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# Patient Education and Emotional Support Practices in Abortion Care Facilities in the United States

Heather Gould, MPH *, Alissa Perrucci, PhD, MPH, Rana Barar, MPH, Danielle Sinkford, BA, Diana Greene Foster, PhD

*Advancing New Standards in Reproductive Health (ANSIRH), Bixby Center for Global Reproductive Health, Department of Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco, California*

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A B S T R A C T

*Purpose:* Little is known about how patient education and emotional support is provided at abortion facilities. This pilot study documents 27 facilities' practices in this aspect of abortion care.
*Methods:* We conducted confidential telephone interviews with staff from 27 abortion facilities about their practices.
*Main Findings:* The majority of facilities reported they rely primarily on trained nonclinician staff to educate patients and provide emotional support. As part of their informed consent and counseling processes, facilities reported that staff always provide patients with information about the procedure (96%), assess the certainty of their abortion decisions (92%), assess their feelings and provide emotional support (74%), and provide contraceptive health education (92%). Time spent providing these components of care varied across facilities and patients. When describing their facility's care philosophy, many respondents expressed support for "patient-centered," "supportive," "nonjudgmental" care. Eighty-two percent agreed that it is the facility's role to provide counseling for emotional issues related to abortion.
*Conclusions:* All facilities valued informed consent, patient education, and emotional support. Although the majority of facilities considered counseling for emotional issues to be a part of their role, some did not. Future research should examine patients' preferences regarding abortion care and counseling and how different approaches to care affect women's emotional well-being after having an abortion.
*Practice Implications:* This information is important in light of current, widespread legislative efforts that aim to regulate abortion counseling, which are being proposed without an understanding of patient needs or facility practices.


## Introduction and Background

Little is known about abortion facilities' provision of patient education and emotional support. Frequently lumped under the term "abortion counseling," the aims include provision of information about the clinic visit, aftercare instructions, and review of the risks, benefits, and alternatives to the procedure (Perrucci, 2012) Styles of pre-abortion information provision and counseling vary (Upadhyay, Cockrill, & Freedman, 2010), but central to each is the process of informed consent. Guidelines for abortion counseling have delineated requirements for informed consent, as well as for ascertaining that the patient has considered her pregnancy alternatives and made a voluntary decision (Paul, Lichtenberg, Borgatta, Grimes, & Stubblefield, 1999; Paul et al., 2009).

The National Abortion Federation, the largest professional association of abortion providers in the United States, devotes a chapter in its medical textbook to informed consent, patient education, and counseling. The authors identify these components of care as "separate but overlapping." Counseling, they suggest, "provides an opportunity for a woman to explore the circumstances, emotions, expectations and beliefs that may influence her abortion experience." Although they acknowledge that not all women desire counseling, they propose that responding to patients' emotional needs when they arise is consistent with patient-centered care (Paul et al., 2009).

In recent years, many states have passed legislation regulating the provision of patient information and counseling to women seeking abortions (Guttmacher Institute, 2012a, 2012b). Proponents of these regulations, which include waiting periods, scripted patient information, and ultrasound protocols, state that

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* Correspondence to: Heather Gould, MPH, 1330 Broadway, Ste. 1100, Oakland, CA 94612. Phone: (510) 986-8990.
*E-mail address:* gouldh@obgyn.ucsf.edu (H. Gould).

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their aim is to ensure that women make informed decisions. However, there is no evidence that they achieve this goal, and some of the mandated information has been shown to be medically inaccurate (Joyce & The Guttmacher Institute, 2009; Richardson & Nash, 2006). Research evaluating the effects of different patient education and emotional support practices in abortion facilities is lacking; however, several professional resources and a few articles about patient experiences are available to guide their practices (Baker, 1995; Breitbart, 2000; Ely, 2007; Harris, 2004; Paul et al., 2009; Perrucci, 2012; Picker Institute, 1999).

Despite public policy debates, little is actually known about how abortion facilities provide information and emotional support in the clinical setting and their beliefs about the importance and value of each. This pilot study documents some of the practices facilities use to do this.

## Methods

Between December 2010 and July 2011, we conducted confidential telephone interviews with 27 key informants from abortion care facilities about their institutions' practices related to patient education, emotional support, and general abortion provision. Interviews comprised 61 quantitative questions and 9 open-ended questions. Key informants (clinic directors, program managers, clinicians, or counselors) worked at facilities that recruited participants for an ongoing, longitudinal study known as the "Turnaway Study." The Turnaway Study aims to assess the mental and physical health and well-being of women seeking abortion, including those who receive an abortion and those who are ineligible to receive one (i.e., they are "turned away") because they present for care beyond the clinic's gestational limit. At the time they were selected to conduct recruitment for the Turnaway Study, each site had the latest gestational limits of any facility within 150 miles. Recruitment sites were identified using the National Abortion Federation membership directory and professional contacts in the reproductive health research community. Of the 30 sites, 27 are included in the current study; one had closed and two declined to participate. Key informants were identified by administrators within each facility as being among the personnel with the most intimate knowledge of the facility's education and emotional support practices. The University of California, San Francisco research staff followed up by email and/or telephone, provided study information and informed consent forms, screened interested individuals for eligibility, and obtained verbal informed consent.

Research staff conducted the telephone interviews and entered data directly into a password-protected online database (SurveyMonkey). No personal identifiers were entered. The survey, which averaged 51 minutes (range, 22–103), contained 69 questions about each informant's educational and professional background, job duties, and details about the facility's staffing, training, and abortion care policies and practices, including their patient education, informed consent, psychosocial assessment, and emotional support practices. All quantitative questions used predetermined response options, which key informants viewed on a response sheet provided before the interview. However, many questions allowed them to elaborate on their responses. To compare our data to nationally representative data, we collected information on facility type and location in similar fashion to Jones & Kooistra (2011). For this analysis, we present data from three of the nine open-ended questions: (1) "Is there anything else your facility does on a regular basis to inform, educate, or support abortion patients that we didn't ask about?"; (2) "To your knowledge, have your facility's patient education or counseling practices have changed over time? If yes, please explain how and why these practices have changed"; and (3) "If you had to describe your facility's philosophy about abortion care and counseling, how would you summarize it?" The transcribed responses for the third open-ended question were analyzed for salient themes. Each response was independently analyzed for themes by two of the authors and discrepancies were reconciled by consensus. The frequency of each theme was tabulated and the top themes were summarized and presented. This study was approved by University of California, San Francisco's Institutional Review Board.

## Results

All key informants worked directly with patients as a part of their job, and the majority (89%) were responsible for supervising other staff members who educate or counsel patients. Respondents performed multiple job functions and had worked at their facilities for an average of 10 years (range, 3–45; Table 1).

Study facilities varied in location, size, and structure. Of the 27 facilities, 9 (33%) were located in the South, 7 (26%) in the Midwest, 6 (22%) in the West, and 5 (19%) in the Northeast (Table 1). Fourteen facilities were abortion clinics in which at least 50% of patient visits in 2010 were for abortion care (52%), 11

**Table 1**
Abortion Care Facility Characteristics *(N = 27)*

| Facility Characteristics | Number (%) Turnaway Data |
|---|---|
| Region | |
| South | 9 (33) |
| Midwest | 7 (26) |
| West | 6 (22) |
| Northeast | 5 (19) |
| Facility type | |
| Abortion clinics | 14 (52) |
| Other clinics | 11 (41) |
| Hospitals | 2 (7) |
| Physicians' offices | 0 |
| Facility status | |
| Not-for-profit | 14 (52) |
| For-profit | 13 (48) |
| Approximate number of abortions performed in previous 12 months | |
| Median | 2,400 |
| Range (volume) | 440–8000 |
| 1–29 | 0 |
| 30–399 | 0 |
| 400–999 | 6 (22) |
| 1,000–4,999 | 16 (59) |
| ≥5,000 | 5 (19) |
| Percent services abortion related | |
| Average | 75% |
| Range | 5–100 |
| Percent abortions that are medication abortions | |
| Average | 19% |
| Range | 1–50 |
| Gestational limits (wks) * | |
| ≤14 | 5 (19) |
| 15–20 | 7 (26) |
| ≥21 | 15 (55) |
| National Abortion Federation member? | |
| Yes | 24 |
| No | 3 |

* No lower limit. Abortions performed at first recognition of pregnancy.

(41%) were "other" clinics in which less than 50% of patient visits were for abortion care, and 2 (7%) were hospital based.

Collectively, facilities reported a median of 2,400 induced abortions performed in 2010 (range, 440–8,000). Six facilities (22%) performed between 400 and 999 abortions, 16 facilities (59%) performed between 1,000 and 4,999 abortions and 5 facilities (19%) performed 5,000 or more. The facilities' maximum gestational limits ranged from 10 weeks to the end of the second trimester; 55% provided abortions beyond 20 weeks gestation. All facilities offered medication abortions, which comprised 19% of total abortions. Ninety-six percent of facilities dispensed contraception; some offered a wide range of methods, including over-the-counter, prescription, and procedure-based methods (e.g., intrauterine contraception, implants), whereas others offered fewer options. Twenty facilities were located in states with parental involvement laws, 11 facilities were in states with mandated waiting periods and counseling requirements, and 7 were in states with ultrasound laws.

### *Patient Education and Emotional Support Practices*

Key informants provided information about their facility's information provision and emotional support practices. Overall, the facilities' models of care were similar, with a few notable differences. The majority of facilities reported relying primarily on trained, nonclinician ("nonlicensed") staff to deliver information about the procedure (85%), assess patients' certainty (77%), and provide emotional support (74%) and contraceptive education (63%). Most facilities required either a high school diploma or bachelor's degree as a minimum educational requirement, although several also utilized licensed mental health professionals, nurses, and certified medical assistants to educate and/or counsel patients (not shown).

Twenty-one facilities (78%) described formal training programs with specific objectives for nonclinician staff. Training methods included observation of staff by their supervisor (100%), shadowing existing staff (96%), regular discussions with supervisor and peers (96%), review of written materials (96%), attendance at internal in-services/meetings (88%), review of a training resource manual (65%), review of informational videos or DVDs (58%), values clarification exercises (54%), and attendance at external meetings or conferences (35%). Three quarters of respondents (77%) reported that their facility's training activities are "very effective" in preparing new staff to carry out the tasks required of them, whereas 23% deemed them "somewhat effective."

Informed consent and information provision emerged as important aspects of the counseling provided at most facilities. Twenty-six facilities stated that patients routinely participate in a dedicated pre-procedure information or counseling session. Facilities reported that the time spent in this session varied depending on the needs of the patient, from 10 to 75 minutes (average, 24). Although some labeled this interaction "counseling," and others described it as "intake" or "education," the content of these discussions was highly consistent. Key informants were asked whether or not the staff at their facilities routinely carry out four specific activities as a part of their informed consent, patient education and emotional support practices, and, if they do, whether they do so "always," "when the patient raises the issue," or "when the individual staff member thinks it is important." They asserted that staff "always" do the following with each abortion patient: 1) Provide information about the procedure (96%), 2) assess the certainty of patients' abortion decisions (92%), 3) assess patients' feelings and provide emotional support (74%), and 4) provide contraceptive health education (92%; Table 2). In most cases, nonclinician staff members were charged with these tasks, although some were said to be provided in multiple ways by different individuals at various points during patients' visits. All facilities encourage patients to take more time to consider their decision if they expressed ambivalence about the abortion.

The majority of facilities regularly assessed patients' mental health and psychosocial needs. All but three reported that staff or physicians routinely ask patients about their prior mental health

**Table 2**
Abortion Care Facilities' Patient Education and Emotional Support Practices ($n = 27$)

| | Staff Provide Information, *n* (%) | Staff Assess Certainty of Decision, *n* (%) | Staff Assess Patients' Feelings, *n* (%) | Staff Provides Contraceptive Health Education, *n* (%) |
|---|---|---|---|---|
| Frequency | | | | |
| Always | 26 (96) | 25 (92) | 20 (74) | 25 (92) |
| When the patient raises the issue | 1 (4) | 0 (0) | 6 (22) | 1 (4) |
| When an individual staff member thinks important | 0 (0) | 1 (4) | 1 (4) | 1 (4) |
| We do not do this | 0 (0) | 1 (4) | 0 (0) | 0 (0) |
| Approaches used (choose all that apply) | | | | |
| In person | 27 (100) | 27 (100) | 27 (100) | 26 (96) |
| Group | 8 (30) | 2 (8) | 1 (4) | 4 (15) |
| Video | 9 (33) | 2 (4) | 2 (8) | 2 (8) |
| Phone | 21 (78) | 10 (39) | 15 (56) | 12 (44) |
| Written materials | 23 (85) | 6 (23) | 8 (30) | 24 (89) |
| Website | 18 (67) | 2 (8) | 1 (4) | 10 (37) |
| Other | 4 (15) | 3 (12) | 5 (19) | 1 (4) |
| Missing data | 0 | 1 | 0 | 0 |
| Most frequently used (choose all that apply) | | | | |
| In-person | 22 (81) | 26 (100) | 26 (96) | 24 (89) |
| Group | 5 (19) | 1 (4) | 0 (0) | 1 (4) |
| Video | 0 (0) | 0 (0) | 0 (0) | 0 (0) |
| Phone | 4 (15) | 0 (0) | 1 (4) | 1 (4) |
| Written materials | 11 (41) | 0 (0) | 1 (4) | 6 (22) |
| Website | 1 (4) | 0 (0) | 0 (0) | 0 (0) |
| Other | 1 (4) | 3 (12) | 1 (4) | 0 (0) |
| Missing data | 0 | 1 | 0 | 0 |

history, through a medical intake form (78%), verbally (37%), or both (41%). Seven facilities (26%) utilize a dedicated needs assessment form to help evaluate patients' emotional state and psychosocial needs related to the pregnancy and/or abortion, or the circumstances surrounding them. Fifteen (56%) include questions designed for this purpose on other clinical forms.

Greater variability was evident when examining the materials and methods used to inform or educate patients, as well as the time spent on providing information, assessment of certainty, and emotional support. The majority of facilities reported using an individual, in-person format; however, some also use a group format, as well as written materials, telephone, websites, and videos. Reports of the amount of time staff typically spend providing different components of care varied significantly across sites. On average, staff spend 20 minutes providing information about the procedure, 23 minutes assessing patient's certainty, 29 minutes discussing feelings/providing emotional support, and 9 minutes providing contraceptive education (including the time spent in a counseling session and other parts of the visit). Reports of time spent on these activities were wide ranging. For example, 13 facilities (48%) reported spending and average of 10 minutes or fewer with patients assessing their feelings and/or providing emotional support, whereas 9 (33%) reported spending 11 to 25 minutes, and 5 (19%) reported spending longer than 25 minutes doing this (mean, 29 minutes; range, $\leq$5–180; not shown).

The abortion care visit often served as a point of referral to other health and social service agencies or hotlines. As a group, facilities reported giving patients the following referrals "always," "very often," or "sometimes": Postabortion talklines (92%), domestic violence organizations (89%), free or low-cost contraception services (85%), mental health services (78%), sexual assault organizations (74%), pro-choice, faith-based groups (59%), adoption organizations (44%), and suicide prevention organizations (23%; Table 3). These percentages reflect the perceived needs of the patients, the knowledge and responsiveness of the staff, and the availability of these services in their community. When asked about the availability of services, nine (33%) facilities identified a lack of pro-choice, faith-based groups that are not anti-abortion and two (7%) said that there were no organizations that offered open adoptions in their communities. One facility was unaware of postabortion talklines and three were unaware of suicide prevention hotlines.

When asked the open-ended question about other efforts to educate or support patients, facilities described many, including warning patients about protestors in advance of their visit, providing clinic escorts, posting positive messages in the clinic (e.g., "Good women have abortions"), providing music therapy, creating special rooms or spaces where patients could reflect or pray, offering special care options for women with a fetal diagnosis (e.g., private waiting/recovery rooms, clay footprints), and postabortion telephone consultation.

### *Organizational Philosophy*

Key informants were asked whether they "strongly agree," "agree," "disagree," or "strongly disagree" with a series of statements about different beliefs, and were instructed to answer from the perspective of their facility, even if their personal values differ. Table 4 illustrates respondents' perceptions of their facility's values. All respondents reported that their facility agrees or strongly agrees that "positive messages about abortion from clinic staff can reduce abortion stigma" and 96% reported that their facility agrees or strongly agrees that "staff–patient interactions can affect patients' future feelings (96%)." The overwhelming majority agreed or strongly agreed that it is important to ask patients whether they feel coerced by someone else to have the abortion (96%), about the quality of social support for their abortion (93%), and to talk with them about their feelings about their abortion decision (89%), as well as their expectations and strategies for coping after the abortion (85%). The majority of key informants (82%) also reported that their facility subscribes to the view that it is part of its role to provide counseling for emotional issues related to abortion. Facilities that reported that they strongly agreed with this sentiment spent more time counseling patients than those that simply agreed or disagreed with the statement ($p < .03$). About two thirds (63%) said that their organization believes "it is the role of clinic staff to talk with patients about spiritual or religious conflicts related to abortion when they arise."

When asked to rate how strongly they agreed or disagreed with a list of statements about potential challenges affecting the staff at their facility, respondents strongly agreed or agreed that staff were affected by four top challenges: 1) Feeling burdened by state or local abortion laws (59%), 2) feeling stigmatized by the work that they do (56%), 3) suffering from burnout (56%); and 4) experiencing stress from anti-abortion protestors (48%). Fewer, but still a substantial percentage of respondents, agreed or strongly agreed that their staff members were affected by not having enough time to spend with each patient (41%), lacked training that could make them more effective (41%), felt frustrated by the level of financial compensation they receive (41%), and had difficulty managing the many priorities and tasks required of them (37%). A smaller percentage reported difficulty with staff remaining nonjudgmental about patients' behaviors when interacting with them (19%), struggling with their feelings about abortion (15%), or lacking a safe space to talk about their feelings (4%). None of the key informants reported that facility staff lacked empathy for patients' problems.

**Table 3**
Percent of Respondents Reporting that Mental Health and Social Services Are Available in Their Communities, and Percent of Frequency of Referrals ($n = 27$)

| (a) Available in Community or Via Hotline? (b) How Often Staff Give Referrals? | Yes (%) | No (%) | Don't Know (%) | Always (%) | Very Often (%) | Sometimes (%) | Rarely (%) | Never (%) |
|---|---|---|---|---|---|---|---|---|
| Postabortion hotlines | 96 | 4 | 0 | 12 | 46 | 35 | 4 | 4 |
| Domestic violence organizations | 100 | 0 | 0 | 0 | 26 | 63 | 11 | 0 |
| Free or low-cost contraception services | 100 | 0 | 0 | 22 | 52 | 11 | 11 | 4 |
| Mental health services | 100 | 0 | 0 | 0 | 7 | 70 | 19 | 4 |
| Sexual assault organizations | 100 | 0 | 0 | 11 | 63 | 26 | 0 | 0 |
| Faith-based groups (not anti-abortion) | 63 | 33 | 4 | 5 | 18 | 36 | 18 | 23 |
| Adoption organizations that offer open adoptions | 85 | 7 | 8 | 4 | 4 | 37 | 52 | 4 |
| Suicide prevention hotlines | 89 | 11 | 0 | 0 | 0 | 23 | 50 | 27 |

**Table 4**
Key Informants' Perceptions of Organizational Beliefs and Values ($n = 27$)

| | Agree/Strongly Agree, *n* (%) | Disagree/Strongly Disagree, *n* (%) |
|---|---|---|
| Positive messages about abortion from clinic staff can reduce abortion stigma. | 27 (100) | 0 (0) |
| It is important for clinic staff to provide emotional support during the abortion procedure. | 27 (100) | 0 (0) |
| Patients' interactions with clinic staff can influence their future feelings about the abortion. | 26 (96) | 1 (4) |
| It is important to ask patients whether they feel coerced by someone else to have the abortion. | 26 (96) | 1 (4) |
| It is important to ask patients about the quality of social support for their abortion decision. | 25 (93) | 2 (7) |
| It is important for clinic staff to ask patients how they feel about their abortion decision. | 24 (89) | 3 (11) |
| It is important for clinic staff to talk with patients about expectations and strategies for coping after the abortion. | 23 (85) | 4 (15) |
| It is important for clinic staff to talk with patients about spiritual or religious conflicts related to abortion when they arise. | 17 (63) | 10 (37) |
| It is *not* our role to provide counseling for emotional issues related to abortion. | 5 (19) | 22 (82) |

Ninety percent of facilities asserted that their education and counseling practices had changed over time. Among those, 12 described adopting new approaches to respond to perceived patient needs (e.g., discussion of spiritual/moral issues, comforting patients upset by protestors). Nine facilities reported incorporating new resources (e.g., counseling recommendations presented at conferences) and referral options (e.g., faith-based talklines, pre- and postabortion hotlines). Seven facilities reported changes to accommodate organizational shifts (e.g., increased or decreased staff size, extended gestational limits, introduction of new technologies). Three facilities mentioned modifications to comply with new state laws and regulations.

Interestingly, several respondents described changes designed to expand their facility's ability to address patients' emotional issues, whereas others described moving away from that approach. One person explained: "We used to approach it as if every woman was unsure about her decision coming in … but we found that many women are sure of their decision and don't want that. Of course, we will provide it if they think they want it or if we think they would benefit from it. I find it sometimes a little disrespectful to get into the whole counseling thing if they don't want it." Another described a tension she sometimes feels during informed consent: "Sometimes the patients think we are trying to talk them out of the procedure, but that's not it at all. We just want to make sure that they are sure about their decision."

The final, open-ended interview question asked respondents to summarize their facility's philosophy about abortion care and counseling. The top five themes that emerged revealed values that most considered important, including (in order of frequency) the provision of "patient-centered," "supportive," "nonjudgmental" care that incorporates emotional support and is "compassionate" and "empowering." Eleven respondents specifically mentioned patient-centered care, including one who said, "It's a very open, patient-centered, interactive approach to health care. We aren't doing things to patients; it is a joint effort between patient and provider." Another expressed, "We are very adaptable. We really try to fit the needs of the individual as they arise, and (to) be very flexible."

Eleven respondents made explicit statements about their "supportive," "nonjudgmental" role; eight described emotional care as a part of their facility's philosophy, and seven used the term "compassionate." One person said, "We're here to support a woman with whatever decision she chooses to make about her pregnancy. We feel her emotional care is equally as important as her physical care." Another stated, "Our mission is to provide the highest level of emotional and medical care with dignity and compassion." Six key informants talked about patients becoming "empowered" through the counseling process. One related, "We want to empower women. We want to be supportive in whatever way we can. I think we believe that there is a lot of value in listening. In general, women are not listened to in the world. If we can create a place where a woman can hear her own voice—that is what we are trying to do." Four respondents described interactions with patients as an opportunity to help them transcend the stigma of abortion and manage their emotions afterward. One asserted, "Our philosophy is to provide support and reassurance and a space where there is no judgment and we can reduce stigma and … increase coping around the abortion decision."

Although these sentiments were prevalent, they were not universal. Two respondents specifically rejected the idea that abortion clinic staff should provide emotional counseling. One declared: "(W)e aren't counselors; we do education. We do very effective education for patients." The other stated, "It is not our place to ask how you are going to deal (with an abortion). It's kind of like a loaded question, expecting that they (patients) will have a hard time dealing (with the abortion)."

## Discussion

This pilot study illustrates that many aspects of care are similar across facilities. All facilities prioritized information provision and most prioritized emotional support. However, their practices varied somewhat, especially with regard to the time staff spend providing information, assessing certainty, and offering emotional support. It is not surprising that facilities that reported spending more time counseling patients reported strongly subscribing to the view that it is their role to provide counseling for emotional issues.

Although most facilities seem to believe that discussing patients' emotions about their abortion decisions is an important part of care, a minority did not. These findings suggest that there may be philosophical differences between facilities that underlie different approaches to counseling, with some putting greater emphasis on discussion of women's decisions and emotions than others. The fact that the time dedicated to these aspects of care varied both between facilities and patients at the same facility supports the idea that staff may be guided both by their perception of their role and by the individual needs of each patient. Facility values about the importance of providing emotional support, along with resource constraints, may influence administrative decisions about staffing, training, scheduling, and use of space, which in turn impact counseling interactions. It is interesting to consider these findings in light of the relatively high proportion of respondents that reported feelings of stress, burn-out, and job-related stigma. Despite the clear commitment that these facilities had toward meeting their patients' needs, their staff desired better compensation, advanced training (e.g., skill building to discuss religious/spiritual

issues), and more time to do their jobs effectively. Although prioritizing self-care and cultivating professional development are important in any vocation, it is worth noting the unique challenges posed by anti-abortion harassment and state and local mandates that can negatively impact work in abortion provision.

Because facilities were recruited from a sample drawn for purposes other than the present study, these results may not be representative of all abortion facilities. This sample has a greater proportion of facilities that provide abortion beyond 20 weeks gestation than the universe of facilities across the United States. As such, their practices may have been influenced by the perceived needs of women seeking later abortions, including those who delayed care owing to difficulty making the abortion decision or who had a fetal diagnosis. Compared with a larger, national study of abortion facilities, our sample includes fewer hospital-based practices (7% vs. 34%) and physician's offices (0% vs. 19%) and more abortion clinics (52% vs. 21%) and "other" clinics (41% vs. 26%). Our findings were distributed similarly to the national study's findings with regards to abortion caseload, with the smallest percentage of facilities offering 1 to 29 abortions annually (0 in our sample and $<$0.5% nationally) and the greatest percentage offering 1,000 to 4,999 (59% vs. 64%). Nineteen percent of our facilities and 17% of national facilities perform 5,000 or more abortions annually.

Key informants' reports of their facilities' practices and values were based on their own experiences and perceptions. Although we are confident that they were well integrated into their facilities and intimately familiar with their practices, it is possible that they reported ideal practices, rather than actual ones. Further, it may have been difficult for them to accurately estimate the amount of time staff typically spend providing different components of care.

Our findings suggest a possible effect of state-mandated counseling requirements on the time staff spend assessing the certainty of patient's decisions and providing emotional support; it is possible that our measure of counseling time was not precise enough to capture the full effect of the regulations. It is also possible that staff in these states may perceive a greater need to provide emotional support than those in other states, especially if they consider the regulations to be distressing to patients.

In light of the widespread legislative efforts to regulate information provision and counseling in the abortion context, these data are particularly meaningful. Despite their limitations, these data provide a rare view of the practices and values of abortion facilities across the United States, including those related to provision of patient-centered care and the integration of emotional assessment and support into their clinical care. These facilities reported having rich, individualized interactions with patients, regardless of whether or not they were subject to regulations that mandated waiting periods, counseling requirements, or ultrasounds. Future research should examine patients' preferences regarding abortion care and counseling and how different approaches to each affect women's emotional well-being after having an abortion.

## Acknowledgments

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## Author Descriptions

Heather Gould, MPH, is a senior research analyst with the Advancing New Standards in Reproductive Health (ANSIRH) Program at the Bixby Center for Global Reproductive Health at the University of California, San Francisco (UCSF).

Alissa Perrucci, PhD, MPH, is a clinical psychologist and counseling and administrative manager at the Women's Options Center at San Francisco General Hospital and author of the book Decision Assessment and Counseling in Abortion Care: Philosophy and Practice.

Rana Barar, MPH, is project director and Danielle Sinkford is a research associate for the Turnaway Study at ANSIRH.

Diana Greene Foster, PhD, a demographer, is the principal investigator of the Turnaway Study, Director of Research at ANSIRH, and an associate professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at UCSF.