

Internalised abortion stigma: young women's strategies of resistance and rejection

Abstract: This paper examines the ways in which young women demonstrated strategies of resistance to internalised abortion stigma. It does so through secondary analysis of young women's narratives from two qualitative studies in England and Wales. Whilst participants felt stigmatised by their abortion[s] in different ways, many also resisted stigmatisation. They did this through different stigma resistance strategies, depending on their socio-economic situation; family and relationship situations; the circumstances in which they became pregnant; and their beliefs and values with respect to abortion and motherhood. Being able to construct their abortion decision as morally sound was an important element of stigma resistance. Although socio-cultural norms and values on abortion, reproduction and motherhood were shown to constrain women's reproductive choices, these norms were all open to challenge. The women were more likely to struggle with their abortion decision-making when they had internalised negativity around abortion.

The concept of abortion stigma can help explain a range of negative aspects of women's abortion experiences, such as why women experiencing an unintended pregnancy may find it difficult to decide to have an abortion and why women who have an abortion may wish to conceal this. Women's abortion experiences, though, and their feelings about their abortion, can vary substantially (Cockrill & Nack, 2013; Kimport, Foster, & Weitz, 2011). It is therefore important to develop nuanced understandings of abortion stigma and ways in which it may be resisted, and rejected. Such understandings could inform strategies oriented to mitigate experiences of abortion stigma, as well as provide insights to be applied in other areas of stigma research. This article draws on data from two studies of young women and abortion in England and Wales in order to analyse variations in how the women may have felt stigmatised by their abortion[s] and to explore individual stigma resistance strategies. Particular attention is paid to considering how women resolve personal dilemmas generated when their decision to have an abortion clashes with their own moral views on abortion. Insights into these processes can also provide insights into methods of managing complex decision-making.

In the UK, apart from Northern Ireland, the legal framework for abortion is the 1967 Abortion Act. This Act, as amended by the Human Fertilisation and Embryology Act 1990, permits abortion up to 24 weeks in specific circumstances (when two doctors agree that continuing with the pregnancy would be more harmful to the physical or mental health of the pregnant woman, or any existing children of her family, than if the pregnancy was ended). After 24 weeks an abortion is permitted in very limited circumstances concerning health of the pregnant woman or her child if the pregnancy proceeds. Abortion, however, remains politically controversial and subject to regular attempts by those opposed to abortion to introduce a more limiting framework or restrict particular types of abortion (Hoggart, 2003; Lee, 2013). Most recently these have included attempts to introduce mandatory abortion counselling and proposals to change the law to prevent sex-selective abortions. These challenges to current abortion provision, alongside the frequently expressed assumption that abortion is inherently undesirable, have contributed to what has been characterised as 'abortion negativity' (Lee, Clements, Ingham, & Stone, 2004). Researchers have begun theorising this negativity through the study of the generation of abortion-related stigma, and the consequences for women seeking an abortion (Astbury-Ward, Parry, and Carnwell, 2012). The sociocultural positioning of abortion in the UK thus invokes moral deliberations (Purcell, Brown, Melville, & McDaid, 2017).

Theoretical Framework

Stigma was originally theorised by Ervin Goffman (1968) as a discrediting or discreditable attribute, behaviour or reputation. Goffman distinguished between three different types of stigma: those related to personal appearance; character blemishes which include moral failings; and 'tribal stigma' (related, for example, to race, religion, or ethnicity). This paper builds upon more recent theorisations of stigma, in relation to the sociology of health, as well as a body of work, primarily originating in the United States (US), that examines abortion-related stigma.

Research has shown that although the stigma of abortion may exist in both liberal and restrictive legal settings, it is more evident in settings where abortion is highly restricted (Cockrill & Nack, 2013; Major & Gramzow, 1999; Quinn & Chaudoir, 2009; Shellenberg & Tsui, 2012). Stigmatisation is thus context-sensitive and it has been argued that socio-economic and cultural contexts, particularly gendered norms, influence abortion stigmatisation (Kumar, Hessini & Mitchell, 2009). Kumar et al (2009) go on to argue that women who have an abortion are stigmatised because they are transgressing gendered ideals of women's sexuality and motherhood. Another study (Norris, Bessett, Steinberg, Kavanagh, De Zordo, & Becker, D. 2011) suggests additional drivers, including attributing personhood to the foetus. Other researchers have pointed to the importance of religion as a contributor to abortion stigma (Bloomer & Fegan 2014; Bloomer & O'Dowd, 2014;). The role of media discourses in framing abortion in negative terms has also been identified by recent studies (Purcell, Hilton, & McDaid, 2014). Overall, these contextual factors, in different ways, contribute towards a construction of abortion as - to a greater or lesser extent - morally wrong.

A number of aspects in the theorisation of stigma are relevant. The concept of deviance is particularly important for analysing abortion-related stigma. Deviance signifies a violation of societal norms and values, implies a moral deficit, and incorporates the notion of blame into the creation of stigma (Scambler, 2009). Cockrill and Nack's (2013) adaption of Herek's (2009) framework on sexual stigma is key to understanding individual-level abortion stigma: internalised stigma signifies women's acceptance of negativity associated with abortion; felt stigma includes women's assessment of other people's attitudes towards abortion; enacted abortion stigma relates to actual experiences of actions that reveal negative attitudes towards abortion. This article focuses on internalised stigma. Internalised stigma can involve a fear of societal attitudes; an acceptance of negative stereotype; and perhaps attempts to conceal the 'moral failing'. Above all, 'internalized stigma often takes a toll on a woman's ability to feel like she is a good woman, both internally and in the eyes of others' (Cockrill and Nack, 2013, p. 983) Thus, with respect to internalised abortion stigma, an understanding of how deviance contains the idea of moral transgression is important.

The contextualised construction of abortion-related stigma does have consequences for women seeking an abortion. Goffman (1968) posited that people respond differently to the normative context. Internationally, small-scale studies, focused on particular geographic areas, have found that abortion-related stigma generates fear and guilt, and contributes to feelings of shame in societies characterised by a conservative morality (Schellenberg et al., 2011). Similarly a recent UK study has shown concealment of abortion is related to women's perceptions of abortion as potentially stigmatising (Astbury-Ward et al., 2012). In Northern Ireland and Ireland, moral conservatism, gendered social norms and religious legitimation – all embedded within legal restrictions – contribute towards especially negative experiences for women undergoing an abortion. Exploratory research on abortion-related stigma in the US has suggested that the more women experience stigma, the more likely they are to have adverse emotional outcomes (Major & Gramzow, 1999). Recently, Kumar argued that care needs to be taken not to use the concept of abortion stigma indiscriminately (Kumar, 2013). Other work has shown that abortion stigma may affect women in different ways (Norris et al., 2011). Stigma processes are thus contested, and this has been shown to be especially pertinent with respect to how women may construct different moral framings. Cockrill and Nack (2013) found that whilst some women perceived their abortion as instances when they breached their own moral code, these moral codes themselves may vary. Other work also acknowledges and discusses the importance of women's own moral views on abortion as an influence on both their decision-making, and post-abortion emotions (Hoggart 2012) .

This article focuses on how individual women's views on abortion, their abortion decision-making, and their feelings about their own abortion, are articulated. Critical realism requires analysing the ways in which individuals give meaning to their experiences in relation to their socio-cultural context (Archer, Bhaskar, Collier, Lawson, & Norrie, 1998), in this case focusing on individual internalised abortion stigma in relation to gendered social norms. The central tenets carried forward to the analysis are: an understanding of internalised stigma as varied and diverse, and influenced by women's individual contexts as well as socio-cultural norms and values. In order to do this, the analysis applies a critical realist framework. The political and policy context (England and Wales) is one in which a pragmatic acceptance of the need for abortion interlinks with a moralistic framing of abortion, such that abortion is necessary but also undesirable (Furedi, 2014). The women's narratives were examined in relation to how they internalised stigma differently, depending on the interaction between their circumstances; their reactions to gendered social norms; and their own moral framings. These issues, central to understanding the complex range of women's reactions to internalised abortion stigma, and complex decision-making, will be discussed in the body of this paper, following an explanation of the methods adopted.

Methods

The data for the analysis were gathered in two qualitative research projects on young women's experiences of abortion, undertaken between 2009 and 2014. These were applied social research projects, undertaken by research teams led by the author, for funders whose interest was to increase knowledge about young women's need for abortion. Research Ethics Committee approval was obtained for both studies. Women's experiences of abortion stigma emerged as an issue in the studies, and data relating to this theme have been analysed for this paper.

In total, forty-six young women (16-24), from a broad range of class, family and ethnic backgrounds in England and Wales, presenting for an abortion, were interviewed by female interviewers (white British in her early 50s, white British in her late 20s, black Caribbean in her late 30s).

Most participants self-identified as white British, followed by black British, black African, mixed race, and white European. There was a fairly even split between women who described their backgrounds as working class and middle class. A range of family situations was evident, though most reported that they grew up in 'nuclear' families. Eight women had experienced more than one abortion, 13 had children, and 3 had also experienced a miscarriage or ectopic pregnancy.

Participants were recruited in the same way for both studies. We asked providers to approach all women within the age range, only excluding those who did not speak English or were having an abortion for a foetal anomaly. However, as this task was undertaken by clinic staff who were not accountable to the research team we are not able to verify whether any other women were excluded. Those who responded positively were asked for consent to pass their contact details to the research teams. We were able to contact approximately two thirds of those women whose contact details (mobile phone numbers) were passed to us; the reasons for non-contact were incorrect numbers, and calls not answered (a maximum of three attempted calls). For those women whom we contacted, the researchers then explained the study, and arranged for an interview to take place if they were still interested. We lost further participants at this stage, and then again when women did not attend the interview. We interviewed approximately 40% of the women who had originally given consent for their contact details to be passed to us. We do not have records of how many women were asked if they would like to take part and refused. We did not aim to recruit a sample that would accurately represent all women within the age range presenting for an abortion. We recruited a small proportion of the number of women eligible for the study, resulting in a self-selected group of young women who were willing to talk to researchers about their abortion experience. Such a sample was appropriate for our qualitative study, in which we aimed to explore a range of views in depth. We continued recruiting to the projects until we were confident that we had appropriately rich data. This recruitment strategy has implications for the interpretation of the results: it is not possible to generalise from the findings of these studies.

The participants provided written informed consent immediately prior to the interview. The interviews were recorded with the participants' permission, the transcripts were anonymised, and pseudonyms were used in all publications. The interviews lasted between forty-five and ninety minutes and allowed space for women to talk about any issue of concern to them, as well as for the interview questions to be addressed. The questions were focused on: individual abortion decision-making; sexual and contraceptive behaviour before and after their abortion[s]; perceptions of social and cultural attitudes towards abortion; the influences of 'significant others' on decisions and experiences; and post-abortion feelings and emotions.

In both studies, the data were originally analysed independently by two researchers who checked each other's selection of themes, and adopted a data-driven first stage of thematic analysis (Braun & Clarke, 2013). Our reading and familiarisation of the transcripts generated a largely descriptive coding frame that was used in the qualitative software programme NVivo. Whilst analysing the data in the original projects. We analysed the narratives with respect to different processes of stigma internalisation and explored these in relation to the women's circumstances; their reactions to gendered social norms; and their own moral framings. The researchers found that their interpretations differed in interesting ways when abortion stigma was in focus, and those disagreements gave the impetus for this article. Some differences were resolved by further reading of the transcripts and secondary literature, whilst some remained (as noted later in the paper). Indeed, it was probing these differences that led us towards an understanding that women's reactions to stigma may involve abortion stigma being simultaneously internalised and resisted.

For this article, Braun and Clarke's (2013) approach was again adopted, using a top-down analysis guided by theoretical concepts related to abortion stigma. Theoretical thematic analysis can identify events, experiences and the reality as described by participants; then the researcher can analyse and interpret the ways in which as researchers they understand and interpret the women's narratives. These analyses also involved interpreting the processes by which individuals understood their own decisions and behaviour. The transcripts were also re-read in order to retain a contextualised understanding of each participant's analysis. In this way it was possible to analyse complex patterns in the participants' responses to similar circumstances, and also how their responses drew on norms and values in different ways.

The themes that were identified in this process centred on stigma resistance – or rejection - strategies that mitigate negative internal judgements about abortion through minimising or rejecting feelings of shame and/or blame. The themes are: views and values on motherhood; responsible/irresponsible sexual behaviour; personal views on abortion. I begin by considering those participants – a majority of the young women - whose narratives indicate that they struggled with internalised abortion stigma, and examine their narrative strategies of resistance. I then analyse the narratives of those who had not struggled in this way, and examine their narrative strategies of stigma rejection. Individual quotations are selected to illustrate the three themes, rather than the views of any one participant.

Struggling with internalised abortion stigma

Most women framed their narratives in ways in which internalised abortion stigma was acknowledged, whilst simultaneously to a greater or lesser extent resisted. Internalised stigma could be expressed as a sense of having morally transgressed, feeling guilty, or having done something wrong or shameful. It was not uncommon for participants to talk generally of not ‘believing’ in abortion, as an explanation for why they felt they had done something wrong, as with the interview extract below:

Katie: I didn't believe in abortions.

Interviewer: That's what a lot of people say as well, so I wonder if you can try and explain to me why you don't believe in abortions, or why you say you didn't believe in abortions?

Katie: Because, I don't know, you're getting rid of say like a part of you.

Interviewer: Your friends or the people you hung out with, what did they think about having abortions, do you know?

Katie: My mate [friend] is pregnant, I said to her “Are you having an abortion?” but she don't believe in them so she's going through with it.

When Katie is pressed to explain why she “doesn't believe in abortion”, she draws on an identification with the foetus as ‘part of’ her, which could be interpreted as one of the drivers of internalised stigma mentioned earlier -- attributing personhood to the foetus (Norris et al 2011), but alternatively can be seen to represent a rejection of the foetus as a separate being. Also worthy of note is that Katie's view is seen to chime with the belief of her friend, and (at another part of the interview) with her partner, thus suggesting that a context of abortion negativity may be influencing her own views. However the statement is interpreted, it is clear that Katie is struggling with abortion morality.

Other ways in which women expressed a sense of abortion as morally wrong included talking about ‘not agreeing’ with abortion; describing the foetus as ‘innocent’ and positioning themselves as ‘guilty’; stating that it was a ‘horrible thing to do’; describing it as ‘not fair’ or as ‘bad’; and describing themselves as selfish:

I suppose it's a selfish decision on my part but also I didn't want to bring a child into something where I couldn't give them everything I wanted. (Cassandra)

Whilst what precisely is wrong with abortion was often left vague, it is clear that such formulations chime with a political and policy context in which abortion may be seen as necessary but also inherently undesirable (Furedi, 2014).

With respect to stigma resistance, the overarching counter-narrative adopted by some of the women was to designate their own abortion as, in some way, justified and morally sound. This was primarily in relation to the themes outlined above: views on motherhood; sexual (ir)responsibility; and individually held moral views on abortion. These were not mutually exclusive but coalesce and conflict in complex ways. Most of the narratives contain multiple, sometimes conflicting, framings and understandings.

Stigma resistance: the good mother

Deciding to have an abortion in the interests of existing children, thereby drawing on gendered notions of 'good mothering' was one of the most strongly expressed justifications for an abortion. Here are two examples.

Lara became pregnant three months after giving birth. She was still seriously ill following a very difficult pregnancy in which she had suffered from pre-eclampsia:

And I was like, "I've got a three month old baby, what is best for my three month old baby is not for me to be getting very ill, being pregnant again."

Lara described her decision to have an abortion as "completely the right decision" and said she had "no regrets at all", despite describing herself as personally opposed to abortion, both before and after her own abortion.

Larissa had a three year old daughter and had no doubt that she made the right decision to have an abortion following unanticipated "reunion" sex:

I'm already a single parent, I'm 22, my daughter is three and a half now, she's doing brilliantly. I've got a nice home, I'm scraping by, like week on week it is a struggle to get us through. If I had another mouth to feed, it would mean that her quality of life would drop and I know it probably sounds really horrible because that was a baby as well but she's here and now, and she's more important than anything ... And so I just thought really, it was for the best.

Both Lara and Larissa expressed different moral framings during the course of their interviews. As noted above, Lara talked about being morally opposed to abortion. Larissa did not, although her statement "it probably sounds really horrible because that was a baby" suggests an internalisation of some abortion negativity on the basis of attributing personhood to the foetus. Both women expressed certainty that they had made the right decision, had done what was "for the best" (Lara) for existing children, who are "more important than anything" (Larissa). They have both resisted internalised stigma, drawing on notions of 'good mothering' in different ways: Lara is concerned that she needs to protect her physical health in order to take care of her daughter, whilst Larissa is concerned about her economic situation and does not want her daughter's "quality of life to drop". Nonetheless, what was different about these two young mothers was their moral framing of abortion. Although Lara expresses strong moral opposition to abortion she is able to justify her own abortion by pointing to her extremely poor health:

I'm angry at myself for putting myself in the position where I had to go against what I believe in, because I still believe that abortion is wrong. But, on the other hand, I know that, I think the thing that swayed it for me and the only reason I went through with it, I would have kept the baby if it wasn't going to have killed me.

Lara was interviewed twice, and taking her narratives as a whole, and following discussions with the co-researcher, our interpretation of Lara's emotions was that she only felt able to declare having "no regrets" because of the severity of her ill health.

Participants without children also drew upon notions about the 'right time', to become a mother. This did not represent a rejection of motherhood, but a rejection at a particular moment in time. This rationale is articulated as responsible, as opposed to irresponsible, motherhood. Annette, for example, stated "I'm not in a position right now where I think having a child is a good thing for me or for the child", and purposefully sets herself apart from other women who may want a child to fill "a hole in their heart". Here she is relating the discussion she had with her partner:

And I said to him, I don't think it's fair to the child right now because I don't have anything to give anyone, like, emotionally. I don't think that's fair. I think a lot of – lots of people, you know, if they feel like they've got a hole in their heart or something, they try and fill that by having a child and making them happy, but I think you should be happy within yourself before you can offer a child anything.

Annette voiced a view of motherhood timing for herself which precluded continuing with an unintended pregnancy until she was emotionally ready. Similarly, other women talked about their vision of themselves as a future mother which incorporated other concerns they had for a future child. One such concern was not having to struggle financially, as highlighted by Anna:

I'd like to be able to give my children what they want and not struggle, I know it can be done, but I don't want to struggle, I want my kids to just have anything they want. I don't want them to be spoiled but I want them to have opportunities and have money really. So the reason why I did it was because I thought I need to get a job and make sure that I can have a child when I can support it.

A final, important, driver in decision-making was rejection of unplanned motherhood in the context of what they thought might not be a lasting relationship.

I've always said to myself, I'm never going to have children until I'm well off or you know I'm in a relationship where I love that person and I know that I'm going to be with that person forever, because what's the point of having a child and bringing it into a broken home.
(Gemma)

These are all examples of how life-stage considerations within an overarching framework of planned, responsible, motherhood, can be drivers in women's decision-making and in resisting feelings of shame or blame. Participants considered their own wellbeing, plus the wellbeing of a future child and of any existing children. In particular, many of these young women, often drawing on popular conceptions of 'good' motherhood which chimed with their own personal values around marriage and family, stated that they would be unable to bring up a child as they wished because of economic disadvantage.

When talking about such scenarios, the women seemed concerned to present their decision to have an abortion as the responsible course of action for their own future lives, but within a framework of a future family. Notions of 'family life' and 'stability' were fore-fronted, as was a desire "be fair" and not to "struggle" bringing up a child. Their narratives also indicate that they believed they were making morally sound decisions.

A related response was found in some women's expression of guilt associated with undergoing an abortion in circumstances in which responsible motherhood might possibly have been attainable. Although Annette, for example, (as noted above) was certain that she was not in a position to become a mother, she went on to say that her decision would have been easier had she not been in a stable long-term relationship: "And then I was very – I think it would have been an easier decision if it had been like a one night stand or something, but the fact I'd been with [partner] for five years, it was – that sort of made it a harder decision".

Annette's narrative indicates that women's guilt about their abortion may be associated with their conceptualisation of what needs to be in place for responsible motherhood. According to Annette some of these requirements were in place for her (a long-term stable relationship), but others were not (emotional and personal readiness).

These narratives are interpreted as indicating stigma resistance. The extracts containing these women's framings of their own stories were initially interpreted as examples of women making reproductive decisions for their own self-fulfilment, but within a contextualised understanding of motherhood as only one aspect of women's lives. However, we came to understand that in this process, they are also partly reinforcing gendered norms, by embracing future, fully considered and planned, motherhood. This was expressed in terms of what would be best for a future child rather than what they desire for themselves.

Within this theme of stigma resistance, I would argue that individual justifications for an abortion decision depend on women positioning themselves as 'good women', thereby implying an alternative: 'poor' motherhood.

Stigma resistance: narratives of sexual responsibility

Another factor that appeared to affect the extent to which abortion stigmatisation was internalised or successfully resisted involved reflecting on the circumstances of becoming pregnant and drawing on notions of responsibility with respect to sexual behaviour and attempted reproductive control. This second theme involved differentiating between unintended pregnancies that had occurred despite what was described as careful and responsible contraceptive use and those which resulted from unprotected sexual encounters, behaviour that could be viewed as feckless and deviant, and thereby blameworthy.

If it wasn't an accident and I'd not been using anything I wouldn't have gone through with it but as I was trying to prevent myself from getting pregnant and it was obviously breakage of a condom, I think that's why I did. (Maddie)

It seemed particularly important for Maddie to justify her abortion to herself, because, as she said later, she thinks "it's a bad thing to do". The use of contraception protected her from blame; but not from guilt: Maddie continued, "I feel like I made the right decision but sometimes I do feel a bit guilty".

Abortion concealment may be an indicator of internalised stigma (Astbury-Ward et al., 2012; Cockrill and Nack 2013). Our participants seemed less likely to conceal their abortion and more inclined to discuss their abortion with family and friends if the circumstances of their pregnancy were not shameful to them. Marlie, for example, was a contraceptive user in a long-term relationship. Like the other participants in her position, she was confident that the "time was not right" and had no trouble discussing her decision-making with her family and friends:

I mean everybody has said they'll support me whichever decision I make, especially my parents and my partner's parents. Obviously for them grandchildren would be amazing but they know it was the wrong time. They'd have been there no matter what decision we've made. Same as friends really, just helped me make my decision, made it a bit easier as opposed to making me feel bad about it, they've supported the fact that this wasn't the right time for it.

These accounts indicate how gendered norms about reproductive responsibility may impact upon women's experiences of internalised abortion stigma. Maddie and Marlie both could avoid feeling guilt for the pregnancy because they had attempted to exercise reproductive responsibility. By way of contrast, many women who had not been using contraception and became pregnant articulated blame as well as shame.

I just felt [pause] like a bit of a slapper. You know? Like, it's not difficult. Contraception is free. It's not difficult to come by, and if you don't want to go to the doctor's there's ... I mean I know this area really well and there's places all over the shop where you can access contraception. And you know, I just felt like a bit of a wrong 'un, you know. (Natasha)

Natasha has internalised a view of unintended pregnancy as a marker of women's irresponsibility. She expressed a sense of shame, but also a sense of blame, because she did not use contraception which, as she said, is "not difficult to come by". Women who told similar narratives often referred to themselves as "stupid".

Some indications of stigma and shame are evident in almost all the young women's accounts of their feelings about their abortion. In the subgroup of women who had experienced more than one unintended pregnancy and abortion, however, there was often a stronger voicing of self-blame, particularly for their sexual behaviour. The negativity associated with abortion as a consequence of 'irresponsible' sexual behaviour seemed to be magnified by a sense that they should have 'learnt their lesson'. Natasha put it, "once is bad twice is unforgivable" and MaryAnn claimed: "It's just like one time is probably bad enough, but the second time it looks quite irresponsible". These statements give indications of self-judgements of fecklessness and irresponsibility.

Stigma rejection narratives

In this final section I turn to an analysis of the ways in which women's own views on abortion may play a role in making it possible for them to reject internalised abortion stigma.

Lara's narrative above illustrated how important it was for someone who described herself as morally opposed to abortion to have a very strong rationale for her abortion. In contrast, women who did not express views of abortion as morally wrong told different narratives that, in the main, did not include lengthy justifications for their decisions. Some participant' accounts are interpreted as stigma rejection, rather than resistance, even though they did not always express rejection explicitly. Instead they indicated rejection throughout their narratives by: articulating a rejection of blame and shame; and making no attempts to rationalise or justify their decision not to continue with a pregnancy that was not part of their vision for themselves at that point in time. Some women explained their decision-making in terms of what they themselves wished for their own futures, their own self-fulfilment, rather than what might be best for a potential child. Although as will be seen, some spoke as if they should be feeling guilty or ashamed, they went on to reject such feelings.

Dee had considered what she might do in the event of an unintended pregnancy and told us that she always knew that if she got pregnant she, would have an abortion: "I made my decision before it was even true". Her sister had previously had an abortion, and it appeared from Dee's narrative that neither she nor her sister felt they had done anything morally wrong and thus had not internalised abortion stigma. Dee described her boyfriend as passive in their discussions: "I just said what was happening and I said what I was going to do. It was my fault but I wasn't like blaming myself, but just unfortunate I got myself in that position".

Though Dee has described her situation as "my fault", her immediate assertion that "I wasn't blaming myself" and her description of her situation as "unfortunate" indicate a concern to avoid attribution of blame. "Unfortunate" was a term echoed by other participants, including Alex:

I knew what I had to do. It was an unfortunate situation. I kind of just stayed on the surface, got it done then I don't really look back. So, I mean, yeah, I did have moments before I actually got it done where I would lie in bed and I mean I couldn't feel anything inside me, but I did have the moments of sadness where I thought there's actually my child is in my stomach, you know, that's amazing and I had them feelings but as I said I just didn't go there because it would have really upset me. And I, it is always going to be a part of my life and something I had to go through but, life happens, you know.

For Alex, feeling upset seems not necessarily to imply self-blame, and neither here, nor elsewhere in her narrative, did Alex express any sense of having morally transgressed. She also drew on notions of foetal personhood, but, again, did not use this to imply that she had made a mistake. Although Alex's narrative thereby contains elements of a stigma narrative she has indirectly rejected internalised abortion stigma.

Analysing the accounts of Dee and Alex led to a significant re-think about abortion stigma, in particular with reference to the attributions of the concepts of blame and shame. Taking their cases as wholes, rather than relying on selected quotations, Dee and Alex came across as young women with a non-judgemental approach to abortion. They appeared to feel confident about the decision they had made, and they did not articulate feelings of shame or blame – key feelings related to internalised stigma - following their abortion. They did not draw on norms about motherhood or responsible sexuality. They had the support of their families and friends and did not maintain secrecy and silence. They talked about abortion as necessary for their own self-fulfilment, they expressed confidence in their decision, and whilst there may have been some indications of emotional distress and ambivalence, especially with Alex, they both tried to reject feelings of blame, shame and regret. Could it be that, for them, abortion was normalised? Could it be that for them, abortion may be "unfortunate" but not out of the ordinary? The narratives indicate that these young women are comfortable about prioritising their need for reproductive control in order to continue their lives as they had envisaged before the pregnancy. The narratives also indicate a sense of abortion normalisation, in particular in the way in which they describe the support of their families and friends. When abortion was normalised in some way through the help and support of family and friends this can help deflect abortion stigma.

Conclusion

The preceding section is an interpretive analysis of young women's accounts of their abortion experiences. The analyses focus on the women's abortion decision-making and feelings about their abortion; and how they resisted, and in some cases rejected, internalised abortion stigma in a number of different ways. Although it is not possible to assess the extent to which the women were open about their feelings, these were the feelings that these particular young women chose to reveal, and they can be taken as indicators of the vocabulary within which they could express their opinions and emotions. These insights into how internalised abortion stigma may be resisted and rejected draw attention to the need for a nuanced understanding of abortion stigma which acknowledges that it may affect women in a myriad of different ways, and can also be challenged by abortion acceptance and normalisation.

Internalised abortion stigma is characterised as women's acceptance of negativity associated with abortion (Cockrill and Nack 2013). This paper has shown how young women engage in narrative strategies in order to resist abortion stigma. It has also illustrated how, for many of these women, there were tensions between their wish to exercise reproductive control and to reject a particular pregnancy; and their moral beliefs about abortion. A sense of abortion as morally wrong was embedded in many of the narratives, most often expressed by women stating they did not 'believe' in abortion. Abortion stigma, was real to these participants, and subjectively understood and internalised. This internalisation involved a variety of responses to their abortion, and a range of individual rationales drawn on in narratives that sought to justify their decision-making.

When faced with a pregnancy that is unacceptable to them, the women in this study made it clear that they had to make a decision informed by a complex web of beliefs and desires, which were simultaneously individually and socially generated. These findings confirm Cockrill and Nack's (2013) conclusion that women develop 'individual stigma management strategies', and adds to a body of work which shows how these strategies are located within contemporary socio-economic and cultural contexts, in this case in England and Wales. As noted at the start of this paper, the literature suggests that socio-cultural contexts, particularly gendered social norms, influence abortion stigmatisation; and that correspondingly, abortion can be seen as transgressing gendered ideals of women's sexuality and motherhood (Kumar et al., 2009). This article has illustrated how two possible transgressions from the 'ideal of "womanhood"' (Kumar et al., 2009, p.628) are historically, socially and culturally located. These are: rejection of motherhood and non-procreative sexual behaviour. Both of these transgressions will now be considered in turn.

Many of the participants drew on notions about the 'right time' to become a mother, and also prioritised the needs of existing children, in a similar discourse to that presented in Chiweshe, Mavuso and Macleod's study (2017). This rationale does not signify a rejection of motherhood, but a rejection of unprepared and unwilling motherhood. It simultaneously complicates the transgression of rejection of motherhood whilst - as the most confidently drawn upon strategy - illustrates its power. It reflects contemporary understandings of motherhood, in which women are under pressure to 'meet the requirements of "good" motherhood' (Budds, Locke, & Burr, 2016), and in which many women anticipate combining employment and motherhood (Dow, 2015). Consequently, by presenting their decision to have an abortion while positioning themselves as 'good women' committed to good mothering, the participants were reinforcing - rather than rejecting - gendered ideals regarding motherhood.

In contemporary UK, the notion that engaging in sex without a desire for procreation is a transgression is outdated (Mercer et al., 2013), but the view that free and easily available contraception renders unintended pregnancy a marker of women's irresponsibility is current. This view was expressed by our participants, who were less likely to express feelings of blame if they felt they had done everything they could to avoid unintentional pregnancy. This view disrupts the connection between deviance and stigma through breaking the connection between shame and blame: some women - again to varying degrees - articulated shame and internalised negativity but rejected self-blame and resisted abortion stigma in this way.

The women thus drew on a number of protective ideas: they had been responsible (using contraception); they were not rejecting motherhood but embracing 'good motherhood'. Additionally, they were making their decisions based on the dynamics between themselves and significant others. In these ways they were assuming the responsibility for their choices. Patterns in the data suggest that the women who struggled with that process were more likely to experience internalised abortion stigma. The protective ideas to which these women took recourse did not challenge gendered norms. The only participants who challenged such norms were the ones who prioritised their own self-fulfilment and told narratives that rejected internalised abortion stigma.

Finally, the importance of moral framings of abortion should not be underestimated. The women who felt that abortion was morally wrong told of particularly troubled feelings about their own abortion, and seemed less able to resist abortion-related stigma than the other participants. There was a complex relationship between the women's wishes to prioritise their own future lives (self-fulfilment) and their moral positionings on abortion. The women who could express their intentions as morally sound seemed to find the decision-making process easier. Taken as a whole, the analysis indicates that the women in this study who were best able to act for themselves and their self-fulfilment whilst not contravening their own moral frameworks, were also best able to resist or reject individually internalised abortion-related stigma. They were further supported when they disclosed their abortion to family and friends and experienced support and non-judgemental attitudes, and when they were treated in a non-judgemental manner at the abortion clinic.

In conclusion, this study has shown that abortion stigma processes are neither inevitable nor uncontested. This study focused on young women, and future work could extend understandings generated here through a focus on women across their reproductive life-course. Nevertheless, regardless of the specific focus, it is significant that the research has shown how abortion stigma processes are neither inevitable, nor uncontested. It therefore provides new evidence in support of literature (Cockrill 2014) which argues that activities and publicity that seek to normalise abortion may help to de-stigmatize abortion, thus providing a very different context for women's abortion experiences.

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Eva Magnusson served as the Action Editor for this article, and the usual blind review procedure was followed.

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