

Original research article

# Beliefs about abortion risks in women returning to the clinic after their abortions: a pilot study

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## Abstract

**Background:** Misinformation regarding the risks of abortion is prevalent and commonly includes medical inaccuracies about health, depression, infertility and breast cancer. This pilot study sought to assess misinformation among abortion clients as well as the origin(s) of their abortion knowledge.

**Study Design:** Women who presented to the Mount Sinai School of Medicine Family Planning Division for postabortion follow-up were recruited for participation. Participants completed a researcher-administered survey regarding knowledge and beliefs about abortion.

**Results:** Sixty-seven women completed the survey between 1/11/10 and 8/6/12. Common sources of abortion information included clinicians (79.1%), Web sites (70.1%), friends (50.7%) and family (40.3%). Over two thirds of women (77.6%) overestimated the health risks, and close to half (43.3%) overestimated the risk of depression after a first trimester abortion.

**Conclusions:** Misperceptions about the health risks of abortion were prevalent among this sample. Education tools should be developed to provide accurate information about the risks of abortion.

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## 1. Introduction

Inaccurate information about abortion is prevalent and often exaggerates the medical and psychological risks of the procedure [1–3]. Abortion misinformation is an important issue because all individuals deserve accurate information to make informed health decisions. Exposure to false information about abortion risk may increase women's anxiety about the procedure and influence their expectation of how well they will cope afterwards [2]. In addition, misinformation, particularly that which makes abortion seem uncommon or promotes negative stereotypes about women who have abortions, can contribute to abortion stigma [4]. From a broader

perspective, incorrect information about abortion in the public domain leads to public support (and politician justification) of policies that restrict access to abortion and of state-legislated mandatory physician scripts that violate the standards of informed consent [5–7].

Common types of abortion misinformation include assertions that abortion is dangerous, causes severe mental health disorders, impairs future fertility and increases the risk of breast cancer [1–3]. The evidence does not support these claims [8–14], and yet this type of incorrect material has been identified on Web sites [1,15], in abstinence-only education programs [16], in crisis pregnancy centers [1,3,17,18] and in state-legislated mandatory scripts for physicians [6,7].

Misinformation is prevalent and comes from many sources, but it is unclear what women having abortions actually believe about the service they are seeking. To the authors' best knowledge, there are no published studies from the United States

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regarding abortion clients and misinformation. The purpose of this study was to pilot a series of questions assessing the level of misinformation among abortion clients as well as the origin(s) of their abortion knowledge. The findings will inform a larger, cross-sectional study.

## 2. Materials and methods

This was a hypothesis generating pilot study that utilized a researcher-administered survey to assess knowledge and beliefs about abortion and the types of services that could be offered to women around the time of abortion. A convenience sample of women who presented for a surgical abortion follow-up visit at the research site (Mount Sinai School of Medicine Family Planning Division, New York, NY) was invited to participate. Patients receiving abortions there are routinely scheduled for postoperative visits 2–3 weeks after their procedure. Eligibility criteria included being between the ages of 14–50, speaking English and being present on a day when a research team member was available for enrollment. Exclusion criteria included having had a termination procedure for a spontaneous or incomplete abortion. Those expressing interest met privately with one of the investigators where they were provided details about the study. Informed consent was obtained, for women wanting to participate, using a consent form in which no signature was required to ensure anonymity. The principal investigator administered the survey orally. Eligible women who declined participation were asked to complete a nonparticipant sheet, which included only demographic information. The study received Institutional Review Board (IRB) approval from the Mount Sinai Institutional Review Board.

Prior to embarking on this pilot study, we tested recruitment feasibility at both abortion preoperative and postoperative visits using a similar survey instrument. We found that very few women agreed to participate at their preoperative visit, even when we shortened the survey to 15 min. We understand that women returning for their postoperative visits may not be representative of all patients receiving abortions; however, due to our low numbers of potential subjects overall as well as difficulty recruiting at preoperative visits, we decided to focus on postoperative patients in order to achieve a meaningful enrollment rate.

The survey contained 25 dichotomous, multiple choice, Likert scale and short answer questions that included topics on common myths about abortion (4 questions), sources of abortion information (1 question), abortion support services (5 question), an educational opportunity question (1 question) and participant demographics (14 questions). The questions regarding common abortion myths and the educational opportunity question are included in Appendix 1.

Although the survey questions were not piloted specifically for the literacy levels of our population, the authors felt that administering the survey orally and providing op-

portunities for participants to ask for clarification could overcome literacy limitations. In addition, efforts were made to avoid bias in the common myth questions. The question regarding awareness of groups that provide inaccurate abortion information was inserted as an educational opportunity, to be addressed after answers to the myth questions were reviewed. The survey took approximately 15–25 min to complete. Following completion of the common myths, sources of information and educational opportunity questions, participants were given a fact sheet with evidence-based answers to the myth questions. The researcher then reviewed the evidence-based answers with the participant, especially the questions that were answered incorrectly, and discussed potential sources of abortion information and misinformation.

Data were collected by the survey administrator and then entered into Excel 2010 (Microsoft Corporation, Redmond, WA, USA). Analyses were conducted using STATA version 11 (StataCorp, College Station, TX, USA); survey responses are presented by frequency and/or means. Fischer's Exact tests were used to compare demographic data between correct and incorrect answers for the four common myth questions.

## 3. Results

Of the 79 potential participants who were offered participation in the study, 67 (84.8%) agreed to complete the survey between 1/11/10 and 8/6/12. Participant characteristics are presented in Table 1. The collected demographics of the nonparticipants were comparable to those of the study participants (not shown). A large majority of women (79.1%; 53/67) reported getting information about abortion from their doctor or nurse (Table 2). In addition, many women obtained information from Web sites (70.1%; 47/67), friends (50.7%; 34/67) and/or family members (40.3%; 27/67). Fewer reported getting information from the media (31.3%; 21/67) or from their partner (10.4%; 7/67).

Over two thirds of all participants (77.6%; 52/67) overestimated the health risks of a first trimester abortion compared to the risks of continuing a pregnancy and giving birth (see Table 3). Close to half of participants (43.3%; 29/67) overestimated the risk of depression after a single first trimester abortion compared to the risk of depression after continuing an unplanned pregnancy. In addition, more than 2 in 10 women (22.4%; 15/67) erroneously believed that abortion impairs future fertility and 6.0%; 4/67 incorrectly answered that abortion is associated with an increased risk for breast cancer. Older women and women with children were more likely to answer the infertility question correctly (Fischer's Exact test = .001 and .036, respectively); women with less education were more likely to answer the depression question correctly (Fischer's Exact test = .007); and compared to non-Black women, Black women are more

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