfare queens.” Unfortunately, these prejudices are also directed toward women who choose abortion as well as the nurses and physicians who provide comprehensive termination services (Major et al., 2009).

As such, to fully understand the dynamics of abortion, it is essential to discuss elements of influence in terms of social messages and public perception.

In many instances, public opinion and societal messages translate to personal judgment, a conflict often impacting the decision of women and men seeking abortion. The context of the socio-political environment “can shape a woman’s appraisal of abortion not only at the time that she undergoes the procedure, but also long after the abortion” (Major et al., 2009, p, 868). Likewise, the pervasiveness of social messages can encourage women who have had an abortion to consider their actions as disgraceful, negatively impacting their mental well being pre- as well as post-abortion (Major et al., 2009).

For over 30 years, researchers have examined public attitudes and opinion relating to the divisive issue of abortion (Jelen and Wilcox, 2003). In general, many Americans have an opinion regarding abortion, a majority of which claim the topic has significant meaning to them (Jelen and Wilcox, 2003). Nevertheless, public opinion of abortion is as complex as its politics, revealing little about the understanding of abortion at the national level. Even though an estimated 55% of citizens support a woman’s right to a first-trimester abortion, an additional 75% are in favor of increasing public funding made available for family planning services and counseling (Donohue, 2004). The political division is polled at roughly equal, 49% of citizens view themselves as more “pro-choice” and 46% of citizens identify with being more “pro-life” (Donohue, 2004). As such, abortion discourse remains in a suspended state of perpetual conflict within society, while its influences continue to impact the perspectives of women and men who choose abortion.

2.4.3 Abortion Perspectives: Why Women and Men Choose Abortion

The experience of abortion is immeasurably individualized, as it is a reflection of women's and men's knowledge, beliefs and attitudes. Likewise, the dynamics of personal culture including: ethnicity, religion, morals, spirituality, education, can have a significant influence on the decision to terminate a pregnancy. Therefore, as a component of understanding abortion, it is important to examine both women's and men's perspective about choosing termination.

Of the three million women who have an unintended pregnancy each year, about half choose to continue to full term, 14,000 place their child for adoption, and the remaining 1.3 million resort to termination (Finer et al., 2005). Why women choose abortion can be attributed to a vast array of reasons. Foremost, women who choose abortions are very conscious of the responsibilities of parenthood, and thus, are making a decision in light of what is best for their current life situation (Boonstra, Gold, Richards, & Finer, 2006). Women have expressed various reasons why they choose abortion, the most frequent answers provided were as follows: concern about or responsibility to others (74%), cost of raising a baby (73%), a baby would disrupt school, employment or other children (69%), or difficulty of being a single parent or difficulty in current relationship (48%) (Finer et al., 2005).

As many as half of women who choose termination base their decision on the commitment of the male to the relationship, either because they do not want to be a single parent, are experiencing marital or relationship problems, or they have chosen not to include him in any capacity (Reich and Brindis, 2006). As a result, men's perspectives on abortion are neglected, and more often than not, considerably downplayed in research on abortion. Nevertheless, the male perspective is a significant component to understanding abortion. Men are in many instances excluded from the process of pre-abortion counseling. Research indicates that

including men as a part of the post-abortion counseling session may aid in preventing unplanned pregnancies in the future (Reich and Brindis, 2006).

In a study conducted by Reich and Brindis (2006), the authors interviewed 20 men about their abortion experiences, with outcomes centered upon variant themes of “responsibility.” The results indicated that most men within the study regarded decisions about unintended pregnancy as ranging from “assigning total responsibility to women, to ignoring the issue entirely, to seeing it as a shared duty” (Reich and Brindis, 2006, p. 141). In general, a common theme in the study was how men emphasized the need to act responsibly and many equated this with either being financially supportive, or setting up the medical appointments (Reich and Brindis, 2006). This perspective is in accordance with gender roles and norms in U.S. society, which imply that fatherhood is considered primarily as a financial role (Reich and Brindis, 2006). Abortion clinics that seek to engage men in the process beyond financial obligations, either through counseling or as a procedural support person, are pioneering a new vision for advancing reproductive health.

2.5 GAPS IN THE LITERATURE

To fully grasp the multifaceted nature of the abortion environment, it is necessary to explore its vast historical and social constructs. As such, a majority of the literature review focused on the dimensions of abortion related to the demographics of women seeking termination, barriers and accessibility to abortions and contraceptive services, and abortion law, health system policies, political support or opposition to abortion care, as well as religious attitudes, societal messages, and the perspectives of women and men managing abortion.

In 2008, Allegheny Reproductive Health Center was one of the first clinical sites in the country to erect and implement a space, such as the *Sanctuary*, to assist women and men through the therapeutic decision-making process of abortion. Due to the recent execution of the *Sanctuary*, the approach has never been examined prior to this study. Thus, this thesis aims to address a gap in research related to abortion care, by exploring the impact of the space on the women and men coping with the experiences of abortion.

3.0 METHODOLOGY

This exploratory study was used to investigate the impact of a meditative space on women and men managing the complexities of abortion. The study was conducted from September 2009 to March 2010 at Allegheny Reproductive Health Center (ARHC), which established a reflective space, the *Sanctuary*, during the summer of 2008. The author had a previously established a relationship with ARHC, as a former employee, and was granted permission to conduct research by the director and staff. Due to the sensitivity of the topic and the population involved, the design of the study was careful to ensure the privacy of participants. The research was conducted through the use of semi-structured interviews with clinic workers, and by asking visitors to the meditative space to respond to a short questionnaire, which upon completion was placed in a secure box installed within the *Sanctuary* at the clinic. This qualitative research design was approved by the University of Pittsburgh Institutional Review Board (IRB) (PRO09060271) (See Appendix B.)

3.1 SAMPLING

The sample population for the interviews included clinic workers, predominantly female, ranging in age from 18 to 60. Additionally, individuals who could contribute to the *Sanctuary* box

questionnaire include pregnant women aged 18 to 60, non-pregnant women aged 18-60, and men aged 18 to 75.

3.2 RECRUITMENT

The recruitment process for the semi-structured interviews of clinic workers was conducted through the use of a mediator, Pamela Wilson, the head counselor of ARHC. Ms. Wilson read an announcement at a monthly staff meeting to request volunteers for interviews regarding the *Sanctuary*. All interested parties were asked to submit their contact information into the secured box located within the *Sanctuary* to ensure confidentiality among clinic staff. (See Appendix D for recruitment script.)

Allegheny Reproductive Health Center (ARHC) has three designated procedural days: Tuesdays, Thursdays and Saturdays. On average, the clinic provides services for an estimated 10 to 30 women per procedural day (ARHC, 2010). As such, all individuals who chose to visit the *Sanctuary* during their appointment had the opportunity to voluntarily participate in the questionnaire (see Appendixes E and F for Box Speech and Sharing Document.)

3.3 INTERVIEWS

Allegheny Reproductive Health Center (ARHC) is a small workplace employing an estimated 20 clinical workers. A majority of the clinic workers are situated in various positions throughout the clinic, including front desk, counselor, lab attendee, operating room (OR) attendee, and

recovery room nurse. By involving volunteers from the entire clinic staff, the research reveals various experiences, builds context and background regarding abortion, yields stories about the *Sanctuary*, and gives insight into personal use of *Sanctuary* space. In addition, an interview was conducted with the previous clinical director to discuss the history and development of the *Sanctuary*. Interview participants were provided a numerical identifier, and all direct quotes will exhibit this identifier. As requested by IRB guidelines, the participants were read an informed consent script at the beginning of each interview (see Appendix C.)

This researcher conducted all interviews in a setting chosen by the interviewee and recorded them as a MP3 using a Macintosh Computer program. A total of five interviews were conducted, including the special interview with the previous clinical director. Within the interview, general topics discussed include working in an abortion clinic; connecting with women and men managing abortion; development, advantages and limitations of the *Sanctuary*; worker and patient use of the space. (See Appendix G for the interview questions.)

3.4 SANCTUARY BOX

In order to respect the confidentiality and emotional state of patients visiting the meditative space at Allegheny Reproductive Health Center (ARHC), this researcher relied on collection of qualitative data through a questionnaire and placement of a secured box (see Figure 1) within the *Sanctuary*. A script was placed with the box with several open-ended questions regarding the use of the *Sanctuary* for visitors to answer. The *Sanctuary* box remained available to participants for approximately six months.



Figure 1. *Secured Box Within Sanctuary.*

3.5 TRANSCRIPTION

Interviews were transcribed from MP3 to Microsoft Word documents by two professional transcribers. As requested by the IRB, all personal identifiers were removed, and individuals were given pseudonyms to protect their identity.

Responses retrieved from the *Sanctuary* box were typed into Microsoft Word document format. No identifiers were requested by the accompanying script, and if given, were replaced with a pseudonym.

3.6 THEMATIC ANALYSIS

The current study was examined using thematic analysis, involving elements of grounded theory, applied to semi-structured interview transcripts and responses collected from the *Sanctuary* box. Relying on influences by Glaser and Strauss (1967) and Braun and Clarke (2006), I integrated the technique of thematic analysis with rudiments of grounded theory, such as coding and comparative analysis, to illustrate a conceptual framework for understanding the impact of the *Sanctuary*.

Braun and Clarke (2006), define thematic analysis as a method commonly utilized in qualitative studies to identify similarities within collected data by applying a theoretically flexible approach. In support of this study's intent, the inductive process of thematic analysis connects emerging themes to provide rich and detailed narrative accounts (Braun and Clarke, 2006). Glaser and Strauss (1967) emphasize the method of grounded theory as a technique that permits the researcher to engage in a profound examination of the data through a flexible process of analysis leading to variability in theory development. This approach is similar to thematic analysis, by allowing the researcher to identify emerging themes that share cross-over commonalities through a process of coding. Moreover, as discussed by Glaser and Strauss (1967) the utilization of the "constant comparison" method, as integral to grounded theory, allows transcripts to be compared for similarities and differences. A noted disadvantage of utilizing the grounded theory approach within this type of study, is that the process is "theoretically bound" (Braun and Clarke, 2006). Therefore, by combining these analytical practices, the process of thematic analysis, as less theoretically driven, allowed the data to be openly interpreted, while grounded theory offered a structure for defining the emerging themes.

Foremost, the analysis process involved the identification of themes, which were coded by the author. Each transcript and box response was read thoroughly, than read again before initial coding, followed by a third reading. Upon the third reading, the codes were methodically compared within the context of each previous transcript and response. This process was conducted through the method of constant comparison in the grounded theory technique (Glaser and Strauss, 1967). The preceding component of the analysis relied on dividing the codes gathered. Each code was divided into categories which were used to identify interconnecting themes. The Glaser and Strauss (1967) strategy of “memoing” in grounded theory was also applied throughout each stage of the research as a means of supplementing as well as supporting the resulting discussion and conclusions.

4.0 RESULTS

Initially, the focus of this research study was to investigate the various uses of the *Sanctuary* by women and men coping with abortion. Nevertheless, as a significant portion of the data heavily relied on information collected from the interviews, other elements relevant to providing a holistic approach to abortion care emerged from the analysis. Therefore, a shift in the perspective of the research is evident in the discussion of the results.

4.1 CHARACTERISTICS OF INTERVIEWEES AND BOX RESPONDENTS

The analysis consisted of reviewing interviews of five female participants, employees of Allegheny Reproductive Health Center (ARHC), who had volunteered to contribute to the study. Of the participants, two were full-time counselors, one was a security guard, one was an operating room assistant, and one was the retired executive director of ARHC, who had also acted as head counselor. Of the participants, their experience working in the abortion field ranged from as little as a one year to 30 years, with one currently retired, and all but one employed at ARHC prior to establishment of the *Sanctuary*.

Additional analysis was conducted through review of the box responses supplied by individuals using the *Sanctuary* throughout the six-month study. During this time, there were four responses submitted to the box, one in November, two in January and one in February. All

respondents indicated on their submission that they were female, current attending patients, and aged 21, 21, 29 and 31.

4.2 EMERGING THEMES

Through the process of applying grounded theory, several themes emerged that were relevant to understanding the abortion experience in relation to the *Sanctuary*. This section of the paper will focus on four main themes that emerged from the analysis of the transcripts. Specifically, these themes are the environment of an abortion clinic, a holistic approach to abortion care, the development, advantages and limitations of the *Sanctuary*, and clinic worker and patients uses of the space. The connection between these themes and the responses collected from the box will be included following the results.

4.2.1 Theme #1: The Environment of An Abortion Clinic

At the beginning of the interviews, participants were asked about their experiences working at a facility that provides abortion care. Since interview participants possessed a range of experience within the abortion field, various interpretations were presented about their perceived understandings relating to the external factors that influenced their work, the emotional complexities of providing termination services as well as the importance of abortion work.

4.2.1.1 External Factors Impacting the Work of an Abortion Clinic

In the interviews, a number of participants identified one specific external factor that consistently had a significant impact on the environment of the clinic: the presence of anti-choice protestors. In particular two participants had been a part of the experience at ARHC for several decades and thus endured the immediate consequences associated with the dynamic socio-political influences resultant from the passage of *Roe v. Wade*. One participant discussed the impact of protestors during the 1980s and 1990s:

That and, a particular time with the protests that was late, in the late 80's, when 600-800 protestors would come on any given day and block the doors and the police would have to come and arrest all of them before we could enter the clinic and begin seeing patients. And even though I knew intellectually that I couldn't fix it, that it was a problem way bigger than me, I still as though it was my job to see to it that our patients were well taken care of, the staff felt safe, um, the physicians felt that I was, I was doing all that I could to make this problem go away, but it took a very long time for that to happen (1).

This picture of protestor involvement is very different from the experience currently encountered by patients and clinic workers. Nevertheless, for decades, directed violence has been a constant issue for health care facilities that provide abortions. Fortunately, ARHC has in recent years been spared such violence. One participant in particular spoke about a specific violent incident related to the 1989 firebombing of the clinic:

Well, it's kind of amazing, being in this field for such a long period of time and going through all sorts of problems where women couldn't get into the clinic because of some damage or some other or threatened explosions or deaths or whatever, women mostly talked about a willingness to put themselves at risk just to not be pregnant. Like, "I don't care if you've had a fire, I don't care. Just can I get my procedure done?" (1).

Currently, the presence of the protestors, although to a much lesser extent in their numbers and engagement, still continues to be a constant source of anxiety for patients and clinic workers. Today, on any given procedure day, ten to 150 protestors stand outside the clinic to confront patients. One participant discussed in length her interactions with the protestors:

It's really stressful too because no one wants to be judged and then when you come around the corner, everybody, I don't care how sure you are of your decision or whatever, everybody is sort of like you have to come to this place for everybody and to be chased down from your car and tell you you're bad, tell you you're going to hell, tell you, everybody is gonna be at maxed level of stressed out about the time. It makes me so angry that they even have the right to be there, you know if-if you're standing out front of your regular gynecologist office, standing out front of your dentist and they're telling you you're going to die and stuff like that, I just don't see how it's legal to do that to somebody. I don't see how it's legal (3).

Despite the additional complications that arose as a result of external influences of the protestors, the interview participants discussed how they overcame the stress brought on by the protestors. One participant expressed how she channeled her feelings regarding the interaction with the protestors for the purpose of assisting patients:

I take my focus off of them. I make my focus on the patient, 'cause I know in my heart that I'm doing a really good thing, how many people we help on a daily basis, and if it's a bad day I go in and I sit down and I don't stand outside. If I see a patient coming, I walk right out there and I sing a song or I tell 'em tell the protestors off, she knows what's going on, she's smart enough to make her own decisions. I just try to drown them out and focus on the patient because I, really, she is who it's going to affect, not the people outside (3).

For many, the presence of anti-choice protestors outside the clinic was pinpointed in causing additional complications for patients and clinic workers. The current presence and interactions of the protestors with patients and workers result in an additional degree of anxiety, a factor that can carry over into the emotional environment within the clinic.

4.2.1.1 The Emotional Complexity of Working in an Abortion Clinic

For those employed in the abortion field, the working environment within the clinic is often saturated with the heightened emotional state of patients. Though clinic workers are trained to help women and men cope with the abortion process, they are also managing the complexity of their own emotions. More often, clinic workers are enduring significant emotions associated with the daily burden of listening to the tragic circumstances that surround a woman's

decision to have an abortion. In particular, one participant discussed her daily interaction of scheduling patients for appointments over the phone:

You hear people crying all the time. In a regular day you're taking twenty calls, many of them are like horrible stories, very sad, where someone has no support, not just financially but everybody they told is judging them and it's a fifteen-year-old girl that maybe already has a few little kids. People always want to give their opinions, even people that have had abortions (3).

On a typical procedure day, Allegheny Reproductive Health Center (ARHC) provides services for between ten to 30 women. The average clinic worker interacts with patients in various settings, which provides the opportunity to learn more about the experiences and life circumstances of any particular woman. On many occasions, the situation that results in a woman's need to seek termination services has a deep impact on clinic workers. One participant discussed one woman's story that made a profound impression on her:

...when I've been particularly upset about a particular case of, there was a woman that came in and she had suffered a lot, personal details I can't really share because she could be identified. But she suffered a lot, and the whole staff was just torn apart about it (4).

Some of the interview participants expressed feelings of stress they experienced during an average workday at the clinic. As such, many discussed the types of coping strategies they employed to manage any overwhelming feelings or emotions they experienced as a result of a stressful day:

Well, sometimes I talk to my coworkers, if I-if I- if I have a hard case and I'm not sure what to do, I'll talk to my coworkers, sometimes if I get very emotional, I'll take a few minutes and maybe be by myself to collect myself before I go towards something else. You know there are times when I get pretty involved with somebody and I feel bad and cry and so I have to sort of recollect myself, that's how I do it (2).

...even if I have to, as well, just go outside the building and walk around the block, for a couple minutes or I'll talk to one of my coworkers that I feel really comfort, comfort in talking to when I'm stressed out, because a lot of times if I'm stressed out about something, somebody probably is too (4).

Although clinic workers experience significant levels of stress, they understand that they are providing important services to many women and men.

4.2.1.2 The Importance of Abortion Work

In the interviews, each participant expressed the underlying importance of abortion work. Many of the participants said that their core beliefs regarding a woman's right to choose was central to how they personally defined themselves. When asked how they felt about working at the clinic, participants expressed how important abortion work is to them and for others:

Without the right to control over our bodies, we're not free and so, it's es-it's essential, one, one, one of my essential core beliefs that, the need for this, this, this freedom is essential so it's, it's, it's a core belief of mine so it, it in part defines who I am (2).

I mean, before working at the clinic, I didn't know what I wanted to do with my life and now, I can't imagine doing anything outside of women's healthcare, specifically abortion services (4).

Several participants expressed pride regarding their work as well as their capacity to help women. In particular, one participant discussed her feelings regarding "choice":

I'm proud of it, there, I think it's important- I think it's important that people work there who are (inaudible) pro choice but are really, (inaudible) to understanding people's situations, make connections to people, and you just realize how important it is that this choice is out there and that it's safe and you treat it with respect wherever you go (3).

When asked about how they felt working in a clinic that provides abortion services, each individual emphasized how necessary it is for people to be willing to work in the abortion field, and how important it is to provide personalized care for women and men in need:

...where the patient still counts and we would want to continue to listen to them and kind of knock ourselves out to do things the best way we can even imagine (1).

Several interview participants discussed how their work has been generally positive. Specifically, one participant expressed how she considered her time at ARHC as her life's work:

It's true, this was my life's work. I didn't know it when I started.... But rather I would be in a position to actually effect changes. To create, the kind of clinic environment, healthcare environment that I thought would be more respectful and responsive to women than, the models that I had been exposed to in most clinical settings (1).

The need to continue providing abortion services is explicitly noted throughout the discussions. As such, many of the interview participants, through their experience at ARHC, highlighted the critical connection between the importance of abortion work and the need to continually improve abortion care services.

4.2.2 Theme #2: A Holistic Approach to Abortion Care

Throughout the interview process, each participant interviewed expressed particular feelings, emotions and perceptions related to the health care approach Allegheny Reproductive Health Center (ARHC) has employed over its many years of providing abortion services for women and men. As such, an important theme that emerged from the analysis was that ARHC offers a holistic approach to patient-centered care.

4.2.2.1 The Approach

For many patients, the process of obtaining an abortion can be exceedingly difficult. As such, the particular patient care provided for the women and men managing the complexities of abortion are is extraordinarily different from that in the average healthcare facility. Throughout their interviews, participants expressed their feelings about working within a medical setting that specifically offers abortion care. As a component of this discussion, each participant, regardless of their position within the clinic, referred to the unique approach ARHC utilized as part of the care they provided for patients. As one individual says:

I mean, it's very personal and it's, it's important and I mean it's not, it's not abortion at Allegheny Reproductive is not treated like a business. It's treated like a, a healthcare experience, a good healthcare experience that women deserve.... (4).

At ARHC, providing care for woman and men coping with abortion embraces a unique approach. Central to this method is the idea of listening to what women are saying, as one participant expressed:

Mostly just by listening to the women and finding out what it was that they wanted, I was, extraordinarily privileged to be able to enact, and change, policies to create a clinic that would more accurately reflect what women were asking for (1).

As emphasized by some participants, the counseling approach is less clinical and more individualized. In many instances, clinic workers attempt to customize the type of care patients are receiving to reflect and attend to their personal needs, strengths and weaknesses. In particular, one of the interview participants was attracted to this philosophy.

Yeah, it was definitely a different approach to counseling, and differences in terms of being less clinical, like, a Planned Parenthood and very scripted and very medical to being, it seemed, a more holistic approach in terms of patient care, which is really what I like about it (5).

Moreover, displaying to patients the degree of compassion the clinic provides improves women and men's experience with the abortion experience. As one participant expresses, she felt that she was not only caring for patients, but also empowering them to understand the process.

My favorite story is kinda, not one story, but my favorite situations are when women come in they look all freaked out. On the phone they tell you they're against it and they get there and they're still against it and blah blah blah and by the end they feel empowered, because you know, we've shown them that, you know, well, number one we all don't make tons of money to work there and, just the level of compassion along each step along the way (inaudible) and all of them at the clinic, they do really strive to take care of my body so in a way, we're not just making sure it's safe with a doctor, but if you have any kind of concerns or whatever, we do have the resources and a lot of people that work there have personal experiences with it so... so (3).

Overall, interview participants emphasized the importance of patient care at Allegheny Reproductive Health Center that seeks to address the particular needs of the women and men coping with abortion.

4.2.2.2 Connecting with Patients

At Allegheny Reproductive Health Center, the core foundation for providing personalized care is the capacity of employees to establish an emphatic relationship with patients. Interview participants emphasized how their personal goal in providing care was ensuring each individual of her importance during her time at the clinic.

I feel like I have to have a personal connection with everyone I interact with them on some level. It would be more personal in cases where I made the appointment or like counseled them, but if I can give them my name and do something special for them that show them that they're not just another patient, you know, that makes me feel like I'm doing a good job (4).

At ARHC, the type of personal connection many of the interview participants reference is generally depicted as central to the holistic approach emphasized within their abortion care. In particular, several interview participants explained the importance of establishing a connection as a means of reassuring patients that they could feel comfortable and safe.

I like to be able to make that connection before they come in, because if I say things to them on the phone like, I would go to this doctor, you're gonna be safe, everybody is gonna take care of your mind, body and soul. I always say that to people because people do have different concerns and stuff like that. A lot of times it's physical, like you're gonna be OK and a lot of times it's, you know, everybody leading up to this appointment has been giving their opinion how they feel about it and what's happening (3).

Overall, the patient care model administered at ARHC aims to provide a “positive” abortion experience. As one participant emphasized, the connection is often about ensuring that patients are able to endure the clinic process.

Ultimately you're getting them through the day and hopefully having them leave with an experience that was positive, and not that, they're not going to have lasting issues (5).

Considering the complexities of the situation, the type of care administered to assist with termination is equally difficult to perform. The interviews revealed that clinic workers at ARHC have developed a model that focuses on patients by establishing an intimate relationship, as a means of ensuring that their emotional, physical and spiritual needs are properly addressed.

4.2.2.3 Unique Methods of Assisting Women

As one of the pioneers in abortion care, Allegheny Reproductive Health Center has implemented several unique techniques, prior to the *Sanctuary*, aiming to assist women and men manage the emotional complexity of abortion. Throughout the interviews, participants mentioned the use of these methods as a significant part of ARHC's holistic approach of helping women and men.

At ARHC, clinic workers have coined a phrase, "support person" as a means of identifying the individual(s) accompanying the woman during her appointment. As an innovative step to ease the discomfort experienced by women, ARHC introduced the idea of permitting a patient's "support person" to accompany her during the abortion procedure. Offering patients the option to have a family member, friend or partner present during the procedure provides women with a greater sense of comfort. In particular, several participants discussed how unique the idea of a "support person" entering the procedure room was:

Even bringing support persons in was something that really had never been done before (1).

Our clinic is so special just with, you know, allowing partners and support people in the rooms (3).

Nevertheless, there are many occasions in which a “support person” does not fulfill the role implied by the term. One participant discussed this related directly to the shame associated with termination.

Well, the shame surrounding abortion I think is really interesting because we’ve had people that come in and they bring a support person, which is not always a support person because they’re against it (3).

Often, women attending the clinic will either choose to not include their “support person” or will not have someone with them for their appointment. On these occasions, if requested by the patient, clinic workers will often step in to fulfill this role. In particular, clinic workers who interact with patients as a counselor or operating room attendee encounter this situation on a more consistent basis. As one individual said,

If the patient doesn’t have a support person then I’ll often offer to hold their hand, talk to her through the procedure, you know depending on what her needs are. Sometimes they just wanna be quiet, sometimes they wanna hear the hose, sometimes they wanna talk about other things and just get their mind off of the procedure, and if somebody that I’m setting up seems particularly scared and I’m not the assistant, then I’ll offer to go in as a support person, just to talk to them and hold their hand (4).

Throughout the interviews, participants mentioned several other ways of supporting women and men managing the array of emotions associated with abortion. In particular, interview participants identified two methods, the use of the stones, and the writing on paper hearts:

So we have these stones in our counseling rooms that have been there for a long time. It was one of our director’s ideas that it would be nice, so generally at some point we offer the stone. It just sits there, it’s in a basket and we ask the person if they might like to have a stone or sometimes they’ll ask, “What’s a stone for?” I just say, “It’s whatever you want, people take them for all sorts of reasons” (2).

Basically it’s construction paper hearts for you to write a message to your fetus, baby. It’s inspirational or factual. A lot of them call them babies, just you know kind of give them a couple words or just talk about your experience. It’s really good and women come in and see them and we have binders for them and we tape them all over the walls and it really gives a sense of comfort, like you’re not going to hell. Little things like that and I think

the kind of language they choose is interesting it just comes from all different kinds of women (3).

Every individual, woman or man, experiences the process and emotional environment of abortion from a different perspective and cultural background. Thus, it is important to allow a variety of options to channel accompanying feelings. As such, the significance of providing an alternative outlet to direct their emotions, such as the stones and hearts, can be an important approach, in addressing the concerns of women and men managing abortion.

4.2.3 Theme #3: The Meaning Behind the *Sanctuary*

For over 30 years, Allegheny Reproductive Health Center has been at the forefront of the abortion field, led by an innovative director as well as the support of a dynamic and dedicated staff. In connection with the revolutionary practices for abortion care that ARHC and its staff have introduced over the years, erection of the *Sanctuary* is a culmination of their missions' directive to provide specialized abortion care for women and men. The following outlines the development of the *Sanctuary* as well as the subsequent advantages and limitations that developed after its implementation.

4.2.3.1 Development of the *Sanctuary*

In order to fully understand the *Sanctuary* it is important to recognize the process of its evolution. The development of the *Sanctuary* was an exceedingly complex undertaking for the previous Director of ARHC. Nevertheless, despite numerous barriers, detours and difficulties, the Director managed to design, fund and implement the *Sanctuary*. This section is based on the interview with her and will document the steps administered throughout this process.

The concept behind the *Sanctuary* existed for many years prior to its implementation. Throughout her interview, the previous Director credited the many decades of listening to women discuss their feelings related to complexities of their abortion experience as the sole reason for undergoing her quest to provide the *Sanctuary*:

...these things take time. Just because I or someone else has an idea doesn't mean that instantly other people are exactly at that same place. If it's taken me X number of years to really formulate this in my head, to take it from just dialog that occurs within counseling sessions to an actual physical, other people need to be able to go through their own processes, other administrators, directors, to think of how that might happen (1).

Well, again just learning to listen to women. And the support persons because sometimes it would really be a parent, a mother, a father, a grandmother, an aunt, who would express a need, like "oh I, I wish that I could just sit and think about this" or "you have helped me to see this whole thing in a whole different light. Now I wish that I could just sit quietly by myself and think about this whole thing in this new light (1).

With the completion of her conceptualization for the *Sanctuary*, the Director embarked on the task of locating an architect to design the space within the clinic. This was difficult, as it was necessary to identify an individual willing to be associated with a controversial topic such as abortion:

And so I just continued talking to people, asking people who did they know that might be able to help. I talked with faculty at [local university 1] I talked with the architecture department there. The art department, I talked to people at [local university 2]. I was thinking that some student group could take it on because we've had other students do projects within the clinic. I just kept working it for years every angle that I could think of. Every opportunity was always in my mind, and eventually I got the architect (1).

In addition, the Director emphasized how essential it was to identify an individual who would not only be willing to design the space, but also to understand her vision.

A restaurant opened on the South Side and as soon as I walked into the restaurant I just thought whoever designed this is going to get what it is that I am trying to do. And will help me to, to put down on paper how I think this ought to be. And so, I asked the name of the architect and I called him up and met with him a couple of times and told him what it was that I wanted to do and that I didn't have a single penny to pay him with. And, he was thrilled with the idea. He was thrilled that I had loved the restaurant space that he had designed because he's a very young architect. And he was really just, getting started, he

was part of a large firm and he had to get permission from them even to do this pro bono. And there was a conflict within the architectural firm as to whether or not they could allow them to be connected with anything related to abortion. So eventually it was decided that he could do it but he couldn't put his name on any of the drawings that any builder might see (1).

Despite the Director's fortune in locating an architect in line with her vision for the project, the process of hiring an affordable contractor almost ended the execution of the space:

And then I put it out to bid and the bids came [laugh] so high I knew that it was out of the question, just that it was never going to happen. And there were a lot of little steps along the way of the project needing to be scaled back even further (1).

Oh yeah, I mean the first contractors didn't want anything to do with it so they would give me these exorbitant build-out costs, like \$40,000 and \$20,000 (1).

Nevertheless, the Director, in collaboration with the architect, was able to simplify the design, and acquire additional funding through an anonymous donor, as well as identify a willing contractor. Regardless of these many accomplishments, on several occasions the design of the *Sanctuary* was altered.

And just finding other ways to do it that weren't going to be necessarily 100% according to my vision of it but I still think that it came out absolutely beautifully (1).

So, that we knew that we had a bit of a budget. But the construction crew actually modified it even further. Because the lights for example that are within the *Sanctuary*, the blue lights even the scaled back version, was oh I can't remember. I think they were going to be like \$2000 (1).

Throughout the tedious and prolonged construction process the clinic managed to continue seeing patients, despite the mess of the construction, which involved tearing down and creating walls, and installing carpeting and tiling. Moreover, complications arose, in particular with city building permits relating to the establishment of an ADA certified bathroom. Nevertheless, the Director was able to overcome the challenges.

And it looked like it was going to be like \$2000 more to put in a different sink. But they figured out how to do it and they made the trip down to the inspector, the person who signs off on it, to make sure that absolutely it was ok. And then in fact, when the city

came to sign off on it, the inspector who came said, “this won’t do.” And so luckily they had the letter that the other guy had signed off on it and, also was able to quote, the actual part of the law that permitted this particular kind of sink (1).

Overall, though the experience of developing and implementing the *Sanctuary* was daunting, the Director noted the impact this development process had on those involved, including the architect and the construction crew.

But because he was so supportive and ultimately his wife was too, we just kept working forward... (1).

So, ultimately the construction crew, I think people who end up working on these things, end, up really loving what it is that they’re doing and being very proud that they’re doing this work. So this construction crew, like others that I’ve had in the past, again they’re all guys and they come into it thinking, oh I’m going to be around all these girls all the time (1).

Many times throughout the development process, the Director felt the *Sanctuary* would never be implemented. Even so, she held strong to her conviction that the space was necessary for the improved care of woman and men managing abortion:

Luckily, that was able to be resolved because when that came up, I just felt like this is never going to happen. I’m never going to be able to retire because I had made a pact with myself that I would not retire until the *Sanctuary* was built. I felt that that was what I needed to leave there for both the staff and for the patients for the future (1).

Although the process of erecting the *Sanctuary* was an intense and prolonged undertaking, interviews with staff reveal that the presence of the space generally lends to the supportive environment of ARHC.

4.2.3.2 Advantages of the *Sanctuary*

Today, within the abortion field, patient care should strive to encompass approaches that address the variety of emotional and religious needs of those seeking termination. As such, the *Sanctuary* is a novel approach for assisting women and men coping with the complexities of abortion. Throughout the interviews, participants identified a range of advantages presented by

the use of the *Sanctuary*. In particular, the helpful quality of the space, and its calming presence which offered a sense of privacy.

Each of the interview participants acknowledged that the *Sanctuary* was a helpful addition for the clinic. In particular, one stated that she felt they were “the luckiest clinic on the planet” because of the space. Other individuals were able to capture characteristics of the space, as illustrated in the following direct quotes:

It’s just, well, it’s really pretty, and it has a quiet feel and the clinic does not have that kind of a feel, you know, the clinic is very, well, it’s a medical facility, there’s a lot going on, there’s a lot of people, a lot of activity, people coming and going, stress levels are high, not mine but the women are waiting there for hours and hours, it’s a hard, it’s a hard way to spend a day and the *Sanctuary* is just kind of the opposite of that (2).

I feel like there’s so many aspects that go into the *Sanctuary*, it’s just an added thing that you offer in the clinic. If it’s not a patient maybe it’s their parent, maybe it’s their boyfriend, whatever, and it’s just an added way the clinic really cares, great doctors, great staff and we can all see the way it improves overall needs, I mean, everybody’s need. I think everyone would benefit from it (3).

Moreover, several interview participants suggested that the presence of the *Sanctuary* created a positive atmosphere for patients and clinic workers. As with any medical facility, the clinic is often perceived as a sterile and cold environment. Interview participants suggested that the existence of the *Sanctuary* provides an additional sense of comfort, quiet and privacy for patients. In the following quote, one participant discussed how she felt the clinic could generally offer a warmer atmosphere for patients.

I actually think that some of the other parts of the clinic are maybe more sterile and they need to be, I would actually like to see the whole clinic become a warmer atmosphere. So perhaps without the *Sanctuary*, which is a little bit warmer of an atmosphere than the rest of the clinic, it would be a little bit more sterile. Do you see what I’m saying? I mean I would like to see the waiting rooms redesigned. I’d like to see all the waiting rooms, the counseling rooms, you know, I think it could be more than it is now. So you know, without that it would be even less than it is now (5).

Overall, this theme is reinforced by data collected from the box responses, as patients emphasized the significance of privacy when managing the complexities related to abortion.

4.2.3.3 Challenges of the *Sanctuary*

Since the *Sanctuary* was established in 2008, clinic workers of Allegheny Reproductive Health Center have had to adapt their approach with patients to encompass the benefits of offering a space for reflection. As such, many challenges surfaced within the interviews, including the difficulty of discussing the space with patients, clinic workers capacity to forget to offer this as an alternative option for patients, as well as the *Sanctuary's* general location within the clinic. This section will include a discussion on the challenges associated with the *Sanctuary* based on the interviews.

Specifically, one of the challenges frequently highlighted within the interviews was the difficulty of introducing the *Sanctuary* for use by patients. As one participant explained during her interview, clinic workers do not exactly know or understand how to discuss the space with patients. In particular, a number of interview participants referenced the challenges faced when initially incorporating the concept of the *Sanctuary* into the counseling regime.

I wanted to let them know that it exists. I wanted to let them know the kinds of uses that people might consider, but without being didactic about it. So it, it took me a while to pose its existence in a way that was an open invitation, but that it wouldn't make them feel bad. Because you never know how people are going to (inaudible), even people that you know well (1).

Another challenge discussed by several interview participants, was forgetting to offer the *Sanctuary* to patients. This may be a result of the emotionally charged environment within the clinic, which often can distract workers from incorporating newer techniques. Consequently, a patient who could have benefited from the space may have inadvertently been denied a means of

solace. In particular, two of the participants discussed the difficulty of integrating the *Sanctuary* into everyday practice.

Well, I think clinics that focus on handling abortion the way our clinic does might consider it because it's a good addition even though I'm guilty of not offering it. I think it can be a nice addition absolutely (2).

We're the ones that see the same things every day and it's easy just to put it on the back burner and just to kind of overlook when it could be really beneficial to someone. And like I said before, when we have new staff coming in, I don't think they're really introduced to the *Sanctuary* and taught its history (4).

Moreover, although the *Sanctuary* is a unique approach for assisting women and men managing abortion, its use can be difficult to explain to patients. A few individuals discussed the idea of the *Sanctuary* as a "new agey" approach, thus implying that it may be considered "unusual" by certain types of patients.

Lastly, the location of the *Sanctuary* was identified as a significant challenge to patient and clinic worker use of the space for reflection. Thus, several participants considered the placement of the *Sanctuary*, in the front of the clinic centrally located next to several of the waiting and counselor rooms, as a barrier for private use. Specifically, some participants questioned the space's sense of privacy due to its location being "in the middle of everything," and whether or not this element impacts individuals use of the space by "holding people back."

As one participant discussed,

Well, they just feel that it's conspicuous. The one I remember in particular who, who thought it was a nice idea said, she didn't know how long she was allowed to spend in there. She felt like if it were a little more hidden, she could go in there and not, you know, people were watching her and wondering what was going on, and I think that people already feel conspicuous when they're walking into an abortion clinic and so they're very conscious of everything that you're, of your existence during those hours that you're in the clinic and the seconds that are ticking by when you're in the waiting room. You're wondering what other people are thinking and you're wondering what other people are there for and how they're feeling and why they're there. I think that they're conscious of walking into that space and not necessarily wanting any more attention paid to them (4).

Regardless of the *Sanctuary*'s challenges, all of the interview participants agreed that the space is a helpful addition to the clinic, and could not imagine removing it as an option for patients.

4.2.4 Theme #4: Uses of the *Sanctuary*

The *Sanctuary* was designed to encourage personal reflection and quiet meditation among patients and clinic workers coping with the complex issues surrounding abortion. Nevertheless, individual use of the *Sanctuary* is more or less a personal decision. Thus, the reasons individuals choose to utilize the space are unclear. The following section will explore the various reasons why clinic workers and patients choose to use the space, as well as include a discussion of the responses obtained from the secured box.

4.2.4.1 Clinic Worker Uses of the *Sanctuary*

Although the *Sanctuary* was created based on the needs and requests of the women and men coping with emotional complexities associated with abortion, the space has had a positive impact on clinic workers of ARHC. One of the questions asked of interview participants was if they had ever utilized the *Sanctuary* for personal reasons, whether associated with the work environment or external factors. All but one of the participants discussed having used the space in moments of particular vulnerability or emotional wavering. The participant who had not was relatively new to working within the abortion field, a factor that may have played a role in her lack of utilization.

I don't know that I would ever use it anyway [laugh], but I like it, I love the design of it. It's really peaceful (5).

Interview participants who used the space consistently referred to the stressful environment of the clinic as a contributing factor. Additionally, some interview participants viewed their primary responsibility as caring for patients, and acknowledged that if under duress, they would use the *Sanctuary* as a means of centering themselves:

I felt the need to go in there and I went in and it was really peaceful in there, and quiet and it felt like I got the break that I needed from the work and the day (2).

Those moments where you are questioning right and wrong and like your existence in general, where you just want to contemplate and that's when you think about going in there, at least I do anyway (4).

To get away from the stress...somebody you know freakin' out and stressed out and I've gone in there to have some peace and quiet before (3).

And, I did use it a couple of times after that. In situations that were less dramatic but it was just clearly a place that I knew that I had access to that I could utilize in a way that I could find myself in a place where I needed to be, to be able to work with the women (1).

Use of the *Sanctuary* by clinic workers was typically on non-procedural clinic days, or before opening the doors to patients.

When I'm at the clinic and I'm stressed out, I've sat in the sanctuary before. I never do it when patients are there because I feel like it's a place for patients. If I'm having an awful day and I'm stressed out, I'll go in there and turn on the little purple light and just sit in the quiet because it is really quiet in there compared to the rest of the clinic (4).

I think it's great. I go in there sometimes, obviously when I'm not with patients but I go in there sometimes (3).

Abortion care is unlike any other type of health care service. Both the patient and the clinic worker experience a range of complex emotions unique to the abortion process. Although the intent of the *Sanctuary* was designed to assist patients, clinic workers have also sought the use of the space. Nevertheless, its use in many instances was a means of re-focusing their capacity to provide a positive abortion experience for their patients.

4.2.4.2 Patient Uses of the *Sanctuary*

Throughout the interviews, participants talked about the beneficial nature of the space, in terms of providing an alternative option for patients and their support persons. Of the situations discussed, interview participants were generally unable to characterize the type of individual most likely to use the *Sanctuary*. Nevertheless, all the participants were able to provide a spectrum of examples and reasons of why individuals use the *Sanctuary*, based on their personal interactions and observations of patients.

In general, interview participants identified two specific reasons they or other clinic workers would recommend to patients the option of using the *Sanctuary*. Specifically, these were related to a patient's need to acquire a moment of peace and quiet, or to privately contemplate religious concerns:

Well, if, for example, the woman was talking about how she knew that she really needed to have the abortion but she didn't know how it was really going to sit with her, and in her life or in her house there's always a lot of chaos, and she never really had the opportunity to sit in a quiet space to rethink it. And I would say, "Ah, we have a quiet space." So it was that sort of thing. Or if somebody would say, "I don't know if this is something that can ever be forgiven, if God will forgive me for this." And I might say "well there's a place where you can go for quiet contemplation if you would like to do that." I might say, "There's a little something that you could take in there to read if you want to." So I would try to relate it to each of them using their own words or what it was that they had said to me. So that it wasn't something that I was bringing in because it's there as opposed to bringing because it was something that I could see would fit their own particular situation as they described it to me. So it was always a question as to how to customize it (1).

Often, patients are coping with the inner turmoil of their decision at the same time that they are enduring the stressful environment of an abortion clinic. At ARHC, termination services are offered only three days per week, a limitation that often results in an increased patient load (15 to 35 patients) on procedural days. Moreover, although the procedure in most cases is performed in less than ten minutes, appointments can last from three to five hours. This is

primarily a result of the number of patients and the doctor's schedule, as well as the steps patients need to complete prior to the abortion, such as counseling. Thus, patients are forced to spend a number of hours in relatively close contact with other individuals, most of whom are strangers and are also managing the complex emotions related to their personal experience with abortion. Some examples provided by interview participants discuss the external and internal stress associated with the clinic and how the provision of the *Sanctuary* could ease those tensions.

Well it's not my imagination because a lot of people say the clinic is a difficult place to be because you're there for so long waiting for your surgery, which in and of itself is scary. People say, I've had a lot of time to think and I've been here a long time and blah blah so in general it's a stressful day for many reasons and having the *Sanctuary* there I believe for some women helps them manage their stress (2).

Because I think there's a lot of nervous chatter for some women when they first come into a counseling session, because they still feel kind of scattered or scared, or they're all over the place, nervous or incidents may have happened with their partner or their job or their kids and so having the opportunity to be in the *Sanctuary* just to ah [sigh] relax, take those deep breaths, then you may just want to stay in that space and not talk about it anymore (1).

Not that long ago a boyfriend and girlfriend came in and they thought it (fetus) was like eight weeks and they found out it was like twelve and they were in the stairwell. So I'm like, "Are you guys OK?". They were college kids and they'd been together a while but still it was harder 'cause they found out they're were further along, so you know instead of them crowding in the hallway being you a witness to or standing outside by the protestors, I suggested they, because the girl had religious concerns, and he was still somewhat emotional about the situation, I suggested they go sit in there for a little bit and they were in there for about thirty minutes (3).

The women and men seeking termination services come from different backgrounds, cultures and experiences; therefore, there are a variety of religious and spiritual beliefs that need to be addressed by clinic workers. A number of the interview participants inferred that use of the *Sanctuary* was often recommended based on an individual's insecurity regarding her religious beliefs in relation to abortion.

One lady just was saying how great the clinic was and was really kind of glad she had space to go to because she needed private time in there or whatever, and she was extremely religious, extremely upset by the protestors. She was by herself, and she thought it was really nice that there was a place for her to have a private moment with God (3).

Some really wanted to be praying to God and making sure that God got to hear their fervent prayers of why this needed to be, even though it might be contrary to their religion (1).

Yeah, I mean the women I've talked to who have spent time in there because they wanted to pray, were very religious, they were Catholic or they just had a really deep connection to God, wanted to get forgiveness. Those were the times when I, when it's been really simple, when someone's been in there for a certain reason (4).

I also found one woman who felt like she was killing her baby and she couldn't get over that feeling even though she knew she had to have the abortion. She felt like she was a bad person for killing her baby and she felt like she lost her connection with God and after we talked for a long time, she spent some time in the *Sanctuary* and I don't know if it helped her. She didn't report back about it, she was actually pretty self-contained and it was a pretty private experience but that was a case of someone using the *Sanctuary* (4).

Many women and men have difficulty connecting their faith with decision of abortion. Thus, a space like the *Sanctuary* can help bridge this gap between abortion and religion.

Examples regarding patient use of the *Sanctuary* were limited, as some of the interview participants held different responsibilities throughout a procedural clinic day that did not allow them to directly recommend the use of the space. As such, some of the stories discussed in the interviews were recollections depicting how they observed patients and/or their support persons using the *Sanctuary*.

I know one woman who used it. When I was looking for her to go back for the procedure, she was in the *Sanctuary* and I couldn't find her, when she was in the *Sanctuary* and I just let her be alone. She wanted to stay in the sanctuary a while longer and I checked on her after a while. She was crying and she was sitting on the bench, she had her head in her hands. I don't know if she was praying or not but that's actually happened a couple of times when I've been looking for someone and they've been in the *Sanctuary*, they were usually pretty upset (4).

Even if it's just looking at a patient when they come out it seems to be a positive experience. That's more of what I would notice, just people coming out of it. Well,

particularly if they go in because they're feeling really emotional, there's tissues in there stuff like that. So then they seem more together after they come out. More calm (5).

At times, patients were told about the *Sanctuary* and chose to not use it. As one participant explained, she experienced several instances in which an individual refused to accept the offer.

But I can tell you that there were times that I suggested it that the offer was not accepted. A couple of times it was, "No, I, I think that just talking with you I already feel differently than when I came into the clinic. And so I don't feel that I need that now." And, and I would just say, "It's here if you change your mind and you don't have to come on the day that you, you're having your abortion, you could come another day. You could even bring other people if you want." So it was more just keeping the possibility open for them. But I don't think there was anybody who ever told me she felt worse. I know one woman told me that she had not allowed herself to cry and once she went in there and had that quiet, where she wasn't going to be interrupted, she started to cry and then she couldn't stop. But, I think that a lot of us could relate to that at one point or another in our lives [laugh], that we're afraid to let ourselves start for fear that we won't be able to stop (1).

Although interview participants were able to provide a number of stories discussing instances when patients utilized the *Sanctuary* as a means of coping with abortion, there is no definitive means of identifying the type of individual that is more likely to use the space. Thus, it may be that in abortion care, only patients could explain the reasons they would use the *Sanctuary*.

4.2.4.3 *Sanctuary* Box Responses

From September 2009 to March 2010, individuals who visited the *Sanctuary* had the opportunity to voluntarily participate in the research by means of a short questionnaire regarding utilization of the space. During this time, four respondents contributed to the box, writing brief answers that discussed their emotions and reasons for using the *Sanctuary*. All were patients at the time of their submission. Participants were asked to respond to three specific questions: *Why did you decide to use the Sanctuary? Was this space helpful for you? Is there anything else you would like us to know?* For the most part, participants did not address each question specifically, but responded in a few brief sentences.

Of the four respondents, two mentioned that religion was a contributing factor for them to utilize the space. One respondent in particular discussed forgiveness in relation to her religious beliefs, questioning whether or not her God would understand her decision for choosing termination, and if she, as a person, could be as understanding. The other individual mentioned her need to find a place to pray and gather her thoughts.

Two respondents directed sentiments towards the staff of Allegheny Reproductive Health Center. In particular, one individual declared emphatically that the staff was “blessed.” Another respondent stated that “the staff is very friendly and nice, everyone seems to be doing their best to make everyone comfortable.”

In regards to the environment of the clinic, three of the participants expressed a desire to “get thoughts together.” In particular, one respondent expressed how she felt that the *Sanctuary* was better than the lobby because it was more private and allowed her to be more focused. Another respondent discussed the volume and number of people in the waiting room as a reason for her entering the space. Moreover, she claimed that other individuals “look happy” or had a support person, aspects which may have contributed to her seeking the space.

Two of the participants hinted at the external stresses involved with the abortion process. In particular, one individual referenced the stress she felt when unable to locate someone to drive her to the clinic. Another individual talked about the responsibility of having a child, and that in this economic crisis it would be an unwise decision to “bring in more mouths to feed.”

Even though this provides only limited insight into a woman’s experience immediately prior to undergoing an abortion, these few submissions do offer a unique opportunity to begin to understand the inner turmoil involved with the decision. Specifically, only one individual directly answered the question of whether or not the *Sanctuary* was helpful (her response was

positive). Nevertheless, these women used the *Sanctuary*, and for whatever their reason, were able to find a sense of peace during their experience with abortion.

5.0 DISCUSSION

Allegheny Reproductive Health Center is one of the few clinical sites in the country to have implemented and erected a space such as the *Sanctuary*, designed to assist women and men managing the complexities of abortion. Thus, the data collected in this study were the first to examine the use and subsequent impact of a space such as the *Sanctuary*. In summary, the results identified four themes: 1. Working within the abortion field is both complex and important; 2. The next step in abortion care is a holistic approach that addresses a patient's specific needs; 3. The development of the *Sanctuary* is a step toward advancing abortion care for women and men; and 4. To establish an understanding of how the space is used by patients and clinic workers.

Interview participants engaged in a discussion about the emotional complexity and importance of abortion work. Related evidence indicates that the range of complexities identified in the interviews stems from the intense nature of the abortion experience for women and men, necessitating the application of a holistic approach to abortion care, such as the creation of the *Sanctuary*, that seeks to attend to a patients' physical, emotional and spiritual needs. Further analysis related to the various uses revealed that the *Sanctuary* addresses these needs by offering a calm space for quiet reflection, meditation and/or religious connection for women and men. The following section will discuss the meaning of the components which emerged through the analysis of each theme.

5.1.1 Theme #1: The Environment of an Abortion Clinic

The interviews revealed a number of concerns specific to individuals working within the field of abortion. Foremost, the environment of an abortion clinic, as emotionally complex, is unlike any other type of setting in healthcare services. There are a variety of external and internal influences that can have an impact on the everyday process of a typical clinical day. In particular, the intense interaction between clinic workers and the anti-abortion protestors is a conflict specifically encountered at a women's health clinic that provides termination services. Moreover, the presence of protestors can negatively impact both workers and patients within the environment of the clinic.

It is significant to note that those who work within the abortion field are trained to help women and men. Nevertheless, there is a substantial burden connected with learning about the life experience and personal circumstances that surround a woman's decision to have an abortion. Many coping with abortion, are managing additional factors related to legal, financial, physical, emotional, religious and spiritual, which can influence the clinic setting (Finer, et al. 2006). Thus, in many cases, the stressors related to working in an abortion clinic are a constant presence. Despite these complications, many of the interview participants discussed the methods they employed to address the stress encountered as a result of the external and internal influences. Many of the participants focused on the mission of abortion work; the meaning of a woman's right to choose; the necessity of helping women, and the need for people to continue working within the field. Several interview participants explained how these factors help to mitigate the many difficulties of working within an abortion clinic by strengthening their resolve to move forward with their mission.

5.1.2 Theme #2: A Holistic Approach to Abortion Care

Abortion, as discussed in the literature review, is complicated by a number of factors in terms of cost and accessibility to termination services, health policy and laws, as well as religious and societal perspectives and influences (Healy, 2006). Thus, it is significant for approaches in abortion care to incorporate the distinct situation of each patient seeking termination services. In an effort to embrace a more holistic approach to abortion care, Allegheny Reproductive Health Center, employs services that place greater value on the varied experiences of women and men coping with abortion. Foremost, the clinic provides centralized care for patients through a counseling style that is less clinically focused and more individualized to specifically reflect patients personal needs. In support of this concept, and emphasized in the interviews, is the objective of clinic workers to establish an intimate connection with patients. In particular, this step in the abortion process is an important means of reassuring, and supporting as well as empowering the women and men seeking termination services at Allegheny Reproductive Health Center.

As a pioneer in abortion care, the clinic has adopted several practices--the inclusion of support persons, the use of stones, as well as the writing on paper hearts--to assist women and men. The overall goal of these strategies is to provide women a greater sense of comfort with the many steps involved with the abortion process. Thus, the provision of the *Sanctuary*, a safe, comfortable and peaceful space, aims to significantly improve the abortion experience for women and men.

5.1.3 Theme #3: The Meaning Behind the *Sanctuary*

Abortion providers throughout the country often seek new approaches to better address the concerns of their patients. As such, the establishment of a space like the *Sanctuary*, at the forefront of this movement, could be considered the next step in expanding choices utilized to accommodate the emotional needs of women and men coping with abortion.

The vision of the *Sanctuary* was created because of voiced concerns of individuals and their feelings related to termination. Nevertheless, the development of the *Sanctuary* was encumbered by a variety of impediments. As evidenced by the interview participants, the establishment of the *Sanctuary* was a difficult task undertaken by clinic and staff. As such, following the erection of the space into the everyday activity of the clinic, a number of advantages and challenges emerged.

Interview participants identified various advantages relating to the helpful quality of the space as well as the calming impact the presence of the *Sanctuary* has offered through its use. As previously highlighted, the environment of an abortion clinic is suffused with the emotions, feelings and tensions related to the complexities of abortion. Thus, the capacity for clinic workers to offer another means of coping in the advent of a space such as the *Sanctuary* can be reassuring in providing help and comfort. Moreover, Allegheny Reproductive Health Center is a medical facility, in which women seek medical procedures, and thus, the atmosphere may have a connotation of being cold and sterile. Therefore, the inclusion of the *Sanctuary* provides a place of peace and privacy for women and men.

Additionally, clinic workers discussed various challenges related to the use and implementation of the *Sanctuary*. Specific issues regarding the adoption of the patient care approach related to the proper means of offering the space for individual use emerged. Interview

participants stressed the importance of not forcing patients to use the space, as the objective behind the *Sanctuary* is to only encourage patients based on expressed or felt personal need. Clinic workers struggled with issues related to introducing the space to patients and forgetting to offer the space as an option for patients. An unanticipated challenge that emerged in the interviews was concern regarding the location of the *Sanctuary* as a barrier for private use. Several interview participants referenced concern over the *Sanctuary's* being “in the middle of everything.” Despite these concerns, all the interview participants concluded that the establishment of a space like the *Sanctuary* could be a beneficial approach for women and men.

5.1.4 Theme #4: Uses of the Sanctuary

The future of abortion care is intimately linked to understanding the patient, in terms of her environment. Thus, the *Sanctuary* is another means of respecting the variability in experiences encountered by individuals managing the complexities of abortion. As evidenced by this study, the *Sanctuary* has provided women and men a tool for coping with the associated difficulties surrounding abortion. Nevertheless, there is no clear understanding of why women and men choose to use the space. Thus, the objective of the interviews was to generate an idea of the personal reasons individuals utilize the *Sanctuary*.

Many of the narratives extracted from the interviews focused on the use of the *Sanctuary* by clinic workers. As previously noted, workers within the abortion field experience stress related to the daily exposure to the circumstances that surround a woman's decision to have an abortion. Many of the participants used the *Sanctuary* as a means of re-focusing their energy on ensuring that women and men are having a positive abortion experience.

It is not possible to characterize the type of individual most likely to use the *Sanctuary* from interview data; however, participants were able to catalog their interactions with and observations of patients to provide a variety of examples why individuals use the space. In particular, two specific reasons, peace/quiet or religious reflection, were identified to explain why patients use the *Sanctuary*. In most cases, a patient's need for peace and quiet is a direct result of the stressful environment of an abortion clinic, stemming from the external difficulties of obtaining abortion. Many of the interview participants identified this as being a direct contributing factor for patients and/or support persons utilizing the *Sanctuary*. Religion, a factor often ignored in abortion care, is another reason identified for patient use of the *Sanctuary*. For a majority of women and men, concerns regarding religious beliefs and practices are difficult to connect with the decision of abortion. Thus, the *Sanctuary*, as a multipurpose room, attempts to bridge this gap, by offering individuals the option to utilize the space for religious or spiritual meditation.

The concept of actively listening to the needs of women and men is a significant element of the patient-centered holistic approach employed by Allegheny Reproductive Health Center. The *Sanctuary* is another means of addressing the needs and requests of women and men. Due to the sensitivity of the topic and the population, questionnaires were used to gather information directly from patients regarding their use of the *Sanctuary* and were designed to ensure privacy of the participant. Some of the information obtained from the box responses provided a general framework for the reasons why individuals choose to use the space, including the need to engage in religious contemplation, positive feelings regarding the staff and the tumultuous environment of the clinic, as well as external stresses involved with the abortion process. Although the responses were few in number, they provide a unique insight into a woman's experience with

abortion in relation to the use of the *Sanctuary*. Most significantly, these data reveal similarities between the concepts that emerged from the box responses and several themes identified in the interviews.

6.0 IMPLICATIONS AND CONCLUSIONS

6.1 IMPLICATIONS FOR ABORTION PROVIDERS

As this research study was exploratory, discussion regarding implications for abortion providers is principally a descriptive examination of the implementation and utilization of a meditative space, with the goal of providing guidance for others seeking to incorporate a similar space.

Beyond the scope of needing assistance such as funding and the proper space for implementation, support in terms of staff acceptance was central to effective creation of the *Sanctuary*. As acknowledged by interview participants, there is an assumption that abortion providers interested in pursuing the erection of meditative space will have an abortion care approach similar to that of Allegheny Reproductive Health Center. Nevertheless, the concept is so unusual that resistance among other providers may be difficult to overcome. In particular, one participant expressed the difficulty of introducing new ideas about abortion care to other clinics:

Well, the only thing I can tell you is it took more than 10 years for providers to accept the idea of responding to the men who accompany our patients. There's no reason for me to think that this is going to happen any more quickly. There, there's a little bit of a difference, I mean because, when, when I was doing the, the "let's be more responsive to the male partners of our patients" thing, there wasn't anybody else who was doing that or even wanted to hear it. So it was only me plodding along (1).

Thus, the likelihood of successfully implementing a meditative space is dependent on the willingness of clinic workers to accept change and adopt new concepts within abortion care.

Today, addressing the religious and spiritual needs of the women and men managing abortion is critical for providing holistic abortion care. Although the *Sanctuary* was designed as a multipurpose space, religion appears to play a role in its use by patients. For example, interview participants expressed how the space bridged the gap between religion and the decision of abortion. In particular, one interview participant discussed at length misconceptions pertaining to the relationship between religion and abortion:

I wish that every clinic would have a *Sanctuary*. Especially because I think people think that religion and spirituality and abortion are mutually exclusive, those protestors who stand outside that claim to be religious or spiritual and they judge women who come into the clinic who also are religious and spiritual, act as though they are somehow more moral or holier than the people who have abortions, and that's not true. The women who have abortions are often very spiritual, I mean not that those are the only women who benefit from the *Sanctuary* but that is a blessed space, women who have abortions who have a connection to God, deserve the kind of healing that God can give them (4).

Thus, an important step for establishing a meditative space is to acknowledge the importance of patients religious or spiritual concerns in relation to abortion care.

A significant component to consider in the development of a meditative space is its location. As one participant expressed,

To be honest, I think it's a nice thing. When I start to think about the thing, if it was in a more private place. Even though you tell people you can close the door or even for staff, it's like right in the middle of where everybody is. So, it's kind of like people just don't do that. I was thinking if it were back where the bathrooms are behind that sort of wall or something like that. If that's where it was and people didn't even know you were going in or out or if it was more private, I think it would be nicer. For both staff and for patients (5).

Location of the *Sanctuary* was determined by the size and layout of its facility. Nevertheless, location can be a contributing factor in patient and staff use of the space, and thus should be carefully considered in terms of offering privacy and easy accessibility for its users.

One of the themes identified in the results was the difficulty of introducing individuals to the unique concept of the *Sanctuary*. Many interview participants suggested supplying

alternative means, beyond counseling, in order to effectively introduce the *Sanctuary* to patients. For example, at Allegheny Reproductive Health Center, next to the door of the *Sanctuary* is a framed description expressing the meaning of the space. Nevertheless, this relies solely on patients noticing as well as pausing to read the explanation.

Although some interview participants mentioned that brochures about the *Sanctuary* have been created, many were unclear about their use or current location within the clinic. In particular, one participant discussed a description of the *Sanctuary* on Allegheny Reproductive Health Center's website but had little knowledge of whether the information was actually included in the site's content. As previously discussed, a few interview participants admitted to forgetting to recommend the *Sanctuary*. Thus, additional recommendations highlighted within the interviews are related to the necessity to educate experienced and new clinic workers about how to present the space to patients, as well as providing additional information about the *Sanctuary* in the form of brochures and website design.

6.2 STUDY LIMITATIONS AND FUTURE RESEARCH

This study had several limitations that should be taken into account when interpreting the results and discussion. Foremost, the experiences of the workers at this particular clinic are unique to them, and therefore, their experiences cannot be generalized to other abortion clinics and clinic staff. Secondly, because of the researchers relationship with the clinic workers, they may have felt inclined to provide generally positive feedback about their experiences with the *Sanctuary*. Thirdly, narratives about patients were from the perspective of the clinic workers, and thus provide only one viewpoint of patient use of the *Sanctuary*. Lastly, out of respect for patients

attending the clinic for termination, data gathered from the secured box within the *Sanctuary* depended on patient discovery of the box and their desire to contribute to the research. Additionally, the *Sanctuary* was not designed to encourage written expression and thus, the request of written response may have interfered with the tone and purpose of the space and resulted in a low number of submissions. Therefore, the data from the box responses were limited and are not representative of individuals utilizing the space nor can they be generalized to all individuals who visit abortion clinics.

Given the availability of additional resources and support, future studies, should consider conducting a more in depth examination of patient uses regarding the *Sanctuary*. In particular, the term *Sanctuary* is not a neutral term, but possesses religious connotations as a sacred or holy place. Thus, labeling the meditative space the *Sanctuary* has brought to question the influence of the underlying meaning on an individual's use of the space. Therefore, additional studies may benefit from focusing on the label for the space and the subsequent impact on individual use. Moreover, in order to provide a larger sample for exploration of these elements, future studies should consider examining other abortion clinics that have implemented meditative spaces.

6.3 CONCLUSION

This thesis presented a background on the context for abortion in the United States. At the forefront of abortion care, Allegheny Reproductive Health Center seeks to uphold a holistic patient-centered approach by offering care options for women and men coping with abortion. In 2008, the clinic erected and implemented a space, the *Sanctuary*, as a means of encouraging personal reflection and quiet meditation among patients and clinic workers managing the

complexities of abortion. This study, among the first to examine the use and subsequent impact of a space such as the *Sanctuary*, explored the various reasons for individual use. From the data collected, results indicated four overarching themes: 1. Working within the abortion field is both complex and important; 2. The next step in abortion care is a holistic approach that addresses a patient's specific needs; 3. The development of the *Sanctuary* is a step toward advancing abortion care for women and men; and 4. To establish an understanding of how the space is used by patients and clinic workers. Moreover, the content of these themes are interrelated.

Evidence from the interviews and patient responses indicates that a range of complexities are involved with the intense nature of the abortion experience for women and men, necessitating the application of a holistic approach to abortion care, such as the creation of the *Sanctuary*, that seeks to attend to a patients' physical, emotional and spiritual needs. Discussion of the various uses indicate that the *Sanctuary* addresses these concerns by offering a calm space that encourages quiet reflection, meditation or religious connection. Additionally, the themes which emerged in the interviews exhibited similarities between the interviews and the patient responses.

Overall, these findings indicated that a majority of interview participants expressed strong support for the placement and use of the *Sanctuary*, for themselves and for patients. The study highlights the potential benefits of providing a space such as the *Sanctuary*, as an innovative step in imparting an additional level of care in addressing the multitude of concerns experienced by women and men managing the complexities surrounding abortion. Furthermore, within public health, professionals can utilize this research to advance the understanding of how to assist women and men coping the complexities of abortion.

APPENDIX A

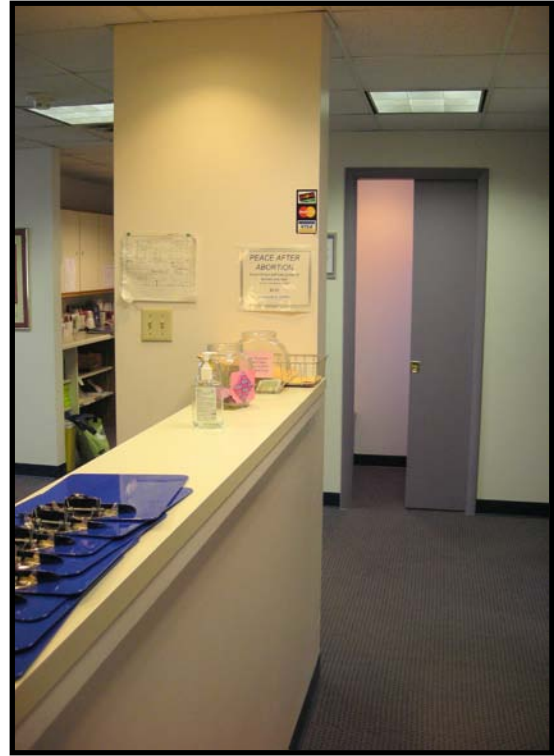
PHOTOGRAPHS OF THE *SANCTUARY*











APPENDIX B

INSTITUTIONAL REVIEW BOARD APPROVAL LETTER



University of Pittsburgh

Institutional Review Board

3500 Fifth Avenue
Pittsburgh, PA 15213
(412) 383-1480
(412) 383-1508 (fax)
<http://www.irb.pitt.edu>

Memorandum

TO: ANNA VITRIOL

FROM: SUE BEERS, PhD, Vice Chair

DATE: 08/31/2009

IRB#: PRO09060271

SUBJECT: Examination of the Sanctuary

The above-referenced project has been reviewed by the Institutional Review Board. Based on the information provided, this project meets all the necessary criteria for an exemption, and is hereby designated as "exempt" under section 45 CFR 46.101(b)(2).

Please note the following information:

- If any modifications are made to this project, use the "**Send Comments to IRB Staff**" process from the project workspace to request a review to ensure it continues to meet the exempt category.
- Upon completion of your project, be sure to finalize the project by submitting a "**Study Completed**" report from the project workspace.

Please be advised that your research study may be audited periodically by the University of Pittsburgh Research Conduct and Compliance Office.

APPENDIX C

INFORMED CONSENT SCRIPT

Today we will be discussing your experiences and opinions relating to your interaction with the *Sanctuary* as a place for you to use or a place that you recommend to patients. There are no right or wrong answers. I am particularly interested in your opinions, views and beliefs because you are one of the only clinic workers who may have had the opportunity to use or recommend the space. The overall purpose of this study is to determine whether or not the presence of a designated meditative space, such as the Sanctuary, is of a benefit to the patients and workers of a Women's Health Clinic that specifically provides abortion services. For that reason, I am interviewing clinic workers from Allegheny Reproductive Health Center and asking them to answer a few questions.

Please keep in mind this interview will be recorded. All your responses are confidential, and the results will be kept under lock and key. Your responses will not be identifiable in any way. I am asking all participants to not give personal information beyond your general responsibilities at the clinic that relate to the topic.

There are no foreseeable risks associated with this project, nor are there any direct benefits to you. You will not receive any type of payment or compensation for your

participation. Your involvement is voluntary, and you may withdraw from this project at any time. The interview should take approximately 1-½ hours depending on your responses.

APPENDIX D

RECRUITMENT SCRIPT

The purpose of this study is to determine whether or not the presence of a designated meditative space, such as the Sanctuary, is of a benefit to the patients and workers of a Women's Health Clinic that specifically provide abortion services. I am particularly interested in discussing your experiences using this space with patients, because Allegheny Reproductive is one of the only clinics in the country to have a space like the Sanctuary available. For these reasons, I will be seeking to interview clinic workers from Allegheny Reproductive Health Center about their experiences for approximately 1 1/2 hours depending on the responses given.

If you are willing to participate, your interview will be recorded and will not be shared with anyone. All responses are confidential, and results will be kept under lock and key. Your responses will not be identifiable in any way. No original interview forms, audio recordings or transcripts of interviews will be shared with anyone outside of the Principle Investigator. Drafts of the paper, which may include quotations from interviews, will be shared with members of the thesis committee and with the head counselor at ARHC. There are no foreseeable risks associated with this project, nor are there any direct benefits to you. You will not receive any type of payment or compensation for your participation.

Any type of involvement is considered voluntary, and you may withdraw from this project at any time. If you have any additional questions or are interested in participating please feel free to contact the researcher, Anna Vitriol, who can be reached at (215) 833-6103, or avitriol@gmail.com.

APPENDIX E

BOX SPEECH

Would You Like To Share With Us Today?

There are very few clinics in the country that offer a space like the Sanctuary. To help us understand the Sanctuary we are doing a research study about how people use this space.

Today we invite you to take the time to answer these questions:

- Why did you decide to use the Sanctuary?*
- Was this space helpful for you?*
- Is there anything else you would like us to know?*

What you tell us today is valuable. Please feel free to write as little or as much as you like. There is no right or wrong answer. Sharing with us will help us and others know if this is an important space for clinics to have.

★ If you want to share with us today, please understand:

- Do not write your name.*
- You must be 18 years or older to contribute.*
- You do not have to participate.*
- What you write is anonymous and will be used for research purposes only.*
- All information will be locked in the box until the researcher collects the materials every Monday.*

APPENDIX F

SHARING DOCUMENT

APPENDIX G

INTERVIEW QUESTIONS

- What types of duties or responsibilities do you perform on an abortion clinic day?
 - What kind of interaction do you have with patients?
- How do you feel about your work as a part of a clinic that provides abortion services?
 - Could you give some examples about how this makes you feel?
- How do your friends or family feel about the type of work you do at the clinic?
 - How does this impact your feelings about your work?
- Do you consider this work stressful?
 - How do you feel about the amount of stress this work causes you?
 - What coping mechanisms do you use during your average workday at the clinic?
- Did you work at the clinic prior to the Sanctuary's establishment?
 - If yes, do you think it's been a helpful addition to the clinic?
 - If no, how do you think the clinic would be without the Sanctuary?
- How do you feel about the *Sanctuary*?
 - Have you ever used the *Sanctuary* for personal reasons?
 - If so, how do you feel about the *Sanctuary* for your own personal use?
 - When do you think the *Sanctuary* would not be beneficial to you?
- How do you feel about the *Sanctuary* for patients?

- Do you often recommend the *Sanctuary* to patients?
- Could you give an example when you feel the *Sanctuary* would not be beneficial to a patient?
- Could you give some examples about a patient experience with the *Sanctuary*?
- Could you characterize the type of patient who would use the *Sanctuary*?
- Do you see any common themes among women who use the *Sanctuary*?
- What kinds of comments have patients reported about their time in the *Sanctuary*?
- Could you give some examples where the patient has responded positively or negatively to their experience utilizing?
- Could you give some examples where the patient has responded positively or negatively to the presence of the *Sanctuary*?
- How do you feel about the *Sanctuary* for other clinics to use?
 - Do you think other clinics will ever adopt this approach?
 - If yes, what kind of supports do you think should be in place for a clinic to implement a space like the *Sanctuary*? i.e. people, space, resources, funding, philosophy.
 - Would you ever recommend a space like the *Sanctuary* for other clinics to use?
- Additional Questions for Claire Keyes, prior director of Allegheny Reproductive Health Center
 - How did the idea for the *Sanctuary* develop?
 - Were there any barriers that impacted the development and implementation of the *Sanctuary*?
 - Was there anything that you did not expect to be a problem?
 - In retrospect, is there anything that you would do differently about the development and implementation of the *Sanctuary*?
 - How do you feel that the *Sanctuary*, as it is being used now, is what you had envisioned when the idea first began to be discussed?
 - What do you think the next step should be in promoting the use of the *Sanctuary* to others?

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