‘Repeat abortion’, a phrase to be avoided? Qualitative insights into labelling and stigma

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ABSTRACT

Background In recent years there has been growing international interest in identifying risk factors associated with ‘repeat abortion’, and developing public health initiatives that might reduce the rate. This article draws on a research study looking at young women’s abortion experience in England and Wales. The study was commissioned with a specific focus on women who had undergone more than one abortion. We examine what may influence women’s post-abortion reproductive behaviour, in addition to exploring abortion-related stigma, in the light of participants’ own narratives.

Study design Mixed-methods research study: a quantitative survey of 430 women aged 16–24 years, and in-depth qualitative interviews with 36 women who had undergone one or more abortions. This article focuses on the qualitative data from two subsets of young women: those we interviewed twice (n=17) and those who had experienced more than one unintended/unwanted pregnancy (n=15).

Results The qualitative research findings demonstrate the complexity of women’s contraceptive histories and reproductive lives, and thus the inherent difficulty of establishing causal patterns for more than one abortion, beyond the obvious observation that contraception was not used, or not used effectively. Women who had experienced more than one abortion did, however, express intensified abortion shame.

Conclusions This article argues that categorising women who have an abortion in different ways depending on previous episodes is not helpful. It may also be damaging, and generate increased stigma, for women who have more than one abortion.

Key message points

- Young women’s experiences of seeking reproductive control may be as complex following an abortion as before. There is no one ‘silver bullet’ that can ‘solve’ unintended pregnancy.
- Young women may discontinue contraception selected at the time of their abortion if they experience side effects that are unacceptable to them, or if their personal circumstances change.
- Research participants undergoing a subsequent abortion experienced a heightened sense of shame and were thus subject to additional abortion stigma.

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INTRODUCTION

It is not uncommon for women in the UK to have more than one abortion in their reproductive lifetimes. In 2014, 37% of all abortions performed in England and Wales were subsequent procedures.[1] Yet, in recent years there has been a noticeable upswing in UK media, political and policy focus on women who have multiple abortions. An explicit policy concern around what has been labelled ‘repeat abortion’ was included in the British Government’s 2013 Framework for Sexual Health Improvement in England.[2] With no explanation as to why this may be an adverse outcome to be avoided, it was maintained that the provision of contraception, particularly long-acting reversible contraceptive (LARC) methods, by the abortion provider can reduce ‘repeat abortions’. No accompanying rationale for such a concern has been given. Research literature seeks to identify women who may be ‘at risk’ of having more than one abortion, and to provide evidence-based policy recommendations to reduce the rate.[3–7]

A recent systematic review identified poor contraceptive use, domestic abuse

and other adverse life events as consistent determinants for 'repeat abortion' but was not able to specify the determinants that have the most significant associations due to the methodological heterogeneity of the studies.[8] Other quantitative research in the UK has identified patterns associated with sexual behaviour: women are more likely to have been younger at first sexual experience, been poor users of contraception at first sexual experience, and had a greater number of lifetime sexual partners.[5] Such patterns are not altogether surprising, for women who are poor users of contraception and more sexually active are likely to have more unprotected sexual encounters than women who do not share these characteristics. There is, however, a scarcity of literature that explores these issues following an abortion. In this article we draw on a recently completed study on young women and abortion in order to examine the precepts informing policymakers' views on 'repeat abortion'. Does it make sense to categorise women who have more than one abortion as somehow distinct from other women, including women who have a single abortion? We break this down by discussing young women's experiences of seeking fertility control following an abortion; and assessing whether categorising women who have abortions depending on number may be overly simplistic and unnecessarily stigmatising.

RESEARCH METHODOLOGY

We conducted a mixed-method research study into young women's abortion experiences in England and Wales. This involved a quantitative survey of 430 young women (aged 16–24 years) and 36 qualitative interviews. The study was approved by a National Health Service Research Ethics Committee. Participants were recruited from abortion clinics at six sites across the UK. The findings from all these data sources are published in detail elsewhere.[9 10]

This article focuses on what can be learnt about multiple unintended and/or unwanted pregnancies from a purposive selection of the qualitative data about young women's post-abortion contraceptive journeys. For this branch of the study we did not specifically target recruitment towards young women who had experienced more than one abortion, as we wanted to avoid stigmatising recruitment practices. Recruitment was targeted more broadly at women undergoing abortion, assuming that this would include a proportion of participants who had experienced previous abortions. Additionally, the key issue of contraceptive and sexual behaviour following an abortion could be explored through qualitative longitudinal interviews with women whom we were able to follow up. We therefore concentrate on two subgroups of young women who we believe can shed most light on contraceptive behaviour post-abortion. First, 17 participants who gave a second interview between 6 months and 1 year following their abortion; and second, 15 participants who had experienced multiple unintended/unwanted pregnancies (with a variety of outcomes, including live birth). Ten women spanned both subgroups.

In our analysis we utilised thematic and case-based approaches. The data were coded thematically using the data management software package NVivo (QSR International Pty Ltd, Doncaster, Australia). Alongside this process the transcripts were read and re-read, thus retaining case level analysis. All participants have been given pseudonyms to protect their anonymity.

RESULTS

The complexities of women's post-abortion contraceptive pathways

Women's contraceptive choices following an abortion are clearly a major factor in determining the likelihood of a subsequent abortion. Our quantitative results showed that many young women are prompted to change contraception at the time of their abortion.[9] Much can therefore be learnt from analysing contraceptive pathways over time following an abortion, and drawing on the longitudinal qualitative interviews we demonstrate the complexity of women's contraceptive experiences and motivations following an abortion.

One pattern was switching from a pre-abortion user-dependent method to a LARC method following abortion, and then discontinuing the LARC method within a few months due to side effects. Women later returned to user-dependent methods, though not usually their pre-abortion methods. Maddie, for example, had been using condoms when she became pregnant. After her abortion she selected an injectable as her preferred method of contraception, but later swapped to oral contraception. She was not happy with side effects she thought had been caused by the injection, saying "It just makes you put on weight and gives you spots … It made me really moody as well".

Other participants who discontinued the contraceptive method received at the abortion clinic stopped using contraception entirely. This decision was often accompanied by an intention not to be sexually active in the foreseeable future, sometimes – but not always – linked to the end of a relationship. Jacqui, for example, had changed her contraception from the pill to the levonorgestrel intrauterine system (LNG-IUS). By the second interview she was planning to have the IUS removed because she was no longer in a relationship. She also wanted a break from hormonal contraception: "I just want my body to actually go back to normal".

Some participants, primarily citing a desire for reliability, did continue with the long-acting contraception provided by the clinic after abortion. Cassandra opted to have an implant, and at her second interview she had retained the method although she was not entirely satisfied with it and was experiencing irregular bleeding. Cassandra said she would go back to the

doctors if it became problematic, but at the moment it was "manageable". She was very motivated to avoid another unintended pregnancy, and this was the driver in her tolerance of a method with which she was not entirely satisfied.

Other patterns included continuing with their pre-abortion method whilst trying to improve compliance, and switching from one user-dependent method pre-abortion to trying different alternatives post-abortion. Edie, for example, chose to continue with the same contraceptive pill but with a greater awareness of when it may fail; whilst MaryAnn changed from withdrawal to switching between condoms and the pill. Above all, the longitudinal interviews highlight contraceptive changes, over a relatively short period of time, because women were not happy with the way their selected method affected their body, or because their situation had changed.

Multiple unintended/unwanted pregnancies

The qualitative research revealed a multifaceted story behind each woman who experienced more than one unintended and/or unwanted pregnancy. The most important finding was that there were no clearly identifiable patterns of behaviour.

One important theme in multiple unintended pregnancies was women's hope, following one abortion, that they would not become unintentionally pregnant again. This belief was underpinned by changes in reproductive (sexual and/or contraceptive) behaviour. Carrie, for example, had experienced three unintended pregnancies, and changed behaviour after each. She became sexually active when she was 16 with her boyfriend who was 17. They sometimes used condoms, but she did not think about the possibility of becoming pregnant "until it happened". She was 16 when she had her first abortion, following which she was "proper worried, really worried, about it all happening again". She was therefore not sexually active again for about 2 years. After going on the pill, she did not expect to become pregnant a second time, and "was devastated, proper devastated, a bit hysterical" when she did. Because Carrie and her boyfriend had been together for a while, and lived together, they decided to continue with the pregnancy. After she had her son, Carrie started on a different type of pill which she believed would be more reliable, but after a few months she felt ill and was pregnant again. She does not know how this happened – "I just don't seem to have any luck", and she decided to have an abortion so she could concentrate on looking after her son.

One thing that was particularly striking with this subgroup was the strength of the theme of unanticipated sex for a subsequent unintended pregnancy. Natasha described being unintentionally pregnant three times. Her most recent pregnancy occurred after "unexpected sex" with an ex-partner. She had just finished her pack of pills and had not renewed her prescription as she was not expecting to be sexually active. She was aware that she might be at risk of pregnancy, and accessed emergency hormonal contraception (EHC) which did not work for her.

As noted previously, women may change their contraception in a response to an unintended pregnancy and abortion, but struggle to find a method that they are satisfied with. This was evident with the cohort of women experiencing more than one unintended pregnancy. Kara, for example, had tried different contraceptive pills throughout her teenage years and had not found one she was happy with. She had also tried the implant but had it removed after 1-month due to bleeding irregularities and mood-related problems. Kara had experienced two abortions, one at age 18 and one at 24. At the time of her most recent pregnancy she used EHC but still became pregnant. Following her abortion she left the clinic without contraception. She was unwilling to use hormonal contraception and decided she could not have an intrauterine device (IUD) fitted, believing it would make her periods worse. Her preferred method was condoms but her boyfriend did not like to use them. Her search for a contraceptive thereby continued to be frustrating: "It's really difficult … I don't want to be on any hormonal kind of contraception … there isn't really many other options".

Abortion stigma

Overall our study indicates that although many women may change their contraception with the intention of improving reproductive control, this can be challenging for them. The negative language associated with the discourse of 'repeat abortion' carries an assumption that women should have "learnt their lesson". This is not only simplistic, but potentially damaging to women who do experience more than one abortion.

Although stigma and shame feature in almost all the young women's accounts of abortion, in the small subgroup of women who had experienced more than one abortion there was a stronger sense of failure and self-blame. As Natasha put it, "once is bad, twice is unforgivable … I just felt like a bit of a wrong 'un'". Poppy felt that she would be punished later in her life for having two abortions: "It's just what happens, isn't it? It's just what ends up happening. You do something like that and then your punishment is basically that you can't have kids or something goes wrong or miscarriage".

Many women shared this recognition of the increased potential for shame, even those who resisted self-blame: "Three times, that's really, really bad … I can't really blame myself because I'm on contraception and I've been using condoms now and again … I use the Cerazette® and I also took the morning-after pill with this one" [Gemma]. Here Gemma is voicing

a common stigmatising perception, that having more than one abortion carries additional shame. She tries to minimise this stigma by arguing she was using contraception but that it did not work for her.

DISCUSSION

The analysis in this article has highlighted the complexity of our participants' contraceptive pathways following an abortion, and how although they may change sexual and reproductive behaviour, the possibility of experiencing more than one abortion cannot be excluded. The finding that young women may struggle to settle on an acceptable contraceptive following an abortion echoes accounts of dissatisfaction with existing methods in other research.[11–13] Younger women who experience more than one abortion are thus not wholly distinct from women more generally who often struggle to find a suitable contraceptive method.

Difficulties with known contraceptive methods, intolerance of unpleasant side effects, dislike of hormonal contraception, reluctance to use contraception whilst not in an established sexual relationship, and preferences for user-dependent methods are all evident following an abortion, just as they are before. There is thus no single 'silver bullet' that can reduce women's need for abortion as part of their reproductive control. Increasing LARC uptake among women following an abortion can potentially reduce the possibility of a subsequent unintended pregnancy, but only if the methods are acceptable to women and retained. Recent research has shown high discontinuation rates of implants and injectables following abortion and has suggested that this may be a consequence of over-promotion.[6] Whilst young women should be offered a full range of contraception, including LARCs, this needs to be in the context of woman-centred contraceptive counselling, without undue coaxing towards any one method, and including a discussion of possible side effects. Young women could also benefit from long-term support and advice to help manage side effects of a selected contraceptive method or to move to alternative contraception.

It is possible that insights from this study with young women may not apply when abortions are further apart. This was a non-representative group of younger women whose abortions were relatively close together. More research is needed into women's experiences of more than one abortion across their reproductive lifespan in order to develop further understandings of longer-term post-abortion behaviour and experiences of abortion stigma. Nevertheless, the way in which language is used can have a stigmatising effect,[14] and the use of the term 'repeat abortion' also implies value judgements about abortion generally. 'Repeat abortion' carries connotations of 'repeat offender', suggests a cycle of repeated risky sexual and contraceptive behaviour and of not learning from previous 'mistakes'. In this way, the discourse around 'repeat abortion' contributes towards abortion-related stigma, both for women generally, but especially for women who have more than one abortion. Research on abortion-related stigma in the USA has suggested that the more women experience such stigma, the more likely they are to have adverse emotional outcomes, and vice versa.[15]

CONCLUSIONS

This research has provided a snapshot of the many complex pathways that may lead to one or more unintended and/or unwanted pregnancies. Often experiencing more than one abortion was not due to a repeated 'mistake', but rather to separate difficulty using a (frequently different) contraceptive method. Nevertheless, in this study, participants who had experienced more than one abortion expressed increased personal shame and guilt about their subsequent abortion, thus internalising the social stigma of 'repeat abortion' as somehow more shameful than a single abortion. Helping women improve their reproductive control following an abortion is clearly important, but this does not have to be labelled as an effort to prevent 'repeat abortion'.[16]

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