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Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences

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Abstract

Stigmatization is a deeply contextual, dynamic social process; stigma from abortion is the discrediting of individuals as a result of their association with abortion. Abortion stigma is under-researched and under-theorized, and the few existing studies focus only on women who have had abortions. We build on this work, drawing from the social science literature to describe three groups whom we posit are affected by abortion stigma: Women who have had abortions, individuals who work in facilities that provide abortion, and supporters of women who have had abortions, including partners, family, and friends, as well as abortion researchers and advocates. Although these groups are not homogeneous, some common experiences within the groups - and differences between the groups - help to illuminate how people manage abortion stigma and begin to reveal the roots of this stigma itself. We discuss five reasons why abortion is stigmatized, beginning with the rationale identified by Kumar, Hessini, and Mitchell: The violation of female ideals of sexuality and motherhood. We then suggest additional causes of abortion stigma, including attributing personhood to the fetus, legal restrictions, the idea that abortion is dirty or unhealthy, and the use of stigma as a tool for anti-abortion efforts. Although not exhaustive, these causes of abortion stigma illustrate how it is made manifest for affected groups. Understanding abortion stigma will inform strategies to reduce it, which has direct implications for improving access to care and better health for those whom stigma affects.

Introduction

Abortion stigma, an important phenomenon for individuals who have had abortions or are otherwise connected to abortion, is under-researched and under-theorized. The few existing studies focus only on women who have had abortions, which in the United States represents about one third of women by age 45 (Henshaw, 1998). Kumar, Hessini, and Mitchell (2009) recently theorized that women who seek abortions challenge localized cultural norms about the "essential nature" of women. We posit that that stigma may also apply to medical professionals who provide abortions, friends and family who support abortion patients, and perhaps even to prochoice advocates. Does abortion stigma affecting these groups stem from the same root? Do they experience this stigma in the same way? We build on Kumar et al.'s work by exploring how different groups experience abortion stigma and what this tells us about why abortion is stigmatized.

Stigmatization is a deeply contextual, dynamic social process; it is related to the disgrace of an individual through a particular attribute he or she holds in violation of social expectations. Goffman (1963, p. 3) described stigma as "an attribute that is deeply discrediting," reducing the possessor "from a whole and usual person to a tainted, discounted one." Many have built on Goffman's definition over the past 45 years,[a] but two components of stigmatization consistently appear across disciplines: The perception of negative characteristics and the global devaluation of the possessor. Kumar et al. (2009) define abortion stigma as "a negative attribute ascribed *to women* who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood" (p. 628, emphasis added). Like Kumar et al. (2009), we dispute any "universality" of abortion stigma. We retain their useful multilevel conceptualization, understanding stigma as created across all levels of human interaction: Between individuals, in communities, in institutions, in law and government structures, and in framing discourses (Kumar et al., 2009).

Abortion stigma is usually considered a "concealable" stigma: It is unknown to others unless disclosed (Quinn & Chaudior, 2009). Secrecy and disclosure of abortion often pertain to women who have had abortions, but may also apply to other groups - including abortion providers, partners of women who have had abortions, and others - who must also manage information about their relationship to abortion. As with women who have had abortions, none are fully in control of whether their status is revealed by - and to - others. Consequently, those stigmatized by abortion cope not only with the stigma once revealed, but also with managing whether or not the stigma will be revealed (Quinn & Chaudior, 2009). Researchers have theorized that concealing abortion is part of a vicious cycle that reinforces the perpetuation of stigma (Kumar et al., 2009; Major & Gramzow, 1999).

We examine how abortion stigma, created across levels of human interaction, is made manifest for different individuals within groups and across groups. Abortion stigma can affect all women. Here, we focus on how different groups - women who have had abortions, abortion providers (e.g., doctors, nurses, counselors, clinic staff), and others who are supporters of women who have had abortions (e.g., husbands, boyfriends, family members, close friends, as well as advocates and researchers) - although not homogeneous, are positioned differently with regard to abortion. Intergroup differences illuminate how people manage abortion stigma and begin to reveal the roots of abortion stigma itself. Understanding abortion stigma will inform strategies to

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[1] The growing field of abortion research relies, necessarily, on other fields in which examination and measurement of stigma is more developed.

reduce it, which has direct implications for improving access to care and better health for those stigmatized. We limit our focus here to the United States; a thorough analysis of abortion stigma in other settings is beyond the scope of this paper and deserves attention in its own right.

Groups Affected by Abortion Stigma

Women Who Have Had Abortions

Women in the United States voice complex emotions after abortion, and not all women feel stigmatized by it. Many, however, follow the "implicit rule of secrecy": Women are expected to keep quiet about abortion (Ellison, 2003). Recent research indicates that two out of three women having abortions anticipate stigma if others were to learn about it; 58% felt they needed to keep their abortion secret from friends and family (Shellenberg, 2010). The experience of stigma varies by individual characteristics, such as religious beliefs, cultural values, and economic status (Kumar et al., 2009). Major and Gramzow (1999) examined effects of individual-level abortion stigma, finding that the more a woman perceived others were looking down on her for having an abortion, the more she felt a need to keep the abortion secret. More than two thirds of women talked about their abortions "only a little bit" or "not at all." This secret keeping in turn led to more thought suppression regarding the abortion, which hampered postabortion psychological adjustment. That is, the more women experienced stigma, the more likely they were to have adverse emotional outcomes (Major & Gramzow, 1999). Women may believe they will cope poorly with having an abortion because of misinformation they have received about its physical and psychological risks (Major et al., 2009; Russo & Denious, 2005).

Social support that women receive from their immediate social networks, particularly their partners, mitigates the effects of abortion stigma (Kumar et al., 2009). Women who perceive community support for the right to terminate a pregnancy are less likely to feel guilt and shame than those who do not (Kumar et al., 2009). Conversely, stigma surrounding abortion may keep women from seeking or receiving social support. Stigma may also have economic costs for women who feel they must conceal their abortions. Jones, Finer, and Singh (2010) found that, among the 30% of abortion patients covered by private insurance, nearly two thirds paid for abortion care out of pocket, which they attribute in part to stigma. Finally, the persistence of self-induced abortion in the United States may be another indicator of how stigma affects women's actions (Grossman et al., 2010): Self-induced abortion is one way that women can keep their terminations secret.

The experience of abortion stigma can be transitory or episodic for some abortion patients. Abortion may not become a salient part of their self-concept and may re-emerge only at key moments. For example, a woman who rarely thinks of the abortion she had 20 years ago may find herself face-to-face with abortion stigma when her new father-in-law loudly asserts anti-abortion rhetoric at a holiday dinner or she may re-experience it when she is asked about her reproductive history by her obstetrician. Thus, we caution against reification of individually experienced abortion stigma as something that one always "has" or is always salient.

Women who have had abortions are a heterogeneous group (Jones et al., 2010). Their reasons for terminating their pregnancies also vary (Finer, Frohwirth, Dauphinee, Singh, & Moore, 2005). In public discourse and from the perspective of women having abortions, however, the idea that there are "good abortions" and "bad abortions" stemming from "good" and "bad" reasons for having them, is prevalent. Stigma experienced by women who have had

abortions may be mitigated or exacerbated by whether their abortions fall into one category or the other. “Good abortions” are those judged to be more socially acceptable, characterized by one or more of the following: A fetus with major malformations, a pregnancy that occurred despite a reliable method of contraception, a first-time abortion, an abortion in the case of rape or incest, a very young woman, or a contrite woman who is in a monogamous relationship. “Bad abortions,” in contrast, occur at later gestational ages and are had by “selfish” women who have had multiple previous abortions without using contraception (Furedi, 2001). Women who have had abortions may be both the stigmatizer and the stigmatized, believing they had “good abortions” and distancing themselves from others who had “bad abortions” (Rapp, 2000). These moral distinctions may be drawn by any woman having an abortion, whether anti-abortion or prochoice (Arthur, 2000).

Individuals Who Work in Abortion Provision

Most abortions in the United States are provided in freestanding clinics (Jones & Kooistra, 2011). These separate clinics were originally conceived of by women’s movement activists to ensure sensitive, women-controlled care. Today, however, this separateness isolates abortion from mainstream health care and marginalizes both abortion and those who provide it. Although abortion is one of the most common medical procedures among women in the United States (Owings & Kozack, 1998), 87% of U.S. counties lack an abortion provider (Jones & Kooistra, 2011). This inconsistency between supply and demand indicates that a small number of providers supply women with a large proportion of abortion care. In essence, many doctors and staff are channeled by structural forces into becoming “abortion specialists” (Joffe, 1995).

Physicians who are trained to but do not provide abortions describe explicit and subtle practice restrictions and fear of repercussions from colleagues (Freedman, Landy, Darney, & Steinauer, 2010). Consequently, some providers opt to perform abortions only under “extraordinary” circumstances. The climate of harassment and violence at abortion clinics - exacerbated by the murder of abortion provider Dr. George Tiller - also contributes to providers’ experience of stigma (Joffe, 2003; Freedman et al., 2010; Joffe, 2009). Stigma may also depend on the types of abortions physicians perform, with second-trimester abortion more stigmatized than first-trimester abortion (Harris, 2008; Yanow, 2009).

The experience of abortion stigma is different for providers than it is for women who have had abortions. Abortion stigma is close at hand for providers (Harris, 2008). Their work identity is connected to abortion, and exposure to stigmatizing behaviors may be continual. The concentration of the abortion load on a relatively small number of providers suggests that abortion and its associated stigma may be consistently integrated into the identities of abortion clinic doctors and staff.

The consequences of abortion stigma for the well-being of abortion providers have not been well studied, but hypothesized effects include stress, professional difficulties with anti-abortion colleagues, fears about disclosing one’s work in social settings, and burnout. Some efforts are currently underway to help abortion providers cope with the stresses and stigma of their work (Harris, 2008). Providers counter the negative effects of abortion stigma with positive beliefs that their work is valuable and that it contributes to patients’ well-being in a profound way. Many abortion providers actively support each other.

Supporters of Women Who Have Had Abortions

Supporters of women who have had abortions, including partners, family, and friends, as well as abortion researchers and advocates, may experience a "courtesy stigma" that arises from being associated with women who have had abortions or with providers (Goffman, 1963). Research about male partners of women obtaining abortions has found that they often experience complex emotions similar to those reported by women: Ambivalence, guilt, sadness, anxiety, and powerlessness (Shostak, Koppel, & Perkins, 2006), yet whether they also experience stigma has yet to be studied. Research is needed to understand whether abortion stigma affects male partners and other family members.

Information about stigma experienced by prochoice advocates and researchers who study abortion is also limited. Based on our own experiences, we believe that researchers may experience difficulty securing funding for studies on abortion or may encounter pressure to study "less controversial" topics. We would be interested to see an investigation of how this stigma influences scholars' research funding, publication patterns, and overall career paths.

Why Is Abortion Stigmatized?

Abortion Is Stigmatized Because It Violates "Feminine Ideals" of Womanhood

As Kumar et al. (2009) deftly demonstrate, abortion violates two fundamental ideals of womanhood: Nurturing motherhood and sexual purity. The desire to be a mother is central to being a "good woman" (Russo, 1976), and notions that women should have sex only if they intend to procreate reinforce the idea that sex for pleasure is illicit for women (although it is acceptable for men). Abortion, therefore, is stigmatized because it is evidence that a woman has had "nonprocreative" sex and is seeking to exert control over her own reproduction and sexuality, both of which threaten existing gender norms (Kumar et al., 2009).

The stigmatization women experience may not be rooted in the act of aborting a fetus; stigma may instead be associated with having conceived an unwanted pregnancy, of which abortion is a marker. Stigma may be associated with feelings of shame about sexual practices, failure to contracept effectively, or misplaced faith in a partner who disappoints. Abortion can be seen here as one of several "bad choices" about sex, contraception, or partner (Furedi, 2001).

Abortion Is Stigmatized by Attributing Personhood to the Fetus

Technological changes during the past three decades – fetal photography, ultrasound, advances in care for preterm infants, fetal surgery - have facilitated personification of the fetus and challenged previous constructions of boundaries between fetus and infant. Prochoice groups have debated appropriate gestational age limits (Furedi, 2010). Anti-abortion forces have helped to shape this debate by using fetal images (many of which were not alive or in utero as implied by the photos) and interpreting them in ways that suggest abortion is equivalent to murder (Morgan & Michaels, 1999). These images have effectively erased pregnant women from view, decontextualizing the fetus and overstating its independence from the woman who carries it and the social circumstances of her life (Taylor, 2008). Abortion stigma is affected both by legislative initiatives that establish fetal personhood and gestational age limits and by discourses that influence cultural values. By constructing the fetus as a person and abortion as murder, anti-abortion forces argue that women or providers - or both - should be seen as murderers.

Abortion stigma via personification of the fetus affects individuals differently. Women who have had abortions may find ready justifications for a one-time action. Providers, in contrast, have to cope with an ongoing relationship to abortion, sometimes as they themselves become pregnant or parents (Harris, 2008).

Abortion Is Stigmatized Because of Legal Restrictions

We see an important intertwining of law, morality, and stigma. Legal restrictions (e.g., parental consent requirements, gestational limits, waiting periods, and mandated ultrasound viewing) in the United States make it more difficult for women to obtain abortions and reinforce the notion that abortion is morally wrong. Stigma is a barrier to changing abortion law. This is of particular concern because severe legal restrictions are correlated with unsafe abortion, which contributes to morbidity and mortality (Singh, Wulf, Hussain, Bankole, & Sedgh, 2009).

Changes in the legal situation do not necessarily diminish stigma in social discourse. The stigma of abortion did not go away when it was legalized in the United States. In fact, lowering the legal barriers revealed an enduring cultural stigma (Joffe, 1995).

Abortion Is Stigmatized Because It Is Viewed as Dirty or Unhealthy

The legacy of "back alley" abortionists has left a perception in the United States that abortion is dirty, illicit, and harmful to women. Unfortunately, abortion is still marred by unsafe practices in some places, usually where it is illegal. Occasionally abortion is unsafe in places where, although legal, stigma flourishes, including some instances in the United States. Drawing on this deep historical stigma, anti-abortionists in the United States have championed a new argument that "abortion hurts women." This argument, which positions women as victims of a profiteering abortion machine and the ostensible objects of pity, reduces providers to cruel and callous manipulators and women to "damaged goods." Unsubstantiated links between abortion, breast cancer, and impaired fertility have been used to frame a "women-centered" anti-abortion strategy (Littman, Zarcadoolas, & Jacobs, 2009; Siegel, 2008). In contrast with other examples, in which abortion reveals or symbolizes flaws in women's character, here women become flawed because of the experience of having an abortion, and the abortion provider is further tainted, now harming both fetus and woman.

Seven states have integrated groundless claims about the psychological effects of abortion (such as so-called post-abortion syndrome) into regulations. These institutional practices deny the normalcy of abortion as technique and as medical care and reinforce stigmatizing ideas that abortion is unhealthy.

The clinic, itself a stigmatized place, can reinforce stigma for women: Set off from other medical practices and beset by picketers, the institutional arrangements of abortion provision may validate abortion stigma. Abortion providers themselves are not always free of stigmatizing attitudes, and women may internalize abortion stigma so deeply that they feel judged even by those who support their decisions. Abortion stigma may cause women to feel less empowered to ask questions about the procedure and its health consequences. Research is needed to understand whether women are less likely to challenge poor treatment, or to tell others if they receive low-quality care, or if they feel that they "got what they deserved" if treated disrespectfully. When male partners accompany women to abortion visits, they are generally not allowed to stay with their partners during the procedure and rarely receive information or counseling from the staff

(Shostak et al., 2006). The experience of being in the clinic does not have to be stigmatizing; however, it can be a powerful source of comfort and destigmatization for women having abortions, their supporters, and the individuals who work there (Littman et al., 2009). Women's experiences at the clinic may be strongly influenced by their expectations as well as by what happens there, and research is needed to clarify the role of the clinic in abortion stigma.

Abortion Is Stigmatized Because Anti-Abortion Forces Have Found Stigma a Powerful Tool

The anti-abortion movement increasingly seeks both to erect overt barriers to abortion and to change cultural values, beliefs, and norms about abortion so that women will seek abortion less frequently regardless of its legal status. From photographing women entering clinics to distributing flyers to the neighbors of providers, the anti-abortion movement foments abortion stigma as a deliberate tactic, not just as a byproduct of its legislative initiatives. Eroding public support for the idea of abortion is seen as an underpinning of future institutional limits (Joffe, 2009).

Conclusion

One pernicious effect of abortion stigma may be that physicians are unable to receive training in abortion procedures, decline to be trained, or, if trained, face barriers to providing abortions. Future studies should investigate whether abortion stigma leads some physicians to refuse to provide legal abortions. Conscientious objection on religious grounds, by challenging the morality of abortion, may lead both to lack of training opportunities and to trainees refusing to be trained, further enhancing abortion stigma. Another concern warranting study is that abortion stigma may cause some women to carry their pregnancies to term, to assume a disproportionate economic burden for care, or to seek abortion care clandestinely. It may be that the most vulnerable groups of women are unable to get abortions because of this social barrier. We propose the following recommendations to counter abortion stigma.

Normalize Abortion Within Public Discourse

Silence is an important mechanism for individuals coping with abortion stigma; people hope that if no one knows about their relationship to abortion, they cannot be stigmatized. Nevertheless, even a concealed stigma may lead to an internal experience of stigma and health consequences (Quinn & Chaudior, 2009). We recognize the importance of advocacy and programs that aim to normalize abortion and allow people to speak, such as Baumgardner's "I had an abortion" T-shirt campaign and Exhale's "pro-voice" services, among others. Abortion providers, like women who have had abortions and those who support them, may need targeted supports and outlets. We should engage popular media, including popular entertainment, in the effort to remind people that abortion is common and usual. We need to continue to work with policy makers so that health care and other reforms do not further marginalize and stigmatize abortion services (Weitz, 2010). Empirical research would help to assess the effectiveness of these initiatives and their potential for decreasing abortion stigma. We see a need for work comparing abortion with other social phenomena that have become less stigmatized, such as cancer and homosexuality, to understand better the processes of destigmatization.

Be Aware of Language Used Within Community of Abortion Supporters

The prochoice community, researchers, and advocates need to avoid language that endorses “good” versus “bad” reasons for abortions. Prochoice people should not distance themselves from abortion, invoking “safe, legal, and rare” language, which perpetuates the stigma (Weitz, 2010). Considering the controversies, political advocacy, and social discourse around abortion may illuminate the ways in which particular conflicts have increased or reduced abortion stigma.

Maintain and Strengthen Training Initiatives

The growing movement to make abortion training more research based has helped to improve its standing and to integrate abortion care within academic medicine. The Family Planning Fellowship provides advanced abortion training to board-certified obstetrician/gynecologists and family medicine physicians in 21 universities across the United States. The Society of Family Planning and the National Abortion Federation support ongoing training and research by providing cutting-edge curricula and institutional support for clinical researchers and providers. Physicians for Reproductive Choice and Health has created prizes for abortion providers at the American College of Obstetrics and Gynecology and the New York Academy of Medicine specifically to counter stigma and push medicine to claim abortion as a legitimate procedure. As social scientists who have benefitted tremendously from the Charlotte Ellertson Social Science Postdoctoral Fellowship in Abortion and Reproductive Health, we advocate for the resumption of this program, which filled an important gap in training.

Conduct Research Into Experiences of Stigma Within and Among Groups

Measuring abortion stigma is not easy. We eagerly anticipate new work from Kumar on program design and evaluation for measuring abortion stigma as well as a validated stigma scale for women having abortions being developed by Cockrill and others at Advancing New Standards in Reproductive Health, a program of the University of California at San Francisco’s Bixby Center for Global Reproductive Health. We look forward as well to the contributions of Harris and colleagues about the stigma of abortion work. We acknowledge the concern of some prochoice advocates that a renewed focus on abortion stigma may inadvertently heighten that stigma. We argue, however, that abortion stigma is worthy of attention specifically because the evidence is so limited. Refining our understanding of how stigma operates within and between groups and why abortion is stigmatized will benefit not only the groups identified, but also society in general.

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