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## Survivors of Sexual Trauma: Abortion Experiences of Black Women in the Southern United States

Katie Grace Geter  
*Walden University*

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# Walden University

College of Social and Behavioral Health

This is to certify that the doctoral study by

Katie Grace Geter

has been found to be complete and satisfactory in all respects,  
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the review committee have been made.

Review Committee

Dr. Kristin V. Richards, Committee Chairperson, Social Work Faculty

Dr. Brittany Peters, Committee Member, Social Work Faculty

Chief Academic Officer and Provost  
Sue Subocz, Ph.D.

Walden University  
2026

Abstract

Survivors of Sexual Trauma: Abortion Experiences of Black Women in the Southern

United States

by

Katie Grace Geter

MSW, Valdosta State University, 2018

BS, Mercer University, 2015

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

Walden University

February 2026

## Abstract

Women who experience both sexual trauma and abortion within their lifetime are highly likely to struggle with serious mental health symptoms; however, social work students and practitioners lack education and knowledge on how to serve these women. Recent events, including the uprising of gender and race related movements, COVID-19, heightened political division, and increased governmental control on abortion rights also impact social-work practice. Acknowledging intersectionality, the purpose of this qualitative study was to explore the experiences of abortion for Black women in the Southern United States who have a history of sexual trauma. The experiences of 6 Black women with a history of sexual trauma and abortion who reside in the Southern United States were explored using an online self-administered survey. Inductive thematic analysis was used to analyze the data, resulting in the following themes: importance of voice/choice, unmet support needs, unresolved sexual trauma impacts abortion experiences, negative impact of internal and external conflicts, racialized and gendered healthcare experiences, and individual needs for healing process. The Trauma-Informed Socially Just Research (TISJR) framework was used to guide this study, incorporating important concepts of trauma-informed care and intersectionality. The findings of this study may be used by social-work practitioners and other community stakeholders to create positive social change for people of color.

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## Dedication

This dissertation is dedicated to my daughter, a beautiful brown baby girl whose life is just beginning and whose future holds both limitless possibility and potential challenges. Though you are only seven months old, your presence has already deepened my commitment to justice-centered scholarship and to questioning systems that may not fully protect or affirm girls like you. It is my hope that this work contributes to a world where your voice is valued, your body is respected, and your identity is honored. May you grow surrounded by equity, love, and opportunity, and may you always know your worth and the power of your existence.

Additionally, I dedicate this work to all who have lived through sexual trauma and abortion—experiences that are too often met with silence, judgment, or misunderstanding. Your strength in surviving what should never have happened, and in carrying forward despite complex grief, pain, resilience, or healing, is profound. May this work honor your stories, affirm your dignity, and contribute, in some small way, to a world that listens more carefully, responds more compassionately, and upholds your right to safety, care, and wholeness.

## Acknowledgments

First and foremost, I give all honor and thanks to God, whose presence sustained me throughout this journey and reminded me that I was never alone. I am grateful for His faithfulness and for the assurance that He had a purpose and a plan to prosper me, even during moments of doubt and exhaustion. I am a blessed and highly favored child of God.

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To my husband, Yacques, thank you for being my biggest cheerleader when I felt like giving up. Thank you for being the steady strength God provided in my weakest moments—lifting me when I could not stand and loving me with the faithfulness of a man devoted to God and his family. To my children, Eli, Nasir, and GG, you are my driving motivation to better myself and to contribute to meaningful, positive social change. I pray that you always follow your heart, face your fears, dream big, and know that you can do all things with Christ.

I am deeply thankful for my family, friends, and colleagues whose encouragement and support carried me along the way. Finally, I acknowledge Mrs. Rhonda Lastie, my first college advisor where I first began, at Athens Technical College, who challenged me to grow in ways that shaped both my academic and professional journey. I am forever appreciative that you introduced me to the field of social work and saw in me things I did not know existed.

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## Section 1: Foundation of the Study and Literature Review

### **Introduction**

Women with a history of sexual trauma are more likely to experience mental health issues, substance abuse issues, poverty, domestic violence, and are often sexually revictimized (Altschuler et al., 2017; Brunton & Dryer, 2021; Ely et al., 2018; Ely et al., 2020; Sperlich et al., 2020; Sperlich & Gabriel, 2022). Additionally, women with a history of sexual trauma are also likely to experience unintended pregnancies within their lifetime (Altschuler et al., 2017; Brunton & Dryer, 2021; Ely et al., 2018; Ely et al., 2020; Sperlich et al., 2020; Sperlich & Gabriel, 2022). When faced with an unintended pregnancy, some women may consider abortion. Other reasons women choose abortion include financial difficulties, abusive relationships, and sexual victimization (Brown et al., 2022; Chae et al., 2023; Jones et al., 2023), which are similar to issues that women with a history of sexual trauma report experiencing. Further exploration is needed to identify and understand any connections between the experiences of abortion and sexual trauma. Black women have intersectional identities associated with race and gender that could impact their experiences of sexual trauma and abortion in ways their White counterparts do not experience or understand.

Although predominantly studied amongst White women, there has been a significant amount of research on abortion experiences and sexual trauma as separate phenomena, however there is limited research combining the experiences of these two major phenomena. A moderate amount of research exists that depicts how intimate healthcare practices can be difficult experiences for sexual trauma survivors. However,

there is an absence of research on abortion is experienced for sexual trauma survivors. Another important component for consideration is the unique impact that legislation continues to have on Black women, and the obvious gaps within the literature expressing the scarcity of research on Black women's' experiences of various phenomenon. The dearth of knowledge on the relationship between sexual trauma and abortion inspired me to conduct this study. The purpose of this study was to gain an understanding of what is needed to improve social work education and practice when working with women that have experienced both abortion and sexual trauma, with an emphasis on the concept that variances in intervention may be necessary when serving populations that have experienced multifaceted inequities.

Acclaimed scholar Kimberle Crenshaw focused on how factors of gender and race intersect, creating an overlap of sexist and racist discrimination faced by Black women, and presented legal issues this complex discrimination accounted for (Crenshaw, 1989). In addition to intersectional identities, the sociopolitical context of the Southern United States created distinct differences in the treatment of the Black women in this region. These differences have been captured in literature such as Zora Hurston's famous fiction novel, *Their Eyes Were Watching God*, referring to the Black woman as "de mule uh de world" when sharing about the Black woman's experience specific to the South (Hurston, 1937, p. 14). Hurston further depicts a unique experience of inequality by Black women in comparison to Black men, as she wrote, "So de white man throw down de load and tell the [Black] man tuh pick it up. He pick it up because he have to, but he don't tote it. He hand it to his womenfolks" (Hurston, 1937, p. 14).

In this qualitative study, I examined the abortion experiences of Black women who have a history of sexual trauma, exploring how the components of intersectionality regarding race and gender may have implications on these experiences. I also examined how geographic context may have influenced these experiences, given the South's historical legacy of slavery, violence, and discrimination affecting Black communities. In respect to the sociopolitical context of the United States, regarding the recent Supreme Court decision in 2022 to overturn the monumental case of *Roe V. Wade*, combined with advances in technology and the media over the last 10 years that have increased awareness about injustices continued to be experienced by the Black community, the timeliness of this research is amplified.

The rich insight gained from this qualitative study about the experiences of abortion for Black women with a history of sexual trauma that are residing in the Southern United States has the potential to contribute to positive social change at a pivotal time. In very restrictive states, abortions can lead to criminal consequences not only for clients, but also for practitioners involved in assisting clients to access and obtain abortion care (Baker et al., 2023; Begun et al., 2016; Chowdary et al., 2022; Ely et al., 2018; Swan et al., 2021; Witt et al., 2022). It will be important for social work practitioners to continue to support the self-determination of the client, while also considering how to approach this delicate matter in a way to protect the client and themselves (NASW, 2023). I analyzed these sensitive phenomena within a diverse group, contributing missing information to the social work field and supporting a clearer

understanding of practice needs to enhance support and services for individuals within this population under current conditions (Ely et al., 2018; Swan et al., 2021).

In this chapter, I will provide an overview of the study including the problem statement, purpose statement and research question, the nature of the doctoral project, the significance of the study, the theoretical framework used to inform the study, values and ethics relevant to the social work problem, and a thorough review of the literature. In Chapter 2, I will provide information on the research design and data collection of this study. I will describe in depth the methodology in this study to include prospective data, participants, instrumentation, existing data, data analysis, and ethical procedures. In Chapter 3, I will present the findings of this study, and provide additional insight on the data analysis techniques that were utilized. In Chapter 4, as related to the social work practice problem within this study, I will address the application of professional ethics in social work practice, recommendations for social work practice, and the potential implications for social change.

### **Problem Statement**

One out of three women report sexual abuse in their lifetime (Wycoff & Matone, 2019). Statistics from the National Center for Injury Prevention and Control (2022) indicate that if sexual trauma occurs during childhood, a woman is 2-13 times more likely to be revictimized as an adult. A study guided by the Life Span Theory found that sexual trauma symptoms lessen in severity as women aged, potentially related to completing tasks within the different life stages that resulted in strengthened coping skills and resiliency, however the study had limitations as it did not consider how revictimization

might affect the findings. In addition, most participants were White women, therefore findings did not represent how Black women experience sexual trauma symptoms (Wolf et al., 2022).

For women that have experienced sexual trauma in their lives, intimate healthcare exams may reintroduce negative emotions and trigger responses related to unresolved trauma (Fukumoto, 2022), indicating that an intimate healthcare practice such as an abortion could result in secondary trauma (Altschuler et al., 2017; Ely et al., 2018; Ely et al., 2020). The literature is congruent in that women who experience sexual trauma are at high risk for experiencing severe trauma symptoms (Wolf et al., 2022), mental health issues (Murphy-Oikonen et al., 2022), and struggles with addiction (Salim et al., 2023). Other experiences, such as discrimination, have also been positively correlated with mental health issues, specifically that of posttraumatic stress disorder (PTSD) and depression, with Black women reporting the highest rates of discrimination out of all minorities (Walsh et al., 2022).

Recent qualitative studies found that sexual trauma has an impact on women's choices about sexual healthcare and family planning (Meier et al., 2021; Sperlich & Gabriel, 2022). Survivors of sexual trauma that choose abortion are more at-risk for serious mental health illness, making these women a highly vulnerable population (Ely et al., 2018; Ely et al., 2020; Meier et al., 2021). Despite sociopolitical efforts to ban abortions, recent studies show that 30-33% of women will have at least one abortion in their lives by the time they reach 45 years old (Altschuler et al., 2017; Ely et al., 2018;

Sperlich et al., 2020). According to Swan et al. (2021), this means that approximately one million abortions take place each year in the United States alone.

Black women experience unique barriers in making reproductive health decisions related to the intersectionality of race and gender combined with historical, structural, and institutionalized racism (Brown et al., 2022). In this time of radical political movements, particularly in the Southern United States related to abortion, along with a gap in the literature about experiences of abortion and trauma for Black women, it is important to explore the concepts of sexual trauma, abortion, and factors of intersectionality and geographical location, to increase the capacity of social work practitioners' in demonstrating equitable support and care for this population. Data presented by the Guttmacher Institute (2022) indicates Texas, Oklahoma, Louisiana, Arkansas, Missouri, Alabama, Tennessee, Kentucky, West Virginia, and South Carolina as having some of the most restrictive abortion policies within the United States, establishing a guide for this study when considering geographical significance.

EBPs on approaches to take when caring for survivors of sexual trauma have been identified to be person-centered, women-centered, and trauma-informed, yet studies indicate a frequent lack of trauma assessment and care being administered in healthcare practices (Altschuler et al., 2017; Bruton & Dryer, 2021; de Medeiros Guimarães & da Silva Ramos, 2017; Ely et al., 2018; Ely et al., 2020; Meier et al., 2020; Reeves & Humphreys, 2018; Sperlich & Gabriel, 2022; Wycoff & Matone, 2019). In 2021, the National Association of Social Work (NASW) expressed concerns and recommendations for best practice and policy changes to the Biden-Harris administration and Congress

emphasizing current social problems involving physical and mental healthcare needs, violence, and racism (NASW, 2023). More recently, the National Association of Advancement for Colored People (NAACP) addressed the violence associated with the changes in abortion legislation by forming a compact with multiple civil rights agencies to advocate for social justice for various minority groups (NAACP, 2023). In this time, context, and location, social work students and practitioners must consider these recommendations and the implications that research and advocacy could have for vulnerable populations.

Social work students and practitioners lack education about abortion and/or reproductive health care needs, do not feel confident in addressing these needs with their clients, and rarely refer clients for abortion services (Begun et al., 2017; Ely et al., 2018; Swan et al., 2021; Witt et al., 2022). In 2016, the American Academy of Social Work and Social Welfare (AASWSW) developed thirteen grand challenges to the field of social work including closing the health gap; this included a recommendation that abortion should be normalized as a reproductive healthcare and family planning choice (ASSWSW, 2023; Ely et al., 2018). Then, the worldwide pandemic of COVID-19 further elevated the need for healthcare revisions to combat the impact of the virus, as health disparities increased for minority groups (Division of Viral Diseases, 2023). During a time deemed a federal public health emergency (PHE) by the United States President, the country experienced high unemployment rates, loss of childcare, and quarantine restrictions meant to prevent the spread of the virus and protect citizens' health.

In 2023, the PHE was lifted and studies on the impact of COVID-19 emerged, depicting staggering increases in rates of family violence during the pandemic. In a recent study, over 75% of participants reported physical Intimate Partner Violence (IPV) during the first year of COVID-19. In addition, over 30% of participants reported Intimate Partner Sexual Violence (IPSV) that year, with higher rates extending within the Black community (Wood et al., 2023). Concerns for minorities are heightened when taking into consideration that trauma is reported more often by marginalized groups (Voith et al., 2022), yet these groups are less likely to seek help from the criminal justice and legal system in relation to negative experiences causing distrust in institutions (Crenshaw, 1989; Division for Viral Diseases, 2022; Iwasaki et al., 2023; Tummala-Narra et al., 2023). Acknowledging that an extra layer of hesitance in reporting a sexual assault to law enforcement is demonstrated amongst all races is another critical implication in supporting the needs of survivors of sexual trauma (Murphy-Oikonen et al., 2022).

### **Purpose Statement and Research Question**

#### **Purpose of Study**

The purpose of this qualitative study was to explore the experiences of abortions for Black women with a history of sexual trauma that reside in the Southern United States. Researchers have noted correlations between sexual trauma, exposure to community violence, poverty, domestic violence, undesired pregnancies, and mental health issues (Altschuler et al., 2017; Bruton & Dryer, 2021; Ely et al., 2018; Ely et al., 2020; Sperlich et al., 2020; Sperlich & Gabriel, 2022). An increase in mental health issues such as PTSD, anxiety, suicidal ideation, eating disorders, along with alcohol

abuse issues, were identified in pregnant women who have a history of child sexual abuse compared to those women who do not have a history of sexual abuse. Studies also show that women who have experienced child sexual abuse are more likely to be victimized in relationships throughout their lifetime (Bruton & Dryer, 2021).

A recent abortion study found that over 7% of the participants reported a history of rape, and over 5% reported a history of domestic violence (Ely et al., 2020). Research suggests that childhood sexual trauma may be associated with increased vulnerability to sexual assault and engagement in high-risk sexual behaviors, both of which can contribute to unintended pregnancies. A lack of income, sexual health education, and/or lack of contraception are also factors in undesired pregnancies (Ely et al., 2020; Sperlich et al., 2020). Combined with the additional barriers that are related to obtaining an abortion, and acknowledging the role that racism and sexism may play in these experiences, there is a need in understanding how social work practitioners can best support these clients and the healthcare professionals that engage with them. The goal of this study is to understand connections between Black women's experiences of sexual trauma and their experiences of abortion, with a focus on how dynamics of race, gender, and geographical location may impact their experiences. I identified factors that contribute to a healthy and positive abortion experience for this population, with implications for closing health gaps and informing social work education and practice.

## Research Question

The main research question that I used to guide this study was: What are the experiences of abortion in the Southern United States for Black women who have a history of sexual trauma?

## Key Terms

*Abortion*: a procedure intended to terminate a pregnancy using medication-induced or surgical methods; also known as an induced abortion (MedLine Plus, 2022).

*Black*: a characteristic term to describe a group of people that have African ancestry and are of dark skin color, without excluding any nationalities (American Psychological Association, 2020).

*Gestation*: growth and development that occurs during pregnancy within the mother's womb (Healthline, 2023).

*Health Disparities*: higher rates of health problems for certain populations than others which can be influenced by a combination of factors including race, gender, age, socioeconomic status, place of residence, disability status, etc. (National Center for HIV, Viral Hepatitis, STD, and TB Prevention, 2020).

*Miscarriage*: the unintended termination of a pregnancy through bodily rejection before 20 weeks gestation; also known as a spontaneous abortion (Cleveland Clinic, 2023).

*Pro-Choice*: the view that individuals should be able to make their own decisions about their pregnancy, such as having the choice to bear children or to terminate the pregnancy (Head, T., 2019).

*Pro-Life*: the view that involves the support of government regulations to ensure human life is protected at all costs; in this case, abortion is not a choice (Head, T., 2019).

*Rape Myth Acceptance/Culture*: the belief of myths about the act of rape, along with stereotypes about victims and perpetrators involved in rape; often based on genderized norms (Angelone et al., 2021; Canon et al., 2018; Payne & Fitzgerald, 1999).

*Sexual Trauma*: any non-consensual sexual experience involving forced or coerced acts of penetration or touching of an individual, along with blackmailing, exploiting, or harassing an individual using sexual-related behaviors and/or images; for the purpose of this study, sexual trauma encompasses terms such as rape, sexual assault, sexual violence, child sexual abuse, molestation, sexual harassment, sexual coercion, sexual abuse, IPSV (National Sexual Violence Resource Center, 2023 ; RAINN, 2023a).

*Southern United States*: states that are identified in the Southern region of the United States according to the United States Census which includes: Idaho, North Dakota, South Dakota, Texas, Oklahoma, Louisiana, Arkansas, Missouri, Mississippi, Alabama, Tennessee, Kentucky, and West Virginia (Guttmacher Institute, 2022).

*Survivor*: anyone that has experienced a traumatic event (RAINN, 2023b).

*Woman/Women*: anyone over 18 years old that were originally born with chromosomes and reproductive anatomy that were classified as the female sex, despite differences in gender roles, gender identity or binary or non-binary identity, and/or sexual orientation (Planned Parenthood, 2023).

### **Nature of the Doctoral Project**

In this study, I used a generic qualitative inquiry to explore the abortion experiences of Black women in the Southern United States who have a history of sexual trauma. A generic qualitative inquiry focuses on the subjective experiences of others, can be used with a fully qualitative methodology, and seeks to gain understanding about a topic that has little information which needs to be expanded upon. The primary research question called for subjective insight on the perceptions, beliefs, and attitudes of the participants through the descriptions they provide surrounding significant experiences (i.e., the variables within my study). Using a generic qualitative research design provided flexibility in the development of survey questions, rather than asking questions that are broad in nature, therefore resulting in rich insight of the participants' experiences (Ellis & Hart, 2023; Percy et al., 2015).

I selected a generic qualitative research design that aligned with the Trauma-Informed Socially Just Research (TISJR) theoretical framework used to guide this study. The TISJR framework places value on the accentuation of experiences shaped by intersectional identities of participants, particularly when the experiences are related to trauma. The TISJR framework also encourages participant engagement through the sharing of their experiences and allowing participants to elicit recommendations for changes within practice. This principle of collaboration will result from asking questions that seek knowledge and meaning from participants based on their perceptions of experiences in relation to clinical practice, which is possible due to the flexibility of a

generic qualitative research design (Ellis & Hart, 2023, Percy et al., 2015; Voith et al., 2022).

A guide on how to utilize the TISJR framework recommends using self-administered surveys with the option for participants to decline answering questions, out of consideration for confidentiality, honesty, empowerment, and sensitivity, particularly when asking vulnerable populations to share about traumatic experiences for research purposes as there is historical context and relevance that could potentially result in hesitancy to participate. The source of data collection for this study was an online self-administered survey in which I included open-ended questions to obtain detailed information from participants. By using online surveys with open-ended questions, I was able to obtain abundant and descriptive insight into participants' experiences while capturing participants' own language, which supported inclusion of marginalized populations. By utilizing this type of data collection, I emphasized participant engagement and reduced the power divide between participants and the researcher within the research process, which is a critical component of the TISJR framework (Braun et al., 2021; Voith et al., 2022).

Purposive sampling is common with qualitative studies, particularly when seeking out homogeneity. Inclusion/exclusion criteria allowed me to explore phenomenon with a specific population of interest, which is beneficial when seeking to gain understanding with populations that lack representation within scholarly literature . Due to the intimacy of abortion and sexual trauma experiences, along with different perceptions of these experiences including stigmatization and silencing, participants may not be familiar with

others who have had these experiences; therefore, snowball strategies was not considered a dependable recruitment source for this study (Alase, 2017; Braun et al., 2017; Patton, 2015). In addition, snowball strategies were considered uncondusive to protecting the privacy and confidentiality of participants. Recruitment strategies were implemented using social media.

Lastly, I used thematic analysis with an inductive approach to analyze the data because this approach aligned with the research design and the TISJR framework I used to guide the study. Thematic analysis is appropriate for research involving lived experiences, social processes, and social constructions, and is often used to analyze data from surveys (Percy et al., 2015; Saldana, 2016). Thematic analysis is recommended for qualitative studies when researchers are using the data to inform clinical practice, when sources of data collection other than interviewing are implemented, when researchers are analyzing the data set for emergent themes, when data is being conducted with a focus on diversity and cultural context, when sample sizes are small, and in situations where the timeliness of research is paramount, which are all components of this study (Braun & Clarke, 2020). Furthermore, when the data set is obtained by online surveying, Braun et al. (2021) recommends researchers to analyze participant responses for each survey question altogether rather than separately to successfully code and interpret emerging themes. By approaching data analysis inductively, I did not develop themes prior to the research, reducing researcher bias and allowing the data to represent meanings from the interpretation of the participants' perspectives rather than my own (Braun & Clarke, 2006; Ellis & Hart, 2023; Percy et al., 2015; Saldana, 2016; Voith et al., 2022).

### **Significance of the Study**

I conducted this qualitative study to provide rich insight for social work practitioners regarding how to best support healthy abortion experiences for Black women with a history of sexual trauma living in the Southern United States, particularly within the current sociopolitical context in which abortion access has been challenged. Through this research, I sought to expand practitioners' knowledge of best practices when working with Black women seeking abortion and/or with a history of sexual trauma. I also identified gaps within the scholarly literature, contributing to education within the social work field and related disciplines regarding the appropriate use of prevention and intervention strategies that prioritize clients' best interests. Although social work and healthcare professionals often collaborate in patient care and multidisciplinary services, additional research and intentional collaboration are needed to effectively address social needs within the healthcare system. Based on my analysis, I identified opportunities to strengthen collaboration between social work and healthcare disciplines to enhance multidisciplinary practice.

The implications of these findings may guide multidisciplinary professionals in providing services that protect and support the needs of Black women. By prioritizing participant empowerment in the research process with a population that may be skeptical of researchers and institutions due to historical harm, I sought to foster trust and support relationship-building with the Black community for future research efforts. By centering the perspectives of individuals directly affected, social work practitioners and scholars may gain a more culturally responsive understanding of how to effectively serve clients

in these circumstances. Lastly, I interpreted the findings as evidentiary support for increased advocacy and policy efforts related to reproductive autonomy, access to services, and legislative reform.

### **Theoretical/Conceptual Framework**

The Trauma-Informed Socially Just Research (TISJR) framework served as the guiding theoretical framework for this study. The foundation of the TISJR framework stems from trauma theory and intersectionality theory, with an emphasis on healing for communities impacted by social injustice. Trauma theory led to the development of trauma-informed care (TIC), which seeks to inform professionals on trauma symptomology and improve policies and practices that move toward healing. Intersectionality theory examines how different components of an individual's identity can multiply levels of discrimination and injustice (Crenshaw, 1989). I utilized the TISJR framework to explore the relationship between trauma and intersectionality within this research study, and use the knowledge derived from the participants about their unique experiences to challenge social injustice (Voith et al., 2020; Voith et al., 2022).

#### **Trauma-Informed Socially Just Research (TISJR)**

The TISJR framework was developed by the HEART (Healing, Empowerment, Antiviolence Research Team) researchers at the Jack, Joseph, and Morton Mandel School of Applied Social Sciences, led by Dr. Laura Voith at The Center on Trauma and Adversity at Case Western Reserve University. Recent publications by HEART focus on violence, abuse, and trauma within underrepresented groups, particularly men of color. The TISJR framework encourages concepts of trauma-informed care, intersectionality,

empowerment, healing-centered engagement, community-based participatory research, participant/researcher partnerships, and was specifically designed with the goal of advancing social justice for people of color (Case Western Reserve University, 2023; Voith et al., 2020; Voith et al., 2022). Therefore, I determined that the TISJR framework encompassed central ideas identified in the literature review, aligned with my purposeful intention to emphasize research with underrepresented groups, and was consistent with Walden University's mission of creating positive social change through graduate research (Walden University, 2023).

Many studies related to trauma and women's reproductive health recommend trauma-informed research and practice, along with emphasizing the importance of concepts such as intersectionality, social policies, health policies, social justice, and feminism (Altschuler et al., 2017; Ely et al., 2018; Ely et al., 2020; Reeves & Humphreys, 2018; Sperlich & Gabriel, 2022; Wycoff & Matone, 2019), which are all congruent with proponents of the TISJR framework (Voith et al., 2020; Voith et al., 2022). The connections between the TISJR framework and the nature of my study include a focus on sexual trauma, TIC related to abortion services, and the intersectionality of race, gender, and geographical location existing for Black women residing in the Southern United States. The amalgamation of racism, sexism, sexual trauma, and abortion experiences provides a unique perspective that has not yet been explored (Sperlich & Gabriel, 2022; Wycoff & Matone, 2019). Furthermore, marginalized groups, including women of color, women with low socioeconomic status, and women living in rural areas experience the highest rate of inaccessibility in obtaining

an abortion (Ely et al., 2018; Ely et al., 2020; Sperlich et al., 2020). With this understanding, I interpreted the results as having strong implications for advancing research and practice in the social work field with the targeted population through application of the TISJR framework.

To date, there has only been one study to my knowledge that has applied the TISJR framework, which was completed by its' founders. This qualitative study explored barriers of implementing the TISJR framework using case studies with a marginalized group consisting of African American men with a low socioeconomic status that were also involved in the criminal justice system. The goal of this study was to examine the strengths and weaknesses of applying the TISJR framework in order to inform future research and practice with marginalized groups. The strengths of the study were in the demonstration of how the framework validated the connection between trauma and minorities which incorporates important values and ethics that guide the field of social work. Also, the application of the framework was found to be successful attributed to the founders' intensely curated and detailed steps of how to use the framework in a study to support the social justice needs of marginalized groups. Slight limitations in the study were identified as there were few components in the study to measure how the application of the TISJR framework positively or negatively affected the participants' sense of safety and perception of transparency within the study (Voith et al., 2020).

Although the actual TISJR framework is new, the ideals that build the foundation of the framework have been informing research and practice throughout history (Voith et al., 2020; Voith et al., 2022). The founders also compiled a briefing on the TISJR steps

within each research stage (pre-study, study design, recruitment, informed consent, data collection, and post-data collection) that is a very helpful tool in directing each aspect of my study and suggesting considerations that should be taken when working with a marginalized population (Voith et al., 2022). Lastly, my decision to impose a study with such a newly designed framework stemmed from the value that the social work field has for the concepts that the framework embraces, the desire to elicit findings that can improve clinical practice for marginalized populations, and factoring in that all theoretical frameworks had a beginning which often led to the composition of an empirical database of knowledge and EBPs.

### ***Intersectionality Theory***

Intersectionality theory is pivotal to the foundation of and reasoning behind the TISJR framework. In 1989, Kimberlé Crenshaw initiated the theory of intersectionality in her work titled, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*. The seminal work of Crenshaw pinpointed how feminist and antiracist approaches were exclusive of Black women, as they were singular in nature and supported by White patriarchy. In her work, Crenshaw provided three legal examples that demonstrated how intersectional identities equate to a lack of resolution or negative outcomes for Black women. Her claims have led to the acknowledgement of how the legal system is not designed to remedy the issues of individuals presenting with multifaceted components of discrimination, however challenges remain today for Black women. Crenshaw supported her claims of multiple axis of discrimination for Black women using evidence from

outcomes within legal cases related to race and/or sex, speeches from civil rights movements, and even utilized more contemporary forms from the media. She describes a context in which Black women are overcome by White men and women, while also compromised by complexities related to the collectivist nature of the Black community (Crenshaw, 1989).

Crenshaw highlighted how feminist scholars and activists have primarily based their understanding on that of the majority (White women), which alienates Black women, leaving them with no representation. She also specifically focuses on the concept of power dynamics of rape and how laws are rooted in historical practices that did not provide any protection for Black women. She further goes on to elaborate on how gender roles and socially constructed norms devised by White men imposes more debilitation upon the Black woman (Crenshaw, 1989).

As a White woman studying the experiences of Black women involving sexual trauma and reproductive health, I acknowledged the White privilege that I hold which has a role in changing the way I experience, perceive, and relate to things. In my study, intersectional ties were a highly respected component in understanding how to improve clinical practice with the targeted population, therefore very much so leaning upon intersectionality theory. Furthermore, recent studies that utilize intersectional theory suggest the application of the TISJR framework in future studies with populations that have intersectional identities.

A recent quantitative study guided by intersectionality theory factored in components of race, gender, and trauma with 187 Black and White women and men

diagnosed with mental health issues and serving probation between 2017 and 2019 in an unknown Southeastern state. In a comparison of all groups of participants, women reported more traumatic experiences than men overall, and White women reported the most sexual trauma experiences overall. However, Black women were diagnosed with PTSD more often than any of the other groups. The research was limited in that it did not explore how race-related experiences may have impacted reporting rates and/or mental health needs, and recommended future research to explore if racism, discrimination, and/or the passing down of generational trauma may have a correlation with higher rates of PTSD within Black women. The authors supported the application of trauma-informed and culturally responsive practice and referenced the benefits of this within the TISJR framework when working with populations that have experienced trauma and are impacted by mental health issues (Givens et al., 2022). In consideration of the recommendations for future research, I incorporated questions for participants that inquired about if and how race-related and/or sex-related discrimination were perceived to impact participants' experiences and mental health needs.

Another recent study implemented a systemic literature review exploring the impact of the dominant class (i.e., White males) on the sexual assault of minority women between the 1700's and 2016. The review analyzed 28 sources, finding emerging themes relevant to gender, ethnic minority, and intersectionality. The findings were congruent with Crenshaw's description of the concept of rape as it related to accepted forms of dominance by the White male, a lack of value and protection for Black women, and

socially constructed views of motherhood and womanhood that are favored after White women (Crenshaw, 1989; Ruiz et al., 2021).

The review also focused on the hostile and discriminatory differences in laws toward minorities specific to geographical location (i.e., the Southern United States) throughout history (Ruiz et al., 2021). Although laws have progressed over time, the recent overturning of *Roe V. Wade* is a setback that has transitioned power over reproductive health decisions into the hands of state governments. Once again, hostile and discriminatory differences specific to the Southern United States are being displayed through abortion bans and restrictions on reproductive health decisions.

As Crenshaw (1989) presented in her seminal work around intersectionality theory, a feminist approach for advocacy is important, however it is critical that an emphasis is placed on the double-axis of race and sex to represent how Black women are uniquely impacted. Lastly, results of the systemic review were used to acknowledge how healthcare policies and practices can uphold racist and sexist forms of oppression, and recommendations were made for healthcare professionals to create change through utilizing the perspective of their patient to enhance culturally responsive practice (Ruiz et al., 2021). The significance of race and sex, along with factoring in geographical location, were demonstrated within my study on experiences of sexual trauma and abortion.

### **Alignment**

I identified a direct alignment among the problem, research question, and purpose of this study with the TISJR framework. The major tenets of the TISJR framework are:

- the importance for researchers in recognizing a relevant connection between trauma and marginalized populations,
- that trauma is escalated for these groups significantly in comparison to nonmarginalized populations,
- and that stigma and racism are components potentially exacerbating trauma experiences within marginalized populations (Voith et al., 2022).

The problem addressed in this study is complex and reflects a gap in social work research and practice. First, there is a lack of education, knowledge, and best practice when serving women that choose abortion (Begun et al., 2016; Ely et al., 2018; Swan et al., 2021; Witt et al., 2022), which can be intensified by factors of intersectionality when it is a Black woman, attributed to elements of stigma and racism (Brown et al., 2022). Second, it is highly probable that many women seeking abortion have a history of sexual trauma in consideration of recent statistics indicating that 81% of women report at least one incident of sexual trauma in their lifetime (National Sexual Violence Research Center, 2023), and approximately 33% of women have abortions (Altschuler et al., 2017; Ely et al., 2018; Sperlich et al., 2020). Women with a history of sexual trauma have identified that intimate healthcare practices can be retraumatizing (Altschuler et al., 2017; Brunton & Dryer, 2020; Ely et al., 2018; Ely et al., 2020; Fukumoto, 2022), however no studies I have found have explored the relationship between women with a history of sexual trauma by factoring in an abortion experience as an intimate healthcare practice, and possible retraumatization.

Extending further on sexual trauma, data reveals that IPSV reports increased during COVID19, with the highest rates being reported by Black women (Wood et al., 2023). In conjunction with internalized and externalized stigma, important spiritual, family, and community values, and anti-institutional beliefs rendered by discrimination and racism, it is highly likely that the rates of sexual trauma for Black women is tremendously higher than we are aware of (Crenshaw, 1991; Hoxmeier et al., 2023; Iwasaki et al., 2023; Kelley, 2023; O’Neal, 2019 as cited by Kelley, 2023; Oyesola Oluwafunmilayo Ayeni, 2022; Powell Sears, 2018 as cited by Lacey et al., 2021; Powell Sears, 2020; Tummala-Narra et al., 2023). Walsh et al. (2022) identified that Black women reported the highest rates of discrimination in comparison to other minorities. With strong correlations in the literature between sexual trauma and mental health issues (Fukumoto, 2022; Murphy-Oikonen et al., 2022; Wolf et al., 2022), and between discrimination and mental health issues (Walsh et al., 2022), it was critical to acknowledge how these facets may impact each other in a unique way only experienced by Black women.

In summary, there is a problem within social work practice when working with clients who choose abortion, which has the potential to be elevated when engaged with marginalized populations that have experienced trauma and discrimination. The problem acknowledges a major tenet of TISJR that indicates that trauma is escalated for marginalized populations in comparison to nonmarginalized populations. Elements of intersectionality with this population may ascribe to the perception of trauma experiences, the severity of trauma symptoms, and correlating mental health issues,

which lead to the development of the research question aligned with exploring the relationship between discrimination surrounding intersectional identities within a marginalized population and their trauma experiences. Next, the purpose of the study was to explore the experiences of a marginalized population that has experienced trauma to contribute knowledge and improve clinical practice within the field of social work. In hindsight, the development of the research question and the purpose of this study stemmed from my recognition of a meaningful connection between trauma and marginalized populations, a relationship that I identified as requiring further exploration and that represents a critical tenet of the TISJR framework (Voith et al., 2022).

### **Values and Ethics**

The NASW Code of Ethics provides social workers with values and ethical standards to guide social work practice. I identified the values of social justice, dignity and worth of the person, competence, and integrity as central to this study. The ethical principle surrounding the value of competence is most relevant to the social work practice problem. Scholarly literature has shown that social work practitioners are not generally educated about abortion and either refuse to, or don't know how to, best serve women that are seeking an abortion (Ely et al., 2018; Swan et al., 2021). This demonstrated incompetency does not align with the NASW Code of Ethics and presents a major problem, especially in the current time and environment in which women's reproductive rights are being diminished, resulting in social injustice.

The ethical principle surrounding the value of social justice guides social work practitioners in their responsibility to confront social injustices occurring amongst

vulnerable populations. In social work practice, advocating and lobbying against abortion bans and restrictions that affect vulnerable populations (i.e., Black women) would challenge that social injustice. The NASW Code of Ethics also defines a social worker's responsibility to the dignity and worth of the person, as being respectful of differences, encouraging self-determination, and aiding in conflict resolution between individuals and society. A social work practitioner may not have the same values or beliefs as their client (i.e., the practitioner identifies themselves as pro-life), although they may be working with a client who is seeking an abortion. However, if they are adhering to the value of the dignity and worth of the person, they would be respectful about their client's decisions about her reproductive healthcare and family planning needs, despite having a different opinion, and provide services and resources that fit what the client wants to pursue.

Furthermore, social work practitioners must continue to develop their knowledge and apply that knowledge in practice when working with clients who choose abortion. The value of competence directs practitioners to engage in ongoing professional development to strengthen their practice. This value of competence informed the purpose of my study, as I explored the abortion experiences of Black women with a history of sexual trauma in the Southern United States to address a gap in social work research and practice. I also prioritized integrity throughout the research process, particularly in recruiting and engaging participants from within the Black community, while remaining mindful of the unethical and harmful research practices that have historically affected this population. In conclusion, I aimed to contribute insight into the multidimensional factors of social injustice experienced by Black women in these circumstances, offering

knowledge that may support social work practitioners in promoting positive social change while upholding the values and principles of the NASW Code of Ethics (NASW, 2023).

In conclusion, I determined that the values and principles discussed in this section align with the TISJR framework. Previous research using the TISJR framework is valuable when focusing on social work practice problems that involve individuals who have experienced trauma, social injustice, stigma, and cultural/racial discrimination (Voith et al., 2020; Voith et al., 2022). Crenshaw (1989) highlighted the repercussions that Black women face in a society where laws and policies adhere to a majority population, without any precedence given to the concept of intersectionality as it applies to the minority population. I identified the components of intersectionality, along with the values of social justice, dignity and worth of the person, competence, and integrity, as central to promoting social change for Black women within the sociopolitical context of this study (NASW, 2023).

### **Review of the Professional and Academic Literature**

The literature search was initiated using multi-database searches, to include Thoreau, ProQuest One Academic, CINAHL & MEDLINE Combined Search, and Psychology Databases Combined Search, and filtering the results to include only full-text peer-reviewed scholarly journals that were published within the last five years. I also filtered by subject, to include *social work, social justice, public health, public policy, psychology, nursing, medical, health policy, counseling, clinical mental health counseling, and multidisciplinary*. This led to other databases used to search the

literature, including Academic Search Complete, EBSCO ebooks, Gale Academic OneFile Select, ProQuest Central, ProQuest Ebook Central, SAGE Journals, APA PsycInfo, SocIndex with Full Text, Taylor and Francis Online, Nexis Uni, govinfo, National Institute on Minority Health and Health Disparities (NIMHD), and APA PsycArticles.

I used the main concepts within my research question to search keywords. The keywords searched were: *abortion, medication abortion, surgical abortion, self-managed abortion, abortion care, abortion barriers, abortion stigma, abortion providers, abortion clinics, abortion policies, pregnancy, childbirth, reproductive health, sexual health, healthcare, physician, OBGYN, provider, patient, trauma, sexual trauma, sexual abuse, sexual violence, sexual assault, rape, intimate partner violence, intersectionality, women, female, minorities, ethnic groups, race, people of color, women of color, African American, Black, Southern United States, qualitative, reproductive justice, social justice, social work, medical social work, mental health, anxiety, depression, post-traumatic stress disorder or PTSD, feminist theory, trauma-informed care, trauma theory, Trauma-Informed Socially Just Research (TISJR) framework*. I also checked the references of articles to identify other potential sources, and Google Scholar was an additional search engine used to locate highly cited literature sources.

Seminal works were included if they were of historical relevance, provided information that could be useful to the research design, aligned with theories incorporated into the study, or were a highly cited source on primary concepts within the study. Lastly, online sources were used to gather historical and current information as it relates to

regulations, policies, laws, and statistics. Online sources were only deemed credible if the publication or copyright date was within the last five years, the author and/or organization are providing information that is in their area of expertise or frame of knowledge, references cited by the author and/or organization appear credible based on these same criteria, and there is no noticeable bias.

A reading code organization sheet (RCOS) is recommended to sort and organize data from articles that will be included in a literature review (Shon, 2018). Walden University provides literature review matrix templates within their writing center that resemble a RCOS and supports a structure of organization within a literature review for students (Walden University, 2023). Utilizing these examples, I initially sorted literature into two major topic areas of *abortion* and *sexual trauma*. As I read each piece of literature, I searched for major themes or concepts within each individual article and began to develop thematic codes related to important ideas, gaps, and future recommendations identified by the authors.

This thematic analysis of the data was beneficial in narrowing down my primary research question, expanding my literature search, and determining what headings and subheadings should be used in my literature review based on how many times thematic codes presented within the literature data set. Therefore, if I found that most of the data on a topic stemmed from research conducted with a certain population, creating a gap with others outside of that population, I would apply a thematic code such as “primarily White women.” I began to put the articles in categories related to the gaps identified within the literature and was then able to formulate what gaps my research would focus

on, such as *race*, *gender*, and *geographical location*. Due to gaps in the literature, some peer-reviewed, scholarly articles that were published more than five years ago were included in this literature review. For example, gaps were noted in the literature related to race and geographical location surrounding the concept of abortion, therefore I narrowed the target population of my study to women of color residing in the Southern U.S. These findings within the literature review also led to the development of a new major theme of *intersectionality*, however I found that it was best to include factors of intersectionality as it applies to each theme, rather than making it a theme of its' own as there are specific facets regarding intersectionality unique to abortion and sexual trauma.

With considerations to the initial inclusion and exclusion criteria developed based on my findings thus far in the literature review, and in assessing my timeline, goals, and resources as a graduate student, I decided that I would not have the capacity to conduct research with individuals that did not speak English. This led to my decision to detach from my target population being “women of color,” to specify “Black or African American women,” with the assumption that women in this population would be more likely to speak English in comparison to other races/ethnicities that could be included in “women of color.” In retrospect, I can recognize how identifying a specific target population has the potential to increase the generalizability and external validity of this study.

According to Shon (2018), headings and subheadings should be used to synthesize the literature and pinpoint new ideas relevant to your research study. I found using a simple compare and contrast diagram was helpful in understanding what

components would be important to include within my literature review. The selected data set contributed to a fine-tuned research question, and assisted in the development of interview questions that would be relevant to answering the research question in my study. Furthermore, the data set is representative of my analysis and aligns with the theoretical framework guiding my study. I will now review the two major themes of *abortion* and *sexual trauma*, using subcategories as needed to demonstrate important concepts of both themes, along with addressing intersectionality as it applies to each theme.

### **Abortion**

Abortion has been recognized as a public health issue not only within the United States, but worldwide (World Health Organization [WHO], 2022). In turn, expansive research has been conducted surrounding abortion access, abortion care, abortion experiences, abortion reasons, and abortion stigma. Despite this, there are gaps in the literature on the experiences of underrepresented populations and in more politically conservative and/or rural areas within the United States (WHO, 2022). The experience of abortion may shift and evolve based on intersectional identities of the individual experiencing the abortion, the place where the abortion is experienced, and the time when the abortion was experienced. For example, recent scholars have begun to explore abortion during the pandemic of Covid-19, which will likely incur more attention as the pandemic lessens and more data is available (Jones et al., 2022; Joffe & Schroeder, 2021; Kaller et al., 2021).

More so, the legislative changes stemming from the dismissal of *Roe v. Wade* have started to increase awareness of and encourage more research on social justice and reproductive health matters. The 1973 case of *Roe v. Wade* exemplified the unconstitutional practice of states using their power to impede access to abortion. *Roe v. Wade* was imperative in reducing the power and control that the government previously engaged over reproductive health matters. The outcome prevented states from exaggerating limitations on abortion for almost 50 years, but the recent overturning of the case in 2022 once again enabled states to impose laws, regulations, policies, mandates, and bans that dictate the level of accessibility to abortion care (Center for Reproductive Rights, 2022; Guttmacher Institute, 2023; Temme & Marshall, 2022). The timeliness of this research was monumental with respect to the Supreme Court's decision and a nation recovering from a worldwide pandemic.

Furthermore, I focused this study on the abortion experiences of Black women, who experience racism and sexism. Although women of all races encounter barriers to accessing abortion, Black women face unique challenges in making reproductive health and family planning decisions due to discriminatory and racist practices rooted in historical and systemic inequities (Baker et al., 2023). In *The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*, the afflictions experienced in the Black community are portrayed throughout history within scientific and medical research and healthcare practices, divulging how that mistrust was formed. The Black community was forced to be subjects for surgical experimentation to train doctors and improve healthcare practices, and after deceased, their bodies were continued

to be used for experimentation. They were also used as test subjects for trial medications (Washington, 2008). Black women were targeted by scientists and the government to reduce reproduction rates within the Black community by means of new forms of contraception and sterilization, resulting in consequences if not adhered to, occurring in as late as the 1960's (Baker et al., 2023; Washington, 2008).

A recent study depicts how Black women still face discrimination and stigma surrounding reproductive health matters, even amongst the Black community itself. Black women that encountered unintended pregnancies expressed feeling stigmatized whether they decided to give birth or to get an abortion by their social supports. Often, this leads to secrecy and a lack of support, found to be correlated with increasing stress and physical/mental health symptoms (Moseson et al., 2019). Factors related to race and gender are important components that I explored in this study to understand how intersectional identities may affect the abortion experience.

### ***Abortion Access***

The term "abortion exceptionalism" refers to the idea that abortion is not observed or referred to as other healthcare practices are (Joffe & Schroder, 2021). However, practitioners agree that abortion should be normalized as any other reproductive healthcare practice (Baldwin et al., 2022; Chowdary et al., 2022; de Londras et al., 2022; Ely et al., 2020; Joffe & Schroder, 2021). Despite this, abortion accessibility remains limited. Most of the literature on abortion access identifies emerging themes in relation to barriers that make it difficult for women to seek out and proceed with an abortion. In addition, women report a multiplicity of barriers to accessing abortion, that when

combined, can make the experience even more taxing (Carroll & White, 2020; Ely et al., 2017b; Ely et al., 2020).

One of the biggest barriers was having to travel long distances to access abortion, which was most found most often an issue in the Southern United States or rural areas in general where public transit is not readily available (Biggs et al., 2017; Biggs et al., 2020; Blanchard et al., 2017; de Londras et al., 2022; Ely et al., 2017a; Ely et al., 2017b). For example, even prior to Covid-19, only 7% of the counties in Southern states had existing abortion clinics and/or healthcare practitioners providing abortion services (Jones et al., 2022). Although not all OBGYNs perform abortions, they do provide important reproductive health treatment, however only 35% of counties in the United States have access to an OBGYN (ACOG, 2023).

Furthermore, since the overturning of *Roe v. Wade*, the patient to provider ratio has significantly decreased in states enforcing abortion bans, meaning less access to reproductive healthcare overall for women living in rural and/or Southern regions (ACOG, 2023; Marsa 2018). These areas are now being referred to as “maternity care deserts,” and impede women from addressing sexual healthcare needs unrelated to abortion (ACOG, 2023; March of Dimes, 2023). Reports also show that healthcare students and new practitioners are less likely to train and/or practice in these areas in the future (ACOG, 2023). Women that live in these areas may have to go to other counties or states to be able to receive any type of sexual healthcare. Traveling long distances can be even more challenging for women if they work, attend school, or are already a primary caregiver to children at home (Carroll & White, 2020; Ely et al., 2017b; Ely et al., 2020).

Some sanctions dictate which type of healthcare providers can perform abortions (i.e., OBGYN, internal medicine, family medicine, etc.), however this affects the provider to patient ratio limiting the rendering of services and creating more challenges for women trying to access care (Londras et al., 2022; Patel et al., 2022). Only 3% of healthcare practitioners outside of abortion clinics perform abortions, which can mean difficulty obtaining an appointment (Patel et al., 2020). In addition, some states have extensive abortion requirements, such as mandatory waiting periods and gestational specifications, which often makes abortion less accessible when factoring in transportation and scheduling issues (Biggs et al., 2020; Carroll & White, 2020; Ely et al., 2017a; Ely et al., 2020; Moseson et al., 2022). Even if women could get access to abortion, they were often unable to afford the cost as it is not covered by health insurance like other medical procedures are, preventing them from moving forward (Carroll & White, 2020; Ely et al., 2017a; Ely et al., 2020; Moseson et al., 2022).

Legal components create more challenges for women seeking abortion and the healthcare practitioners that provide abortion services, particularly in the Southern United States as these states have the most restrictions (Barr-Walker et al., 2021; Chowdary et al., 2022; de Londras et al., 2022; Mosley et al., 2022; Patel et al., 2022; Perreira et al., 2020; Raifman et al., 2021). Data that was analyzed from a 2018 Survey of Family Planning and Women's Lives showed a correlation between states with the most restrictions and states where women perceived abortion to be the most inaccessible (Perreira et al., 2020). Furthermore, some current legal restrictions imply criminalization of abortion for clients and providers, resulting in negative consequences for all parties

involved (Baker et al., 2023; Chowdary et al., 2022). In a recent study, 87% of participants were in favor of punishment for individuals involved in the act of abortion including the woman, her partner, and practitioners providing abortion services/care. Recommendations for punishment included incarceration, probation, monetary retributions, forced contraceptive use, sterilization, state-mandated counseling, social and/or religious exile, ineligibility for government assistance/welfare, ability to have children decided by the government, and mandatory church attendance and engagement in Bible studies (Baker et al., 2023).

Currently, there are 13 states identified as having the most restrictive policies across the United States, to include: Idaho, North Dakota, and South Dakota, along with Texas, Oklahoma, Louisiana, Arkansas, Missouri, Mississippi, Alabama, Tennessee, Kentucky, and West Virginia in the Southern region (Guttmacher Institute, 2022). The data shows that in areas with the most restrictions on abortion, the rates of abortion do not decline, and more women look to manage abortion on their own or with the help of someone who is not a qualified healthcare professional. Self-induced abortions are shown to result in severe physical problems for the individual and negative consequences on a larger and economical level as healthcare fields end up providing emergency care in those situations (WHO, 2021).

Women often report barriers to accessing abortion such as a lack of education or understanding of their reproductive health rights, legal limitations in their area, funding options, types of abortion procedures and what they entail, who to ask for help, and where to go for services. The literature is consistent that either women do not have

enough information, or they are misinformed about sexual and reproductive health matters (Barr-Walker et al., 2021; Blanchard et al., 2017; Brown et al., 2022; Chowdary et al., 2022; de Londras et al., 2022; de Medeiros Guimarães & da Silva Ramos, 2017; Ely et al., 2018; Ely et al., 2020; Moseson et al., 2022; Patel et al., 2022; Perreira et al., 2020; Raifman et al., 2021; Wycoff et al., 2019). Misinformation about health conditions stemming from abortion has been found to be dispersed through online sources, pregnancy centers, academic journals, and in materials provided to women seeking abortion (Barr-Walker et al., 2021; Patev & Hood, 2021). Some common misconceptions are that abortion is related to infertility, breast cancer, mental health issues, and regret (Patev & Hood, 2021; National Academies of Science, Engineering, and Medicine, 2021). However, statistics show that there is a low risk for health issues associated with abortion when provided by healthcare professionals (American College of Obstetricians and Gynecologists, 2023; Londras et al., 2022; Patel et al., 2022; WHO, 2021).

There is some incongruency in the literature about the safety, risks, and effectiveness for women who choose to self-induce abortions which appears to be due to varying demographic factors and the method in which these women used to attempt to terminate the pregnancy (Baldwin et al., 2022; Moseson et al., 2020; Perreira et al., 2020, Raifman et al., 2021). However, less than 5% of women who receive abortions by a healthcare practitioner experience physical ailments outside of temporary side effects. Furthermore, the data shows that abortions are safer than some common surgical procedures such as colonoscopies, plastic surgery, dental surgery, and adult tonsillectomies, with less than 1% of physician-facilitated abortions resulting in death

(National Academies of Sciences, Engineering, and Medicine, 2021; Patel et al., 2022). It should be noted there is a slight increase in risk of mortality when women choose to induce an abortion using medication (Patel et al., 2022). In a review of the literature over the past ten years, findings show that women continue to display uncertainty or inaccuracy surrounding many abortion misconceptions (Patev & Hood; 2021).

There are debates within the literature about whether abortion emotionally impacts women (Baker et al., 2023; Barr-Walker et al., 2021). More research is needed on the mental health needs and post-care supports for women after receiving an abortion (National Academies of Sciences, Engineering, and Medicine (2021). However, a recent quantitative study found correlations between barriers to the actual process of accessing abortion and mental health symptoms, which lead to the development of the Psychosocial Burden Seeking Abortion Scale (PB-SAS) (Biggs et al., 2020). The study resulted in four emerging themes related to barriers when accessing abortion, including structural challenges, pregnancy decision, lack of autonomy, and others' reactions to the pregnancy, which were all found to be associated with mental health symptoms, most often in the form of stress, depression, and anxiety. Other barriers also emerged in the study which depict issues related to intersectionality, power dynamics, and stigma (Biggs et al., 2020).

Negative correlations have been identified with women being unable to access abortion, particularly for Black women. Data shows there are higher instances of maternal and infant mortality in the South or rural areas than other areas of the U.S. (Chowdary et al., 2020; Thompson et al., 2021; Thompson et al., 2022). Furthermore, in 2020, there were 1,843,432 live births to White women, with 352 White women dying

due to pregnancy-related issues. That same year, there were only 529,811 live births to Black women, with 293 Black women dying due to pregnancy-related issues. Those numbers show that only 59 more White mothers died than Black mothers during childbirth, even though 1,313,621 more White women had babies than Black women that year. Prior to Covid-19, data still shows that maternal mortality rates have consistently been higher for Black women and has shown tremendous increases over the past several years (CDC, 2022b). According to Redd et al. (2022), Black babies were also more likely to be born premature and have low birth weights in states that were more restrictive on abortion, leading to further health and developmental issues. Additionally, in 2019, statistics show that Black babies were more likely to die before their first birthday than any other race/ethnicity (CDC, 2022a). Healthcare practitioners acknowledge the increase in maternal and infant mortality rates that are affected by limited access to abortion (de Londras et al., 2022; Ely et al., 2020; Watson, 2022).

### ***Abortion Experiences***

The literature depicts both positive and negative experiences of abortion dependent upon many factors such as clinical setting and/or geographical location, the relationship between the patient and the healthcare provider, degree of pain during procedure, the extent of support received, feelings of autonomy, privacy, and safety, the method of abortion, and the level of effectiveness in terminating the pregnancy. Common themes emerged within the literature surrounding concepts that contributed to a positive abortion experience. For example, women were more likely to describe their abortion experience as positive if they did not run into barriers when trying to access abortion.

Even prior to the overturning of *Roe v. Wade*, there were abortion regulations in some states that made it more difficult to access an abortion, such as gestation periods and mandatory counseling or waiting requirements. Often, this led to women having to travel to other states outside of where they reside to get abortion care (Blanchard et al., 2017; Brown et al., 2022).

In addition, women expressed the value of having a relationship with the provider for a good abortion experience, however since abortion is not generally offered outside of specialized clinics, women were most likely being treated by someone and in a setting that they were not familiar with. Despite this, women found that certain factors within this new patient/provider relationship could improve the abortion experience. Women found abortion experiences to be more positive if they felt that providers provided all options and enough information so that they could make an educated decision on their own, and for their decision to be respected without feeling judged. An important component of the patient/provider relationship was sharing control surrounding the patient's body and needs during the procedure (Altschuler et al., 2017; Brown et al., 2022; Kjelsvik et al., 2019; Mosley et al., 2022).

In a recent study with Black and Latinx women, autonomy was identified as a critical factor in the abortion experience, with careful consideration of the discriminatory treatment women of color have experienced related to their reproductive health throughout history (Mosley et al., 2022). Other literature also emphasized a need for healthcare providers to be aware of how experiences of racism and/or discrimination may play a role in the abortion experience for women of color (Baker et al., 2023; Brown et

al., 2022; Cain, 2020). One study found that Black women with literacy levels ranging from 3<sup>rd</sup> through 12<sup>th</sup> grade struggled with medical jargon and language used by healthcare providers, which impacted their ability to make informed decisions about their reproductive healthcare needs. If they also lacked social or familial support, they expressed feeling like they had no one to turn to for information. However, these women identified a trusting and helping relationship with social workers (if available) at the healthcare facilities they visited, which increased their confidence and feelings of being in control (Timika Anderson-Reeves, 2020). Other Black women indicated that doctors would not listen to them and tried to overrule them by claiming a sense of authority and power as the medical provider, resulting in negative experiences (Brown et al., 2022).

Furthermore, experienced and/or perceived stigma and social support were also indicators of whether an abortion experience was positive or negative. Women's own core values and beliefs, along with that of their family, friends, significant others, and religious communities, were factors that could make a difference in their decision-making process, abortion experience, and processing of the experience afterwards (Baker et al., 2023; Brown et al., 2022; Meier et al., 2021; Mosley et al., 2022). Women also face stigma surrounding abortion as it conflicts with the socially constructed norms and expectations of a women's role as a mother (Baker et al., 2023). For women of color, having diverse staff and providers in the clinic improved abortion experiences (Mosley et al., 2022). However, the Black community is not always supportive of abortion, particularly due to spiritual beliefs, sociocultural norms, and historical trauma (Baker et al., 2023; Mosley et al., 2022). Particularly observed in women of color is the preference

for surgical abortion procedures over medication induced procedures, which could be related to mistrust in the medical fields for previous birth control pill testing on Black and Latinx women (Mosley et al., 2022). Lastly, the pandemic of COVID-19, created unique challenges and experiences of abortion for women that are beginning to gain attention (Kaller et al., 2021).

### ***Abortion During COVID-19***

Across the country, the number of pregnancies that were terminated due to abortion increased by 8% over a three-year span from 2017 to 2020, which was then followed by a slight decrease (Jones et al., 2022). The pandemic of COVID-19 spread in the beginning of 2020, leading state governments to introduce travel restrictions, curfews, shelter in place orders, and the designation of essential workers only. According to Jones et al. (2022), many states denied abortion services as “essential,” which could have affected abortion numbers. Many abortion clinics altered the way they provided services, or halted rendering services due to the restrictions placed by state governments to manage COVID-19, which increased difficulty in accessing services that were already superseded by limitations and barriers before the pandemic hit (Joffe & Schroeder, 2021; Kaller et al., 2021). During the outbreak of COVID-19, if a clinic remained open, there was an even more limited workforce to provide abortion care due to staff illness or staff’s concerns about exposure to the virus (Joffe & Schroeder, 2021; Kaller et al., 2021).

A consistent theme in the literature is that the safety and privacy for clients and staff has always remained a major concern, but COVID-19 intensified that concern when protestors gained more freedom with the reduction in security at clinics (Brown et al.,

2022; Chowdary et al., 2022; Joffe & Schroeder, 2021, Raifman et al., 2021; Sperlich & Gabriel, 2022). However, some barriers to accessing services were reduced by COVID-19, as abortion clinics found new ways to provide services, such as providing virtual services and mailing abortion-inducing medications to clients that could be self-managed (Jones et al., 2022; Kaller et al., 2021). Although opinions, commentary, and quantitative reports are available, there is a lack of qualitative research with women surrounding their abortion experiences during the pandemic (Joffe & Schroeder, 2021).

### ***Abortion Reasons***

There are many findings in the research regarding reasons women choose abortion. Some reasons for abortion identified included the women's age at the onset of pregnancy, who and how other individuals are involved in the decision-making process regarding termination of the pregnancy, pregnancies induced by rape, and health/medical concerns for the baby and/or mother. Across recent studies, both pregnant adolescents and adults describe the decision to terminate a pregnancy as complex, time-consuming, and thoroughly and purposefully thought out, often identifying several reasons why they concluded that abortion was the best decision for them at the time of their pregnancy (Chae et al., 2017; Coleman-Minehan et al., 2020; Jones et al., 2023; Roncoroni et al., 2023). Women's reasons for abortions varied based on demographic factors such as age, marital status, education level, and geographical location of urban vs. rural areas (Chae et al., 2017). One study focused on women that did not want to end their pregnancy, but for medical reasons, felt that it was the best decision to have an abortion (Roncoroni et al., 2023). More recent studies indicate the added challenges women have faced during

COVID-19 related to finding or maintaining work/income and childcare, may influence women's decision to have children (Jones et al., 2023).

Studies have also explored others' perceptions of the reasons women choose abortion, which has been shown to be affected by an individual's religion, political position, morals/ethical considerations, gender, group membership, and the extent of an individual's education surrounding abortion (Selebalo-Bereng & Patel, 2019). Brown et al. (2022) identifies how personal and group experiences can also impact an individual's perception of, or reasons for abortion. Not being prepared or wanting to have a child and relationship issues with their significant other are two common reasons women choose abortion. Women that chose abortion because they didn't feel prepared or didn't want to have children define complexities behind their decision, including factors of how their physical/mental health, amount of support, and/or financial struggles would affect their ability to care for a child if they continued their pregnancy (Brown et al., 2022; Chae et al., 2023; Jones et al., 2023). Some women disclosed how experiencing homelessness and pregnancy simultaneously led to a logical decision in terminating a pregnancy (Brown et al., 2022). Other women reported experiencing IPV in their relationships, leading them to choose to abort a pregnancy due to concerns for their self and their unborn baby's safety (Brown et al., 2022; Chae et al., 2023; Crouthamel et al., 2022; Jones et al., 2023). More specifically, varying forms of sexual violence was highlighted as a reason to choose abortion (Brown et al., 2022).

In a recent study on Black women's experiences of abortion, women expressed unique reasons that were race-related for not wanting to have children. A major concern

when considering having a child is the unparallel statistics on infant and mother mortality rates for Black women compared to their peers (Brown et al., 2022). Out of 100,000 Black women giving birth, approximately 40 will experience a pregnancy-related death. In comparison, out of 100,00 White women giving birth, approximately 14 will experience a pregnancy-related death (National Center for Chronic Disease Prevention, 2022). Although many causes or contributing factors to pregnancy-related deaths are the same amongst races, Black women experience higher rates of some health problems in comparison to their White counterparts, putting them more at risk for mortality (National Center for Health Statistics, 2023; Sealy-Jefferson, S., 2022). However, even when Black women experience lower rates of health problems than White women, they still experience higher maternal mortality rates, indicating that health factors cannot be the single source to explain why Black women are disproportionately affected (Sealy-Jefferson, S., 2022).

Fear of police brutality, incarceration, and safety concerns for their significant other and for their unborn child were expressed as reasons for abortion for Black women. A distrust in government and medical systems due to racism and oppression either personally experienced or an awareness of the experience of others in their communities or ancestral history, are noted as other reasons Black women may not want to have children. Despite these distinctive statistics and issues reported within the Black community, defined ideas and beliefs surrounding abortion, mental health, and the expectations of a Black woman, make the decision to terminate a pregnancy conflicting for Black women (Brown et al., 2022).

### ***Abortion Stigma***

Existing qualitative studies show that internal, external, imagined, and/or perceived stigma about the concept of abortion, and about the people who choose abortion, plays a critical role at a micro level when an individual is contemplating abortion, at a mezzo level when enacted in the community (i.e., groups protesting at abortion clinics or being shunned by a religious entity), and at a macro level when passing legislation about reproductive health. Individual beliefs, perceptions, and internalized stigma play a role in a woman's decision about seeking abortion and the type of abortion preferred (Baldwin et al., 2022; Perreira et al., 2020; Raifman et al., 2021). Furthermore, a correlation has been observed between religious/political beliefs and internal and external abortion stigma/perceptions (Baldwin et al., 2020; Perreira et al., 2020). States with most residents being of the Christian faith and strong Republican parties corresponds with higher stigmatization surrounding abortion; this again directs the study to focus on the Southern region of the United States. This higher stigmatization manifests negative perceptions of being able to access an abortion. In states where accessing abortion is perceived difficult, there are higher rates of self-induced abortions, which puts the health and lives of women at risk (Perreira et al., 2020). There is a gap in the literature on how other religions outside of Christianity may impact the stigma/perceptions surrounding abortion (Baker et al., 2023).

It is important that healthcare and social work practitioners understand the significance of stigma and ensure they are not encouraging it when communicating with clients who are considering abortion (Baker et al., 2023; Mollen et al., 2018). Some

report experiencing more stigma than others, including Black women and transgender or non-binary individuals (Baker et al., 2023; Ingraham & Hann, 2022; Moseson et al., 2021). Even practitioners that provide abortion care have reported concerns with their own safety, mental health needs, and feelings of isolation related to the stigma surrounding the act of abortion and their profession (Chowdary et al., 2020).

Similarities have been identified in the literature about women who obtain abortions which include race, age, employment status, and socioeconomic class. There are higher percentages of Black women receiving abortions, although more White women actually receive abortions due to the difference in size of each population. Also, more women receive abortions that are unemployed or considered low-income by federal guidelines. Most women who receive an abortion receive assistance from the government in paying for their health insurance, do not have insurance, or their insurance will not cover abortion costs. Women residing in the Midwest and Southern regions, and rural areas, experience more travel difficulties than women who do not live in these areas, which most likely parallels with the state's hostility level toward abortion. In relation to these characteristics, stigma is most often directed at Black women and women living in poverty or receiving some form of government assistance (Blanchard et al., 2017; Brown et al., 2022; Ely et al., 2020). In this study, I explored how many of these characteristics (race, gender, geographical location) factor into the abortion experience.

### **Sexual Trauma**

According to the National Sexual Violence Research Center (2023), 81% of women experience sexual trauma in their life, with one out of five women experiencing

an attempted or completed rape. However, sexual trauma often occurs during childhood, affecting approximately 25% of girls (Division of Violence Prevention, 2022). These statistics emphasize the importance of considering the impact of sexual trauma and utilizing the best practices for intervention or treatment. Despite sexual trauma being a serious public health problem and its' significance within the scholarly literature, there are still gaps on the sexual trauma experiences of women of color. Research has primarily been conducted with White women, particularly focusing on young women living on college campuses as sexual reports are high in this environment (Gomez, 2021; Hoxmeier et al., 2023), and women with a history of child sexual abuse (CSA) (Brunton & Dryer, 2021).

Congruency exists within the literature on relationships between survivors of CSA and behavioral, criminal, and substance abuse issues, along with mental and physical health problems (Brunton & Dryer, 2021; Kozak et al., 2018). A recent quantitative study identified similar negative impacts that CSA has on children and adolescents in India, focusing on cultural factors that may cause differentiation from other ethnicities and recommending future research with diverse populations (Choudary et al., 2018). Furthermore, in a quantitative study identifying negative impacts that CSA has on children and adolescents in the United States, data showed that Black children participating in the study reported higher rates of CSA and of violent/delinquent behaviors, further acknowledging a need to explore sexual trauma with diverse groups (Kozak et al., 2018). Other studies on sexual trauma occurring during adulthood also indicate a connection between substance abuse issues, mental and physical health

problems, and sexual trauma experiences (de Medeiros Guimarães & da Silva Ramos, 2017; Gomez, 2021; Keshet & Gilboa-Schechtman, 2019; Persson et al., 2020; Scheer et al., 2023; Wamser-Nanney, 2022).

### ***Vulnerability***

Characteristics such as gender, age, mental health status, and disability status can increase risk for sexual trauma (Brunton & Dryer, 2021; Carr et al., 2019; Gomez, 2021; Hoxmeier et al., 2023; Hughes et al., 2019). Survivors of CSA are more likely to engage in risky sexual behaviors, violent and/or criminal activity, and consumption of alcohol/drugs, than those who do not have a history of CSA (Brunton & Dryer, 2021; Kozak et al., 2018). Furthermore, these types of behaviors increase the risk for revictimization (Brunton & Dryer, 2021; Carr et al., 2019; Gomez, 2021; Hoxmeier et al., 2023). Alcohol consumption creating increased risk for sexual trauma may explain higher reporting rates on college campuses and in sororities where alcohol is frequently consumed (Fedina et al., 2018; Gomez, 2021; Hoxmeier et al., 2023; Oyesola Oluwafunmilayo Ayeni, 2022). In addition, common factors have been identified in the literature that are frequently found amongst survivors of sexual trauma, including: (a) knowing their abuser prior to the incident, (b) having a history of sexual trauma, and (c) disclosing to people they know rather than seeking help from law enforcement (Fedina et al., 2018; Hoxmeier et al., 2023, Sears, 2021; Scheer et al., 2023).

Intersectional identities, such as race and gender, may play a role in sexual trauma experiences. Black women's sexual trauma experiences are limited in the research, and studies on White women's experiences cannot be assumed to be the same when factoring

in unique components of intersectionality (Gomez, 2021). In addition, although there are findings on how having a history of sexual trauma impacts women's family planning decisions and intimate healthcare experiences, I did not find any studies specifically on abortion experiences with women who have a history of sexual trauma. Therefore, I explored the relationship between the two experiences, while also focusing on dynamics of intersectionality that may play a role in these experiences for Black women residing in the Southern United States.

### ***Disclosures of Sexual Trauma***

The existing literature related to disclosure of sexual trauma presents that survivors have reported many reasons for not disclosing their sexual trauma experience to others. Regardless of demographics, survivors are less likely to disclose the incident if they were consuming alcohol prior to, or when the incident occurred. Survivors have expressed concerns about whether they would be believed due to their alcohol consumption. In addition, if the survivor knows her abuser prior to the incident, she is less likely to make a disclosure (Hoxmeier et al., 2023; Kelley, 2023; Oyesola Oluwafunmilayo Ayeni, 2022). Underreporting may also be a result of survivors' concerns regarding victim blaming or victim shaming, and fear of judgement after making a disclosure (Reeves & Humphreys, 2018).

The literature is congruent regarding the role that rape myth acceptance has on survivors and their decisions about disclosing the incident. People who have rigid definitions of gender roles demonstrate rape myth acceptance, which impedes upon help provided to survivors and removes blame from the perpetrators. Rape myth acceptance is

not only observed in men, but also in women. Sexism plays a role in rape myth acceptance as it is based upon social constructs of how men and women should act sexually, setting up a double standard. Therefore, if a woman displays behaviors outside of those social constructs, she is at fault for the sexual trauma she experiences.

Furthermore, this hurts male survivors as well, as men are not traditionally viewed within the social constructs of a patriarchal society as being victims (Angelone et al., 2020; Canan et al., 2018; Jozkowski et al., 2017).

The literature shows that rape myth acceptance has been studied for decades, with the Illinois Rape Myth Acceptance (IRMA) Scale being developed in the late 90's (Lonsway & Fitzgerald, 1999). People that accept rape myths often question whether women displayed risky or immoral behaviors, alcohol consumption, clothing style, and whether resistance was clearly indicated when women disclose rape, which places blame on the victim rather than the perpetrator. Not only do perpetrators accept this type of culture, but many women accept it as well due to established societal norms, which has been shown to influence women to believe that they do not have a choice regarding sexual behaviors, or that the sexual incident is not serious enough to be reported as it may not be seen as a crime (Angelone et al., 2020; Canan et al., 2018; Hoxmeier et al., 2022; Jozkowski et al., 2017).

This acceptance of male dominance by society often generates a sense of guilt within survivors. Research reducing rape myth acceptance within the literature has resulted in the development of prevention and affirmative action programs for college campuses where rates of sexual assaults are high, however this has not been overall

successful within this population, and the needs of women outside of that college population are not being addressed (Angelone et al., 2020; Canan et al., 2018; Jozkowski et al., 2017). In addition to traditional sexist norms, collectivism may prevent women from seeking help after experiencing sexual trauma. Women that are part of a group, in which the protection of the group is more important than any one individual within the group, often do not disclose if the abuser is also a part of that group (Decker et al., 2019 as cited by Kelley, 2023; Handler, 1995 as cited by Hoxmeier et al., 2023). For example, female members of sororities in college often protect their peers through non-disclosure (Handler, 1995 as cited by Hoxmeier et al., 2023).

This type of collectivism is also seen within the Black community, and when the survivor and the abuser are both Black, disclosures are less likely to occur (Decker et al., 2019 as cited by Kelley, 2023). Although there are differences amongst ethnic groups that identify as Black or African American, a similar aspect was identified in the value of privacy within the family or community, which may also be related to underreporting of sexual violence (Powell Sears, 2018 as cited by Lacey et al., 2021; Powell Sears, 2020). Few studies focus specifically on Black women's' experiences of sexual trauma, however unique factors are aligned with underreporting amongst this group, including historical and current mistreatment and/or violence to the Black community by systems that would be involved if the incident were reported (Kelley, 2023; Oyesola Oluwafunmilayo Ayeni, 2022). High incarceration rates of Black individuals, instances of police brutality against Black individuals, and a lack of legal consequences for the perpetrator involving crimes against Black individuals have been identified as possible

indications of why Black women do not report sexual crimes (Kelley, 2023; O'Neal, 2019 as cited by Kelley, 2023; Hoxmeier et al., 2023; Oyesola Oluwafunmilayo Ayeni, 2022). The literature is sparse on disclosures and help-seeking behaviors considering factors of intersectionality, showing a need for future research with Black women and their experiences of sexual trauma.

### ***Physical and Mental Health Issues***

Various literature sources report on physical ailments and disease associated with traumatic experiences. Trauma survivors may experience long-term physical health issues such as high blood pressure, cardiac problems, chronic pain, immunodeficiency disorders, and stomach and weight problems (Bessel van der Kolk, 2015; Brunton & Dryer, 2021; Jeglic, E., 2021; Kumari & Mukhopadhyay, 2020). These physical health issues may be higher in already vulnerable populations such as people that have developmental disabilities and/or physical ailments prior to sexual trauma (Hughes et al., 2019). Furthermore, this may be a factor related to existing health disparities in women of color that needs further exploration.

The literature also shows a correlation between sexual trauma experiences and serious harm to one's mental health. For example, women with sexual trauma are more likely to exhibit extreme cases of PTSD than women that have experienced other types of traumatic experiences. Women whose pregnancy was conceived through a rape experienced negative emotions and psychological issues, including suicidal ideation surrounding their sexual trauma and pregnancy diagnosis (de Medeiros Guimarães & da Silva Ramos, 2017). In addition, mental health symptoms are heightened if someone

experiences sexual trauma as a child and is then revictimized as an adult (Brunton & Dryer, 2021). PTSD, anxiety, and depression are common diagnoses in women that have experienced sexual trauma (Brunton & Dryer, 2021; Gomez, 2021; Keshet & Gilboa-Schechtman, 2019; Persson et al., 2020; Scheer et al., 2023; Wamser-Nanney, 2022). However, women trying to seek intervention to address mental health issues are often faced with challenges stemming from insurance policies and coverage, ranging from unaffordable costs associated with treatment, inconsistency with providers, and limitations regarding the length of sessions and number of sessions available to them (Reeves & Humphreys, 2018).

The intensity of symptoms are found to be related to factors such as the number of times sexual traumas occurred, the severity level of each sexual trauma, and the victim's perception of the trauma (Bistricky et al., 2017; Brunton & Dryer, 2021; Clifford et al., 2020; Decou et al., 2019; de Medeiros Guimarães & da Silva Ramos, 2017; Dworkin et al., 2017; Guina et al., 2018; Keshet & Gilboa-Schechtman, 2019; Persson et al., 2020; Wamser-Nanny et al., 2018). For women with sexual trauma, the most prevalent symptom of PTSD is an escalated defensive mammalian startle reflex in response to stimuli (Rowland et al., 2022). In a recent study with women who that have experienced rape, symptoms of PTSD, and depression were more likely to present in women if they have also experienced racism or discrimination. Experiences of racism and discrimination are unmatched for Black and Biracial women compared to women of other races (Walsh et al., 2021). The increased sensitivity to perceived threats could make aspects of

reproductive health challenging to women with a history of sexual trauma, particularly for Black women in conjunction with their previous experiences with different systems.

### ***Reproductive Health Issues***

Recent studies portray that women's' decisions and experiences regarding sexual health care, abortion care, and pregnancy and childbirth are affected by sexual trauma experiences (Brunton & Dryer, 2021; Ely et al., 2020; Mahenge et al., 2018; Meier et al., 2020; Peluso, 2020; Persson et al., 2020; Sperlich & Gabriel, 2022). In a recent qualitative study, women who experienced CSA expressed increased stress/anxiety about gynecological healthcare practices, indicated re-traumatization during intimate healthcare practices, and experienced more fear related to childbirth than women that did not experience sexual abuse in their childhood. Medical testing showed that these women experienced increased cortisol levels, which typically decrease during pregnancy, and these women experienced more gynecological health issues than women who do not have a history of sexual trauma (Brunton & Dryer, 2021). Additionally, in a cross-sectional study with 945 pregnant women, results revealed that over 75% of participants experienced at least one type of trauma in their lifetime (22% involving sexual trauma), 28% of participants struggled with fear of childbirth, and approximately 4% suffered with symptoms of PTSD (Persson et al., 2020).

Not only are survivors affected by their history of sexual trauma during pregnancy and childbirth, but studies show problems stemming from sexual trauma prior to pregnancy and after childbirth. According to Wammser-Nanney (2021), PTSD associated with sexual trauma increases the risk for infertility and miscarriages, particularly in

women of color. In addition, survivors of sexual trauma frequently struggle with postpartum depression after giving birth (Mahenge et al., 2018). Further research is recommended to explore dynamics that may factor into these reproductive health issues (Mahenge et al., 2018; Wammser-Nanney, 2021).

When making decisions about healthcare and family planning, several components were identified including aspects of the patient/provider relationship, previous experiences with the healthcare system, and factors affecting disclosure. Women compared power dynamics within the patient/provider relationship to their experience of sexual trauma, emphasizing that they lacked control over their bodies in both situations (Meier et al., 2020). Another qualitative study found that healthcare practices and/or providers often triggered trauma reminders of historical traumas (Reeves & Humphreys, 2018). Studies showed congruency in that the patient's perceived level of comfort when sharing a trauma experience with a provider, and the provider's response to their disclosure can create a negative or positive experience (Meier et al., 2020; Reeves & Humphreys, 2018). Lastly, women's perceptions of the healthcare system when they were initially treated for sexual trauma can influence the way they feel about seeking healthcare in the future (Meier et al., 2020).

Black women's experiences may vary greatly from what we know about White women's experiences, as there are circumstances of intersectionality that White women have not faced. Throughout history, Black women's decisions about pregnancy and childbirth were not her own, as they were considered property to White slave owners, then became the property of their husband, if they became free. More so, sexual trauma

experiences have been very different for Black women. Black women were often raped by their slave owners, increasing the slave population as their children were born into slavery against their will. Black women were also used for sexual health medical experimentation and testing of surgical procedures in very abusive and inhumane manners. Furthermore, the introduction of the concept of eugenics tried to eradicate the Black population, and implied sexist and racist perceptions of Black women's bodies and sexual behaviors (Washington, 2008). All these historical traumas experienced over generations has developed into a mistrust of systems that Black women may encounter when experiencing sexual trauma, pregnancy, and childbirth. If further exacerbated by forms of racism or discrimination, these systems may further impede help-seeking behaviors to address the reproductive health needs of Black women.

### **Summary**

In this section, I introduced the problem this qualitative study addressed, along with the purpose, research question, nature of the doctoral project, significance of the study, theoretical framework, prevalent values and ethics within the social work field, and literature review. The scholarly literature provided background information on women's experiences of abortion and of sexual trauma, along with important factors to be considered in clinical practice and within interdisciplinary teams engaging with these women. The literature is very limited on women who have experienced both abortion and sexual trauma. Furthermore, the literature is particularly lacking on these experiences for Black women. Most importantly, the literature identifies that there is a lack of education and services provided by social work practitioners on women seeking or experiencing

abortion. In consideration of the literature review, I explored abortion experiences among Black women living in the Southern United States and examined how intersectionality and a history of sexual trauma may have influenced these experiences in the period following the overturning of *Roe v. Wade*.

## Section 2: Research Design and Data Collection

### **Introduction**

The social work practice problem that I addressed in this study was the lack of knowledge and practice capacity of social work students and professionals when working with women seeking abortion or who have experienced abortion. Due to the current state of radical change in abortion laws which are particularly aggressive in the Southern United States, the role that intersectional identities may have on abortion experiences, issues of division within the country, and the overall impact of COVID-19, there is a heightened need for social workers to increase awareness and improve practice (Begun et al., 2017; Ely et al., 2018; Swan et al., 2021; Witt et al., 2022). Furthermore, there is a high rate of women who experience sexual trauma, which has been shown to negatively impact women's experiences of pregnancy, along with mental and physical health conditions. With this knowledge, it is important to consider that many women who experience abortion may also have a history of sexual trauma. There is a gap in the literature on how the combination of these experiences may impact a woman. The literature on abortion and sexual trauma experiences alike are primarily descriptive of the experiences of White women, leaving scholars and practitioners with even less knowledge about the needs of women of color who have these experiences (Mahenge et al., 2018; Wammser-Nanney, 2021).

In Section 2, I will review the research design, methodology, data analysis, and ethical procedures that were implemented in this study. I will also continue to explain how I applied the priority tenets of the TISJR framework to maintain alignment within

this study related to pre-study, study design, recruitment, informed consent, data collection, and post-data collection (see Voith et al., 2020; Voith et al., 2022). Most importantly, the integration of cultural competency across the entirety of this study was essential to the success of this research as I am an outsider to the population being researched (see King et al., 2018).

### **TISJR in the Pre-Study Stage**

The TISJR framework emphasizes the need for consideration and transparency of sociopolitical, cultural, and historical context that may affect a research study involving social justice issues. It is recommended that prior to beginning the development of the research design, the researcher explores how these contexts may impact the study (Voith et al., 2020). Regarding sociopolitical context, recent and ongoing political and legislative actions are affecting the experience of abortion at the same time this study is being conducted. As a result, I considered that barriers may arise in the recruiting and data collection process.

One of the other primary components of this study was how the intersectional identities of participants may play a role in the experiences explored. Intersectionality entails how the disbursement of power and control in society are the results of sociopolitical, cultural, and historical context which in turn impacts individuals/groups differently based on complex characteristics of identity (Crenshaw, 1989). Additionally, these contexts may vary in relationship to geographical location, and understanding those contexts related to the Southern United States was pertinent to this study and answering the research question.

In the United States, cultural, social, religious, and/or political context has historically supported men as being the dominant sex and women being the subordinate sex. Some examples of this include religious teachings that wives should be submissive to their husbands, and laws that recognized women as the property of men. In addition, the White race was deemed superior to the Black race, first demonstrated by the enactment of slavery. Although all women were the legal property of White men, Black women were not afforded the same protection from rape as White women (Washington, 2008). Furthermore, the practice of gynecology originated from the various inhumane surgical experimentations performed on Black women to perfect treatment for White women (Washington, 2008). In addition, Black women did not have rights to the children she birthed and experimentation often occurring during childbirth or infancy on Black mothers and their babies (Washington, 2008).

There has been some progression toward gender and racial equality, however there are still implications of social injustice today for women and people of color. In 1868, the 14th amendment of the Constitution was approved, appropriating freedom and protection for all U.S. citizens. Since that time, the 14th amendment has been used in many legal cases to advocate for the rights of women and people of color alike. However, the 14th Amendment was not applied to end Jim Crow laws related to segregation, voting, and housing for Black citizens until the 1960s, and it was not applied to prevent states from impeding women's abortion rights until the 1970s following the Roe v. Wade decision (Onion et al., 2023).

The geographical setting of this study was the Southern United States, which was the region most dependent on slavery. After the abolition of slavery, racism continued to be displayed in the South through tactics to impede Black communities from integrating and/or growing independently, such as the Tulsa Race Massacre in 1921 (Sullivan, 2023). Today, there are still indications that inequality and racism have continued as demonstrated by incarceration rates, instances of police brutality leading to serious injury or death, housing conditions and accessibility, employment rates, income variances, health disparities, infant mortality rates, life expectancy, etc. (Benjamins et al., 2021; Edwards et al., 2019; Gramlich, 2020; Gregory & Tucker Edmonds, 2023; Hardeman et al., 2021; National Center for Chronic Disease Prevention, 2022; National Center for Health Statistics, 2022; National Center for HIV, Viral Hepatitis, STD, and TB Prevention, 2020). In addition, the Southern United States has been the most stringent region in criminalizing abortion since the overturning of *Roe v. Wade*.

Political decisions are often influenced by stigma stemming from cultural, social, and religious views. In respect to women's reproductive health rights, this has resulted in the division known as pro-choice versus pro-life (Baker et al., 2023; Brown et al., 2022; Meier et al., 2021; Mosley et al., 2022). In conclusion, Black women who have an abortion in the Southern United States may have experiences that are unique in respect to various context and their intersectional identities, and it was imperative to consider how to mitigate any issues in relation to sociopolitical context when fulfilling this study.

During the pre-study stage, I tried to increase my self-awareness of White privilege and consider how systems of privilege and oppression could potentially impact

this study. As a White woman interested in researching reproductive experiences of Black women, it was important to examine racialized and genderized context related to past research and sexual health. The Black community has been subjected to scientific and medical experimentation against their will, and/or without their knowledge, by White scientists, doctors, and researchers alike throughout the years. More specifically, vulnerable populations such as people experiencing mental health issues, people of low socioeconomic status, and people of color have been sterilized without consent or through acts of coercion, with U.S. laws upholding these practices up until the early 1980's with the most recent cases occurring amongst detained immigrants in 2020 (Manian, 2020; Washington, 2007). For these reasons, being open and transparent during all stages of this study about my role and my purpose was important to establishing trust amongst potential participants and achieving quality data (Ross, 2017; Voith et al., 2020; Voith et al., 2022). It is recommended that researchers continuously use reflexive practices to reflect upon position and identity in relation to participants during each stage of research whether considered an insider, outsider, or even an insider-outsider for the study to be successful and to prevent harm to participants (Abrams et al., 2020; Voith et al., 2020; Voith et al., 2022).

### **Research Design**

I sought to generate new knowledge by exploring the abortion experiences of Black women in the Southern United States with a history of sexual trauma to address gaps in social work education and clinical practice in this area. Therefore, I implemented a fully qualitative research design to answer the following research question: What are the

experiences of abortion for Black women residing in the Southern United States who have a history of sexual trauma?

Various qualitative research designs can be used to explore and understand people's experiences and are beneficial in expanding knowledge when there is little to no relevant information on the area of study (Ellis & Hart, 2023; Percy et al., 2015). To align purpose and research design, qualitative researchers must consider the intertwining factors of epistemology, theory, methodology, and method. Epistemology refers to the ways in which knowledge is understood and acquired.

As the researcher, I approached this study with an interpretivist epistemological view as I aimed to explore how participants derive meaning from their experiences. However, I also approached this study with a critical and feminist perspective, acknowledging that subjective meaning can be derived from the experiences of others, however the effect of power dynamics on the meaning of these experiences must also be considered in relation to social justice (Salmons, 2016).

### **TISJR in the Study Design Stage**

In addition, I selected a research design, epistemological view, and set of perspectives that aligned with the TISJR framework, which encompasses critical, ethnic, and feminist theories aimed at promoting positive social change in qualitative research (Outhwaite & Turner, 2007; McGregor, 2018; Voith et al., 2020). Also, important concepts of the TISJR framework that guided this research design were TIC, social justice, and healing-centered engagement. The selection of the TISJR framework was chosen as the best applicable framework for this study as it facilitates bringing awareness

to social injustice issues, improving the way research is conducted and the way practice is implemented amongst vulnerable populations that may have experienced various traumas, and empowering these populations by sharing their voice (Voith et al., 2020; Voith et al., 2022).

### **Methodology**

I selected an exploratory qualitative design to allow flexibility in seeking rich descriptions of participants' experiences and to interpret and verify meaning related to the phenomena from the perspectives of a population different from my own that is underrepresented in the literature. I selected this methodological approach because collecting qualitative data enabled in-depth exploration of participants' experiences within their social context, whereas a quantitative approach relying on statistical or numerical data would not have captured participants' subjective experiences. Employing this methodological approach fulfills the purpose of this study as attaining firsthand information from individuals who have experienced the phenomenon in question can increase knowledge and improve practice in the social work field within a time and sociopolitical climate that is directly impacting the target population of this study (see Creswell, 2007; Ellis & Hart, 2023; Goodson, 2017 as cited by McGregor, 2018; Holosko, 2001; Merriam, 2009; McGregor, 2018; Patton, 2002; Percy et al., 2015; Voith et al., 2020).

### **Prospective Data**

I used online self-administered surveys to ask open-ended questions surrounding important concepts related to the primary research question. Initially, I planned to collect

data using an online method so that I could expand the reach of my study, particularly since geographical location is a strong component of the research question. I also considered my role as a graduate student when conducting this research, and what would be the most feasible data collection method to use to get the information needed to answer the research question. Online data collection was advantageous because it expanded geographical reach across the Southern United States and increased accessibility within my time and resource constraints as a graduate student (Madge & Wellens, 2022; Salmons, 2016).

Next, I explored the pros and cons of using extant, enacted, and elicited methods for collecting data online in this study. Extant data collection could provide a large amount of information on abortion experiences as online users can post anonymously without fear of negative consequences; however, it would be an ineffective method of data collection as there would be no way to determine if the data was from a participant that met the inclusion criteria (Salmons 2016). Furthermore, enacted data collection would not be sufficient if I was a co-participant, as I did not meet the inclusion criteria of this study and could introduce bias by inserting myself into the study and reducing trust and credibility with participants. In response, I decided that enacted data collection would be detrimental to exploring the experiences of Black women. Using elicited data collection methods allowed me to recruit participants from the target audience and ask specific questions to attain data that was used to answer the research question (Salmons, 2016; Voith et al., 2020; Voith et al., 2022).

I used concepts related to intersectionality (race and gender), geographical location, and participants' abortion experiences and sexual trauma histories to guide data collection and to address social justice issues through transparency and healing. I was also intentional in selecting a method of data collection that would prioritize the tenets of the TISJR framework, such as safety, empowerment, and shared power to acknowledge and delineate power dynamic issues the participants may face in their realities outside of this study (Voith et al., 2020; Voith et al., 2022). When reviewing the literature on both abortion experiences, and sexual trauma experiences, I made a connection in that women reported major distress about their lack of bodily autonomy and control/choice, whether that be within the relationship of patient/provider and/or victim/perpetrator (Biggs et al., 2020; Blanchard et al., 2017; Brown et al., 2022; Meier et al., 2020; Mosley et al., 2022). Also, Crenshaw (1989) addresses how intersectionality relates to unfavorable outcomes surrounding power dynamics in issues involving Black women. I considered these factors as critical, as failing to address power dynamics could have impeded my ability to collect data if I did not consider how power dynamics could have impacted participants within and outside of the study.

By using online, self-administered surveys, I provided participants with greater control over how they expressed their experiences, which further prevents bias or misinterpretation by the researcher, and gives illumination to the participants' insight (Braun et al., 2021; Voith et al., 2020; Voith et al., 2022). Participants also had autonomy in choosing a location that they felt met their needs for privacy and that they were comfortable in to answer the survey questions (Amri et al., 2021; Voith et al., 2020;

Voith et al., 2022). I then considered barriers that might prevent a vulnerable population from being able to engage in a study utilizing an online setting to gather data, such as access to technology, language/wording of questions, participants' abilities related to use of technology, scheduling issues/convenience, and comfortability in disclosure regarding sensitive information (Amri et al., 2021; Oates et al., 2022).

A recent study found that vulnerable populations were less likely to be excluded from research when online asynchronous methods were implemented as it promotes accessibility amongst various locations and times. Users would only require enough technological savvy to be able to click on the survey and respond to the questions, reducing difficulties that may exist in navigating across different platforms, or accessing and/or understanding various types of accompanying technology that might be required for audio/visual facilitation (Amri et al., 2021). In a recent mixed-methods study on using various online modes of interviewing when researching sensitive topics, close to 75% of participants refused to participate if audio/visual was required during qualitative data collection. Common issues identified in the study included participants lacking access to technology to complete interviews requiring video, and participants' concerns for their privacy when completing interviews requiring audio. More so, findings showed that online surveys that did not have to be scheduled by the participant were the most successful online mode for interviewing in comparison to scheduled surveys, email, chat, non-anonymous chat, audio, and video (Oates et al., 2022).

Out of 154 participants, close to 70% strongly agreed with being familiar with online surveys, which indicates that most participants responding via online methods of

communication would be able to complete an online survey. Participants also reported less technological issues with this mode of online communication. Additionally, results depicted that the level of honesty, social desirability bias, and self-disclosure rates within the study did not vary based on the type of online method implemented (Oates et al., 2022). Lastly, there are many online companies that offer free or low-cost options to create and disperse surveys that is beneficial to a graduate student without a lot of financial resources for a research study that are also free for participants to access.

Based on these findings, I determined that applying an online, self-administered survey was highly likely to be successful in comparison to other online methods. This data collection approach supported the tenets of safety and privacy central to the TISJR framework for participants within a research study that is sensitive in nature (Amri et al., 2021; Madge & Wellens, 2022; Oates et al., 2022; Voith et al., 2020; Voith et al., 2022). To further demonstrate the tenets of empowerment, voice and choice, and shared power, participants had the option to skip any questions that they did not wish to answer (Candela, 2019; Voith et al., 2020; Voith et al., 2022).

Overall, I selected an exploratory qualitative design to allow flexibility in data collection and to shift control to participants, which allowed for freedom of expression about their experiences and any social/cultural norms or processes that add to those experiences in a neutral setting (Voith et al., 2020; Voith et al., 2022). This online method for interviewing participants has also been recently demonstrated to be effective when researching sensitive topics with vulnerable populations (Amri et al., 2021; Oates et al., 2022). It may also reduce occurrences of bias or assumption within the

researcher/participant relationship as verbal communication and physical observances are eliminated (Abrams et al., 2020).

In conclusion, by gaining information from participants about their experiences, I was able to answer the research question, which could lead to the addition of knowledge within social work education and clinical practice. Within this study, my assumption was that participants would be honest when answering questions, and that by using an asynchronous interviewing method, bias would be reduced as participants did not see or personally interact with the researcher. The selected data collection method supported achievement of the research goal by ensuring that participants' voices were heard, precautions were taken to ensure safety and privacy, and collaboration was demonstrated between researcher and participant to meet social justice needs (Percy et al., 2015; Voith et al., 2020; Voith et al., 2022).

### **Participants**

The participants for this study were Black women with a history of sexual trauma that have experienced an abortion in the Southern United States. To determine eligibility, I used an initial online survey to screen participants based on inclusion and exclusion criteria. A full version of the initial screening questionnaire can be found in Appendix B.

Participants were included in the study if they met the following inclusion criteria: (1) identify with the Black race, (2) are 18 years or older, (3) were originally assigned to the female sex at birth, (4) are fluent in English, (5) live in one of the states in the Southern region of the United States, (6) have obtained an abortion in their lifetime, (7) it has been at least 12 months since they obtained an abortion, and (8) have a history of

sexual trauma that occurred prior to obtaining an abortion. I excluded participants who did not meet all inclusion criteria. Aside from the initial screening questions, no other demographic or identifying information was requested from participants to protect their privacy and mitigate any safety concerns. Clearly defined inclusion and exclusion criteria allowed me to recruit participants who were aligned with the research question and had experienced the phenomenon under study.

### ***Recruitment***

I recruited participants using non-probability, convenience sampling, which is helpful in qualitative studies when exploring phenomenon with populations that are underrepresented in scholarly research. I selected a purposive sample based on clearly defined eligibility criteria to focus on the target population. Purposive samples are beneficial in producing rich qualitative data as it focuses the study on individuals who have experienced the phenomenon being studied (Alase, 2017; Guest et al., 2006; Patton, 2015). Researchers commonly recommend purposive sampling when intersectionality is a central concept in a study (Abrims et al., 2020).

I distributed a recruitment flyer on social media platforms (i.e., Facebook, Instagram, Linked In). I administered the survey via SurveyMonkey (<https://www.surveymonkey.com/>), which was free for anyone to access and allowed me to apply specific inclusion and exclusion criteria. By using multiple advertising avenues, I increased recruitment potential.

The recruitment flyer included a web link directing interested parties to the initial screening survey. If a potential participant answered “no” to any of the initial screening questions, they were thanked for their time and consideration and were not allowed to proceed forward any further. If they answered “yes” to all of the initial screening questions, they were directed to the informed consent. If the potential participant did not answer “yes” to accepting the terms of the informed consent, they were unable to participate in the study and were thanked for their time and consideration. Participants who accepted the informed consent were then directed to the full survey.

By using online recruiting, I hoped to reach more participants as the setting of this study covers a large geographical area, which I would not be able to feasibly cover otherwise. Utilizing online strategies to recruit participants and collect data also takes into consideration health disparities experienced by the Black community, particularly related to higher rates of contracting COVID-19 along with increased complications from the virus (Lessia et al., 2021). The recruitment flyer invited Black women with a history of sexual trauma to participate in a study focused on their personal abortion experiences, with particular interest on the concepts of race, gender, and geographical location in respect to their experiences. Tactics that have been demonstrated to increase participation rates were considered when designing the recruitment flyers, including the usage of culturally relevant images and language (Abrams et al., 2020; Lessia et al., 2021). Lessia et al. (2021) recommends specifically using positive language about physiological health, general wellbeing, social/family responsibility, and physical appearance when targeting female participants.

### ***TISJR in the Recruitment Stage***

In alignment with the TISJR framework, I incorporated transparency in the recruitment process addressing factors such as the purpose of the study, the procedures of the study, the voluntary nature of the study and the lack of payment for participation in the study, the confidentiality guidelines, and the risks of participating in the study within the informed consent document. In particular, the geographical location and the sociopolitical context surrounding abortion laws at this time could cause hesitancy for participants to engage in the study due to risks, therefore confidentiality was emphasized (Voith et al., 2020; Voith et al., 2022).

### ***Sample Size***

I obtained survey responses from six to 12 participants in this study. To determine an appropriate sample size, I first considered why sample size was important and its' relationship to data analysis procedures. Justification for sample sizes used in qualitative studies varies; there is no defined sample size that has been collectively agreed upon (Alase, 2017; Guest et al., 2006; Guest et al., 2020; Mason, 2010; Patton, 2015). In qualitative research that applies purposive sampling, sample size is determined during data analysis when a point of saturation occurs (Guest et al., 2006; Mason, 2010). Additionally, when applying an inductive approach to data analysis, the point of saturation is met when no new themes emerge (Guest et al., 2020; Hennink & Kaiser, 2022; Saunders et al., 2017).

In qualitative research, the goal is to achieve thick and in-depth data, which can be impacted by the number of participants in a study. Therefore, I considered several

factors when selecting the sample size. I reviewed the level of homogeneity versus heterogeneity amongst participants, the sensitive nature of the phenomenon being explored, and sample sizes within other scholarly studies that applied similar methodology and data collection methods. I also evaluated how barriers might affect the study related to sample size.

In this study, I applied purposive, or judgmental, sampling with numerous criteria, and narrowed down participant characteristics which indicated that the sample was more likely to be homogenous than not (Bullard, 2022; Subedi, 2023). Seminal works recommended smaller sample sizes if researching a homogenous population (Guest et al., 2006; Lincoln & Guba, 1985). In a study that had similarity related to the topic of self-disclosure and reproductive health, findings indicated that six to 12 participants were sufficient to reach data saturation (Guest et al., 2006). In addition, studies with similar methodology and data collection methods were able to reach saturation levels exceeding 70% when using sample sizes ranging from five to sixteen (Guest et al., 2006; Guest et al., 2020; Namey et al., 2016). Lastly, I acknowledged the likelihood of barriers within the recruitment process as this study asked participants to self-disclose about experiences that may be self-incriminating depending on state regulations, that are sensitive/intimate in nature, and that often entail internal and/or external stigma. Based on this anticipation, the sample size of six to 12 participants provided flexibility in range while also accounting for minimum recommendations for data saturation.

## **Instrumentation**

In this qualitative study, I developed open-ended questions that were implemented in the form of an online self-administered survey to address concepts of intersectionality and trauma as it relates to Black women's experiences of abortion in the Southern United States. I created the survey using Survey Monkey (<https://www.surveymonkey.com/>). It is recommended that less intrusive questions be asked initially, allowing time for the participants to become more comfortable before diverting to more intrusive questions when studying sensitive topics (Oates et al., 2022; Troncosco-Pantoja & Amaya-Placenia, 2017). Furthermore, the first question should not focus on the major concepts that make up the research question, but the arrangement of questions should build up to these concepts (Troncosco-Pantoja & Amaya-Placenia, 2017). The full list of survey questions that were presented to participants are shown in Appendix C.

Using open-ended survey questions reduced cost, increased efficiency, and supported timely saturation (Saunders et al., 2017). As there is little way to build rapport when using a self-administered online survey, I considered the ordering of survey questions critical to obtaining high-quality data (Oates et al., 2022). In continued alignment with the TISJR framework, safety and trust are important tenets in the data collection process, therefore the researcher should consider ways to protect the security and emotional health of participants during the development of the instrument being used and its' application (Voith et al., 2020; Voith et al., 2022). For transparency, in the instructions provided prior to beginning the survey, I prepared the participants to set aside at least an hour to complete the survey questions. No responses were required to continue

to the next survey question, allowing participants to refuse to answer any question(s) that they did not feel comfortable with. Additionally, a list of national crisis/support hotlines were provided in consideration of any emotional duress experienced during the survey.

### **Data Analysis**

I used inductive thematic analysis to generate codes from emerging themes within the qualitative data I received (Braun & Clarke, 2006; Guest et al., 2020). According to Percy et al. (2015), researchers commonly use thematic analysis across many types of qualitative research. It is particularly useful when the research question is studying “subjective experiences of objective things” (Percy et al., 2015, p. 80). According to Saldana (2016), thematic analysis is appropriate for lived experiences, social processes, and social constructions, which encourages my decision to select this plan for data analysis.

Responses to survey questions were provided electronically, so transcription was not required. I printed all survey responses so that I could read them thoroughly and repeatedly as necessary. I began by immersing myself in the data of individual participants’ surveys without comparing it to other participants’ responses and identified codes within the individual interviews before looking across all participants interviews (Braun & Clarke, 2006; Creswell & Poth, 2018).

As I read, I used highlighters of various colors to help identify potential patterns and made notes in the margins that guided the initial coding process. I then reviewed the codes to identify possible patterns amongst the codes that could be identified as categories and/or themes (Braun & Clarke, 2006). After completing these steps for all

participants' survey responses individually, I then went through the same process of developing codes and themes across the entire data set by comparing participants' responses to each other. I preferred this coding method, because it requires the researcher to pull away from what they think they know about the research topic and look for patterns and themes from the answers provided by the participants (Braun & Clarke, 2006; Patton, 2015; Percy et al., 2015).

I continuously revised codes and themes to ensure that I could convey clear findings and demonstrated my findings presented visually in a table format for readers to view. Finally, I was able to write the analysis based on these findings (Braun & Clarke, 2006).

### ***Rigor***

The level of rigor in qualitative research is based on credibility, transferability, dependability, confirmability, and trustworthiness (Lincoln & Guba, 1985; Subedi, 2023). To enhance the overall rigor of this study, I reflected upon the Braun & Clarke's (2006) checklist of criteria that are recommended to determine if I conducted a good thematic analysis. I also additionally asked my peer debriefer and chair/committee members to compare my work to these criteria and provide feedback. I revised the data analysis during the reflection and critique stage (Shenton, 2004).

Credibility in a qualitative study is enhanced by adopting and employing clear and consistent research methods, building a relationship with participants, random sampling, and peer debriefing (Shenton, 2004). I clearly identified and defined the research design and methodology, along with the TISJR framework that guided the study's alignment and

required emphasis on research needs when implementing studies related to trauma with vulnerable populations (Voith et al., 2020; Voith et al., 2022). Although there are limitations in this study regarding building relationships with the participants, I hoped to strengthen the relationship surrounding this study through transparency surrounding my purpose and my hopes for this work, which were expressed in the informed consent.

Although random sampling can increase the credibility of the study, purposive sampling was the best approach for this study in wanting to reach participants that have specific inclusion criteria to add to the depth and fulfill the purpose of the study (Shenton, 2004). I also engaged in peer debriefing with a peer that identifies as a Black woman, as she may have more shared experiences or commonalities to the target population that I do not have as a White woman in relationship to intersectionality (Crenshaw, 1989). In addition, she also lives in the Southern United States, so she can relate to context related to geographical location, which is an important concept of this study. Her perspective as a Black woman was a valuable asset throughout this study.

During peer debriefing, I sought ways to reduce bias in the language of the survey questions prior to implementation with participants. I also invited constructive criticism when reviewing and reflecting on my findings and interpretations, which is a recommended method to increase credibility and trustworthiness in qualitative research (Shenton, 2004; Subedi, 2023). Reflective supervision was also ongoing and continuous since the beginning of the capstone process with my chair, along with additional guidance and feedback from my second committee member; this continued until the completion of this study. Lastly, I made notes or memos throughout establishing the research question,

across the research design process, and during the development and revisions of the survey questions, to hold myself accountable and increase self-awareness throughout the research.

Transferability is enhanced in qualitative research when the researcher provides clear and detailed steps taken throughout the research process. Shenton (2004) encourages researchers facilitating qualitative studies to focus on increasing transferability by providing thick descriptions of information within their study to provide readers with a great understanding of the research process. Voith et al. (2020) provides principles and steps within each stage of the research process, including pre-study, study design, recruitment, informed consent, data collection, and post-data collection. In Section 2, I provided detailed information related to research design and data collection. Additionally, throughout the entirety of the research process, I continued to answer the checkpoint questions of the TISJR framework that are supplied for each stage to not only ensure the alignment of the study with the framework, but to depict, with clarity, the relevance of this study to other context (Subedi, 2023).

Results may not be the same with other participants if this study were to be replicated as social construction of reality and the meanings or interpretations of experiences for everyone varies. However, I detailed the complete research process so that other researchers would be able to follow my research plan and implement it in exactly the same manner in future research. It is recommended to be as detailed as possible with the research design, data gathering, and the reflective process of the researcher (Shenton, 2004).

Dependability is enhanced in qualitative research when there is detailed information about data collection and analysis provided to the reader (Shenton, 2004). I provided descriptive information related to data collection and analysis stages, along with visual tables to mitigate areas of bias and emphasize transparency.

On the recruitment flyer, I provided my name, credentials, and affiliation with Walden University to further establish trustworthiness and dependability with potential participants. In addition, it was very crucial to thoroughly explain to participants how I planned to protect and present the data during the informed consent process; this was important to provide a sense of safety and empowerment with the population of interest surrounding sensitive topics being explored (Voith et al., 2020; Voith et al., 2022).

Researchers enhance confirmability in qualitative research by providing evidence to support how data collection and analysis took place. My detailed description along with visual tables were presented, which enables participants and readers to see how interpretations were made during analysis. This was also a way to keep myself informed and self-aware of any bias I may have as I reflect upon my ideas throughout data collection and analysis (Shenton, 2004; Voith et al., 2020; Voith et al., 2022).

In conclusion, researchers establish trustworthiness in qualitative studies through credibility, transferability, dependability, and confirmability. The guiding questions of the TISJR framework was a way to examine the fidelity within my role of researcher. Throughout Section 3, I answered the guiding questions of the TISJR framework in relation to the different stages of research. As I proceed into the next section, I continue

to reflect on and answer these guiding questions to strengthen the trustworthiness of this study (Voith et al., 2020; Voith et al., 2022).

### **Ethical Procedures**

Prior to beginning data collection, I obtained the approval of Walden University's IRB; the approval number for this study was 12-03-24-1046256. In preparation, I reviewed the steps of the ethical approval process by Walden University's IRB and the required forms to be submitted to the IRB (Walden University, 2024c). I also participated in a Zoom meeting with an IRB member to explore ethical challenges in research with human subjects specific to my study and explored ways to minimize risk of harm to participants and ensure a quality study. In addition, I completed the Walden University Doctoral Student Researchers series of courses facilitated by the Collaborative Institutional Training Initiative (CITI) Program as a way to train and educate myself further on important ethical considerations before beginning research with human subjects that belong to a vulnerable population. (Voith et al., 2020; Voith et al., 2022).

According to the Belmont Report and the Common Rule, there are ethical principles that are critical to adhere to for research with human subjects, including respect for persons, beneficence, and justice. Important factors to consider related to the adherence of these ethical guidelines are risk assessment, applying informed consent procedures starting with recruitment/screening and continuing throughout the entirety of the study, protecting privacy and confidentiality, and understanding the reporting requirements when unexpected problems occur in social and behavioral research. As this research study acquired knowledge related to a participants' health, along with the usage

of technology to obtain data, it was also important that I considered challenges that may arise with electronic informed consent (eIC) and be aware of federal protections related to health information, such as the HIPPA and Health Information Technology for Economic and Clinical Health (HITECH) Act. Overall, sensitivity to cultural beliefs and values were maintained throughout the study (Citi Program, n.d.).

As a member of the NASW, a licensed master social worker (LMSW), and a Walden University Doctorate Social Work student, adhering to values and ethical principles of the NASW Code of Ethics is necessary for clinical practice and learning. Additionally, Walden University requires students to implement the American Psychological Association (APA) style for scholarly writing. Along with these associations' guidance on ethics, Walden University promotes its' own research ethics and compliance policies for students (Walden University, 2024d). The NASW Code of Ethics, the APA Code of Ethics, and Walden University's Research Ethics Guides and Manuals were used to inform the development and future implementation of the study. These ethical guidelines promoted ethical procedures considered for the application of this study including:

- respecting the privacy and confidentiality of participants related to data collection, storage, dissemination, and retention,
- giving attention to individual competency by undergoing relevant trainings,
- increasing cultural competency through an exhaustive literature review,
- seeking supervision and approval for the research study by dedicated committee members, educational administrators, and Walden University's IRB,

- the implementation of research methods that reduces potential to harm others,
  - the utilization of voluntary informed consent practices,
  - and accurately representing findings and applying credit when due to others
- (American Psychological Associations, 2024; National Association of Social Workers, 2024; Walden University, 2024e).

### **Informed Consent**

To ensure respect for persons, I designed the informed consent document to fully inform potential participants about the purpose of the research, the time expected to complete the survey, the voluntary nature of completing the survey questions and their right to skip questions or end the survey at any time, notification that the survey questions may be sensitive in nature, how survey responses would be stored/protected and disposed of, how their information would be used for current and future research, possible risks of harm and means of reducing risks of harm. I also reviewed the terms and conditions regarding privacy and confidentiality when utilizing Survey Monkey, and the platform allows for anonymous responses without sharing data to third parties. Survey Monkey requires that the terms and conditions of its' platform be provided and agreed upon by all users, so participants acknowledged this in addition to the informed consent for this study. If there were any questions or concerns specific to the terms and conditions of Survey Monkey, participants could view the Frequently Asked Questions (FAQ) section and/or get support via chat online from Survey Monkey representatives (Survey Monkey, 2024).

To ensure beneficence, discreet voluntariness in participation and anonymity reduces risks of harm to participants. No demographic information outside of race/gender was requested from participants. All data is safely stored within the Survey Monkey data centers/servers, and on my computer which is password protected and accessible only to myself. Any printed material of survey responses is stored in a locked file cabinet that only I have access to. Survey Monkey automatically permanently deletes electronic survey data from their system within 60 days unless a longer timeframe is requested (Survey Monkey, 2024). Printed material of survey responses will be destroyed five years from the date of consent. The data will only be shared amongst myself, the peer debriefer, and necessary members of the research/doctoral team at Walden University.

Within the data collection stage of research, the key tenets of the TISJR framework are safety and building/maintaining trust with participants (Voith et al., 2020; Voith et al., 2022). I collected data in this study on abortion experiences during a time and place where abortion may be a banned or illegal activity, and the questions utilized in the surveys for data collection asked participants to disclose responses that could be self-incriminating (Walden University, 2024b). Studying this topic could threaten the safety of participants as there could be potential legal risks involved. To address this potential threat, I designed the study to be completely anonymous.

It is also recommended that the researcher be prepared to promote emotional and behavioral self-regulation with participants due to the sensitivity of the concepts explored (Voith et al., 2020; Voith et al., 2022). I considered how a more recent abortion experience and/or postpartum depression could increase the risk of psychological harm to

participants, so I modified the inclusion criteria to specify that participants must have experienced their abortion at least 12 months ago to minimize risk. Additionally, I advised against disclosing a description of sexual trauma experiences as applicable in survey questions in an effort to reduce distress experienced by the participant that might arise. As I did not have any direct contact with the participants, I provided national crisis hotlines in the case that a participant needed support during the course of, or after their participation in the study.

To ensure justice, the research study was designed to gain knowledge that would contribute knowledge and benefit the population in which the participants belong. I gave special attention to the research setting, accessibility for participation, and language used in the informed consent and survey questions. I wrote the informed consent for easy comprehension for individuals at an 8<sup>th</sup> grade reading level modeling the Walden University template informed consent template and the child assent form template. There are also benefits of eIC to participants such as the ability to increase text size and/or having consent read aloud electronically to remove barriers to participation for individuals with disabilities. Participants also had the ability to save and/or print the informed consent document for future reference. Lastly, the eIC had a checkbox requiring completion to be able to move forward with participation, which prevented those who did not agree to the informed consent from engaging (Kucera & Logsdon, 2018).

### **TISJR in the Informed Consent Stage**

According to the TISJR framework, it is a priority to ensure that not only are ethics followed to reduce harm to participants, but also that an understanding of other

factors that could impact participants within the research design and sources of data collection methods be considered in respect to possible trauma experiences related to intersectional identities of participants. The guiding questions for the application of the TISJR framework encourages the researcher to respect participants' sense of privacy and safety through a collaborative research process. In this study, I sought to achieve qualitative data with participants on sensitive topics involving personal and/or traumatic experiences. I considered that underlying racialized/genderized trauma experiences may come into play during the data collection process as well. More so, due to the criminalization of abortion in some areas, protecting confidentiality and levels of comfort for participants is crucial. In each aspect of the informed consent, I applied foundations of the TISJR framework to ensure alignment (Voith et al., 2020; Voith et al., 2022).

### **Summary**

In this section, I described the research design, methodology, data collection procedures, data analysis process, and ethical procedures that I utilized within this study to answer the research question: What are the experiences of abortion in the Southern United States for Black women who have a history of sexual trauma?

In review, qualitative data collection occurred via online, self-administered surveys that proposed concepts related to the primary research question with specific focus on factors of intersectionality. Inductive thematic analysis was used to develop initial and redefined codes and themes, which was supported with a table for visualization. In the next section, I present the findings from this study.

## Section 3: Presentation of the Findings

### **Introduction**

The purpose of this qualitative study was to explore the experiences of abortions for Black women with a history of sexual trauma that reside in the Southern United States. In Section 3, I present the findings of the study and answer the following research question: What are the experiences of abortion in the Southern United States for Black women who have a history of sexual trauma?

I collected the data for this study with an online self-administered survey. The TISJR framework was critical in the continued alignment of this study and its use in the data collection and post-data collection stages are described in this section. Additionally, in this section, I provide an in-depth description of the data collection process, thematic data analysis procedures, validation procedures, and study limitations.

### **Data Analysis Techniques**

IRB approval from the Walden University Institutional Review Board (IRB) was required prior to data collection; approval # 12-03-24-1046256 was received on December 3, 2024. Data were collected between January and May 2025. I collected the data using a completely anonymous, 12-question online self-administered survey with open-ended questions administered to six Black women who had experienced both sexual trauma and abortion in the Southern United States.

I began my recruitment efforts on January 18, 2025, by posting a recruitment flyer advertising the need for participants for a completely voluntary and anonymous online survey for a new study focused on understanding abortion experiences in the Southern

United States of Black women who have experienced sexual trauma. Between January and March, the flyer was posted on multiple social media platforms, including Facebook, Instagram, Snapchat, TikTok, Reddit, and LinkedIn on various occasions. Between January and May, the online survey was accessed 37 times. Out of these 37 views, six participants responded to and completed the survey; this equated to a 16% response rate.

### **TISJR in the Data & Post-Data Collection Stage**

In the data and post-data collection stage, the tenets of safety, maintaining and building trust, empowerment, voice, and choice, are central to the TISJR framework. It was important to consider any harm that could impact those involved in the study, along with ways to ensure their safety and security during data collection (Voith et al., 2020; Voith et al., 2022). Therefore, the survey was designed to collect data in a way that focused on protecting participants, along with providing the participants with control and privacy on their engagement in this study. Voith recommended considering emotional and behavioral regulation needs of participations, while considering resources for participants, along with an acknowledgement of the work of participants demonstrated with their involvement in the study (Voith et al., 2022).

Participants were able to remain completely anonymous as they were able to answer the initial screening questions, review the informed consent, and proceed to the online survey without any interaction with the researcher and in the location of their choosing. Since there was no direct engagement between the researcher and participant, to ensure participants' safety, crisis hotlines were provided during the data collection stage in the informed consent document which allowed participants to maintain their

anonymity and seek assistance if distressed. It was also critical that no responses were required to continue to the next survey question, which allowed participants to refuse to answer any question(s) that they did not feel comfortable with and choose how to proceed in their involvement with the data collection process. As the study was completely anonymous, the researcher informed participants of how to view the results of the study through the informed consent document with the pertinent study information that would be published upon completion.

### **Data Analysis Procedures**

Thematic analysis was used to analyze the data received from the six participants, following recommendations from experts in the literature about how to conduct the different phases of the thematic analysis process (Braun & Clarke, 2006; Willig & Rogers, 2017). I printed survey responses and read and re-read individual participant surveys individually prior to comparing them with each other. I developed codes, categories, and themes for each individual participant by making notes, underlining keywords, and highlighting phrases. After completing these steps for all participants' survey responses individually, I followed the same process of developing codes, categories, and themes across the entire data set by comparing participants' responses to each other.

During the thematic analysis process, I continually reviewed the data for recurring patterns and new concepts. By the fifth and sixth participant responses, no new codes or concepts emerged, indicating thematic saturation. Given the sensitive topic and

exploratory design, data demonstrated adequate information power (Malterud et al., 2015).

By participant 37, the same core categories (voice/choice, support needs, trauma, belief conflict, stereotypes, after-care) were still appearing. Nothing radically new surfaced. My cross-participant table shows that voice/choice, support needs, sexual trauma impact, internal/external conflicts, identity influences, and healing processes are present in multiple participant accounts and are repeated consistently. There is also richness and variation within themes as both sides of several experiences were captured (i.e. participants who described positive versus negative medical care, or those who reported sexual trauma impacts versus those who did not), yet these differences mapped onto the same overarching themes.

To summarize, I considered and pulled excerpts from the data that illustrated the codes, categories, and themes that were emerging from the data. I also wrote up a concise description of each theme to support and validate their importance. To support my interpretation, I developed a table to visually demonstrate my findings (see Braun & Clarke, 2006; Creswell & Poth, 2018; Willig & Rogers, 2017; see Table 1).

### **Validation Procedures**

To enforce structure using inductive thematic analysis, I followed Braun and Clarke's (2006) six phases of analysis, which included "familiarizing yourself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report" (p. 87). To determine whether I conducted a good thematic analysis, I compared my process to the 15-point checklist of criteria

recommended when applying thematic analysis to qualitative studies (Braun & Clarke, 2006; Willig & Rogers, 2017). I used peer debriefing to further strengthen the validity of this study. My chair intentionally recommended the peer debriefer based on her dedication to her own research, her knowledge of the doctoral capstone process, and her shared demographic characteristics with study participants, including being a Black woman living in the Southern United States. Her perspective provided insight that I, as a White woman, did not hold.

I interacted with the peer debriefer in telephone meetings throughout the different stages of the study for reflection purposes of the design and implementation of the study. Then, after data collection was completed, the transcripts from survey responses were provided to the peer debriefer for her own reflection. Throughout the data analysis process, the peer debriefer provided targeted feedback that enhanced both credibility and reflexivity. For example, during the review of Participant #24's data, I initially coded the phrase "I asked God for forgiveness of my actions" under *emotional distress*; however, the peer debriefer suggested this was more accurately categorized as *internalized religious shame*, offering a culturally grounded interpretation I had not considered. She also encouraged me to reflect on how Participant #15's feeling of "being treated like another statistic" demonstrated racialized bias, prompting me to adjust my theme to better capture this intersectional dimension. As a Black woman living in the Southern United States, her insights revealed blind spots in how I, as a White researcher, initially understood certain expressions of mistrust and resilience. These exchanges substantively

influenced how themes were refined and strengthened the overall cultural validity of the findings.

Tables were designed to show the development of codes, categories, and themes for individual participant responses to provide a clear illustration of the interpretation of the data after review with the peer debriefer. I continued reflective supervision with my chair and received additional guidance and feedback from my second committee member. Sharing this visual evidence to support how data collection and analysis occurred will be important for participants and readers to base their opinion on the validity of the study, which was of critical importance to align with the TISJR framework guiding this study. Lastly, by continuing to answer the guiding questions of the TISJR framework throughout each stage of this study, I was able to examine my fidelity within the role of researcher (Voith et al., 2020; Voith et al., 2022).

### **Limitations**

There were some limitations identified during this study. Firstly, there were limitations related to the TISJR framework guiding this study. The TISJR framework is fairly new, so there is a lack of measurement or demonstration of the success of the framework. However, I felt confident in the use of this framework based on the theoretical frameworks that led to the development of the TISJR framework being highly accepted and utilized in research within social work and related fields (Voith et al., 2020; Voith et al., 2022). Additionally, I used a different method to data collection than what has been implemented thus far using the TISJR framework. As the data collection for this study was completely anonymous, there is no way to receive feedback and assess how

this change in methods may have been perceived by participants in relation to the purpose of the TISJR framework. Furthermore, the inability to reach out to participants limited any probing, follow-up, or further discussion if desired.

Secondly, the timeframe for recruitment and data collection was very lengthy compared to the response rate. In a time span of approximately 5 months, the response rate was only 16% to the survey. Limitations that may have impacted the response rate could be related to only recruiting via social media, the sensitivity of the topic being explored in the survey, the historical harm to the target population through research, or other unknown explanations. It may be beneficial for future research to partner with organizations or entities, or with other researchers, that are not considered “outsiders” as I am as a White woman, in order to obtain more data.

The decision to maintain complete anonymity strengthened participant protection but limited opportunities for follow-up clarification or member checking. Although participants could not verify the thematic interpretations directly, this methodological trade-off aligned with the trauma-informed tenet of safety by prioritizing participant control and minimizing potential distress. Future studies could allow participants to create unique identifiers for optional follow-up, balancing confidentiality with opportunities for validation.

## **Findings**

### **Participant Context**

Due to the anonymous design of this study, I did not collect demographic information from participants. Although demographic data were not collected, the

detailed narratives and thick descriptions of abortion contexts provide sufficient contextual richness for readers to assess transferability. I made this methodological choice intentionally to protect participant safety and uphold the trauma-informed principles of the TISJR framework, which emphasize minimizing potential distress and preserving participant control. As a result, the study does not include information such as participants' ages, timelines of abortion experiences, or specific trauma histories. While this limited the ability to contextualize individual experiences based on demographic or historical factors, it also enhanced participants' sense of privacy and emotional safety. By excluding identifying information, I prioritized the trauma-informed value of safety over disclosure and enabled participants to engage authentically without fear of recognition or judgment. I acknowledge this trade-off as both a strength and a limitation of the study.

Initially, I presented individual participant tables in the main body of Section 3; however, to enhance clarity and readability, they have been consolidated into a single cross-participant summary table. I maintained transparency by relocating the complete data tables to Appendix A while allowing the main text to focus on the synthesized patterns across participants. Table 1 provides a consolidated summary across participants, highlighting selected excerpts that exemplify each emergent theme. The complete individual participant tables (A1–A6) have been relocated to Appendix A to maintain transparency while improving readability and reducing repetition. Emergent themes included: (1) Importance of Voice/Choice, (2) Unmet Support Needs, (3) Unresolved Sexual Trauma Impacts Abortion Experiences, (4) Negative Impact of Internal &

External Conflicts, (5) Racialized and Gendered Healthcare Experiences, and (6) Individual Needs for Healing Process.

### **Theme 1**

Theme 1 is the Importance of Voice/Choice. Three of the six participants describe how their parents or significant others made the decision for them or strongly influenced their decision about getting an abortion. The other three participants shared how they made the decision on their own accord, with the ability to consider their personal needs/wants. The participants' feelings about their abortion experience appear to be strongly impacted by whether they felt coerced or forced into getting an abortion or were able to independently decide.

### **Theme 2**

Theme 2 is Unmet Support Needs. Five of six participants reported a lack of support and heightened emotions indicating emotional isolation during all stages of the abortion process (pre-, during, and post-). Unmet support ranged from various areas such as personal relationships, medical care, and after-care or follow-up services. Unmet support needs exacerbated emotional isolation.

### **Theme 3**

Theme 3 is Unresolved Sexual Trauma Impacts Abortion Experiences. Four of the six participants indicated that their past sexual trauma experiences had an identifiable influence on their abortion experience, while two participants stated that they did not perceive a direct impact at the time. However, when I analyzed each individual participant's response, I feel justified in claiming that five out of six participants

indicated a level of impact sexual trauma had on their abortion experience. For example, despite participant 16 explicitly denying sexual trauma having an impact on her abortion experience, she later stated, “It is only through trauma recovery coaching that I've been able to heal from my sexual trauma and recognize how much abortion triggered me because of the sexual trauma of my past.”

Among the four participants who described a connection, unresolved trauma surfaced through feelings of guilt, shame, mistrust, and self-blame that mirrored emotions from their sexual trauma histories. These participants compared how they felt during the abortion experience to the emotional aftermath of their trauma, noting similarities such as loneliness and fear of judgment. In contrast, two participants described an absence of perceived impact, which may suggest that some individuals compartmentalized these experiences or had developed coping mechanisms that minimized emotional overlap. This variation highlights that the influence of trauma is not universal but contextually shaped by personal meaning-making, coping strategies, and stage of healing.

#### **Theme 4**

Theme 4 is Negative Impact of Internal and External Conflicts. Four out of six participants identified moral or religious conflict with choosing abortion. Three out of six participants dealt with stigma and hid their abortion from others in fear of judgement. Internal and external conflicts negatively impacted healing.

#### **Theme 5**

Theme 5 is Racialized and Gendered Healthcare Experiences. Five out of six participants identified that their identity as a Black woman impacted their abortion

experience. These participants describe how stereotypes and bias related to their identity as a Black woman uniquely impact how others perceive/judge their decision to have an abortion. Four participants described how their identity negatively influenced the type of medical treatment they received as they felt cold, rushed, and dehumanized by medical staff.

### **Theme 6**

Theme 6 is Individual Needs for Healing Process. Three out of six participants described continued and suppressed grief and emotional trauma after the abortion experience. Three out of six participants describe personal growth and resiliency that they were able to achieve with counseling or trauma coaching. It is important to note that all participants noted a lack of after-care services provided at the time of abortion, so any counseling/coaching was attained without the help of the healthcare staff that were involved in the abortion experience.

### **Table 1**

#### *Cross-Participant Thematic Summary*

<b>Themes</b>	<b>Description</b>	<b>Illustrative Excerpt</b>
Importance of Voice/Choice	Participants' abortion experiences were strongly impacted by whether they had a voice/choice in the decision-making process. When participants' personal wants/needs were considered and they were included or in control of the decision-making process, participants appeared more confident and supported, while those who lacked the ability to be involved in this process felt a lack of respect and support. Having a	"I was told by my dad that I was going to have an abortion." (P15) "I made the decision that was best for me and my family as a single parent." (P24)

Themes	Description	Illustrative Excerpt
	voice/choice in the abortion experience was a positive component in the experience itself and in participants' lives afterwards.	
Unmet Support Needs	Participants describe unmet support needs in different areas such as lack of support from significant others in the decision-making process and/or abortion experience itself, substandard medical care/attention, and an absence of after-care/follow up services. Unmet support needs made the abortion experience more difficult and leaves participants feeling alone.	“I wasn’t supported at all.” (P16) “I had to deal with it on my own.” (P24)
Unresolved Sexual Trauma Impacts Abortion Experiences	Participants with unresolved sexual trauma describe negative internal narratives and increased vulnerability that correlated with how they felt about their abortion experience. For example, lack of trust resulting from participants’ sexual trauma experience carried over into the abortion experience, and loneliness, shame, and guilt were similar heightened emotions amongst both sexual trauma and abortion experiences that took an emotional toll on participants.	“I think the sexual trauma reinforced my belief that everything that happened including the abortion was my fault.” (P15) “I think the sexual trauma and abortion were very similar experiences because with both I felt alone and ashamed.” (P34)
Negative Impact of Internal & External Conflicts	Internal conflicts with personal and/or religious belief systems about abortion, along with external conflicts (others’ beliefs and persuasion/coercion tactics) complicate the decision-making process, add stress to the abortion experience, and interfere with the healing process afterwards.	“I asked God for forgiveness of my actions.” (P24) “There were so many people protesting outside that we were both uncomfortable and embarrassed to get out.” (P36)

Themes	Description	Illustrative Excerpt
Racialized and Gendered Healthcare Experiences	Some participants describe a lack of care and/or medical attention from healthcare staff connected with gendered and racialized bias and stereotypes, while other participants were uncertain if their level of care was related to their identity. Participants identify perceptions of Black women that may impact how others view their decision about abortion. Additionally, participants reflect on a general lack of personal value (not specifically related to gender/race) that resulted in depersonalized healthcare experiences.	“I felt the staff treated me like another statistic of a Black woman.” (P15) “I felt like I was living a stereotype—young, unwed, Black female aborting a child.” (P37)
Individual Needs for Healing Process	Participants discuss individualized change, growth, and healing processes important to the abortion and post-abortion experience. Participants who valued the professional help they received from counselors/coaches appear to have a more positive healing process than participants who describe wanting to work through their sexual trauma and/or abortion experiences on their own.	“It is only through trauma recovery coaching that I’ve been able to heal.” (P16) “I still struggle with certain things like not having my voice heard and respected, but I have come a long way.” (P15)

### Summary

In relation to RQ1, I identified several factors that are important for social work and healthcare practitioners to consider when working with this population. These factors are reflected in the following themes: (1) Importance of Voice/Choice, (2) Unmet Support Needs, (3) Unresolved Sexual Trauma Impacts Abortion Experiences, (4)

Negative Impact of Internal and External Conflicts, (5) Racialized and Gendered Healthcare Experiences, and (6) Individual Needs for the Healing Process. First, autonomy over decisions and bodily control emerged as a critical factor influencing whether participants described their abortion experiences as positive or negative. Participants' narratives indicated that a lack of autonomy often mirrored dynamics present in their sexual trauma histories and contributed to emotional distress. Second, when participants felt unheard, reported unmet support needs, and experienced internal or external conflicts, the decision-making process became more complex and emotionally taxing, which negatively affected their post-abortion healing. Finally, participants described experiences of substandard healthcare that they perceived as related to racialized and gendered bias, further complicating their abortion experiences. In response to these emergent themes, Section 4 presents applications for professional ethics, recommendations for social work practice, and implications for social change.

## Section 4: Application to Professional Practice and Implications for Social Change

### **Introduction**

Black women in the Southern United States face compounded challenges related to sexual trauma, abortion access, and discrimination subject to gender and race factors (Brown et al., 2022; Walsh et al., 2022). Despite high rates of sexual abuse and victimization, existing research has largely excluded Black women's experiences, especially in the context of abortion and trauma (Brunton & Dryer, 2021; Gomez, 2021; Hoxmeier et al., 2023; Wolf et al., 2022). Intimate healthcare procedures like abortion can trigger secondary trauma, and Black women are disproportionately affected by mental health issues, discrimination, and restrictive abortion policies (Altschuler et al., 2017; Ely et al., 2018; Ely et al., 2020; Fukumoto, 2022; Murphy-Oikonen et al., 2022; Walsh et al., 2022). Social work practitioners often lack the education and confidence to support these women adequately, leaving a critical gap in trauma-informed care and reproductive health services (Altschuler et al., 2017; Begun et al., 2017; Bruton & Dryer, 2021; de Medeiros Guimarães & da Silva Ramos, 2017; Ely et al., 2018; Ely et al., 2020; Meier et al., 2020; Reeves & Humphreys, 2018; Sperlich & Gabriel, 2022; Swan et al., 2021; Witt et al., 2022; Wycoff & Matone, 2019).

I explored the abortion experiences of Black women with a history of sexual trauma living in the Southern United States and examined how race, gender, and geographical location intersected to shape these experiences. My goal was to inform social work education and practice by identifying factors that contribute to equitable,

trauma-informed, and culturally responsive care—ultimately helping to close the health gap for this vulnerable population.

### **Key Findings**

The study revealed several key themes shaping Black women’s abortion experiences in the Southern United States. A central finding was the importance of having a voice and choice in the decision-making process; participants who felt included and empowered reported more confidence and emotional support, while those excluded felt disrespected and unsupported. Many described unmet support needs, including lack of emotional backing from significant others, inadequate medical care, and absence of follow-up services, which intensified feelings of isolation, a very different experience from those who indicated having support. Unresolved sexual trauma played a significant role, with participants expressing heightened emotions such as shame, guilt, and mistrust that carried over into their abortion experiences. Internal conflicts related to personal or religious beliefs, along with external pressures and coercion, added stress and complicated both the decision-making and healing processes. Participants also noted that their identity—particularly race and gender—impacted the quality of care they received, with some perceiving bias and depersonalization in medical settings. Finally, the healing process was deeply individualized; those who accessed professional support reported more positive outcomes, while others preferred to navigate recovery independently, underscoring the need for flexible, trauma-informed care approaches.

### **Absence of After-Care Services**

One of the most significant findings of this study was that all six participants reported receiving no after-care services following their abortions. This complete absence of post-procedure support reflects a major gap in trauma-informed and culturally responsive reproductive healthcare. None of the participants were offered follow-up counseling, check-in calls, or informational resources after their procedures. The lack of after-care was associated with ongoing distress, feelings of abandonment, and unresolved grief.

This finding has major implications for social work and allied health professionals. Post-abortion after-care could include brief follow-up contact within 48 hours and again within two weeks, a resource packet containing mental health and community supports, and optional counseling referrals. Existing after-care models in sexual assault response and post-surgical recovery could be adapted for reproductive healthcare settings. Developing and institutionalizing such protocols would align with trauma-informed principles of safety, trust, and empowerment while improving client well-being and long-term outcomes.

### **Extended Knowledge**

These findings offer valuable guidance for social work practice, particularly when supporting Black women who have experienced sexual trauma and abortion. Each emerging theme indicates an area that social workers should focus on when working with these women. For example, the emphasis on voice and choice underscores the importance of empowering clients in decision-making processes, which fosters trust, confidence, and

emotional safety. Social workers must also recognize and address the widespread unmet support needs—ranging from emotional backing and medical care to post-abortion follow-up—that leave clients feeling isolated and vulnerable. The lingering effects of unresolved sexual trauma further complicate abortion experiences, making trauma-informed care essential.

Additionally, internal conflicts related to personal or religious beliefs, along with external pressures and coercion, add layers of stress and hinder healing, suggesting that practitioners should create safe, nonjudgmental spaces for clients to process these complexities. More so, the perception of racial and gender bias in healthcare settings calls for anti-oppressive, culturally responsive practice to ensure equitable treatment. Finally, the diverse ways participants approached healing—whether through professional support or self-guided recovery—highlight the need for flexible, individualized care plans. Together, these insights urge social workers to deepen their understanding of intersectionality, trauma, and reproductive justice, and to advocate for systemic changes that better serve marginalized populations.

### **Application to Professional Ethics in Social Work Practice**

As it relates to the NASW Code of Ethics (NASW, 2023), the value of social justice and the value of dignity and worth of the person are relevant to this study. This study extends the TISJR framework by demonstrating how trauma-informed principles can be operationalized in fully anonymous research designs, balancing participant safety with analytic rigor. Through this approach, the study contributes to methodological innovation within social work, providing a model for ethically grounded, culturally

responsive, trauma-informed research practices. In the initial stages of this study, it was evident after reviewing the literature that there was not only a gap in the literature, but a lack of education and a lack of services rendered by social work students and practitioners that needed to be addressed. Prominent organizations such as the AASWSW, the NASW, and the NAACP identified problems related to abortion services, with an emphasis on women of color, and called for social justice movements in the social work field (ASSWSW, 2023; Ely et al., 2018; NAACP, 2023; NASW, 2023). Therefore, the foundation of this study was the TISJR framework, specifically designed to encourage work that advances social justice for people of color (Case Western Reserve University, 2023; Voith et al., 2020; Voith et al., 2022).

While the value of social justice aligns with the problem statement and purpose of this study, the need for a focus on the value of dignity and worth of the person is clearly identified in the findings of this study. Half of the participants indicated that they felt like they did not have a voice/choice in their abortion experience and how being left out resulted in them feeling unsupported, alone, and in despair, while the other half of the participants that had a voice/choice depict a more confident and positive experience. The value of dignity and worth of the person emphasizes individuals' rights to self-determination, or to make their own decisions about what they need. This value also highlights the importance of providing quality service to individuals void of discrimination, which is critical as this study showed that 83% of participants felt their identity as a Black woman negatively impacted their care.

### **Actionable Practice Recommendations**

Based on these findings, I recommend trauma-informed and culturally responsive interventions that move beyond general awareness to specific, actionable strategies across multiple levels of social work practice.

Social workers can enhance direct practice by implementing trauma-informed screening questions that create opportunities for open dialogue about abortion and past trauma. For example, practitioners might ask, “Have you experienced any past trauma that might make this experience more difficult for you?” Such questions help establish emotional safety and affirm client agency. Practitioners should also provide written and verbal after-care information and offer opt-in follow-up contact within 48 hours and again within two weeks after the procedure. These actions align with trauma-informed principles of safety, trust, and empowerment by ensuring that clients receive care that continues beyond the clinical encounter.

Agencies and organizations should develop standardized after-care templates and referral protocols to ensure consistency in post-abortion support. Staff should receive annual training on reproductive justice, racial bias awareness, and trauma-informed engagement with marginalized populations. Incorporating reflective supervision and peer consultation can also strengthen practitioner accountability and responsiveness to client needs.

Social workers can engage in advocacy efforts to establish post-abortion after-care as a standard component of reproductive healthcare policy. Advocacy might include promoting funding for community-based trauma-informed reproductive health services

and supporting legislation that protects the reproductive rights and dignity of Black women.

In the area of education and training, social work programs should integrate reproductive justice and trauma-informed practice content into MSW curricula. Coursework should include focused instruction on intersectionality, abortion care, and trauma recovery, ensuring that emerging professionals are equipped to deliver competent and compassionate care to this population.

Collectively, these recommendations demonstrate how social workers can move practice from theory to application by operationalizing the values of service, dignity, and social justice. Through intentional assessment, policy advocacy, and education reform, practitioners can help close the gaps in care and ensure that Black women who experience abortion after sexual trauma receive the equitable, respectful, and supportive services they deserve. I will apply these findings directly in my work as an advanced social work practitioner by reinforcing the importance of trauma-informed, client-centered care. By understanding the complex emotional, structural, and relational factors that shape these experiences, I am better positioned to create safer, more validating spaces, advocate more effectively for equitable resources, and integrate practices that strengthen voice, choice, and empowerment.

### **Regional Context: The Southern United States**

Although this study did not include direct questions about how participants' geographical location influenced their abortion experiences, I intentionally situated this research within the Southern United States, where restrictive abortion policies, high

religiosity, and systemic racial inequities shape the broader sociocultural context in which these experiences occur. The Southern region has historically presented more barriers to abortion access and reproductive healthcare, particularly for Black women who often face intersecting forms of oppression related to race, gender, and class. While participants did not reference location-specific experiences in their survey responses, interpreting these findings within the Southern context is critical for understanding the structural conditions that may underlie their narratives of stigma, limited support, and unmet needs. Future research could build upon this foundation by explicitly examining how regional policy environments, rural versus urban settings, and access disparities in the South affect abortion-related care and recovery for Black women with histories of trauma.

### **Transferability**

While this study offers valuable insights, its findings are not intended to be generalized to all Black women who have experienced abortion and sexual trauma. Instead, they provide a transferable understanding of key patterns that may resonate with similar populations. Variations in regional policy, religious influence, socioeconomic status, and access to resources could shape different outcomes in other contexts. Therefore, these findings should be interpreted as a foundation for awareness and practice enhancement rather than universal conclusions. These findings nonetheless contribute meaningfully to social work knowledge by illuminating gaps in after-care, intersectional stigma, and trauma-responsive service delivery that warrant further exploration.

### **Limitations**

This study presents several limitations that may affect its overall usefulness, particularly in terms of generalizability and trustworthiness. First, the use of the Trauma-Informed Socially Justice Research (TISJR) framework, while theoretically grounded, is relatively new and lacks established metrics to evaluate its effectiveness (Voith et al., 2020; Voith et al., 2022). This limitation introduces uncertainty about how effectively the framework guided the research process and shaped the findings. Additionally, the study employed a fully anonymous data collection method, which, while protecting participant privacy, limited opportunities for follow-up questions, clarification, or participant feedback—key components that often enhance the depth and credibility of qualitative research.

The low response rate, despite a lengthy recruitment period, also impacts the study's generalizability. With only 16% of participants responding over five months, the sample may not fully represent the broader population of Black women in the Southern United States who have experienced sexual trauma and abortion. Factors such as recruitment through social media, the sensitive nature of the topic, and historical mistrust of research within marginalized communities may have contributed to this limited engagement. These constraints suggest that while the findings offer important insights, they should be interpreted with caution and may not be broadly applicable without further research involving more diverse and representative samples.

### **Complexities in After-Care and Voice/Choice**

An important nuance emerged from Participant #37, who was the only participant offered post-abortion resources yet chose not to follow up. Her decision underscores the need for after-care approaches that prioritize autonomy and non-intrusiveness.

Participants may decline follow-up due to privacy concerns, stigma, or emotional readiness. This finding reinforces that trauma-informed after-care must be flexible and client-directed.

Additionally, although participants who had voice and choice in decision-making generally described feeling more empowered, three of those same participants reported persistent guilt, sadness, or moral conflict afterward. This paradox suggests that while autonomy is essential, it is not sufficient to guarantee emotional well-being. Social workers should therefore pair empowerment with ongoing emotional and spiritual support to address unresolved trauma and internalized stigma.

### **Anonymity and Trustworthiness Reflection**

I grounded the decision to conduct this study anonymously in the trauma-informed principles of safety, empowerment, and choice outlined in the TISJR framework. While anonymity strengthened participant protection and may have encouraged more open and honest responses, it also limited opportunities for follow-up clarification, probing, or member checking—processes often used to enhance credibility in qualitative research. Because participants' identities were unknown, it was not possible to confirm the accuracy of interpretations directly with them. I accepted this limitation as an intentional methodological trade-off made to prioritize participant safety and

emotional well-being. By removing the risk of identification, participants retained full control over their disclosure, which is consistent with trauma-informed ethics. Future research might explore ways to balance these priorities, such as allowing participants to create optional identifiers for follow-up, while still maintaining confidentiality and minimizing potential harm.

### **Recommendations for Future Research**

Based on the strengths and limitations of this study, I propose several grounded recommendations for further research. First, future studies should continue to explore the experiences of Black women with histories of sexual trauma and abortion, particularly within the Southern United States, to build on the rich qualitative data gathered here. Expanding the sample size and diversifying recruitment methods beyond social media—such as partnering with community organizations or clinics—could improve response rates and enhance the representativeness of findings. Second, additional research could examine the application of the Trauma-Informed Socially Just Research (TISJR) framework using varied data collection methods, including non-anonymous formats that allow for follow-up interviews or participant feedback. This would help assess the framework’s effectiveness and refine its use in future trauma-informed studies.

To disseminate the findings of this project, I recommend two practical strategies. One is to present the research at professional social work conferences, particularly those focused on trauma, reproductive justice, or racial equity, where practitioners and scholars can engage with the findings and apply them to practice. I have already presented the beginning stages of this study at a professional conference last year and many

professionals were interested in what the findings would be. Another way is to publish the study in a peer-reviewed journal within the fields of social work, public health, or women's studies, ensuring the research reaches academic and clinical audiences who can use it to inform policy, education, and direct service work.

### **Implications for Social Change**

The findings of this study have the potential to promote positive social change across micro, mezzo, and macro levels. On a micro level, the findings can influence how social work practitioners provide services and care for Black women who have experienced sexual trauma and abortion and encourage practitioners to seek ways to apply evidence-based practices that are trauma-informed and culturally sensitive. On a mezzo level, the findings can promote policy changes within agencies or organizations and joint efforts to promote safe and supportive environments across multi-disciplinary teams serving this population of women. On a macro level, the findings can add to the knowledge necessary to lobby for change within restrictive legislation surrounding reproductive healthcare rights. Overall, these findings should demonstrate the need to continue to expand education and knowledge in the field of social work in order to adhere the values and principles that social workers commit to when entering the profession.

### **Summary**

This study examined the complex and deeply personal abortion experiences of Black women with histories of sexual trauma living in the Southern United States—an often overlooked and underserved population. Using a trauma-informed lens, I identified how voice, choice, identity, and support systems shaped these experiences, as well as how unresolved trauma, systemic bias, and sociopolitical barriers compounded emotional and psychological challenges. Based on these findings, I recommend ethically grounded, culturally responsive, and trauma-informed social work practices that honor individual healing, challenge institutional inequities, and advocate for reproductive justice. By centering marginalized voices and identifying gaps in care, this study contributes to advancing equity, dignity, and empowerment in social work practice.

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## Appendix A: Tables A1-A6

**Table A1***Thematic Analysis of Participant #15*

Raw Data Excerpt	Codes	Categories	Themes
“I was told by my dad that I was going to have an abortion”	Teen pregnancy; personal needs/wants not considered	Decision-making	Voice/choice
“I was not supported”	Relationships/support	Support system	Support needs
“I think the sexual trauma reinforced my belief that everything that happened including the abortion was my fault.”	Thought patterns	Sexual trauma	Negative internal narratives based on unresolved sexual trauma
“I felt the second my daughter was gone. The emptiness was so pronounced.”	Heightened emotions	Emotional toll	Emotional trauma
“I was strongly against abortion. I	Beliefs	Conflict with belief system	Internal conflict complicated abortion experience

never wanted it.”			
“I never felt respected as a person.”	Respect	Lack of worth	Lack of acknowledgement
“The staff treated me like a number.”	Personal value	Stripping of dignity	Depersonalized medical care
“I felt a level of disgusting from the staff. Like here is another statistic of black woman.”	Stereotypes	Presence of bias	Negative experience of Black women receiving healthcare
“I didn’t get any real after-care after that.”	Follow-Up	Lack of after-care	Lack of services/resources after abortion
“I still struggle with certain things like not having my voice heard and respected, but I have come a long way.”	Growth	Change	Individual needs for the healing process are important

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**Table A2**
*Thematic Analysis of Participant #16*


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Raw Data Excerpt	Codes	Categories	Themes
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“I didn’t want to ruin my life.”	Consideration of personal needs/wants	Decision-making	Voice/Choice
“I wasn’t supported at all.”	Relationships/support	Support system	Support needs
“I don’t think it had an impact that I was aware of at the time.”	Thought patterns	Sexual trauma	No impact related to sexual trauma
““I knew I was pro-choice so I made the best decision for my life.”	Beliefs	No conflict with belief system	No internalized conflict to complicate the decision about abortion
“I was treated second class and cold.”	Personal value	Stripping of dignity	Depersonalized medical care
“There was little compassion and the people protesting outside didn’t seem to care that I was walking in	Stereotypes	Presence of bias	Negative experience of Black women receiving healthcare

just the white girl.”			
“I didn’t get any after care services or resources.”	Follow-Up	Lack of after-care	Lack of services/resources after abortion
“It is only through trauma recovery coaching that I’ve been able to heal from my sexual trauma and recognize how much abortion triggered me because of the sexual trauma of my past.”	Growth	Change	Individual needs for healing process are important

**Table A3***Thematic Analysis of Participant #24*

Raw Data Excerpt	Codes	Categories	Themes
“I made the decision that was best for me and my family as a single parent.”	Consideration of personal needs/wants	Decision-making	Voice/choice

“I had to deal with on my own.”	Relationships/support; abortion kept secret from family/colleagues	Support system	Support needs
“My sexual trauma left me feeling inadequate, loneliness, and the need to feel loved. I think that had something to do with me letting my guard down and not using protection to prevent pregnancy.”	Thought patterns	Sexual trauma	Negative internal narratives based on unresolved sexual trauma
“I did however think about it on the due date that I was given. That was sad day for me and every year afterwards.”	Heightened emotions	Emotional toll	Emotional trauma
“I asked God for forgiveness of my actions.”	Beliefs	Conflict with belief system	Internal conflict complicated abortion experience
“When I arrived at the clinic and	Outside persuasion	Decision-making	External stigma results in added pressure

there were  
pro-life  
protestors  
there and I  
almost left  
but I needed  
to do this  
now or I  
would  
change my  
mind.”

“The staff  
was very nice  
and made  
sure I was  
comfortable.”

Treatment from staff

Medical  
care

Positive  
healthcare  
experience

“So my  
decision was  
mine and not  
one else.”

No stereotypes

No  
presence  
of bias

Experience of  
Black women  
receiving  
healthcare

“No after  
care for me. I  
wanted to  
forget it ever  
happened.”

Follow-Up

Lack of  
after-care

Lack of  
services/resources  
after abortion

“I needed to  
work my way  
through it  
and heal on  
my own.”

Growth

Change

Individual needs  
for healing  
process are  
important

“After that  
day, I  
practiced  
avoidance  
and blocked  
it out of my  
mind.”

Cognitive  
avoidance/emotional  
numbing

Emotional  
toll

Unhealthy coping  
mechanisms  
related to  
emotional trauma  
developed

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**Table A4***Thematic Analysis of Participant #34*

Raw Data Excerpt	Codes	Categories	Themes
“My dad pushed for it and I just did what he said.”	Teen pregnancy; personal needs/wants not considered	Decision-making	No voice/choice
“I don’t feel like I had any support from anyone. My boyfriend dipped.”	Relationships/support	Support system	Support needs
“I think the sexual trauma and abortion were very similar experiences because with both I felt alone and ashamed.”	Connections between sexual trauma and abortion experiences	Emotional toll	Emotional trauma
“I have struggled a lot with that decision ever since and can’t forgive myself.”	Beliefs	Conflict with belief system	Internal conflict complicated abortion experience

“I did feel like I was just another number treated like I meant nothing.”	Personal value	Stripping of dignity	Depersonalized medical care
“I don’t know how white women feel just that I had a very bad experience.”	Stereotypes	Unknown if presence of bias	Negative experience of Black women receiving healthcare
“I didn’t get any after care services.”	Follow-Up	Lack of after-care	Lack of services/resources after abortion
“The counseling I have done helped me work through about about the sexual trauma and abortion and what I need from those around me.”	Growth	Change	Individual needs for healing process are important

**Table A5***Thematic Analysis of Participant #36*

Raw Data Excerpt	Codes	Categories	Themes
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<p>“My boyfriend and I discussed our plans for the future after finding out about the pregnancy, and we both wanted to finish college and start our careers before we started a family.”</p>	<p>Consideration of personal needs/wants</p>	<p>Decision-making</p>	<p>Voice/choice</p>
<p>“I kept my abortion a secret, so I did not have a lot of support other than my boyfriend.”</p>	<p>Relationships/support</p>	<p>Support system</p>	<p>Support needs</p>
<p>“I don’t feel like my trauma affected my abortion experience in any way that I am aware of.”</p>	<p>No connection between experiences</p>	<p>Sexual trauma</p>	<p>No impact of sexual trauma on abortion</p>
<p>“I think I dealt with a lot of internalized shame because having an abortion went against how I was raised and my</p>	<p>Beliefs</p>	<p>Conflict with belief system</p>	<p>Internal conflict complicated abortion experience</p>

religious beliefs.”

<p>“I feel like I was raised to be a “strong” Black woman, meaning that you don’t share about a lot of things that happen in your life...you just don’t talk about things.”</p>	<p>Stereotypes</p>	<p>Presence of bias</p>	<p>Negative experience of Black women receiving healthcare</p>
<p>“I didn’t get any after-care services.”</p>	<p>Follow-Up</p>	<p>Lack of after-care</p>	<p>Lack of services/resources after abortion</p>
<p>“Some days I still get emotional and wonder what it would have been like if I wouldn’t have ended the pregnancy, but I am trying to move forward.”</p>	<p>Growth</p>	<p>Change</p>	<p>Individual needs for healing process are important</p>
<p>“At first, we went to a clinic to get an abortion, but there were so many people protesting outside that</p>	<p>Outside persuasion</p>	<p>Decision-making</p>	<p>External stigma results in added pressure</p>

we were both uncomfortable and embarrassed to get out.”

“Both of our families were pro-life and very religious, and I felt extremely guilty and ashamed of the choice to end the pregnancy, but also that we were pregnant and not married.”

“It’s very painful, both emotionally and physically.”

Heightened emotions

Emotional toll

Emotional trauma

Home vs. Clinic abortion

Pain management

Abortion experience

**Table A6**

*Thematic Analysis of Participant 37*

Raw Data Excerpt	Codes	Categories	Themes
“I was young and struggling to take care of myself.”	Teen pregnancy; personal needs/wants considered	Decision-making	Voice/Choice
“Significant other was not going to	Relationships/support	Support system	Support needs

be supportive, or involved.”				
“I barely trusted anyone before the abortion. I trust people even less after the abortion.”	Trust		Response to trauma	Impact of unresolved sexual trauma resulted in increased vulnerability
“I felt alone. Depressed about the situation. Even”	Heightened emotions		Emotional toll	Emotional trauma
“Felt like a black sheep. Grew up in a strict Baptist family.”	Beliefs		Conflict with belief system	Internal and external conflict/stigma
“They were professional and friendly (I guess). Really was not there for a social visit.	Treatment from staff		Medical care	Positive healthcare experience
“I felt like I was living a stereotype. Young, unwed, Black	Stereotypes		Presence of bias	Experience of Black women receiving healthcare

female  
aborting a  
child.”

“I was given Follow-Up  
some  
resource,  
but I choose  
to not  
follow up  
with any  
resources.”

Lack of  
after-care

Lack of  
services/resources  
after abortion

## Appendix B: Initial Screening Questionnaire

1. Are you 18 years old or older?
2. Were you originally listed as a female on your birth certificate?
3. Do you identify as part of the Black race?
4. Can you read and write in English?
5. Do you live in one of these states: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, or West Virginia?
6. Have you ever had an abortion of any kind?
7. Did the abortion take place within the last year?
8. Has anyone ever forced you to do sexual acts that you did not agree with?
9. Did the forced sexual acts happen before you got an abortion?
10. Have you dealt with your history of sexual harm with a professional (for example: counselor, pastor)?

## Appendix C: Abortion Experience Survey Questions

1. Let us begin with you telling me about your pregnancy.
2. Can you tell me how you came to decide to end the pregnancy?
3. How did other people's beliefs about abortion affect you or your decision?
4. How did your beliefs about abortion affect your decision?
5. How were you supported by family, friends, or a significant other?
6. Can you share with me about your abortion experience?
7. What was your relationship like with the staff that assisted you during your abortion?
8. What was your experience with any after-care services or resources?
9. Without giving any details about your experience of sexual trauma, can you tell me if your experience of sexual trauma affected your experience of abortion in any way?
10. Can you tell me if factors such as race, gender, or other components of your identity contributed to your experience of abortion?
11. What was the most difficult part of your abortion experience?
12. What could have made your abortion a better experience?
13. Is there anything else you would like to share?