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“I’m Not That Type of Person’’: Managing the Stigma of Having an Abortion

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Drawing on interviews with U.S. women, this article offers a social–psychological framework for understanding the stigma of having an abortion and identifies the individual stigma management strategies women use to mitigate negative intrapersonal and interpersonal consequences of abortion stigma. We also contribute to contemporary understandings of abortion stigma by theorizing how aspects of abortion stigma—such as its concealability and episodic expression—interfere with women’s potential to collectively manage or dismantle abortion stigma. Finally, we discuss how our conceptual framework can be used to inform the development of a measure of the stigma experiences of women who have had an abortion, which can help improve health and well-being outcomes for women.

There is a striking disconnect between statistics about abortion in the United States and women’s lived experiences. Abortion is as common a medical procedure as C-Section, with nearly one-third of women having at least one abortion during their reproductive years (Jones and Kooistra 2011). Yet, many of these women report feeling silenced and isolated (Ellison 2003), and nearly 40% of Americans claim they do not know anyone who has had an abortion (Jones et al. 2011).

Women who have abortions do so in the midst of a polarizing public discourse that narrows and decontextualizes abortion (Jelen and Wilcox 2003; Joffe 2010). Prior to having an abortion, women are likely aware of negative attitudes toward abortion—in everyday discussions and through media, especially during elections. Research shows that a significant proportion of women who have abortions come from communities with anti-abortion views, and some women who have abortions are in favor of restrictions on abortion access (Cockrill and Weitz 2010; Jones et al. 2008). Given how selectively women disclose their abortion history to others and the often-negative public status of abortion, there is evidence of prevailing abortion stigma (Major and Gramzow 1999; Shellenberg and Tsui 2012).

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It is useful and necessary to theorize women's abortion stigma because the individual costs of abortion stigma may include harm to one's health (psychological and physiological) and one's social and/or professional relationships (Crocker et al. 1998; Major and Gramzow 1999). Further, women's individual management strategies have social, cultural, and political implications. In this article, we aim to provide a comprehensive theory exploring the stigma of having an abortion that will inform larger studies and interventions.

Goffman (1963) described stigma as a label marking one as *deviant* in the eyes of society, devaluing that person in social interactions, and often impacting her/his identity. In recent years, social scientists have examined stigma affecting individuals or groups connected to abortion. Scholarship has conceptualized abortion stigma as a socio-interactional phenomenon (Kumar et al. 2009). Norris and colleagues (2011) posit three affected groups: (1) women who have abortions, (2) abortion care workers, and (3) supporters of women who have abortions (e.g., significant others, abortion advocates, and researchers). Other scholars have focused specifically on theorizing abortion provider stigma (Harris et al. 2011; O'Donnell et al. 2011).

This article draws on scholarship from deviance, social psychology, and medical sociology to inform analysis of interviews with thirty-four women who have had an abortion. We begin by discussing abortion as a situated and gendered experience, and describing the setting and methods of our studies. Next, we explain the ways in which our data analysis supports the use of Herek's (2009) theoretical framework to illustrate three key aspects of how abortion stigma manifests for individual women. Then, we present our conceptualizations of the types of individual stigma management strategies that respond to each stigma manifestation. And, finally, we consider the social and cultural ramifications of the ways in which women individually experience and manage abortion stigma. Drawing on the rich details of in-depth interview data, we contribute a grounded theory of women's experiences of abortion stigma in the contemporary United States.

THEORETICAL FRAMEWORK

Herek's (2009) framework of three manifestations of sexual stigma informs our understanding of individual women's abortion experiences. First, *internalized stigma* results from a woman's acceptance of negative cultural valuations of abortion. Second, *felt stigma* encompasses her assessments of others' abortion attitudes, as well as her expectations about how attitudes might result in actions. Then, *enacted abortion stigma* is a woman's experiences of clear or subtle actions that reveal prejudice against those involved in abortion: for example, physical or emotional abuse, discrimination, hate speech, as well as verbal judgments/assumptions, avoidance, and displays of discomfort, anxiety, or even disgust (Crocker et al. 1998). These three manifestations are related but distinguishable facets of individual-level abortion stigma.

The literature on the gendered constructions of deviance helps explain how and why abortion stigma attaches to girls/women¹ who have an abortion. All stigmas stem from shared, socially constructed knowledge of the devaluing effects of particular attributes (Herek 2009). Kumar and colleagues 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 the ideals of womanhood*" (2009:628, emphasis added). Abortion stigma is rooted in narrow, gender-specific

¹Hereafter we will use the word "women" to refer to women and girls together.

archetypes that inform cultural meanings of pregnancy termination (Luker 1984), including archetypal constructs of the “feminine,” of procreative female sexuality, and of women’s innate desire to be a mother (Kumar et al. 2009). Throughout a woman’s life, different reproductive and/or sexual experiences have the potential to signal transgressions of these archetypes, including premarital sex, infidelity, infertility, use of contraception, contracting a sexually transmitted infection, sex work, and abortion. Abortion can signal multiple transgressions, including participating in sex without a desire for procreation, an unwillingness to become a mother, and/or a lack of maternal-fetal bonding. Throughout our analysis of individual-level stigma, we will consider how gendered constructions of deviance inform the experience of women who have abortions in the United States.

The stigma of having an abortion falls under two of Goffman’s (1963) three types of stigma: blemishes of character, and tribal stigmas. Abortion is often characterized as a sin that stains a woman’s moral character. Abortion can also represent failure to fulfill the cherished archetype of femininity and demote a woman’s social status. Nack (2002) found that gendered norms of sexual morality have shaped at least two distinct “tribes” of women: the tribe of “good” girls/wives/mothers enjoys a higher status than the tribe of “bad girls and fallen women.” This latter tribe consists of women who have been socially devalued for defying social expectations of feminine “goodness,” especially with regard to sexuality and motherhood. Additionally, the behaviors that trigger this type of tribal stigma—including promiscuity, contracting a sexually transmitted disease and having an abortion—are often viewed as “choices.” Therefore, members of the “bad girls” tribe are seen as deserving stigma because of their own personal failings (Goffman 1963; Jones et al. 1984; Nack 2002).

Tribal stigmas and blemishes of character can be concealable, rather than known (Quinn and Chaudoir 2009). Goffman (1963) argues that the challenge for those with concealable stigmas is information control. In contemporary U.S. society, the moral blemish and negative social status acquired through an abortion experience can usually be concealed. Our analysis shows how and why women manage information about their abortions, weighing potential downsides of being discredited against potential upsides of disclosures that allow for connection with (hopefully) sympathetic others.

When a stigma is concealable, the amount of distress caused by the stigma depends on how central the stigma is to individual identity or how salient the stigma is at a given moment in time (Quinn and Chaudoir 2009). Women obtaining abortions may take on the identity of the “abortion patient” for the short term, receiving instant membership to the “bad” tribe of women. But, abortion-related stigmas do not always last. As the centrality and salience of abortion shifts over time, abortion stigma may take on an episodic quality and the potential for distress may decrease (Norris et al. 2011). Rather than resulting in ongoing negative interactions or critical self-appraisals, the individual stigma of having an abortion may manifest infrequently: during medical appointments or other interactions where women have the option of disclosure.

This study is the first to advance a grounded theory of individual-level abortion stigma management among women and to provide qualitative evidence to support these conceptualizations. By applying Herek’s (2009) three-part model of stigma manifestations, we made new discoveries about stigma management. In this article, we assert that there are specific strategies by which women individually seek to address three larger goals of stigma management: the first is intrapersonal—managing the damaged self, while the second and third are interpersonal—maintaining a good reputation and managing a damaged reputation. Our theoretical contribution provides a framework for understanding women’s individual-level experiences and behaviors

related to their abortions. This framework also helps to illuminate how individual-level factors create social and cultural patterns that perpetuate abortion stigma.

SETTINGS AND METHODS

Prior research consistently finds that women strongly prefer maintaining the confidentiality of their abortion experiences (Picker Institute 1999; Smith et al. 1999). Therefore, in-depth, one-on-one, semistructured interviews are excellent for collecting data with high construct validity that allows for inclusion of non-standardized information (Reinharz 1990).

Our theoretical conceptualizations of individual stigma management strategies draw on qualitative data from two consecutive studies described in detail elsewhere (Cockrill and Weitz 2010; Kimport et al. 2011). The first study aimed to explore experiences and abortion attitudes of women who have abortions in states that heavily regulate abortion access. The second study aimed to extend the first study by focusing on women's feelings about their abortions. While each utilized a different interview guide, both studies featured one-on-one, confidential, in-depth interviews with women over 18 years old who were in the process of obtaining an abortion or who had previously had at least one abortion. Questions were designed to elicit narratives about difficult aspects of women's abortion experiences. Qualitative data analysis revealed similarities across the two sets of narratives, suggesting that the two data sets are compatible.

In the first study, twenty in-person interviews were conducted at three abortion clinics in the Midwest and South during 2006–07. Seventeen of the women were recruited by interviewers in one of three abortion clinics; three others were referred by an abortion provider or a friend. This study had a response rate of 63% and used purposive sampling to insure range in age, race, and socioeconomic status. Eighteen of the interviews took place within two weeks of an abortion; two other interviews took place within six months of an abortion. Questions asked about respondents' social and emotional experiences of decision making, seeking care, and interactions with significant others around the time of their abortion.

The second study involved one-on-one phone interviews with fourteen women who were recruited to participate from non-judgmental, peer-counseling "talklines" that offer social and emotional support following an abortion. Data collection took place in 2009. Interviewees were asked about the following: their emotional experiences related to pregnancy and abortion, how pregnancy and abortion affected their personal relationships, what they knew about abortion before having one, their perception of abortion attitudes in their communities and families, and their experiences talking about their abortion(s) with others. Talkline counselors were trained to describe the study to women who called and to provide a phone number for more information. Counselors were asked to take notes on eligible callers: those who were over 18, spoke English, and were seeking post-abortion support. Thirty-one women were referred to the study. The study had an approximate response rate of 45%.

Pseudonyms were used to protect the confidentiality of participants in both studies. The average interview length across both studies was 75 minutes. Prompts were used to ask participants to describe their social and emotional experiences both before and after their own abortion procedures. Of relevance to this analysis, respondents in both studies were asked to describe their decision-making process and with whom they discussed their abortions. All interviews were audio-recorded and transcribed (see Table 1 for demographic information on participants).

TABLE 1
Respondent Demographics

<i>Pseudonym</i>	<i>Age</i>	<i>Ethnicity/Race</i>	<i>Religion</i>	<i>Education</i>	<i>Number of children</i>	<i>Number of abortions</i>	<i>Which study?</i>
Aisha	21	white/Native American	none	Some Tech	1	2	1
Alicia	27	black	Baptist	College Grad	1	1	2
Allison	29	white	No Current/raised Catholic	Bachelor's	0	1	2
Amanda	25	white	Baptist	Some College	4	1	1
Angela	20	black	none	Some College	1	2	1
Beth	39	white	none	Some College	2	1	1
Brandy	21	black	Christian—Not Specified	Some College	0	1	2
Cassie	25	white	none	College Grad	0	1	1
Cheryl	43	white	Baptist	GED	2	1	1
Cynthia	36	white	none	Graduate School	1	2	2
Deb	41	white	No Current/raised Catholic	Graduate School	3	1	1
Jackie	unknown	black	unknown	Some College	3	2	1
Jennifer	27	white	none	College Grad	0	1	1
Jessie	18	Asian/Native American	Baptist	High School	0	1	1
Jordan	25	black	Baptist	High School	1	1	1
Joy	28	white/Native American	None	Some Graduate School	0	3	1
Julie	40	white	Christian—Not Specified	Some Graduate School	2	1	2
Katia	25	Peruvian/British	spiritual/raised Catholic	College Grad	0	1	2
Kelly	43	black	Christian- Not Specified	College Grad	1	2	2
Lana	28	Asian	none	College Grad	0	2	2
Laura	37	white	Christian—Not Specified	Graduate School	0	2	2
Lisa	23	white	Christian—Not Specified	Some College	2	2	1
Lyndsay	18	white	Christian—Not Specified	High School	0	1	1
Makayla	27	black	Baptist	Some Graduate School	2	1	1
Maricel	24	Latina	none	Some High School	1	2	1

(Continued)

TABLE 1
Continued

<i>Pseudonym</i>	<i>Age</i>	<i>Ethnicity/Race</i>	<i>Religion</i>	<i>Education</i>	<i>Number of children</i>	<i>Number of abortions</i>	<i>Which study?</i>
Melinda	29	white	none	College Grad	0	1	2
Michelle	39	white	Christian—Not Specified	College Grad	1	2	2
Nicole	38	white	None	Graduate School	2	1	2
Sonja	25	black	Christian—Not Specified	College Grad	0	2	1
Susan	47	white	None	College Grad	8	4	2
Tamara	35	white	None	College Grad	0	1	2
Tanya	25	black	Baptist	College Grad	4	1	1
Tricia	19	white	Methodist	Some College	0	1	1
Vanessa	23	black	none	College Grad	0	1	1

We intentionally drew on two groups of women who would be able to report on abortion stigma. We inferred that the first sample, recruited from abortion clinics in states where abortion was highly regulated, experienced greater exposure to anti-abortion attitudes than women in states with more liberal abortion laws. We inferred that our second sample, drawn from talklines, was more actively seeking support for individual-level stigma (Kimport et al. 2011). Both samples included some women with multiple abortion experiences. All of the women in our sample had obtained an abortion within three years of their interview. We acknowledge that future interviews with women whose abortions were less recent might reveal additional perspectives about the ways that individual-level abortion stigma and stigma management change over time.

ANALYSIS

This article draws on the combined total sample of 34 women. While too small of a sample to be generalizable, the dataset allows for theory-building. Our data analysis was informed by the principles of grounded theory, and we used constant comparative analysis to modify analytical coding categories to best fit emerging theoretical concepts (Glaser 1978; Glaser and Strauss 1967). The analytical approach prioritized the emergence of new knowledge by allowing us to verify some theoretical categories, while discarding others as patterns were confirmed by the data. We coded women's experiences for abortion stigma to assess the validity of Herek's (2009) 3-part model of stigma manifestations: internalized, felt, and enacted. We then drew on the individual stigma management literature to categorize the women's strategies for coping with each manifestation. Finally, we analyzed how sociodemographic variables, as well as in-vivo codes generated during interviews, corresponded to the three manifestations of stigma to generate theories about relationships between these variables and implications for individual-level health, as well as for collective stigma management.

MANIFESTATIONS OF ABORTION STIGMA FOR WOMEN

Internalized Stigma

Many of the women in our study had learned negative stereotypes about girls/women who receive abortions (e.g., they are unintelligent, naïve, uneducated, promiscuous, irresponsible, cruel, and/or selfish). Learning these stereotypes facilitated the women's internalizations of abortion stigma, which could be expressed as prejudice or self-stigma. As evidence of such prejudices, six women used the words "irresponsible" or "careless" as general descriptions for women who have abortions. Given these stereotypes, preventing other "careless" women from having access to abortions can be justified. Tricia said "Maybe there should be a law . . . you can only get a certain amount (of abortions). . . 'Cause if you're constantly messing up, that means you're probably just not a responsible person. . . ."

Once pregnant and considering an abortion, the women had to reconcile their own sexual behaviors and abortion decisions with previous attitudes toward "bad" women. Some revised previous prejudices; while, others turned their prejudice inward. Thus, self-stigma manifested when a woman had (1) been exposed to negative discourses about women who have abortions, (2) believed the discourses were legitimate, and (3) believed they applied to her. Those who

believed that women are responsible for preventing pregnancy judged themselves harshly: five described feeling that they were “stupid” once they were seeking an abortion. Self-stigma appeared most regularly in interviews with women who had grown up in families or communities with strong, negative attitudes toward abortion as the norm. For example, Amanda had protested abortion clinics with members of her church. Two other women had embraced a “pro-life” position in high school debates. These women were the most troubled by unintended pregnancies, having harsher self-judgment than the women from families/communities where abortion was less condemned. For example, Amanda did not see her family responsibilities as a valid excuse: “. . . my reason for having an abortion would be selfish because it would be for myself and . . . the rest of the kids in my house [that I would choose] to kill one life.”

Eight of the women in our sample expressed having strong feelings of guilt associated with their abortion; one participant used the word “guilt” 16 times in her one-hour interview, attributing these feelings to her Catholic upbringing. Our data suggest a strong relationship between religion and self-stigma. Half of our sample identified as currently practicing Christians, Protestant or Catholic. Among these 17 women, 65% made statements revealing self-stigma. Among the 17 non-religious participants, only 35% indicated self-stigma. Self-stigma was not exclusive to religious women; it simply appeared at a lower rate among non-religious women.

Felt Stigma

Women’s narratives revealed felt stigma: they imagined many unsupportive reactions to disclosing an unplanned pregnancy, an abortion decision, or an abortion history. Most respondents anticipated that certain individuals would be unsupportive or judgmental (e.g., religious family members, significant others who are anti-abortion, friends who struggled to conceive, and Ob/Gyns who had delivered their babies). These women feared that disclosing abortion would result in unwanted advice, guilt-trips, condemnation, name-calling, or ostracism.

Despite these fears, all of the women in our sample told someone else about their abortion; though, some told only select people or stopped telling people once they had a bad reaction. Major and colleagues (1997) found that women often tell conception partners about their pregnancy and abortion (85%), but only two-thirds tell friends, and less than a quarter tell parents. Our participants described weighing the risks and benefits of abortion disclosures. Jess feared others’ undetectable attitudes toward abortion: “It’s kind of scary for me right now . . . you know what they’d think of you if they found out. You never know what other people’s opinions are.”

Some feared questions about why they had an abortion because many of the reasons bore their own stigma. These women foresaw disclosure of abortion leading to double or even triple stigma if the pregnancy was linked to reasons such as pre- or extra-marital sex, rape, not wanting a disabled child, being poor, or not wanting to become a mother. For Alicia, having a second unintended pregnancy placed her at risk for the labels used to describe Black, single, mothers: “. . . people didn’t realize the stigma that’s attached to this baby . . . this is my second baby-daddy who I had a one-night stand with . . .” Alicia’s fears were based in reality, her daughter’s paternal grandparents called her “[Child’s name]’s baby mama” even when she was present. Alicia believed revealing her abortion would reveal her unintended pregnancy, inviting even more labeling and judgment.

The stigmatizing interactions women expected varied widely and depended on the values and attitudes they perceived in their communities and the people around them. Allison felt stigma

related to community attitudes toward abortion but also pre-marital sex. She explained, "... it's a very conservative town... there's a lot of Catholic people that I encounter, a lot of people who just don't believe that abortion is right no matter what..." Another participant, Brandy, anticipated the strongest stigma from anti-abortion friends who she feared would label her a "murderer or killer." In contrast, Julie feared her pro-choice older sister would label her "irresponsible" because the abortion showed she had failed to use contraception. Although their expectations differed, the women's most common response to felt stigma was to control information, carefully managing personal interactions.

Enacted Stigma

Confrontations between patients and protestors exemplify enacted stigma and were mentioned by 14 participants. However, participants also described many other subtle interactions which demonstrated their loss of status when seeking an abortion or disclosing an abortion experience.

Cheryl, a 43-year-old woman whose youngest child was entering college, sought healthcare for excessive vomiting and abdominal tenderness. At her appointment, she found out she was pregnant and also had a large mass on her uterus. She was consistently clear with her Ob/Gyn that she wanted to terminate the pregnancy; yet, her anti-abortion doctor refused to provide an abortion or to remove the mass for fear of harming the fetus. In the weeks it took Cheryl to find an alternate Ob/Gyn, she continued to receive "care" from her current doctor:

More than once the [fetal] heartbeat was played on a monitor. ... [I think if] someone goes in there [on] day one and says they do not want this pregnancy, I don't think they should have to hear a baby's heartbeat. That gave me some psychological problems right there, because then I knew there was a human life ... still, I, I knew I didn't want to give birth to it. I couldn't.

Enacted stigma from anti-abortion medical practitioners reflects the *moral surveillance* type of practitioner interaction style (Nack 2008). Medical practitioners are often in a dominant role with patients, and moral surveillance interactions take place when patients perceive a practitioner as having condemned their moral character. These professionals may feel justified in sanctioning deviant behaviors—like abortions, unintended pregnancy, or extra-marital sex. The disdain and judgment shown by such practitioners to their patients suggests they hold common stereotypes about the women who have abortions (e.g., they are stupid, careless or heartless). A woman who expects nonjudgmental treatment from a medical practitioner but receives enacted stigma has reason to fear reactions from others in her life, those who are not bound by medical norms of professionalism.

Some of the women reported enacted stigma after voluntary disclosures to significant others. Alicia described her best friend's reaction:

I actually lost her, a best friend, over this situation because she is so against abortion. Without even realizing how strongly she felt about the situation, she actually turned her back on me and was like, "I have no respect for you because you're trying to do this."

Enacted stigma from one's sexual partner was also devastating. Tanya's partner told her that abortion "is the same as going out there and shooting somebody." Since they were raising four

children together, he did not try to prevent her from having an abortion, but he would not help pay for the abortion and made sure she knew he thought it was a sin. Judgment or abandonment can inspire a woman's use of secrecy and information-control strategies and also reinforce negative feelings about herself.

MANAGING THE STIGMA OF HAVING AN ABORTION

Managing the Damaged Self

Writing about racial, ethnic, and religious minorities, Allport (1954) observed that "ego defensiveness" was a common attribute of individuals experiencing prejudice or stigma (p. 143). Some women managed internalized stigma by accepting the legitimacy of stigma, while simultaneously challenging its application to their particular experiences. They rationalized why the abortion happened and why it was a legitimate behavior, despite its taboo. Two ways of rationalizing included *excuses* and *justifications* (Scott and Lyman 1981 [1968]). Excuses allow women to avoid the label of "irresponsibility"; whereas, justifications serve women who accept responsibility for their abortions but deny the wrongfulness of the act, therefore denying any negative devaluations of moral character.

Excuses and justifications appeared with high frequency in the abortion narratives. Lyndsay, introduced above, described her own rationale:

I had a baby, and I gave her up for adoption, and then . . . I got pregnant . . . it was more like of a date rape kind of thing . . . adoption is hard . . . but I'm okay with my [abortion] decision. Especially, like already going through having a baby and all that.

Lyndsay defends her abortion with two excuses: (1) she was not expecting to get pregnant so soon after the birth of a child and (2) the sex that resulted in the need for abortion was not consensual. Her justification for the abortion is that she has already gone through with one adoption, an emotionally difficult experience, and cannot go through with another.

Research has found that excuses and justifications can contribute to the acceptability of abortion. According to Gallup, Americans widely believe abortion should be legal when it saves the health/life of the woman (81–90%) and for fetal anomalies (49–75%) (Saad 2002). The majority of Americans also believe that abortions should be legal for rape victims (74–84%), suggesting that women who are raped are excused from the moral condemnation attached to other women who have abortions. In contrast, abortions for educational or financial reasons receive significantly less support (25–43%), suggesting that Americans see these reasons as poor excuses for abortion. Yet the most socially acceptable excuses and justifications for abortion are the least common reasons cited by women: 74% of women having abortions cite lack of money and the need to finish an education or meet responsibilities to existing children as their reasons for abortion, and only 1% of women cite rape as a reason (Finer et al. 2005).

Some women managed internalized stigma through *stigma transference* (Nack 2000), shifting the stigma burden onto specific or abstract others. The most extreme example of this was Michelle, a woman who felt deeply ambivalent about her second abortion. Feeling pressure from her boyfriend to have the procedure, she made and broke many appointments at the clinic before

finally having that abortion. Although she described a helpful clinic counselor, she began to transfer blame and stigma onto clinic staff after her procedure was completed:

I'm just sitting back thinking, "These people probably just can't get jobs somewhere else." I do not know how they do it. I mean I was so sickened being in that place. . . . I can't imagine the type of person it would take to work in a clinic like that.

In our sample, ten women transferred all or some of the blame for their abortion onto others they deemed more "deserving."

Other women justified their abortions by *appealing to higher loyalties* associated with gendered expectations (Sykes and Matza 1957). With 61% of women who have abortions being mothers (Jones and Kooistra 2011), many women in our study rationalized their abortions as meeting the needs of existing children. Deb, a 41-year-old, white, married mother terminated a wanted pregnancy after having been told the baby had Downs Syndrome:

[My husband and I] had already talked about, you know, what we would do if something was wrong. And we knew . . . that was the course of action we were going to take because we have three kids. It really wouldn't be fair to them. I mean to, you know, take away that kind of, we thought, attention. It sounds selfish

She appeals to the higher loyalties she held toward her children and husband. When she trails off saying "it sounds selfish" we do not know whether she is appealing to the interviewer's empathy, or actually wonders if her reasons for abortion come across as selfish. Even if managed somewhat effectively, 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.

Although abortion stigma can be conceptualized as attaching a new tribal identity, not one woman in the study described having had an abortion as integral to her identity. This refusal to adopt a new identity or label may occur on two levels. Publicly, women avoid moving from primary to secondary deviance by keeping information about their abortion secret (Lemert 1967). If a woman has previously labeled or held negative attitudes about women who have abortions, then she may experience cognitive dissonance in experiencing an abortion herself (Thompson et al. 2003). Thus some women may avoid internalizing the deviant label (Becker 1973) of "woman who has had an abortion," intentionally distancing themselves from the "tribe" of women who have abortions. For example, Lisa reflected on a second abortion she had after having her first abortion a few months earlier: "This isn't the way I live my life. I'm not that type of person." She had clear idea of a "type" of woman who has an abortion and protected herself from tribal stigma, defensively working to create distance between deviant behavior and self.

Maintaining a Good Reputation

For women who have abortions, the knowledge of the abortion carries a great risk to their reputation. After her second-trimester abortion, Deb described the following conversation with her doctor:

He called me the next day . . . and he said, "You are a high profile person in this area. Everybody knows you. You need to tell people that you had a miscarriage. Do not tell anybody that you had

an abortion. . . . Do not tell your closest friend. . . . Anybody that you tell there's a risk of it getting out."

Women who anticipated stigmatizing interactions because of abortion often tried to reduce the likelihood of negative outcomes by withholding their experience from others. For example, some used deceptive *cover stories*: at least three of the women created fictional explanations for why they needed childcare on their abortion appointment dates. Deb's story suggests that cover stories to cover up the loss of a pregnancy are especially important to women who were known to be pregnant by others in their life.

After the abortion, women may also try to *pass* as having not had an abortion when the topic comes up in conversation. However, individual stigma management strategies that reduce likelihoods of stigmatizing experiences (enacted stigma) also increase other stressors. Brandy discussed how she felt when someone who does not know her abortion status talks about their own abortion, "I feel uncomfortable because it's like, 'Okay, I've had one [too] but they don't know it.'"

For some women, abortion is emotionally difficult but fear of stigmatizing interactions discourages them from seeking social support from significant others. Laura said she usually discussed important decisions with her mother but explained why she could not reveal her abortion:

I think there's still a stigma associated to abortion. . . . I don't [want to] say I'm pregnant and having an abortion. He [the man involved in the pregnancy] was the only person I felt like I could say that to. And look what his response has been. He completely abandoned me.

The consequences of passing, covering, and telling outright lies about abortion can be negative for the individual. Major and Gramzow (1999) found that women who kept their abortion secret were more likely to need to suppress thoughts of their abortion and to experience intrusive thoughts about their abortion, which increased their risk of abortion-related distress.

Although women's secrecy was a common response to women's concerns about judgment, the secrecy itself also contributed to felt stigma. Cynthia said, ". . . if you're doing something wrong, you'd be secretive about it, and I think [keeping abortion a secret] makes you feel like you're doing something wrong. . . ." A woman pays a price for passing as a woman who has not had an abortion or for covering up abortion experiences: she loses potential social support and psychological relief that could come from *therapeutic disclosure* to trusted individuals (Miall 1986).

For most women, obtaining an abortion necessitates disclosure of some kind: to clinic personnel and usually to a friend, family member or partner who accompanies the woman to her appointment. Some noted that going to a clinic provided an opportunity to talk with others who might understand. Vanessa said, "At the end of the day, it's easier to know that everybody's here for the same thing . . . it's like, 'Well, the secret's out. You know?'" Outside of abortion facilities, women may not know how to find supportive others. Since abortion stigma is concealable, women often do not know the abortion status of close friends and relatives. Four women in our studies described how disclosing to a mother or a female friend resulted in reciprocal disclosure. In recent years, peer counseling organizations have emerged to serve this need. Katia, who normally shared important life events with her prolife mother, called a talkline for support because "I just wanted to talk to someone that I know wouldn't be judging."

Managing the Damaged Reputation

Stigma experiences led some women to begin to name and critique the stigma they were experiencing. Laura separated the abortion from the stigma: "... from a scientific physical side [having an abortion] it's nothing ... absolutely nothing. But, it's all emotional, psychological, and, you know, just stigma of what people think." Others specifically aimed judgment at those who had stigmatized them: *condemnation of the condemners* (Sykes and Matza 1957). Additionally, enacted stigma motivated some women to try to *normalize* (Elliot et al. 1990) the abortion experience for those who might judge not only them but also other women like them. Unlike the other types of stigma management behaviors, these types of management may take place in varying scopes, one-on-one, with small groups, online through social media, or through broader advocacy efforts.

Through *condemning the condemners*, a woman can assign the greater sin to those who have judged abortion to be wrong and who work to limit women's access to abortion. This neutralizes the act of abortion by socially constructing the anti-abortion value system as more unjust and immoral than having an abortion. Jennifer described how she now viewed anti-abortion bumper stickers in her community:

The other day I was driving behind a car and I saw ... a religious crazy bumper sticker about anti-abortion ... stupid people who have no idea, don't know the circumstances. ... I just felt really mad because it's just more personal now.

Cassie described a level of hypocrisy among Christians in her community:

What gets me with that whole argument is they want to talk about how it's murder and ... you know, the child should be born, but they don't talk about all the children that are born that are unloved, that are abused, that are psychologically ... damaged, because instead of having an abortion the parents kept the child. ... you don't see them trying to support ... single mothers. You, you don't see the churches getting out to ... help children.

Cassie's critique of anti-abortion individuals was not her only strategy for resisting stigma. She also sought to *normalize* the experience for herself and other women: "Abortion is abortion. People want to specify it only should be for rape victims, or abuse victims. No, it should be available for everybody."

Even women who had previously held negative attitudes found that having an abortion inspired critical thinking and reevaluation of attitudes. Six women described how their abortion decision and the judgment they encountered prompted a reversal in their negative attitudes toward abortion. They began to question the negative stereotypes and labels that they had learned to associate with women who have abortions. Aisha described her re-education this way:

... before I ever had [my abortion], I kind of frowned upon people who did that exactly. You know, 'give the baby a chance' ... I think it's actually not being selfish now to have an abortion ... it's like my mind has totally flip-flopped on the idea of an abortion.

Whether newly acquired or ongoing, empathetic attitudes about women's reasons for abortion and the way women who have abortions are treated, caused some women to question whether

abortion should be a discrediting attribute. Some women discussed how they might re-educate non-deviants, redefining their abortion as typical/common in order to reduce its ability to stigmatize them. For these women, statistics often helped to normalize abortion as a medical procedure. Melinda described how she would discuss the prevalence of abortion to try to convince others that abortion is a typical medical procedure “... like 40% of the population has to deal with [abortion]... it just shouldn’t be this secret...”²

A quarter of the women in our study discussed wanting to normalize abortion for the benefit of others, such as supporting another woman who was considering abortion. Tanya had her first child at 15 and intended to talk to her daughter if she ever became pregnant:

... I’d give her the decision... if she would like to have an abortion, or would she like to have a kid? I want her to know that it is a choice... if she does get pregnant at an early age and make sure that she’s not scared to come and tell me about it, let me know, so we can do whatever the case.

Although the women described enacted stigma experiences as harsh and harmful, coming face-to-face with negative attitudes inspired some women to want to improve abortion experiences for others. Joy, who had three abortions, explained how she would like to set up a friendlier environment for all women who need abortion services including “spa” services: “You know, I just want to make it totally real and comfortable and almost ritualized, you know, instead of evil and bad.”

Episodes of Internalized, Felt, and Enacted Stigma

The manifestations of and techniques used to manage abortion stigma may occur in the process of obtaining an abortion, immediately afterward and/or at specific moments throughout a woman’s life. Enacted stigma experiences described by women in our sample were clustered around the times of social interaction associated with the abortion: making an appointment, going to a clinic, interacting with protestors at the clinic, disclosing (to partners, friends, and/or family members). Experiences of felt stigma also clustered around the time of the abortion but can occur afterward as well. For example, Lisa planned to conceal her abortions from her physician because she was certain he would judge her. It is possible that Lisa will re-experience felt stigma each time she sees her doctor and does not report her abortions on her medical history form. Women in our study also described feeling the highest levels of internalized stigma (guilt and shame) around the time of their abortion procedures.

As the time passed, women developed stigma management skills, and the stigma became less salient. Susan described these shifts: “As I get older, it’s different... [my abortion] is a piece of the past, and I don’t want to keep revisiting it...” Susan reveals an important paradox: perceived need for therapeutic disclosure may diminish while the risks to a woman’s reputation may stay the same. Susan’s story explains why many women remain silent about their abortions even when they feel good about their decisions. As a consequence women who have abortions are often isolated from other women who might understand.

²Abortion is slightly less common than Melinda thinks: half of American women will experience an unintended pregnancy by age 45, 10% will have an abortion by age 20, 25% by age 30, and 30% by age 45 (see Jones and Kavanaugh 2011).

DISCUSSION AND CONCLUSION

In the United States, women have abortions in an environment fraught with controversy and judgment, shaping painful stigma that may have ongoing ramifications throughout a woman's life. We find evidence that abortion stigma is deeply entangled with social constructions of feminine "goodness," such that it disproportionately impacts women and incentivizes concealment of a woman's abortion status.

Women in our sample experienced their abortions as moments where they have failed to live up to the expectations of others and to their own moral code. In response, they offered justifications and excuses for their actions and attempted to avoid negative judgments through secrecy and selective disclosure thereby managing their reputations and senses of self-worth. All of the women who called the talkline verbalized a need for social and emotional support beyond what was available to them in their social networks. Even so, as time passes even these women may perceive their abortion as less salient and need less support, decreasing the likelihood of disclosure. We argue that the collective social silence around abortion is, in part, an unintended consequence of successful individual stigma management.

We also argue that abortion stigma has unintended consequences, even for those who believe that it will be a deterrent. Our data confirm that women who believe abortion is morally wrong and also that women who have abortions are careless and irresponsible, will still have abortions. Meanwhile, abortion stigma could endanger a woman's mental health, relationships, social status, and potentially her physical health—if fear of condemnation affects health-seeking behaviors and/or compliance (e.g., post-abortion follow-up appointments, annual gynecological exams, and other medical encounters which require sharing reproductive histories). Our research suggests that stigma results in negative self-evaluations, worries about reputation, and negative social interactions which, can lead to unhealthy actions: secrecy, deception, and social isolation, which distance women from needed social-emotional support. Additional research is needed to explore whether abortion stigma disincentivizes sexual behaviors, which may result in unintended pregnancies or incentivizes the decision to become a mother or choose adoption when faced with an unintended pregnancy. Such research can and should be informed by our framework for individual level abortion stigma.

Given the inter- and intrapersonal consequences of stigma for women who have abortions, our analysis also helps to inform potential destigmatization strategies. Goffman states, "The relationship of the stigmatized individual to the informal community and formal organization of his own kind is . . . crucial" (1963:38). Abortion secrecy promotes invisibility of the abortion experience and can hinder opportunities for such collective stigma management. Clinics, talklines, and counseling services help women who have abortions to connect with individuals who can listen nonjudgmentally and may share their stigma. However, one-on-one interactions cannot create the kind of collective stigma management that is necessary for changing sociocultural norms. To destigmatize abortion, there must be supportive spaces (real or virtual) in which women who have abortions can connect with each other. Online communities present one possibility for collective stigma management and the development of a broader destigmatization agenda (McKenna et al. 2001). Online communities can also allow women to drop-in during stigmatizing episodes, when abortion stigma is most salient.

Increasing social contact between people *with* abortion experiences and people *without* abortion experiences may be one of the most important elements for changing social attitudes. However, our findings also show the need for strategic thinking when it comes to encouraging

direct disclosure in order to destigmatize abortion. Our study agrees with earlier work (Major and Gramzow 1999), showing that many women avoid disclosures, which will increase enacted stigma. Indeed, direct disclosures increase the number of stigma enactments, and could have the unintended effect of reducing a woman's likelihood of disclosure over time. Therefore, de-stigmatizing abortion should not hinge on women coming forward in contexts where enacted or felt stigma is likely. In addition, women who choose to disclose will be better able to handle episodes of enacted stigma if they have ongoing sources of social support.

Rationalization can also unintentionally contribute to the stigmatization of abortion in our culture. It is common for advocates, policymakers, and researchers to highlight women's justifications and excuses for abortion. While these efforts produce short-term successes, they fail to disrupt the narrow gender constructs that fuel individual experiences of stigma. Excuses and justifications may ease the burden of internalized stigma or stigmatizing encounters, but they will not reduce stigma in the long term. A longer-term strategy will seek to problematize the expectations placed on women and deconstruct stigmatizing labels such as "good mother" and "irresponsible." Efforts may include drawing parallels between abortion and other experiences that transgress gendered ideals (e.g., sexually transmitted infections, single-motherhood, adoption, premarital sex, lesbianism). Another long-term strategy might focus on promoting a set of non-gendered virtues that disrupt stigma: compassion, empathy, and understanding.

Our data and analysis have limitations. In this study, we draw on a small convenience sample of women who have abortions that is not generalizable to the broader population. A little over 40% of our sample was drawn from abortion talklines. Women calling talklines for support may have experienced a higher level of stigma than women who do not. In order to explore the prevalence of abortion stigma, and to assess the relationship between stigma and possible negative health outcomes, we must be able to measure the individual-level experience of abortion stigma for women on a broader sample of women who have abortions.

Conceptualizations of individual-level stigma have provided the framework for psychometric scales to measure acute and long-term stigma impacts on individuals living with HIV/AIDS, genital herpes and HPV infections, obesity, epilepsy, and marginalized sexual identities (Breitkopf 2004; Scambler and Hopkins 1986; Herek 2009; Jones et al. 1984; Nack 2000). Likewise, the framework presented in this article has informed the development of a valid and reliable scale individual level abortion stigma scale (ILAS) to measure both intrapersonal and interpersonal aspects of women's abortion stigma experiences (Cockrill et al. 2013). The application of this scale has provided insight to questions left unanswered in this qualitative study. For example, a paper describing the development and application of the scale shows a statistically significant positive relationship between internalized stigma, Catholic religion, and religiosity (Cockrill et al. 2013).

Beyond the development of a new stigma measure, the conceptual framework in this article is also applicable in developing future interventions and research related to abortion stigma. The first author is drawing on the findings presented in this article in another study exploring the disclosure of abortion experiences in women's book clubs. In this same study, the author is exploring whether interpersonal contact with women who have abortions reduces negative attitudes toward abortion. Finally, the authors are interested in applying the findings in this article in public opinion research. Our research suggests that attitudes toward abortion policy are related to but distinct from stigmatizing attitudes toward women who have abortions. Developing measures of abortion attitudes that assess features of community-level stigma (e.g., labeling, stereotyping, separating, and discrimination) will help us better understand abortion stigma overall.

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