Title
Mothers, Morals, and Medicine: Navigating Stigma and Identity in the Abortion Experience

Author
Combellick, Sarah Larissa

Publication Date
2023

Peer reviewed|Thesis/dissertation

Mothers, Morals, and Medicine: Navigating Stigma and Identity in the Abortion Experience

By

SARAH LARISSA COMBELLICK
DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

Sociology

in the

OFFICE OF GRADUATE STUDIES

of the

UNIVERSITY OF CALIFORNIA

DAVIS

Approved:

_____

Drew Halfmann, Chair

_____

Ming-Cheng Lo

_____

Maxine Craig

_____

Lori Freedman

Committee in Charge

2023

Table of Contents

Abstract

Abortion in the United States is generally considered a highly contested moral and political issue. Two competing activist frameworks tend to dominate the public conversation around abortion. Yet the experience of having an abortion is socially complex, often shaped by inconsistent cultural schemas related to motherhood, medicine, life, and death. Little empirical research examines how people talk about the morality of their own abortion experiences. In this dissertation I examine how individuals who have abortions construct moral identities in the face of persistent gendered stigma. The dissertation is in the format of three research papers. In the first paper, I analyze 156 personal narratives from an abortion storytelling website. I identify four discursive frameworks used to confront the problem of abortion as a morally controversial act. In the second paper, I examine eighteen in-depth interviews with cisgender women who obtained abortions after receiving a diagnosis for a serious fetal condition. I examine how participants maintained moral worth and constructed symbolic boundaries between themselves and those who have abortions for reasons other than fetal health. In the last paper, I question why, despite an unambivalent embrace of motherhood ideals and severe fetal diagnoses, this group of women experienced abortion stigma. I identify a need for a theoretical reorientation toward defining abortion stigma as a multi-level social process embedded in existing structures of power and inequality. The findings of this research contribute to an evolving discussion of how the perspectives of people who have had abortions fit into abortion rights discourses and the broader public sphere.

Acknowledgements

I am incredibly grateful to the mentors, colleagues, family, and friends who have supported me on the long road to the completion of this dissertation. I can start nowhere else but with a heartfelt thank you to my advisor and dissertation chair Drew Halfmann. Drew is an ideal mentor – he gave me the freedom and independence to set my own goals for the project yet was consistently present as the giver of valuable advice and support when I needed it. Knowing that Drew was always in my corner was an incredible safeguard against the stress of graduate school, and finding another person who can talk about abortion all day, every day is a rare delight.

Throughout this process I've often felt like I won the dissertation committee lottery. My committee members are thoughtful, brilliant, and exceptionally kind. I am grateful to Ming-Cheng Lo for sharing her expertise on the sociology of health and illness and qualitative research methods, to Maxine Craig for supporting my interest in bodies and embodiment, and to Lori Freedman for outstanding feedback on drafts of my papers. I also thank Laura Grindstaff for sharing her knowledge of culture and intersectionality and for multiple rounds of feedback on the first paper.

The process of conceptualizing this dissertation started long before I began my PhD. I am incredibly grateful for the exceptional mentors I worked with at the University of California, San Francisco. I thank Ushma Upadhyay, Katrina Kimport, Carole Joffe, Claire Brindis, Antonia Biggs, Nancy Berglas, Samira Soleimanpour, and Alissa Perrucci for their meaningful contributions to my intellectual development and continued steadfast support.

I am deeply indebted to the team at the UC Davis Division of Family Planning, most especially to Namrata Mastey and Bimla Schwarz, who invited me to work with them on the

prenatal palliative care project and generously shared the data that provide the foundation for the second and third papers.

To my PhD cohort – Zosia, Teresa, Hannah, Konrad, Asia, and Justin – I cannot have asked for a better group. I would not have survived the first two years of the program without the support of these friends in my classes and around the happy hour table.

As a mother, I am constantly aware of the other women without whom I could not have achieved this type of accomplishment. In the goal of making visible the process of feminine care work, I thank the incredible childcare providers whose labor and love allowed me the time and peace of mind to pursue this degree. I am especially grateful to Liz Graham and Marisa Gonzalez for holding down the home front seamlessly and with such grace.

Finally, I am beyond grateful to my family for their endless support. I thank my parents, Amitai and Marjorie Schwartz, for their endless commitment to my academic success and for instilling social justice values in me from the beginning. The biggest thanks of all goes to my husband, Todd Combellick, for his unwavering support and partnership throughout this process. To enumerate all of the big and small ways he has championed me for the past six years would be an entire dissertation in itself. Finally, this dissertation is dedicated to my daughters, Sasha and Lily Combellick, whose bright shining lights have sustained me through these years of hard work.

1. "My Baby Went Straight to Heaven": Morality Work in Abortion Online Storytelling

Abstract

A major feature of the abortion debate in the United States is its intense polarization. Two competing activist narratives tend to dominate the public conversation around the morality of abortion. Yet little empirical research examines how women talk about the morality of their own abortion experiences. Drawing on a qualitative analysis of 156 accounts from an abortion storytelling website, I find that traditional pro-choice moral arguments invoking privacy and bodily autonomy ("*abortion as a private choice*") were apparent but not dominant in women's accounts. Three other frames emerged as ways to confront the problem of abortion as a morally controversial action: "*abortion as morally unremarkable,*" "*abortion as morally problematic, but justified,*" and "*abortion as morally desirable*". These four frameworks varied in the degrees to which they aligned with politically acceptable abortion narratives. Notably, throughout these frameworks were a number of overlapping themes, including motherhood, responsibility, and religion. Drawing on theories of morality work and moral accounts, I posit that subjects are able to hold a "tension of opposites" while still maintaining cohesive narratives and presenting positive moral identities. For example, many women assigned their fetus a moral status as a life or potential life, yet ultimately felt other factors outweighed the obligation to sustain that life. I argue that this tension is a significant feature of morality work that warrants more attention.

Keywords

abortion, abortion stigma, morality work, moral accounts, online storytelling, tension of opposites

A major feature of the abortion debate in the United States is its intense polarization. Two competing activist narratives tend to dominate conversations around the morality of abortion. Broadly, pro-choice advocates maintain a rights-based framework that emphasizes the moral importance of individual freedom of choice and bodily autonomy. Abortion opponents argue using a fetal rights framework focusing on the moral status of the fetus as an unborn child (Watson 2018). In recent years the antiabortion framework has expanded to include a focus on unfounded claims about the physical and mental health consequences of abortion (Rose 2011). Ethnographic research indicates that pro and anti-abortion rights activists carry opposing values about the roles of women in family and public life (Ginsburg 1989; Luker 1984). However, little empirical research examines the moral frameworks women[1] use when describing their own abortion experiences, and specifically the moral narratives used when telling about their abortion decisions.

The technological revolution of the internet has helped democratize the ability to share personal stories with vast and diverse audiences. In recent years women's abortion stories, often anonymized, have proliferated on the internet (Sanger 2017). Several online initiatives have developed with the goal of ending women's silence around abortion. Many abortion rights activists believe online storytelling has liberatory potential and that it may decrease the stigma around abortion (Michie et al. 2018). This study analyzes abortion stories from one such project in order to interrogate how women construct positive moral meaning from their abortion experiences.

[1] None of the stories I reviewed had narrators that self-identified as men, transgender men, or gender non-binary. However, it is important to acknowledge that men and gender non-binary people also have abortions and should be included in abortion-related research.

This paper addresses the question: *How do women morally account for their abortions given the practice's highly contested status and a narrow scope of available cultural narratives to draw upon?* I draw on theories of moral accounts and specifically Davis' (Davis 2014) concept of morality work to analyze 156 stories from *My Abortion, My Life*, a digital storytelling website. I present my empirical findings of how storytellers perform "the discursive labor of remoralizing the self in the face of pervasive negative moral evaluation (Davis 2014:436)." I find that traditional pro-choice moral frameworks invoking privacy and bodily autonomy ("*abortion as a private choice*") are apparent but not dominant in women's accounts. Three other frameworks emerged as strategies to address the problem of abortion as a morally contentious action: First, "*abortion as morally unremarkable"* rejects the very premise of negative moral evaluation and presents the abortion decision as routine and ordinary. Second, "*abortion as morally problematic, but justified*" uses excuses and justifications to recuperate the subject's moral identity within an otherwise immoral decision. And finally, "*abortion as morally desirable"* claims the moral high ground by presenting the abortion choice as the most honorable of the given pregnancy options. These four frameworks varied in the degrees to which they aligned with "politically acceptable" abortion narratives (Ludlow 2008b). These findings extend existing literature on women's personal abortion experiences by identifying narratives that subvert traditional discourse on abortion; specifically, some narratives use Christian religious discourse and the construction of the fetus as a life or potential life as part of the presentation of self as morally sound. I argue that some subjects comfortably balance a "tension of opposites," that is, the capacity to hold and engage with seemingly contradictory ideas or claims (Harris 2019) in their moral discourse.

The findings of this paper are significant for a number of reasons. First, they offer important implications for understanding lived experiences of abortion and the morality work that must be accomplished in order to present a positive moral identity as a woman who has experienced abortion. Using the approach of analyzing anonymous, first-person digital stories, I develop a more robust model of women's moral accounts of abortion relative to previous work. This study also has implications beyond the abortion case for understanding morality work more broadly. Previous research has focused on the straightforward and unambiguous remoralization strategies that typify morality work. I propose that a tension of opposites framework may be helpful in understanding how subjects engage with nuanced and contradictory perspectives on complex moral questions. Furthermore, I theorize that this more advanced morality work may be achieved while still presenting a positive moral identity and without losing hold of a coherent narrative. These theories point to potential new pathways in research on morality work that credits subjects' abilities to articulate moral viewpoints beyond the simple and binary.

Morality in Narrative and Culture

Broadly speaking, morality can be understood as how individuals and social groups understand what is right or wrong, what behaviors are better than others, and what people should believe, feel, or do (Hitlin and Vaisey 2013). The sociology of morality is less concerned with the universal characteristics of moral judgment and more concerned with the social processes that create and sustain certain moral concepts, moral identities, and variation therein (Anspach 1993; Hitlin and Vaisey 2013). Hitlin and Vaisey argue that individuals and social groups struggle with each other to determine "which kinds of actors and which kinds of persons are more or less worthy and what kinds of practices are permitted or forbidden (Hitlin and Vaisey 2013:59)." Similarly, Lamont's theory of boundary work maintains that although moral

boundaries are an important aspect of all cultures, the prominence, features, and success in constructing and enforcing such boundaries can vary greatly by geographic, structural, and social location (Lamont et al. 1996). Moreover, norms that shape concepts of "good" versus "bad" come to define imagined communities who are like them and who are not. This distinction plays a central role in developing a positive moral identity (Lamont 1992, 2009).

A narrative approach to studying morality in culture uses storytelling as a way to make analytic connections between personal experience and social forces. Through the work of narrative, storytellers convey meaning about how they perceive themselves to be in the world, and how they desire others to see them (Riessman 1990), but are also enabled and constrained by a range of social and cultural circumstances and resources (Chase 2005). Davis summarizes the numerous discursive remoralization techniques that stigmatized groups use to respond to persistent negative moral evaluation as morality work (Davis 2014). A play on Snow and Anderson's identity work (Snow and Anderson 1987), morality work focuses on the performative nature of identity and the intensive labor required to perform morality "in the face of moral stigmatization (Davis 2014:436)." The morality work frame has been applied in cases where individuals account for their own behavior (Davis 2014), where moral boundaries are debated in the public sphere (Davis and Love 2018), and where negative moral evaluation extends to the accused's social network (Davis et al. 2018; Davis and Manago 2016).

While morality work is a relatively recent concept, it is rooted in the rich body of literature on moral accounts. Accounts are particular types of stories that function as social explanations of potentially blameworthy or problematic events or behavior (Lyman and Scott 1970). Situations which somehow break or question the moral order and raise concerns of personal worth require subjects to give accounts (Orbuch 1997). Numerous empirical studies

have explored the moral accounts of individuals who violate norms in cases such as violent crime (Presser 2004), smoking during pregnancy (Wigginton and Lafrance 2014), obesity (Hughes and Degher 1993), and unsafe sex (Boulton et al. 1995). For example, Presser (2004) found that some men who were convicted of violent offenses framed their crimes as out of their normal character (e.g., evil took over), or rationalized their behavior as moral by appealing to higher loyalties (e.g., a woman's honor). In a study of gay men's accounts of unsafe sex, Boulton and colleagues (1995) described accounts in which subjects argued their "usual" control over their sexual responsibility momentarily "lapsed."

In accounts, subjects are required to use discursive techniques to place themselves in the social order and socially constructed morality in which they exist. They must account for their experiences in ways that are intelligible and legitimate in their current social context and may do this by appealing to the accepted values of their culture. For example, in Hughes and Degher's (1993) study of obesity, the condition was often framed as a natural consequence of valuable behaviors, such as hard work or intensive caretaking responsibilities. In Wigginton and Lafrance's (2014) study of smoking during pregnancy, subjects acknowledged and often framed their accounts around the known harmful health effects of their behavior, but also argued that quitting was stressful and thus could potentially be more harmful than smoking a reduced amount. In both examples, individuals drew upon the highly agreed upon moral values of their social context to present themselves as moral actors with nondeviant identities.

Morality and Abortion Stigma

The present research highlights morality work in the narratives of women describing their decisions to have abortions. Abortion is foremost a health care experience in which an undesired pregnancy is terminated and removed from the pregnant person's body. However, in the United

States and elsewhere, the moral status of abortion is highly contested, due in large part to the work of the anti-abortion rights movement. These activist groups have, for the most part, been successful in giving abortion a highly stigmatized status. Many scholars have theorized specifically about abortion stigma (e.g., Cockrill et al. 2013; Cockrill and Nack 2013; Hoggart 2017; Kumar 2013; Kumar, Hessini, and Mitchell 2009; Norris et al. 2011). Kumar et al. offer a definition of abortion stigma that is grounded in Erving Goffman's classic definition of stigma as an "attribute that is deeply discrediting" that "reduces an individual from a whole and usual person to a tainted, discounted one" (Goffman 1963:3). The authors describe abortion stigma as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood (Kumar et al. 2009:628)." Their definition builds on a legacy of scholarship that maintains cultural meanings of abortion are rooted in narrow, gender-specific archetypes that inform cultural meanings of pregnancy termination, including archetypical constructs of the feminine, of procreative female sexuality, and of women's innate desire to be mothers (e.g., Luker 1984). Abortion can signal multiple transgressions of these archetypes including participation in non-procreative sex, unwillingness to become a mother, or lack of maternal-fetal bonding. This perspective maintains that a woman who seeks an abortion is thought to be "challenging widely held assumptions about the essential nature of women (Kumar et al. 2009:628)."

Compounding abortion's stigmatized status as a marker of inferior womanhood is its status as "dirty work". Dirty work has mostly been applied to stigmatized professions (including abortion providers) that are associated with physical dirtiness (blood, death) social dirtiness (contact with outsiders) or moral dirtiness (having to do with sin, duplicity, or deception) (Joffe 1986). Similarly, antiabortion social movement activists have long used graphic or grotesque

images of fetal body parts as a mobilizing tactic, with mixed success (Halfmann and Young 2010). The "dirty" label reinscribes abortion's status as a stigmatized healthcare experience by conceptualizing it as something to be avoided.

Finally, in the United States and much of the West, abortion stigma is shaped by religion, and much of the moralization of abortion is constructed by religiously rooted anti-abortion rights groups. The anti-abortion framework in the U.S. is shaped by Christianity, notably Catholicism and Evangelism. Most Christian traditions in the United States formally oppose abortion (The Pew Forum on Religion and Public Life 2013), and there is a strong connection between Catholic and Protestant religiosity and negative attitudes toward abortion (The Pew Forum on Religion and Public Life 2008). However, Christian affiliation and abortion are both common among American women of reproductive age, and there is substantial overlap between the two experiences (Jerman, Jones, and Onda 2016). The role that religion plays in abortion decision-making is not entirely clear; however, some studies have found that religious background and beliefs are intertwined with the experience of stigma among woman receiving abortions (Cockrill et al. 2013; Cockrill and Nack 2013; Frohwirth, Coleman, and Moore 2018).

Moral Discourse in Abortion Narratives

The present research lies at the theoretical and empirical intersection of moral narratives and abortion stigma. A number of qualitative studies featuring women's abortion narratives reveal that they are rarely simple and are often nuanced and complex (e.g., Allen 2015; Becker 2019; Beynon-Jones 2017; Hoggart 2017; Jones, Frohwirth, and Moore 2008; Kimport, Foster, and Weitz 2011). Women use the narrative process to both embrace and resist socially assigned attributes in order to develop non-stigmatized moral identities. For example, Beynon-Jones (2017) and Allen (2015) established that some women frame their abortion decision as

personally and civically responsible in the context of prominent middle-class cultural beliefs such as the requirement to finish an education or pursue a career prior to parenthood. In the face of persistent gendered stigma, other women frame their decisions as aligning with expectations of proper femininity. Jones et al. (2008), Hoggart (2017) and Becker (2019) all describe women who draw on normative mothering ideals by framing their abortion decisions as in the interest of existing children or a potential child.

Furthermore, women who discuss their abortion decisions must contend with a dominant culture that has determined that some abortion narratives are more socially acceptable than others. Ludlow theorizes three categories of abortion narratives: the politically necessary, the politically acceptable, and 'the things we cannot say' (Ludlow 2008b). Kimport et al. interviewed obstetrician-gynecologists and found that they distinguished between more and less legitimate abortions depending on how well their patients' narratives conformed to normative gendered sexuality (Kimport, Weitz, and Freedman 2016) Finally, Martin and colleagues (Martin et al. 2017) determined that abortion providers feel pressure to self-censor when their own stories do not reflect prominent pro-choice discourse. It is possible that these hierarchies of acceptable abortion stories among providers are also evident in the way women themselves talk about their abortion decisions and experiences.

Scholarship addressing the complexity of the moral discourse around abortion is limited. Ludlow's essay, "Sometimes it's a child and a choice", reflecting on the author's experiences observing women obtaining abortions, offers an alternative to the moral binary set up by pro- and anti-abortion activists (Ludlow 2008a). Ludlow suggests that a major gap in the abortion debate is discussion of the maternal-fetal relationship, "a relationship that many women consider seriously when they choose abortion (Ludlow 2008a:31)." More recently Harris, reflecting upon

her experiences as an abortion provider and researcher, theorizes an understanding of a "tension of opposites" in abortion provision (Harris 2019). She argues that abortion providers hold an "ability to hold and engage with two seemingly opposite, incompatible things (Harris 2019:202)", such as "that abortion 'stops a beating heart' and 'is vital to women's agency' (Harris 2019:202)." Harris suggests that abortion providers may have particularly high tolerances for ambiguity and nuance. The present research explores the extent to which the individuals who have abortions hold this capacity to grapple with opposite tensions as well.

Data and Methods

Data Source

The source of data for this study is 156 anonymous first person accounts of abortion collected on the website www.myabortionmylife.org, part of a project (*My Abortion, My Life*) that aims to encourage public conversation about abortion through storytelling events, podcasts, and an online presence. I took into account many considerations in selecting a website for this study. Unlike previous analyses of abortion storytelling websites (e.g., Allen 2015) that focused on sites that were explicitly political in their framing, I sought out a website that focused more broadly on providing a platform for women's lived experiences of abortion. It is important to note that the sponsor of *My Abortion My Life* is an organization which is both an abortion provider and a pro-abortion rights advocacy organization. However, for this project they solicit a breadth of views about abortion, including those that are complex, nuanced, or negative. An excerpt from the organization's website reads:

> *My Abortion, My Life is changing the conversation by creating safe spaces for sharing abortion stories and having nuanced, respectful conversations about abortion experiences. We recognize that the black-and-white rhetoric from both sides of the political debate leaves little room for the complex stories of people's lives…My Abortion, My Life creates spaces that promote sharing, active listening, and understanding.*

Even in light of this mission statement, the activities of the sponsor organization make clear that it is not an unbiased aggregator of abortion stories. First, as an abortion provider, the sponsor endorses the scientifically accurate viewpoint that abortion is fundamentally safe, whereas frameworks that argue abortion is immoral tend to rely partially on (false) arguments that abortion is dangerous. Second, the stories presented there cannot be generalized to all individuals who have abortions, as they represent women who are motivated to communicate their stories using this particular platform. The organization does a limited amount of outreach to recruit storytellers (putting flyers in clinic waiting rooms, for example); however, most storytellers find the website on their own through internet searches. Further, the editorial staff could, consciously or not, select for submissions that portray abortion in a positive light. Stories are submitted via the website and edited for spelling and grammar by project staff before being published. Editors choose to exclude a small number of stories that they consider to contain inflammatory content. The fact that some of the stories submitted to the website are edited or excluded must be considered an important limitation of the data source. However, even under these circumstances, a wide range of attitudes, emotions, and opinions about abortion are presented in the stories on *My Abortion, My Life,* including those that do not readily comply with pro-choice rhetoric. Moreover, analyzing stories from a more progressive web platform helps demonstrate the moral diversity in abortion stories even among those who are willing to align themselves with such a platform.

Finally, it is important to consider the content of these narratives in context. The stories on *My Abortion, My Life* are actively constructed after the actual events unfold. The accounts exist in a discursive space that may or may not fully represent the reality of the decision-making

process. Accounts likely combine the reporting of actual moral motivations and post-hoc defenses of behavior.

Data Analysis

Data analysis began in June 2018 with a collection of more than 400 stories posted on the website between February 2011 and April 2018. My original intent was to review all these stories; however, saturation was reached sooner than expected. It became clear that the data set was nearing completion when stories became redundant, no new themes were identified (including in 'negative case' examples) , and no new issues arose regarding the categorization of data (Bowen 2008; Morse 1995). Coding was paused after analyzing 117 stories that were submitted between February 2011 and March 2015. At that point I made the decision to employ a sampling strategy to 1) confirm my suspicion that theoretical saturation was achieved, 2) augment established themes, and 3) account for any potential historical biases of analyzing stories in chronological order. For stories published between April 2015 and April 2018, one story per month was chosen at random and included in the final dataset of 156 stories. I compared the 2011-2015 (n=117) and 2015-2018 (n=39) samples and found no differences between the batches.

All stories were merged into a single document which was imported into the qualitative analysis software Dedoose. My analysis was informed by the abductive approach to qualitative analysis based on "the ability to recognize a finding as surprising in light of existing theories (Timmermans and Tavory 2012:169)." The recursive and iterative nature of abductive analysis allows the analyst to look for good and poor "fits" between the data and any number of existing theories. Instead of theories emerging from data as in traditional grounded theory, existing theoretical concepts can be further developed or revised based on puzzling empirical materials. I

subjected the data to multiple rounds of coding and memoing in dialogue with existing literature. In open coding, I identified any and all themes of interest (e.g., "existing children", "responsibility", "religion") to begin specifying the points of view of the subjects and how they describe and evaluate their situations and activities. In later phases, I conducted focused coding where I re-read and re-coded stories after having decided on core categories and most relevant theoretical work (e.g., morality work, abortion stigma). Throughout the coding process, I wrote reflections in the form of analytic memos about salient themes and topics and integrative memos that further elaborated, extended, and integrated themes. These memos served as the starting point for the text of the article.

Findings

In the following sections, I examine how women discuss the morality of their abortion decisions in online storytelling. The morality work required for such a discussion is evident, and storytellers countered negative moral evaluation of their abortions using four general frames: *1) abortion as a private choice, 2) abortion as morally unremarkable, 3) abortion as morally problematic, but justified,* and *4) abortion as morally desirable*. These frames were discussed dynamically; that is, it was common for more than one frame to be presented in a single account, but, for analytical purposes, story excerpts were chosen that best describe and illustrate each framework. Each story excerpt presented here is from a different, unique storyteller; that is, there are no stories that are quoted more than once.

Abortion as a Private Choice

Accounts often include the reproduction of existing frames which resonate with the storyteller. Roughly one-fourth of abortion storytellers relied on contemporary abortion rights framing of abortion as a morally important, yet private choice. This framing is no doubt

influenced by the uniquely American defense of abortion rights relying on privacy arguments used by the Supreme Court in its 1973 *Roe v. Wade* Supreme Court decision (Glendon 1987; Halfmann 2011). These narratives frame abortion decisions as highly individualized and autonomous. They are legitimated by liberal arguments about citizens' individual rights and freedoms:

> *I had an abortion because I wanted one. My reasons are my own and are valid because I say they are. Just like each woman's choice to have an abortion or to not have one is ultimately her own decision and is valid because it is her decision about her body, her life, and her future (December 2011).*

These accounts highlighted the importance of features such as privacy and the doctor-patient relationship. The following excerpt is from a storyteller whose own abortion experience led the way to her involvement in the abortion rights movement:

> *I'm very grateful that abortion was a safe and legal option for me, and I vote pro-choice and contribute to the pro-choice cause. Abortion is not always the right decision for everyone facing an unwanted pregnancy, but it's a private decision that each woman must make herself in consultation with her partner and doctor (March 2014).*

Notably, in the excerpts above, the storytellers do not position their own choices as acceptable or unacceptable in terms of a collective moral conscience (Anspach 1993); instead they emphasize the importance of the private sphere as the site where decisions about abortion should be made. In these examples, boundaries are drawn around who is morally accountable for the decision: the woman involved, the medical provider, and in some cases the man involved with the pregnancy. Perhaps the most important feature of the *abortion as a private choice* frame is that it dismisses the larger society from a role in the abortion decision. It is a form of morality work that stays in close step with "proper" abortion rights discourse; it side-steps a public moral reckoning about abortion in favor of focus on bodily autonomy and privacy.

Abortion as morally unremarkable

There was another strategy for avoiding engagement in remoralization strategies that rested on a different logic. This framework, *abortion as morally unremarkable*, rejected widely accepted notions of abortions as experiences filled with emotion and moral importance, and instead presented the storytellers' narratives as unproblematic. This frame was used by approximately one-eighth of the storytellers:

> *I have no traumatic life story that comes with my abortion….My husband and I simply did not want children. We still do not. I love that there are wonderful women out there that are amazing mothers or that want to become mothers someday, but that is simply not the life that we want to live (August 2013).*

This storyteller refers to the "traumatic" story that is supposed to frame her experience and rejects it in favor of a simple explanation that she and her husband "did not want children." This point, that her abortion was not traumatic, challenges the hierarchy of abortion narratives in which a woman's more tragic circumstances (e.g., rape, domestic violence) are more acceptable reasons for abortion than reasons of so-called convenience (Ludlow 2008b) She goes on to imply that lack of desire for motherhood is normal and within the bounds of moral acceptability. She rhetorically avoids a lengthy explanation laying out the values and considerations that led to her moral reasoning, resisting the label of abortion as deviant and therefore requiring clarification through a moral account. A similar narrative stated:

> *Anyway, people always describe abortion as an emotional and sad thing, but I'm really not sad at all. I'm in my final year of university and do not have a job, and generally do not want a child right now…. anyway, I had my abortion a week ago and I haven't really thought about it that much. I just want to share my story because I want people to realize it doesn't always have to be a deeply emotional issue, there is no shame in that (March 2014).*

Again, this storyteller declines the opportunity to frame her abortion as falling on one side of a moral/immoral divide. Instead, she frames her experience within a discourse of normalization.

Although normalization may not be an explicit argument in support of the morality of abortion, these women can be seen as engaging in stigma resistance work which fulfills similar goals. *Abortion as morally unremarkable* was a less dominant or common framework used by storytellers, but it is significant that this frame resists the normative femininity that is said to cast some abortion narratives as more legitimate than others (Kimport et al. 2016). Moreover, demands for moral accounts are not always accepted by the subject. Refusing to provide a moral account is also a form of discursive morality work.

Abortion as Morally Problematic, But Justified

Unlike the two categories described above, almost two thirds of storytellers did give a moral account of their abortion decision. Nearly one-fourth struggled with the moral implications of their choices, expressing guilt, uncertainty, or ambivalence. These storytellers used accounts to reconcile their understanding of abortion as morally problematic with the fact that it was the course of action they chose to take. One storyteller, in the context of describing the circumstances of her pregnancy, reflected upon her decision by identifying her own guilt:

> *Also, we were arguing a lot and I always told myself that I never wanted to be a single mother. I grew up without a father and I wish I had one. I did not want that to happen to my child, too. Now that I look at it, I feel so guilty (April 2012).*

Even as the storyteller presents an argument in support of having the abortion (not wishing to repeat something she feels was missing in her childhood), she immediately reflects on her decision with guilt about the moral rightness of her decision. This was echoed in another excerpt as a storyteller identified herself as selfish and grappled with self-forgiveness:

> *I still feel these are wholly selfish reasons and I don't think I will ever truly forgive myself for what I've done, but the reasons not to keep it outweighed the reasons to keep it and at 63 days I had a medical abortion (July 2013).*

Even though this woman concedes that having the abortion was the right decision for herself, she evokes the notion that women who have abortions, including herself, are selfish and should not be forgiven (Kumar, Hessini and Mitchell 2009). The tendency for women to internalize abortion stigma is consistent with findings of previous research (Cockrill et al. 2013; Cockrill and Nack 2013).

The desire to reconcile negative attitudes toward abortion with the reality of their decisions led storytellers to use excuses and justifications developed within moral accounts by Lyman and Scott (Lyman and Scott 1970). Excuses appear in accounts "in which one admits that the act in question is bad, wrong, or inappropriate, but denies full responsibility (113)." Justifications are accounts that grant that an act is morally unacceptable, yet make the claim that certain situational features make the questioned act permissible or even required (Lyman and Scott 1970).

The primary way excuses were used in abortion narratives was by demonstrating reduced agency on the part of the women. A discourse developed that someone else was an important decision-maker in the abortion choice as demonstrated in the following excerpt:

> *I wanted it but my parents scared me by telling me about all the disorders my baby could have, that it wouldn't be like raising a normal baby so by 7 weeks and 3 days I had a medical abortion that was very painful (May 2012).*

It is difficult to know whether the pain the storyteller refers to is physical or emotional and it is similarly unclear whether the woman agrees or disagrees with her parents' assessment of fetal health risks. However, the storyteller puts at least some of the decision-making responsibility on her parents' shoulders and frames her own agency as weak compared to theirs. This transfer of responsibility was even more apparent in the following excerpt where the storyteller recalls negotiating the decision with her partner:

> *I was so against abortion before this but when it happens to you everything changes. He didn't want it so I made up my mind but felt as if I wasn't really present (November 2014).*

The woman in this story situates herself as fluidly moving inside and outside of the situation, making up her mind on the one hand, but not being "present" on the other.

Justifications were common in these types of accounts, and closely aligned with 'acceptable' abortion narratives as described in previous literature. Some justifications took the form of a victimization explanation. These storytellers accounted for their role in the abortion as victims of abusive or absent partners that gave them no other choice but to terminate the pregnancy. For example:

> *I wanted to keep the baby, but my circumstances changed. The father of the baby tried to kill me. I was only twenty, and I didn't know how I could protect myself and the child from this man (January 2012).*

Victim justifications allow narrators some discursive distance from their abortion choices. They also help make an implied argument that under other circumstances the narrator may have behaved in a more honorable way:

> *Well I happen to get pregnant again and when I did he packed up his stuff and abandoned me. I had nowhere to go and didn't know what to do. So I knew the best choice for me was to get an abortion. I still think about it every day and it bothers me but I'm hoping one day I can move on from it (August 2013).*

Other women reasoned that their abortions were morally justified due to possessing or demonstrating other highly moral characteristics. A small number of stories highlighted careful contraceptive use prior to the pregnancy in order to invoke the moral value of responsibility. These accounts detailed histories of careful contraceptive use, often listing the method of birth control being used, how long they had used it, or, in cases where no contraceptives were used, how careful they and their partners had been in all other times. This background information was

presented at the beginning of the narrative, to discursively preface the story with an argument in defense of the storyteller's responsibility. The following is an example of such an introduction:

> *I had been dating this amazing guy for about 3 months. Sexually, we had been careful. I had been on birth control for years, and never imagined anything could happen...until I went in for my annual checkup with my gyno (July 2012).*

Careful contraceptive use was often accompanied by claims to belonging to long-term, monogamous relationships. A monogamous identity provided an additional tool to bolster claims of responsibility and non-deviance in the justification of morally contested behavior:

> *My husband and I have been married for 10 years and have 2 children, ages 6 and 4. I have no regrets about my decision, nor do I feel depressed. We were being responsible adults and just got thrown a kink by nature. One of his vas deferens had partially re-attached itself, allowing for a minuscule amount of sperm to join the semen. This was corrected before I took the [abortion] medicine (March 2013).*

Although the argument that abortion is morally justified in cases of contraceptive use and monogamous relationships is more abstract than the preceding examples, it is not incongruous with the concepts underlying abortion stigma (e.g., women's sexual irresponsibility). Moreover, the concept of birth and motherhood as a responsible way to make up for the carelessness or frivolity of unprotected sex is deeply entrenched in religious and popular culture. Following this logic, it is not too difficult to argue that women who are careful and responsible do not deserve such a penalty.

Other women who sought to justify their decisions did so by bringing their existing children into their accounts. Motherhood as a moral status tied directly to the concept of the feminine is well documented (e.g., Russo 1976). Some justified their abortions as morally acceptable due to the fact that they were already mothers:

> *It was the best decision for me at this point in my life. Instead of worrying how to feed another mouth, I will be able to focus on my school and the children I*

> *already have. More poverty would lessen the quality of life for the ones I have already (June 2012).*

This storyteller makes a moral case for her abortion decision by connecting it to the well-being of her existing children. In this argument, "the ones I have already" implicitly take priority over the fetus. This example echoes Becker's argument that abortion can be a form of intensive mothering of current children (Becker 2019).

Another storyteller distinguished between two unplanned pregnancies she experienced, furthering the argument that abortion is morally justified under some circumstances but not others:

> *My first pregnancy was unplanned, but abortion was never an option. With this one, abortion was the option that worked for me and my little family. I promised my daughter a better life than I had, another child would destroy that promise….Because I had that option, my daughter's life (and mine) will be better. I can give her everything she deserves because of my decision. I will never regret it (June 2014).*

An implied corollary of the motherhood justification is that abortion may not be justified in circumstances where there are not existing children to provide for. The idea that there are certain circumstances that justify an immoral act disrupts the dichotomous idea that individuals are either pro- or anti-abortion. Moreover, particularly in the example above, the account challenges the common assumption that there are women who would or would not ever have an abortion. Instead, these findings imply that the morality of the abortion decision can be relational and contextual.

Quantitative and qualitative research has revealed reasons women choose abortion over carrying a pregnancy to term (Biggs, Gould, and Foster 2013; Finer et al. 2005; Kirkman et al. 2009). Notably, many of the moral justifications used by storytellers in the present research overlap with the reasons that women cite for seeking abortion more generally, such as partner-related reasons, financial unpreparedness, and the need to focus on existing children (Biggs et al.

2013). While reasons offer a glimpse into the moral values that are considered in abortion decision-making, reasons alone do not reveal how individuals confront (or do not) the problem of abortion as a violation of certain norms.

Abortion as Morally Desirable

A fourth framework, *abortion as morally desirable,* explicitly presented abortion as the normatively right decision from the perspective of society. This framework, used by nearly two-fifths of storytellers, was distinct from *abortion as morally justified* in that the decision was presented as the *most* moral choice among a given set of options, as opposed to an adequate or tolerable choice in the context of hard circumstances. Davis refers to this strategy as "taking the moral high ground (Davis 2014:445)." In just under half of these cases, abortion was presented as morally desirable if the alternative was to give birth to a child that would potentially suffer:

> *I do have my regrets at times but I look at it as "right now my baby would be suffering because of me". No child should suffer. When I am ready to have kids I know that I will have made the right decision when I look back. My child will always know that I loved it from the first heartbeat but I made a better choice by not putting it through the struggle I had to go through (April 2014).*

This storyteller conceptualizes her fetus as a "baby" and "child," complete with a "heartbeat." However, she accounts for her decision as in the best interests of her baby. She temporarily assumes a mother identity in order to make a decision she feels is in the best interests of her child. This sentiment echoes those of parents making end-of-life decisions for their babies in the intensive care nursery described by Anspach (1993) as well as abortion storytellers using narratives of intensive mothering described by Becker (2019). Assuming the identity of someone performing such ideal femininity (e.g., care for others, selflessness) adds power to this narrative that directly challenges the very definition of abortion stigma (Kumar et al. 2009). The framing of the fetus as a child who is deserving of a compassionate death was echoed in other stories:

> *For the first month I started buying gender neutral clothes, toys, and even necessities, I even went and had ultrasounds, and checkups done, the normal. I got to see my little baby inside of me, and even in the ultrasound it kicked! It was amazing and beautiful…After a long, hard, emotional talk and thought process, I decided it would be best for not only me, but the fetus inside of me to terminate the pregnancy…When you have children its natural to always want better for them than what you had, or to create a life you always wanted for them and I knew I couldn't do that. That is when I made MY FINAL CHOICE to have the abortion (June 2013).*

This storyteller recounts her early pregnancy as exciting. She describes doing the traditional activities of an expectant parent: buying clothes and necessities, going to check ups and ultrasounds. She describes being able to see the "little baby" kicking on the ultrasound screen, a moment often associated with excitement and joy in the broader culture. She ultimately decides to terminate the pregnancy, and it seems more *because of*, rather than *in spite of*, her maternal bond with the fetus. She invokes maternal essentialism with her comment that it is "natural" to want what is best for one's children. And it is with herself in the role of the fetus' mother that she ultimately frames her choice.

The preceding two excerpts represent the previously mentioned concept described by Harris as holding a "tension of opposites" (Harris 2019). These storytellers maintain that abortion ends a baby's or potential baby's life, and at the same time argue that abortion is the "right" thing to do or a morally superior choice. Their morality work in this case is complex without their stories falling into chaotic or non-reflective narratives (Frank 1997). Both facts are true at the same time.

Fewer women framed their abortion decisions as responsible due to the fact they did not want children. These storytellers implied that it would be immoral to have a child knowing they would not be "good" mothers:

> *I never had kids, still don't want them, and I applaud women who realize they shouldn't have kids, that know they aren't cut out to be mothers. I think it is very responsible to terminate your pregnancy under these circumstances (July 2012).*

This woman frames her choice in terms of responsibility, similar to some of the justifications described earlier. However, rather than using past responsibility as a moral justification for an otherwise immoral choice, she frames responsibility as a trait which makes abortion a morally desirable choice.

A small number of storytellers framed their choices as morally desirable because of the ways they might be able to make the world better by declining or delaying parenthood. In essence, this suggests an argument that the availability of abortion can provide a pathway to the accomplishment of moral goals:

> *It's completely normal to have these conflicting emotions. It's hard not to think about your life with a child. But I turned that thinking into the great things I have yet to accomplish and the many lives I may impact upon my journey. Doing this allowed me and my partner to fully dive into our careers and to travel the world. (June 2014).*

This example is interesting because, unlike the "suffering child" narratives, this narrative resists maternal essentialism. Rather than framing abortion as a selfless choice made by a caring mother, continuing a pregnancy is presented as a hindrance to completing *other* moral activities, including leaving a positive impact on others, once again challenging the hierarchy of legitimate reasons for abortion.

Finally, a small number of storytellers framed their abortions as morally desirable simply by asserting an identity for herself and other women as principled and ethical decision-makers:

> *The judgmental will say I'm cold or heartless, but abortion was an easy decision for me -- I knew I didn't want children and was certainly in no position to have/ raise one now even if I did AND I had been raised to believe that women are smart, moral creatures who have both the capacity and the responsibility to make such decisions (March 2011).*

This woman strategically pre-empts what she considers inevitable negative moral evaluation from others and positions her own viewpoint as the correct one. Another approach to performing a moral identity was to include Christian theology as part of the discourse on women as moral decision-makers. This approach can be seen in the following excerpt:

> *I prayed and lifted all that was weighing upon me to God. And, with all the love in my heart, I gave the potential life growing within me back to our Creator…. I truly feel that my experiences with abortion were a blessing—a part of the miraculous cycle of life and part of the millennia long history of humans' efforts to understand and responsibly control our fertility (January 2012).*

The religious perspective was similarly voiced in the moral perspective of the fetus as an autonomous or semi-autonomous subject with a distinct or separate incorporation or "soul" from the pregnant woman:

> *I am Catholic so I had to make up an elaborate miscarriage story to friends to keep from being judged but I don't regret my abortion. My baby went straight to heaven and I know God sees our hearts and loves me and knew my desperation and fear of dying or almost dying in childbirth (October 2014).*

Applying religious discourse in order to frame one's abortion as morally desirable has not been previously documented in empirical studies of women's experiences of abortion. That some storytellers performed morality work by weaving religion into their accounts while simultaneously affirming the morality of women's agentic potential marks a compelling example of resistance to abortion stigma. Moreover, these women can again be seen as holding two seemingly contradicting ideas at once while maintaining a coherent narrative.

Instability of Moral Frameworks

As mentioned earlier, many of the accounts analyzed were not rigid or static with respect to moral frameworks. Some stories were dynamic, shifting back and forth between frameworks throughout. For some women, stories were characterized by ambivalent emotions:

> *It definitely was one of the hardest things I've gone through emotionally and I will never forget my angel no matter what. I know I couldn't have had the baby. It wasn't the right time or the right guy but I always think about how things could have been different. Sometimes I feel like a bad person but I know I'm far from it (August 2013).*

In the preceding excerpt, several competing concepts emerge including emotional difficulty and feeling like a "bad person" on the one hand, and decision-rightness and certainty on the other. A single, linear vision of abortion morality was absent, and the storyteller shifts between moral identities over time *("Sometimes I feel like a bad person but I know I'm far from it"*). Similarly, the following storyteller struggles to construct a clear narrative of her moral experience:

> *I know my past decisions will make me a better mother this time around. I felt guilt over my decision then, and sometimes still do, but that is part of life. I believe in reincarnation, and that the child's soul will be reborn. The situation has made me far more compassionate to people who make big and small mistakes in their lives. (December 2014)".*

Guilt and acceptance are both apparent in this story, as well as empathy. When the author recalls her compassion for those "who make mistakes" she both frames unwanted pregnancy as a moral failing *and* suggests that abortion is an acceptable course of action after such an error. Notably, both of the excerpts above have a spiritual dimension. The first storyteller references the fetus as her "angel" while the second describes the fetus as a child whose "soul will be reborn." These characterizations confer moral and spiritual status to the fetus *and* function as morality work in the face of negative evaluation, demonstrating the ability for these individuals to balance a tension of opposites.

Discussion and Conclusions

The anti-abortion movement in the United States and elsewhere has been largely successful at characterizing abortion as morally stigmatized. Indeed, it is partially due to such characterization that abortion is often experienced as a moral dilemma at the individual level.

Yet the moral narrative from the abortion rights movement has remained relatively static and simple during this time. Abortion rights discourse can become harmful when it prohibits language for people to talk about their abortions honestly. Those who wish to maintain and expand access to abortion care may benefit from a more expansive awareness of how individuals and social groups understand the morality of abortion. Certain ways of talking about abortion may be more resonant or feel more authentic than others, not just to women who have abortions but to all people who form opinions about abortion. Knowledge about personal abortion discourse can potentially influence the public discourse.

How do women who have abortions contend with the morality of their decisions? First, they can argue that such discussions belong in the private realm, not as a matter of public debate (*abortion as a private choice*). Alternatively, they can reject the moral burdens associated with abortion, strategically work to normalize their choices, and present their *abortions as morally unremarkable*. Third, they can attempt to recuperate their moral status through excuses and justifications (*abortion as morally problematic, but justified*). And finally, they may claim the moral high ground by presenting their choice as the "right" choice (*abortion as morally desirable*). I present these four abortion frameworks as examples of *morality work.* While the first and third frames generally align themselves with politically acceptable abortion narratives, the second and fourth frames tend to challenge or resist mainstream abortion discourse.

Many storytellers appealed to highly accepted moral values in society. Women brought up the value of responsibility when discussing careful contraceptive use, stable relationships, and desire to avoid or delay parenting. This type of morality work has emerged in the previous literature on abortion narratives, often framed as part of middle-class or neoliberal ideology (Allen 2015; Beynon-Jones 2017). Additionally, frames that situate abortion as helping to further

moral goals of proper mothering appear in this study as well as previous ones (Becker 2019; Hoggart 2017; Jones et al. 2008). Women invoked gendered motherhood norms when discussing their obligations toward existing children or a potential child, or not wanting to give birth to a child that would suffer. The theme of self-actualization or living an authentic life is new for abortion narratives but appears in prior research on morality work among the transabled (Davis 2014).

This research departs from existing knowledge in important ways. Notably, a new formulation of morality work emerges with this study. The use of Christian religiosity, or in some cases, a broader spirituality, to cast abortion as a moral choice is novel. Religious concepts, including heaven or afterlife, were discussed across moral frameworks and served as discursive techniques for storytellers to defend a good or right decision. Furthermore, many storytellers conceptualized the moral status of their fetus as a life or potential life. This was not incompatible with framing abortion as morally desirable; in fact, conceptualizing the fetus as a baby or child, when used in the context of normative femininity, was used as a defense for the abortion decision in some cases. Both of these findings run counter to the dichotomous understandings of the moral status of the fetus in abortion-related activism. Similar to how previous scholars have theorized about the morality of abortion (Harris 2019; Ludlow 2008a), the present research demonstrates that women who have abortions are themselves capable of balancing a tension of opposites in their discursive processes. Additionally, though it was used by a small minority of women, the notion that a woman can morally contribute to society in ways beyond the family, stated in the context of abortion as morally desirable, is similarly unconventional and intriguing.

The research reported in this paper contributes to the literature on morality, stigma, and women's abortion narratives. It also opens up routes for potential inquiry. This study sample is

predominantly American and reflects the unique environment of abortion politics in the United States. How might abortion morality work look different in a cross-national perspective? Other questions that further research might address include: How has abortion morality work changed throughout periods of history? How does it vary within the context of race, class, and age? Moreover, what does abortion morality work look like away from the anonymity of the online setting, in social interactions and public discourse? This study's findings will also appeal beyond the abortion case. More broadly, these findings disrupt and potentially extend existing theories of morality work by demonstrating that subjects can comfortably engage with nuanced and contradictory viewpoints that go beyond unidirectional remoralization techniques. Current theories of morality work may not give subjects enough credit. It is evidently possible to engage with seemingly conflicting positions while still presenting a positive moral identity and crafting a coherent narrative, at least to some extent. Thus, this call for a more comprehensive understanding of morality work extends to a more general community of sociologists. Future research should investigate this potentially rich area of inquiry more purposively.

References

Allen, Mallary. 2015. "Narrative Diversity and Sympathetic Abortion: What Online Storytelling Reveals about the Prescribed Norms of the Mainstream Movements." *Symbolic Interaction* 38(1):42–63.

Anspach, Renee. 1993. *Deciding Who Lives: Fateful Choices in the Intensive-Care Nursery*. Berkeley and Los Angeles: University of California Press.

Becker, Andréa. 2019. "'My Abortion Made Me a Good Mom': An Analysis of the Use of Motherhood Identity to Dispel Abortion Stigma." Pp. 219–40 in *Reproduction, Health, and Medicine (Advances in Medical Sociology, Vol. 20)*. United Kingdom: Emerald Publishing Limited.

Beynon-Jones, Siân. 2017. "Untroubling Abortion: A Discourse Analysis of Women's Accounts." *Feminism & Psychology* 27(2):225–42.

Biggs, M. Antonia, Heather Gould, and Diana Greene Foster. 2013. "Understanding Why Women Seek Abortions in the US." *BMC Women's Health* 13(1):29.

Boulton, Mary, J. McLean, R. Fitzpatrick, and G. Hart. 1995. "Gay Men's Accounts of Unsafe Sex." *AIDS Care* 7(5):619–30.

Bowen, Glenn A. 2008. "Naturalistic Inquiry and the Saturation Concept: A Research Note." *Qualitative Research* 8(1):137–152.

Chase, Susan. 2005. "Narrative Inquiry: Multiple Lenses, Approaches, Voices." Pp. 651–80 in *The Sage Handbook of Qualitative Research*, edited by N. Denzin and Y. Lincoln. Thousand Oaks, CA: Sage Publications.

Cockrill, Kate, and Adina Nack. 2013. "'I'm Not That Type of Person': Managing the Stigma of Having an Abortion." *Deviant Behavior* 34(12):973–90.

Cockrill, Kate, Ushma Upadhyay, Janet Turan, and Diana Greene Foster. 2013. "The Stigma of Having an Abortion: Development of a Scale and Characteristics of Women Experiencing Abortion Stigma." *Perspectives on Sexual and Reproductive Health* 45(2):79–88.

Davis, Jenny. 2014. "Morality Work among the Transabled." *Deviant Behavior* 35(6):433–455.

Davis, Jenny, Carla Goar, Bianca Manago, and Bobbi Reidinger. 2018. "Distribution and Disavowal: Managing the Parental Stigma of Children's Weight and Weight Loss." *Social Science and Medicine* 219:61–69.

Davis, Jenny, and Tony Love. 2018. "Women Who Stay: A Morality Work Perspective." *Social Problems* 65(2):251–265.

Davis, Jenny, and Bianca Manago. 2016. "Motherhood and Associative Moral Stigma: The Moral Double Bind." *Stigma and Health* 1(2):72.

Finer, Lawrence, Lori Frohwirth, Lindsay Dauphinee, Susheela Singh, and Ann Moore. 2005. "Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives." *Perspectives on Sexual and Reproductive Health* 37(3):110–18.

Frank, Arthur. 1997. *The Wounded Storyteller: Body, Illness, and Ethics*. Chicago and London: The University of Chicago Press.

Frohwirth, Lori, Michele Coleman, and Ann M. Moore. 2018. "Managing Religion and Morality within the Abortion Experience: Qualitative Interviews with Women Obtaining Abortions in the US." *World Medical & Health Policy* 10(4):381–400.

Ginsburg, Faye. 1989. *Contested Lives: The Abortion Debate in an American Community.* Berkeley and Los Angeles: University of California Press.

Glendon, Mary Ann. 1987. *Abortion and Divorce in Western Law*. Cambridge: Harvard University Press.

Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon and Schuster.

Halfmann, Drew. 2011. *Doctors and Demonstrators: How Political Institutions Shape Abortion Law in the United States, Britain, and Canada*. Chicago: University of Chicago Press.

Halfmann, Drew, and Michael Young. 2010. "War Pictures: The Grotesque as a Mobilizing Tactic." *Mobilization: An International Quarterly* 15(1):1–24.

Harris, Lisa. 2019. "The Moral Agency of Abortion Providers." Pp. 189–208 in *Ethical Issues in Women's Healthcare: Practice and Policy*, edited by L. D'Agincourt-Canning and C. Ells. New York: Oxford University Press.

Hitlin, Steven, and Stephen Vaisey. 2013. "The New Sociology of Morality." *Annual Review of Sociology* 39(1):51–68.

Hoggart, Lesley. 2017. "Internalised Abortion Stigma: Young Women's Strategies of Resistance and Rejection." *Feminism and Psychology* 27(2):186–202.

Hughes, Gerald, and Douglas Degher. 1993. "Coping with a Deviant Identity." *Deviant Behavior* 14(4):297–315.

Jerman, Jenna, Rachel Jones, and Tsuyoshi Onda. 2016. *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*. New York: Guttmacher Institute.

Joffe, Carole. 1986. *The Regulation of Sexuality: Experiences of Family Planning Workers*. Temple University Press.

Jones, Rachel, Lori Frohwirth, and Ann Moore. 2008. "'I Would Want to Give My Child, Like, Everything in the World': How Issues of Motherhood Influence Women Who Have Abortions." *Journal of Family Issues* 29(1):79–99.

Kimport, Katrina, Kira Foster, and Tracy Weitz. 2011. "Social Sources of Women's Emotional Difficulty After Abortion: Lessons from Women's Abortion Narratives." *Perspectives on Sexual and Reproductive Health* 43(2):103–9.

Kimport, Katrina, Tracy Weitz, and Lori Freedman. 2016. "The Stratified Legitimacy of Abortions." *Journal of Health and Social Behavior* 57(4):503–16.

Kirkman, Maggie, Heather Rowe, Annarella Hardiman, Shelley Mallett, and Doreen Rosenthal. 2009. "Reasons Women Give for Abortion: A Review of the Literature." *Archives of Womens Mental Health* 12(6):365–78.

Kumar, Anuradha. 2013. "Everything Is Not Abortion Stigma." *Womens Health Issues* 23(6):e329-31.

Kumar, Anuradha, Leila Hessini, and Ellen Mitchell. 2009. "Conceptualising Abortion Stigma." *Culture, Health, and Sexuality* 11(6):625–39.

Lamont, Michèle. 1992. *Money, Morals, and Manners: The Culture of the French and the American Upper-Middle Class*. Chicago: University of Chicago Press.

Lamont, Michèle. 2009. *The Dignity of Working Men: Morality and the Boundaries of Race, Class, and Immigration*. Cambridge: Harvard University Press.

Lamont, Michèle, John Schmalzbauer, Maureen Waller, and Daniel Weber. 1996. "Cultural and Moral Boundaries in the United States: Structural Position, Geographic Location, and Lifestyle Explanations." *Poetics* 24(1):31–56.

Ludlow, Jeannie. 2008a. “Sometimes, It’s a Child and a Choice: Toward an Embodied Abortion Praxis.” *NWSA Journal* 20(1):26–50.

Ludlow, Jeannie. 2008b. “The Things We Cannot Say: Witnessing the Trauma-tization of Abortion in the United States.” *Women’s Studies Quarterly* 36(1/2):28–41.

Luker, Kristin. 1984. *Abortion and the Politics of Motherhood*. Berkeley and Los Angeles: University of California Press.

Lyman, Stanford, and Marvin Scott. 1970. *A Sociology of the Absurd*. New York: Appleton-Century Crofts.

Martin, Lisa, Jane Hassinger, Michelle Debbink, and Lisa Harris. 2017. “Dangertalk: Voices of Abortion Providers.” *Social Science and Medicine* 184:75–83.

Michie, Lydia, Madeline Balaam, John McCarthy, Timur Osadchiy, and Kellie Morrissey. 2018.“From Her Story, to Our Story.” Presented at the Proceedings of the 2018 CHI Conference on Human Factors in Computing Systems - CHI ’18.

Morse, Janice M. 1995."The Significance of Saturation." *Qualitative Health Research* 5(2): 147-149.

Norris, Alison, Danielle Bessett, Julia Steinberg, Megan Kavanaugh, Silvia De Zordo, and Davida Becker. 2011. “Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences.” *Womens Health Issues* 21(3 Suppl):S49-54.

Orbuch, Terri. 1997. “People’s Accounts Count: The Sociology of Accounts.” *Annual Review of Sociology* 23:455–78.

Presser, Lois. 2004. “Violent Offenders, Moral Selves: Constructing Identities and Accounts in the Research Interview.” *Social Problems* 51(1):82–101.

Riessman, Catherine. 1990. “Strategic Uses of Narrative in the Presentation of Self and Illness: A Research Note.” *Social Science and Medicine* 30(11):1195–1200.

Rose, Melody. 2011. “Pro-Life, pro-Woman? Frame Extension in the American Antiabortion Movement.” *Journal of Women, Politics and Policy* 32(1):1–27.

Russo, Nancy. 1976. “The Motherhood Mandate.” *Journal of Social Issues* 32(3):143–53.

Sanger, Carol. 2017. *About Abortion: Terminating Pregnancy in Twenty-First Century America*. Cambridge: Harvard University Press.

Snow, David, and Leon Anderson. 1987. “Identity Work among the Homeless: The Verbal Construction and Avowal of Personal Identities.” *American Journal of Sociology* 92(6):1336–1371.

The Pew Forum on Religion and Public Life. 2008. “U.S. Religious Landscape Survey, Religious Beliefs and Practices: Diverse and Politically Relevant.” Retrieved September 21, 2020 (https://www.pewforum.org/2008/06/01/u-s-religious-landscape-survey-religious-beliefs-and-practices/).

The Pew Forum on Religion and Public Life. 2013. “Religious Groups’ Official Positions on Abortion.” Retrieved September 21, 2020 (http://www.pewforum.org/2013/01/16/religious-groups-official-positions-on-abortion/).

Timmermans, Stefan, and Iddo Tavory. 2012. “Theory Construction in Qualitative Research.” *Sociological Theory* 30(3):167–86.

Watson, Katie. 2018. *Scarlet A: The Ethics, Law, and Politics of Ordinary Abortion*. New York: Oxford University Press.

Wigginton, Britta, and Michelle Lafrance. 2014. "'I Think he is Immune to All the Smoke I Gave Him': How Women Account for the Harm of Smoking during Pregnancy." *Health, Risk, and Society* 16(6):530–46.

2. Mothers, Morals, and Medicine: Boundary Work in Accounts of Abortion for Severe Fetal Anomaly

Abstract

People who have abortions must contend with a dominant culture that views some reasons for abortion as more socially acceptable than others. Women terminating pregnancies for a severe fetal health diagnosis tend to elicit sympathy from the public; thus, their experiences tend to be privileged in the media and in abortion rights activism. However, research has yet to examine how those who choose abortions for serious fetal health issues think and talk about the moral legitimacy of abortion. I sought to understand how those who have abortions in this context construct meaning and moral worth in their accounts of abortion. I analyzed eighteen in-depth interviews with women who obtained abortions after receiving a diagnosis for a life-limiting fetal condition. I find that women manage the moral stigma of abortion by constructing symbolic boundaries between themselves and people who have abortions for reasons other than fetal health. First, they perform gendered moral boundary work by demonstrating how they embrace ideal motherhood and others reject it. Second, they use discourses of medicalization and naturalization to make moral distinctions between their own lived experiences and other imagined abortion experiences. Third, they deny and deflect the label of 'abortion' and reclassify their experiences as 'not abortions' based on medical and social factors. Overall, subjects manage abortion stigma by making claims that their reason for abortion is more morally legitimate than other reasons or by denying that their experience 'counts' as abortion at all. These findings have implications for the study of morality, stigma, and health, and raise questions about the politics and ethics of centering narratives of abortion for fetal health reasons.

Keywords

moral boundary work, stigma, medicalization, naturalization, abortion, motherhood, fetal anomaly

People who have abortions must contend with a dominant culture that not only morally stigmatizes abortion (Cockrill et al. 2013; Hanschmidt et al. 2016; Kumar, Hessini, and Mitchell 2009; Millar 2020; Norris et al. 2011), but has determined that some reasons for abortion are more socially acceptable than others (Kimport, Weitz, and Freedman 2016; Ludlow 2008; Martin et al. 2017). Women terminating pregnancies for fetal health reasons sit at relatively privileged point in a hierarchy of acceptable reasons for abortion (De Zordo 2018; Janiak 2016; Ludlow 2008; Norris et al. 2011). As of June 2022, abortion is criminalized in many states, yet since the 1970s social approval of legal abortion has remained consistently high when there is a serious defect in the fetus (Jozkowski, Crawford, and Hunt 2018; Smith and Son 2013). This social advantage gives such individuals unique opportunities to share their abortion experiences. They are often centered in media accounts and abortion rights activism because their stories elicit high sympathy from the public.

Previous research has yet to examine how those who choose abortions for fetal indications think and talk about the larger moral legitimacy of abortion. This paper examines how individuals who have abortions for life-limiting fetal conditions construct moral meaning and moral worth when recounting their abortion experiences. I chose this group to explore how a morally privileged sub-group within a larger stigmatized group negotiates individual and group identity in the context of a contentious health care decision. I draw on Lamont's theory of moral boundary work (Lamont 1992, 2009) to analyze eighteen in-depth interviews with women who experienced this type of abortion.

My research finds that in the face of abortion stigma, people who have abortions for life-limiting fetal conditions can and do develop positive moral identities through storytelling and meaning-making. However, this often comes at a cost to the moral legitimacy of other types of

abortion experiences. I find that women confront abortion stigma by constructing symbolic boundaries between themselves and people who have abortions for reasons other than fetal health. First, they perform gendered moral boundary work by making claims about how they embrace ideal motherhood and others reject it. Second, they use discourses of medicalization and naturalization to make distinctions between their lived experiences and others' imagined abortion experiences. Third, they deny and deflect the label of 'abortion' and reclassify their experiences as 'not abortions', redefining the category of abortion based on medical and social factors. Thus, they manage abortion stigma by making claims that their reason for abortion is more morally legitimate than other reasons, or by denying that their experience 'counts' as abortion at all.

These findings are meaningful for a number of reasons. I illustrate how moral claims in the case of abortion for fetal diagnosis can be negotiated based on the discursive elements of a narrative. I also demonstrate how discourses of medicalization and naturalization can be used as resources to resist abortion stigma in moral boundary work. Finally, I show that when moral boundaries between similar groups are found to be insufficient, subjects work to obfuscate, deny, and reclassify an event, often redefining their experience as something else entirely. Finally, the findings raise questions about the ethics and politics of centering narratives of abortion for fetal health reasons.

Moral Boundary Work

The study of moral boundaries has been given considerable attention in sociology. Lamont's scholarship identifies moral boundary work as the process by which people and social groups assert their moral worth in reference to others based on social relations (Lamont 1992, 2009). Central to her analysis is the idea of a virtuous or worthy person and a 'polluted' or unworthy person. The discursive labor implied by the word 'work' is to define oneself as

different than others by making distinctions along this moral dimension. This work draws on the cultural resources available to an individual in their society, but moral boundary work is by nature both cultural and structural. It draws on cultural repertoires (e.g., pragmatism, individualism, intellectualism) that are constrained by structural conditions (e.g., geographical mobility, degree of social stratification, strength of the welfare state) (Lamont 1992). Cultural repertoires and structural conditions can change, and thus boundary work should be theorized as historically contingent.

To identify the nature of the criteria that people use to define and discriminate between worthy and less worthy persons, Lamont scrutinizes symbolic boundaries - the types of lines that individuals draw when they categorize people. Different ways of believing that 'we' are better than 'them' are compared by analyzing the standards that underlie status assessments. Boundary work is a fundamental part of the process of constituting the self; symbolic boundaries emerge when we try to define who we are (Lamont 1992). Hence, lines are drawn that delimit an imagined community of 'people like me' who share the same values and with whom they are ready to share resources (Lamont 2009).

The notion of a boundary suggests an especially strong distinction that includes and excludes. A social boundary can work as a mechanism for reducing ambiguity (Milner 2020). Morally ambiguous or fraught situations require clarity for what will receive approval or disapproval, and boundaries work to clarify these distinctions. Thus, moral boundary work is more urgent or necessary in these morally and culturally ambiguous situations. The moral ambiguities involved in cases of abortion for fetal health reasons offer a fruitful site for studying moral boundary work.

Though not always identified as such, some research on abortion explores moral boundaries. Luker's now classic ethnography about the politics of abortion demonstrated that American pro- and anti-abortion rights activists have incompatible beliefs about women's careers, sexuality, and reproduction, and that they largely define themselves in opposition to one another (Luker 1984). Several studies of women receiving abortions demonstrate that subjects sometimes draw distinctions between their abortions and those of 'other women'; that is, they distinguish their reasons for abortion as valid or acceptable compared to others (Cockrill and Nack 2013; Cockrill and Weitz 2010; Gelman et al. 2017; Nickerson, Manski, and Dennis 2014). In general, women who have abortions do meaning work to embrace socially assigned moral attributes in order to develop positive moral identities. For example, in the face of persistent gendered stigma, some women frame their decisions as aligning with expectations of proper femininity or normative mothering ideals. (Becker 2019; Combellick 2021; Hoggart 2017; Jones, Frohwirth, and Moore 2008). Others frame their abortions as morally desirable by suggesting the potential child would suffer, by asserting that women are principled and ethical decision-makers, and by invoking theology or spirituality (for example, the baby would go to heaven or be reincarnated) (Combellick 2023).

Moral Discourse, Femininity, and Motherhood

Scholars have analyzed the relationship between moral claims and the enactment of femininity. The concept of 'gendered moralities' describes the ways in which morality is informed by and expressed through culturally valued enactments of femininity and masculinity (Czarnecki 2022). Reproduction is one way that moral values of 'good womanhood' are expressed. In fact, motherhood and femininity are so closely linked that scholars have theorized motherhood as a social imperative (Hays 1996; Russo 1976) and an institution of power meant to

maintain male dominance (Rich 2021). Moralized concepts like nurturance, protection, self-sacrifice, and care are consistently invoked in the social construction of reproduction (see, for example, Almeling 2011; Blum 2000; Hays 1996). Cultural ideals of what constitutes good womanhood/motherhood are historically contingent and shaped by systems of inequality, including social hierarchies of race and class (Flavin 2008; Harris and Wolfe 2014; Roberts 1999; Skeggs 1997; Solinger 2005). For example, the concept of intensive parenting is situated in white, middle-class ideologies of motherhood (Hays 1996; Lareau 2011; Reich 2014).

Women using reproductive technology have been called 'moral pioneers' due the fact that they are often the firsthand explorers of technology that is ethically unsettled (Rapp 2004). A key distinction in determining whether a reproductive decision is morally acceptable is whether motherhood is perceived as being embraced or rejected (Czarnecki 2022). Much of the literature on abortion as a stigma relies on its definition as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood" (Kumar et al. 2009:628). This perspective maintains that a woman who seeks an abortion is thought to be "challenging widely held assumptions about the essential nature of women" (Kumar et al. 2009:628). The pregnant woman who chooses abortion embodies the archetype of the bad mother because she fails to conform to social expectations of motherhood (Abrams 2015). Thus, a large part of constructing a positive moral identity as a person seeking abortion is to explicate how the abortion decision positively aligns with normative mothering ideals (Becker 2019; Combellick 2023; Hoggart 2017; Jones et al. 2008).

Moral Discourse, Medicalization, and Naturalization

Medical sociologists have sought to understand how moral decisions in medicine are made by individuals and groups and how morality is practiced in the daily tasks of health care

(Anspach 1993; Zussman 1992). Moral and ethical questions in health care are inseparable from the organizational and social settings in which they arrive (Chambliss 1996). Moreover, the institution of medicine has granted physicians not only medical authority, but widespread moral authority as well (Foucault 1973; Starr 1982; Zola 1972).

Some research highlights the relationship between moral claims and medicalization. Through the process of medicalization, many deviant behaviors have transitioned from being considered sinful or criminal to medical, or as Conrad explains, deviance has become redefined 'from badness to sickness' (Conrad 1975, 1979, 1992; Conrad and Schneider 1980). Classic case examples include alcoholism (Schneider 1978), hyperactivity in children (Conrad 2006), and obesity (Ortiz, Kawachi, and Boyce 2017). Such studies tend to focus on macro and meso level forces of medicalization, such as laws, political discourses, and organizational routines (Halfmann 2012). What is less clear is how the medicalization of deviance is achieved at the level of social interaction. Interactional studies of compulsive gambling (Rossol 2001), infertility (Bell 2009), and sadness/depression (Bröer and Besseling 2017), among others, reveal how medicalizing and/or demedicalizing discourses help individuals make sense of and process emotions around lived experience, but still neglect moral mechanisms by which individuals themselves actively construct the transition 'from badness to sickness' through social interaction.

Past scholarship has also revealed a relationship between moral claims and naturalization, including how an embodied state or circumstance can be made moral by highlighting its natural aspects and/or its proximity to nature. Naturalization is key to understanding the gendered moralities of reproduction. Feminist scholarship interrogates the relationship of the female body to nature, in hierarchical opposition to the male body's association with science, intellect, and culture (Davis-Floyd 2022; Martin 2001; Simonds, Rothman, and Norman 2007). Feminists

critique the cultural association of women with nature in the context of a society that values the dichotomized culture/intellect over nature/body. Though the dichotomy places women in a subordinate location, women can also draw on the alignment with nature to make moral claims through selective naturalization (Thompson 2001, 2005). Sociological critique has been paid to the mechanisms through which organic conditions of the female reproductive body, such as pregnancy, have come to be categorized as medically pathological (Barker 1998; Riessman 1983). Beyond the academy, maternal health activists and everyday individuals echo the critique of the medicalization of women's' bodies, highlighting fundamental assumptions that "what is natural is what is good" (O'Connor 1993:149). Examples can be seen in the home birth movement (O'Connor 1993), discourses of childbirth choices (Malacrida and Boulton 2012), and breastfeeding ideology (Blum 2000). Strategic naturalization has been shown to be an effective moral argument underlying the use of reproductive technology (Thompson 2005). One study found that evangelical women discursively associate assisted reproduction with procreation through intercourse in order to morally justify their use of in vitro fertilization (Czarnecki 2022).

More examples of naturalization as moral can be found when looking at the ethical complexities of end-of-life care and organizing a 'good and natural' death. Research highlights the way providers in the ICU construct a "good death" as "letting nature take its course" even when providing the intervention of treatment withdrawal for critically ill patients (Seymour 2000:1245). One study found that health care providers in the ICU strategically practice withdrawing technological support from dying patients in stages in order to mimic the more gradual decline of natural death (Harvey 1997). Chambliss explicates how, in withdrawal of ventilator support, "adjustments can be manipulated so as to allow a patient to die, but in such a way that no active intervention in nature's course was taken" (Chambliss 1996:167).

The medicalization and naturalization of abortion are complex, politically mediated and historically situated processes. Medicalization and demedicalization sometimes occur simultaneously. In the United States since the 19th century, abortion has been strategically medicalized and demedicalized, in varying degrees, at different levels of analysis, for the purposes of various stakeholders (Halfmann 2012). A study of so-called "post-abortion syndrome" (Lee 2003) refers to selective medicalization: how some aspects of reproduction are medicalized and some are not, often for political reasons. The author argues that political arguments on abortion have become increasingly medicalized since the moral arguments of the 1970-80s, mirroring increasing medicalization more generally.

The equating of natural with 'good' or 'right' appears to have infused the discourse on abortion as well. In research on women's preferences for medication abortion, it is often described positively as the more 'natural' option when compared to in-clinic procedures because of its embodied similarity to miscarriage and its occurrence in the home rather than a medical setting (Fielding, Edmunds, and Schaff 2002; Harvey, Beckman, and Satre 2001; Honkanen and von Hertzen 2002). More recent research on the acceptability of a missed period pill in the United States found that many believed the method would have the benefit of less moral conflict and better management of abortion stigma (Sheldon et al. 2020).

Case Example: Abortions for Fetal Health Indications

The present research offers the opportunity to examine the intersections between morality, gender, medicalization, and naturalization through the case of people choosing abortions for life-limiting fetal diagnoses. I ask how the women in these exceptional circumstances perform moral boundary work to separate themselves and their experiences from

others. In doing so, I draw new conclusions and raise additional questions about the nature and characteristics of moral boundary work.

It is widely understood that abortion in the context of a fetal diagnosis is generally experienced differently than abortions for other reasons. It differs from other abortions in that most pregnancies are desired by the parents, differs from other perinatal losses which do not arise from a woman's decision, and differs from other types of bereavement in that the loss is stigmatized (Lafarge, Mitchell, and Fox 2014). Abortions for fetal health indications are typically experienced as a form of bereavement and a traumatic event (Lafarge et al. 2014). Grief reactions following such abortions are similar to those experienced in other types of perinatal loss such as stillbirth or neonatal death (Keefe-Cooperman 2005; Salvesen et al. 1997). Abortion in the context of a fetal diagnosis has been shown to have psychological consequences such as depression, post-traumatic stress and complicated grief for women and their partners (Kersting et al. 2005, 2009; Korenromp et al. 2009; Steinberg 2011; Wool 2011) whereas abortion in other circumstances does not harm women's mental health (Biggs et al. 2014, 2017; Foster et al. 2015). Research indicates that many patients experience abortion stigma (Hanschmidt et al. 2016, 2018; Maguire et al. 2015; McCoyd 2010) and that guilt and social isolation related to abortion stigma contribute to the difficulties of grieving (Maguire et al. 2015).

The extant literature on how pregnant people with fetal health diagnoses make decisions about aborting or carrying to term is small, but we know that they balance medical knowledge with personal and familial values (Kimport 2022). For many, the decision is an explicitly moral one, and many choose to abort as a way to minimize fetal suffering rather than continue their pregnancy in the setting of a serious fetal condition (Kimport 2022).

Many abortions for fetal health indications are for diagnoses that would lead to children born with disabilities impacting their quality of life. The subjects of this study can be considered in a different category. They were diagnosed with a small subset of fetal abnormalities that can be considered lethal or fatal; the term "life limiting" refers to conditions in which survival past the neonatal period is unlikely, and if survival occurred, the child would require continuous and/or advanced medical intervention. In rare cases, such children may reach toddler age, but they would not leave the hospital environment and its critical care services. In other words, the diagnoses these participants received were essentially death sentences, making their cases the most extreme – and the most socially acceptable - of an already distinct category of circumstances for an abortion.

Data and Methods

The data from this study come from a larger study of cisgender women who terminated pregnancies in cases of life-limiting fetal conditions (Mastey et al. 2023). While the larger study is about the potential for perinatal palliative care models (sometimes called perinatal hospice) to support this patient population, the in-depth interviews covered women's wider personal and social experiences of abortion. This qualitative study aimed to interview a diverse group of patients throughout the United States in the weeks following their abortions. We conducted semi-structured interviews with eighteen women. The University of California, Davis Institutional Review Board approved the study and all study documents.

Potential participants were identified and referred by their abortion providers. They were approached if they were age 18 or older, English-speaking, and choosing to terminate a pregnancy with a life-limiting fetal condition. While no consensus exists within the perinatal literature on what diagnoses are always considered "life-limiting", the most straightforward

definition has been described as “a condition incompatible with survival beyond the newborn period” (Wilkinson et al. 2012). For this study, diagnoses were classified as “life-limiting” if the condition was described as “lethal” in the medical literature (Wilkinson et al. 2012) or if survival past the neonatal period would require continuous and/or advanced medical intervention. Our research team contacted participants to ask if they were interested in participating in an interview about their experience from the time of fetal diagnosis to the weeks after the abortion. For those who met entry criteria and gave informed consent, we scheduled an interview two to eight weeks post-abortion. Due to COVID-19 and geographic distance, we conducted all interviews via telephone. Interviews were audio recorded and transcribed verbatim by a professional transcriptionist.

Knowing that structural conditions affect individual experience, we used information from the Guttmacher Institute to target states with varying levels of abortion access. The Institute categorizes each of the 50 states as *supportive, middle ground, or hostile* to abortion rights, and we sought representation from all three types (Guttmacher Institute 2019). The four recruitment states were California (supportive), Nevada (middle ground), Indiana (hostile), and Missouri (hostile).

The semi-structured interview guide covered topics such as pregnancy and fetal diagnosis experiences, the process of labor induction or surgery, social support, and emotions experienced since the abortion. We also asked participants how they felt about abortion more generally and whether and to what extent the current experience changed their attitudes about abortion and the people who obtain them. We conducted interviews between April 2020 and March 2021. Recruitment continued until thematic saturation was reached.

I conducted data analysis using QSR NVivo 12 software. My analysis was theoretically informed by the abductive approach to qualitative analysis based on "the ability to recognize a finding as surprising in light of existing theories" (Timmermans and Tavory 2012:169). The recursive and iterative nature of abductive analysis allows the analyst to look for good and poor "fits" between the data and any number of existing theories. Instead of theories emerging from data as in traditional grounded theory, existing theoretical concepts can be further developed or revised based on puzzling empirical materials. I subjected the data to multiple rounds of coding. In open coding, I identified any and all themes of interest (e.g., decision-making, grief and loss, feelings about abortion) to begin specifying the points of view of the subjects and how they describe and evaluate their situations and activities. In later phases, I conducted focused coding where I re-read and re-coded stories after having decided on core categories and the most relevant theoretical work (e.g., moral boundary work, medicalization, naturalization). Throughout the coding process, I wrote reflections in the form of analytic memos about salient themes and topics and integrative memos that further elaborated, extended, and integrated themes. These memos served as the starting point for the text of the article.

Findings

Description of Sample

Selected demographic and reproductive characteristics of the sample are summarized in **Table 1**. The participants' ages ranged from 19-40 with an average age of 32. Half of the sample (n=9) had previously given birth. Thirteen out of eighteen participants described their pregnancies as planned. Most were between 20 and 23 weeks pregnant at the time of their abortion (n=16). Additionally, half of the participants identified as non-Hispanic, White (n=9).

As is often the case when working with multiple recruitment sites, the distribution of the states of referral was not uniform. There were fewer participants from states categorized as middle-ground (n=1) compared with supportive (n=10) and hostile (n=7). In other components of the main research study, state hostility to abortion rights was a significant category of analysis. In this analysis of moral claims, there were no significant differences among groups by state of recruitment. Therefore, in the qualitative data, I report the state of recruitment for context but do not separate out my analyses along this dimension.

Patients were generally given the choice between two types of abortion techniques: dilation and evacuation (D&E), often referred to as 'surgery' (n=12), or an induction of labor (IOL) (n=6). D&E is the most common technique for second trimester abortion in the United States and includes preparation of the cervix to help it dilate, and then a procedure using suction and forceps to remove pregnancy contents from the uterus. An induction of labor termination involves administering medications to the patient to cause uterine contractions and subsequent delivery of the fetus. In addition, three participants received feticidal injections of medication to the fetus or amniotic fluid to induce fetal death prior to the delivery. The use of a feticidal injection prior to an abortion is often based on patient preference or institutional requirements. There is no medical evidence of that induced fetal death prior to the abortion benefits the patient or fetus.

Moral Boundary Work: Good and Bad Mothers

For the women in this study, presenting oneself as a good mother allowed participants to dispel some of the stigma associated with having to choose to end their pregnancies. Participants engaged in a form of gendered moral boundary work that involved drawing symbolic boundaries

between themselves and other women by developing identities as a 'good mothers' and identifying who can be separated out and labeled as 'bad mothers' (Abrams 2015).

Many women asserted their moral worth based on classic feminine traits – most notably the appeal to ideal motherhood. Discursive elements of Michelle's narrative highlight her natural ability as a good caretaker and the idea of motherhood as her destiny:

> "It's just hard. When you're just like looking forward to something so much and when you feel like you'll have the opportunity to be a mom and give-- I just wanted to be able to provide them love and care that I didn't have from my mom. And I just knew that I had a lot of love to give. That's all… I've always known I wanted to be a mom. I've always been very caring over people that are younger than me who I love, so I just knew that I could be a good mom, so." (Michelle, age 32, white, California)

Carrie discussed the maternal ideals of self-sacrifice and altruism when talking about her decision to end the pregnancy. It is meaningful that she uses the word "mom" twice, identifying the person who had an abortion as a mother. Carrie recognizes herself as the fetus' mother and describes her abortion decision as a parenting decision:

> Interviewer: "You were mentioning suffering [of the baby] and [not being promised no suffering]? Did that thought kind of play a role in deciding to stop the pregnancy?" Carrie: "Yes. Because I could take on the suffering and then my daughter didn't have to suffer… I didn't want her to ever struggle with the breast. I didn't want her to ever struggle with anything." (Carrie, 40, white, Indiana)

Constructing one's own identity as part of a like-minded community was essential to subjects' moral boundary work. Elizabeth drew a moral boundary by associating herself with another 'good mother', a nurse she met at the hospital:

> "[The NICU nurse] came in, and she was supporting the decision to have a D&E because of the diagnosis. Not only does she support the decision; she had one herself… I found that so relieving to know that not only another mom made that choice but a NICU nurse… But it was just reassuring that someone else agreed with us. Not only a professional but a mom who's been through that, so." (Elizabeth, 30, white, Indiana)

Elizabeth's quote is significant in another way as nurses are often described as having moral authority based on feminine ideals of nurturance, care, service, and altruism. Nursing has

previously been described as the professionalization of the domestic sphere (White 2002). NICU nurses in particular may carry extra feminine symbolic capital in their capacity as caretakers for the most vulnerable babies. Elizabeth's discursive element of bringing the validating NICU nurse into her narrative reflects deeply embedded cultural schemas of femininity and care.

Moral claims and boundaries and class and racial boundaries often work together to provide a space in which to affirm dignity, identity, and moral worth (Lamont 2009). Ashley, a 25 year-old white woman from Indiana, used an appeal to gendered class superiority throughout her narrative. Particular class markers apparent in Ashley's story scaffold the idea of her as a deserving mother:

> "I mean, this is definitely a planned, wanted pregnancy. I mean, we were trying to do everything by the book. We were married, we had been together forever. We have a nice house, we're financially capable of having a child, we want a family really bad. So, I mean, that was all the more heartbreaking that this happened when it was such a wanted pregnancy, but yes, we wanted to for a long time now, so… Actually, we bought a car because I was still driving the same car I was in high school, so we upgraded to a mom car. So yeah, we definitely made some plans for the future, for sure…"

In addition to mentioning material class markers such as "a nice house", "a mom car", and being "financially capable", Ashley mentions values-based class markers such as planning, marriage, and monogamy. Ashley's discourse reflects another deeply held cultural schema: the concept of stratified reproduction – the idea that the maternity of some groups of women are valued over others, often based on race and class (Colen 1995; Ginsburg 1995). Including gendered class markers in her narrative helps to imply a high moral status that is in conflict with others whose motherhood is devalued by low socioeconomic status.

In the previous examples of moral claims making, symbolic boundaries are merely implied, but in other examples they were made explicit. Participants did this by describing a group of 'bad mothers' – women who did not embrace motherhood, who do not have instinctive

attachment to their fetus, and do not display cultural ideals of nurturance, protection, and self-sacrifice. Amelia describes other women who have abortions as recklessly killing a life:

> "I don't feel like they should be overly-- if some women that recklessly have unprotected sex and use abortion as a way of birth control, I do not think that that's right. If you don't want to be a parent, then have safe sex or get your tubes tied or something so you're not just over and over again killing a life… If you repeatedly just are doing that as your form of birth control, then I think you need some counseling, maybe." (Amelia, age 36, multi-racial, California)

By positioning other abortions as "killing", Amelia implies that women who have multiple abortions or do not instinctively attach to their fetus are pathological and in need of professional care.

Another way that other women were accused of exhibiting bad motherhood was by causing alleged harm to fetuses they plan to carry to term. In Colette's case she compares herself to women who use drugs in pregnancy:

> "And then we started just-- as awful as it probably sounds, but we were like, 'There's so many people, obviously, that do drugs and do all these things when they're pregnant, and their babies come out fine.' And we just felt like it wasn't fair. Obviously, we were young, but we're like, 'We've been together for so long'. It's not even like it was just a random guy that I got-- it was just all these things that we were like, 'Why? This isn't fair.'" (Colette, age 19, white, Indiana 12)

Colette uses a discourse of fairness to compare her own deservingness to others' deviant maternal behavior. In addition, she associates long-term monogamy with good womanhood/motherhood and casual sex with bad womanhood/motherhood.

In summary, participants used gendered moralities, particularly through clarifying their identities as good mothers, to support the boundary distinguishing their own group from others. Consistent with previous literature, women aligned themselves with positive mothering ideals in order to resist the moral stigma that might be associated with their decisions to abort. By describing themselves in opposition to bad mothers, participants demonstrated that moral

boundary work involves both constructing one's own positive group identity and assigning moral inferiority to a group of others.

Medicalization Discourse as Moral Boundary Work

The participants in this study used a striking amount of medical discourse in describing their experiences. Drawing on a number of discursive elements, women constructed symbolic boundaries between their own abortions as medical events, in opposition to other abortions which were defined as non-medical. Moreover, some used medical discourse to contest whether their experiences were abortions at all.

To understand the relationship between abortion and mainstream medicine, it is crucial to appreciate how abortion stigma and the anti-abortion movement creates myths, misinformation, and distrust of abortion providers. These social forces perpetuate myths about abortion providers as unskilled, malicious, or not 'real doctors' and abortion clinics as unsanitary, unregulated, feminized spaces (Harris et al. 2011, 2013; Joffe 1986, 1996). Anna, a 40 year-old, multi-racial mother of one from Indiana, described the significant fear she felt while looking for a provider to perform her abortion:

> "And I'm going to tell you that I was pretty big, 20 weeks, and thought about doing this not in a hospital environment was just terrifying to me. 'I'm just going to die there'. That's all I was thinking. 'I'm just going to die because there is no way I'm going to go to some—' maybe they have it all set up professionally there and all of that, but I was like, 'I'm ready to do whatever and pay how much as long as it's going to be [in a] normal hospital in case if there is going to be something wrong, there is going to be doctors… whatever that's just to help.'"

Later she continued:

> "And then finally, I start checking the website for Indianapolis, and I've seen the picture of Dr. B where she was saying like, 'I'm going to help you guys with abortions. Here's my information.' And I texted her describing my situation, and she said, 'Absolutely. I'm going to help you.' It was like a miracle. I was like, 'Oh my God.' It was already, let me see, 20 maybe 7th, December 27th or 26th or something like that. And she said, 'I'll try to get you in as soon as we can.' And yeah, we were very happy to find out that she is a

real doctor with a real hospital."

Anna's fears were based on pervasive myths about the safety of abortion that have been promoted by the anti-abortion movement: that abortion is dangerous or even life-threatening, that freestanding abortion clinics (as opposed to hospitals) are unprofessional or illegitimate spaces, and that abortion providers are not "real doctors". Her unfounded (though very real) fears led her to seek out a highly medicalized setting for her abortion.

The passages from Anna's story provide contextual clues into the motivational forces behind language that constructs boundaries between the medical and nonmedical in abortion. A common interview theme was the classification of medically necessary versus other types of abortions, and the perceived moral differences between the two. Medical exceptions have long been part of abortion laws and public discourse (Halfmann 2019), discourse that Anna and others used as resources in their accounts. Therefore, constructing a medical boundary helped to scaffold a moral boundary in a relatively seamless way. Here, Mika uses medicalized language to discuss her abortion decision:

> Interviewer: "And how did you ultimately decide on how to proceed with the pregnancy? What did you end up choosing to do?"
> Mika: "We ended up talking about it. And with all of the statistics and surgeries and survival rates and everything, we thought it best to proceed with the termination for medical reasons and then trying again." (Mika, 38, multi-racial, California)

Mika does not say 'we decided to have the abortion'. She says, "we thought it best to proceed with the termination for medical reasons". Though she may not have been actively trying to do so, she uses medical terminology that frames her abortion squarely under the jurisdiction of medical decision-making.

Ashley was asked how she felt about legal restrictions on abortion. Ashley's experience led her to relax in her feelings regarding the legality of abortion, but she makes the distinction

between acceptable, medically necessary abortions and other kinds of abortions:

> "I'm someone who is definitely against abortion, and I would've never thought that I would've had an abortion ever. That's something I'm against. I'm more pro-life. But I feel like after going through this, it's just not as black and white as it may seem and it was more medically necessary… After what I went through, I'm like, no, I definitely think we should at least keep it [legal] because there are women that need that option medically." (Ashley, 25, white, Indiana)

The "women who need that option medically" operate under a different set of rules in Ashley's moral world. She first and foremost identifies and sympathizes with this group, not with the larger universe of people who have abortions. In Ashley's case, a medical-moral distinction gave way to a distinction for a legal framework – that current or future legal restrictions on abortion should be relaxed for others like them. Elena had a similar set of criteria for group inclusion and exclusion:

> "Even though I never felt like I would want a termination, I just-- I couldn't identify with it because my biggest frustration, and I think my husband would share in this with me, is that I feel like most of us who are terminating for a medical reason wouldn't have chosen to terminate if circumstances were different." (Elena, 29, Latinx, California)

Elena expresses frustration because she doesn't identify as a person who has had an abortion. She positions herself in a different category of person – someone who is "terminating for a medical reason".

Notably, Emma did not even realize that what she was doing was called an abortion before she read over the informed consent paperwork, perhaps speaking to the ways that medical discourse permeates the entire clinical environment in these cases:

> "When I was going through all of the paperwork, I didn't realize at that time that it was an abortion, that I was having an abortion, you know… I'm not someone who would ever get pregnant and have an abortion… if there wasn't a medical reason. You know, kind of hearing that was, you know, it's just difficult that part. I just didn't know until that moment. I didn't realize until that moment." (Emma, 33, white, California)

Emma's discomfort with her procedure being assigned the label of "abortion" is palpable. She is

eager to make clear that she is not part of the group that this label normally applies to – her "medical reason" sets her apart and within a morally desirable group.

Medicalized language worked to create distinctions between what Watson calls "ordinary abortion" (Watson 2018) and subjects' own exceptional abortions which were classified as biomedical and technical. The use of the word "termination" as a replacement for "abortion" was widespread among the women themselves and their health care providers. In conversation with the interviewer, Tameka talked about using "termination" to reduce her exposure to the stigma associated with abortion:

> Tameka: "I would say termination. I couldn't push myself to say abortion".
> Interviewer: "And why was that-- or what's different, I guess, about it?"
> Tameka: "Because termination sounds less harsh. And just saying abortion makes my skin crawl because I would never want anyone to think I purposely did it, or I could've saved him. So I guess just saying termination kind of takes away a little bit of the reality of what happened." (Tameka, 19, black, California)

For Tameka, the word abortion represented a choice, an active decision made, and something done "purposely" whereas termination represented a non-choice which she had no control over. However, she also acknowledges that using the word "termination" hides some aspect of "reality," suggesting the symbolic boundary she is actively constructing is perhaps not as rigid as she would like.

For some women, even the word termination was objectionable because it suggested they were *choosing* abortion. Jamie explains:

> "Honestly, I feel like if they would have said that it was not compatible with life, it would have been a better thing to hear. When the word 'termination' starts getting thrown around, then it's on you to decide." (Jamie, 35, white, Missouri)

Because Jamie found even "termination" stigmatizing, she expressed her desire for an alternative medicalization, "not compatible with life".

Carrie from Indiana used the word "induction" to replace abortion throughout her

interview. This was technically not incorrect as she chose to have an induction of labor to end her pregnancy. However, the word "induction" also served to create a useful medical-moral boundary between her experience and others. Here, Carrie is careful to describe her abortion provider as an "induction doctor":

> "So because I knew I had that timeline coming up I agreed to meet with the induction doctor and hear the information and even sign the paperwork because-- without really having made a decision yet because you have to sign it 18 hours in advance."

Later, she is asked whether her feelings about abortion have changed at all since her experience. She responds:

> "Yeah. I mean, I'm still pro-life for myself. In some ways, I don't consider what I did an abortion, even though I know that's what it was. I prefer the induction term, I guess, but I don't have judgment for anybody that would get a genetic fetal anomaly and decide that they couldn't go forward with their pregnancy…."

Carrie, as with Tameka, drew an unstable boundary between the "induction" she experienced and "abortions" experienced by others. She does not consider what she did an abortion, and, at the same time, knows that it is. Carrie is self-aware about the way she talks about her abortion yet finds satisfaction in using the term induction to make her experience more morally tolerable. Similar to other participants, Carrie's opinion about the morality of abortion has softened, but only to the extent that she has compassion (reserves judgment) for others who end pregnancies for similar reasons to herself. She continues:

> "…Abortion is totally politicized, in my mind, and considered, like I said, one of the worst sins possible. It's like you're a murderer basically, and induction is like oh, termination for medical reasons is like oh, there was a compassionate induction. That, to me, feels a lot different than the word abortion."

Here, Carrie draws a firmer boundary where abortion is positioned squarely in the realm of politics versus induction in the realm of medicine. She brings back the dichotomy between medical necessity and non-medical reasons for abortion. However, Carrie's argument marks a

turning point in my analysis. I noticed that in some circumstances, moral boundary work gave way to something else: a denial of the abortion itself. This phenomenon is explored further in the following sections.

To summarize, participants used medicalized language to construct and stabilize moral boundaries between their own abortions and others'. Some were self-reflexive enough to state they know, logically or rationally, that they had abortions, but used alternative, medical vocabulary as a discursive strategy to symbolically separate their experience from others.

Naturalization Discourse as Moral Boundary Work

While some respondents relied on medicalized language in their moral boundary work, in a somewhat unexpected turn, others used demedicalized language to describe their abortions as naturally occurring events. Different technical circumstances can enable or discourage naturalization, and this discourse was especially available to those who had inductions of labor. Common phrases used by these participants were "natural labor", "giving birth", and "the baby didn't make it". When Carrie from Indiana was asked about making the choice between a D&E or a labor induction, she explained:

> "I didn't like the option of the D&E… because I wanted a chance to hold our baby. And in Indiana, the way that abortion had been described to me in the past, having no real, firsthand experience, was that your baby got vacuumed out of you. And so, I didn't want to picture a vacuum coming to me. And also, I wanted things to happen as naturally as they could, even given the circumstances."

Carrie's decision between procedures hinged on a desire to make the abortion happen as naturally as possible. She frames the medical intervention necessary for the D&E, "a vacuum", as grotesque compared to the moral desirability of a natural labor. She also expresses a desire to engage with the materiality of the fetus as a way to feel connected to her baby.

Amelia, a 36 year-old, multi-racial mother of two from California, had a similar reaction

when she learned about the options to remove the fetus from her body:

> "My thoughts on the surgery was I did not want him to be chopped or anything like that. I went ahead and went with the induction because I did want to see him, I did want to hold him. I firmly believe in having natural labors and so the surgery was just immediately not an option… I just knew, 'Okay, yeah, we're just going to have an induction. I want to see him, anyway. I want him to come out whole, I want to look at him."

Similarly to Carrie, Amelia expressed a desire to engage with the fetus as a parent engages with a newborn baby. She contrasts the grotesqueness of the baby being "chopped" in a D&E with her "firm belief" in "natural labors". The use of the term "firm belief" implies a moral quality to her decision. To believe in something means one thinks it is better than other beliefs. Amelia used this decision point to, among other things, embrace and align herself with idealized natural motherhood. The discourse of naturalization became part of her moral boundary work.

Certain medical practices arose that were particularly difficult to naturalize, which could be distressing to the participant. Later in the interview, Amelia discussed how upset she was to receive the feticidal injection that stopped the fetus' heart:

> Amelia: "I wish I didn't have to do that injection part…"
> Interviewer: "What about it was not good for you?"
> Amelia: "To be totally honest, I just felt like I was cutting his life short. It feels like I made the decision to really cut his life short. I already knew that's what the whole process was, but I feel like I wish I could've delivered him and then he just passed away naturally from being born too early. That would've been better for me."

In an expressed preference for her fetus to have a natural death, Amelia asserts that part of naturalization is about denying one's own part in the decision-making process. She acknowledges that the fetus would die either way, but to her the injection felt like she was making an active choice rather than waiting for the fetus to die "naturally". Without the feticidal injection, her experience would have felt less like an abortion and more like the birth that she desperately wanted.

Other women used the language of 'birth' or 'natural birth' to describe their abortions. Colette used 'birth' as a replacement word for abortion, even as she recognized the unnatural aspects of her abortion experience:

> "So I guess everyone has their own opinion, but to me, I guess I'm just thinking, 'Yeah, I signed paperwork, and the state of Indiana calls it an abortion, but I birthed her, and I know I started'-- I mean, they started the process unnaturally, but…"(Colette, 19, white, Indiana)

For Colette, doing the physical labor to birth the fetus partially neutralizes the fact that it was her decision to abort. Collete's boundary work comparing more and less morally acceptable abortions began to give way to comparing 'real abortions' to 'not abortions', or denying her experience as an abortion at all.

Collete's discourse was not an isolated case. Other respondents took the idea of giving birth more literally, deflecting the abortion label by turning their abortion stories into birth stories. Michelle from California narrated her story:

> "They started out, I think, 10:00 pm and they were doing that every three hours-- giving me the next dose, and then finally, I want to say, around-- I want to say, 9:00 or 10:00 in the morning I started getting really, really bad contractions. And I already knew. I asked them for the epidural. So then they called the doctor and he came and was giving me the epidural. And as they were giving me the epidural, my water broke right there. And then the baby was born, obviously, at 11:10 in the morning, on May 6th. Yes. But the baby, unfortunately, had passed before she was born.*"*

Michelle's narrative includes familiar aspects of a birth story: she describes contractions, asking for an epidural, and her water breaking, all parts of a western cultural narrative of a hospital birth. She describes the baby as being born but also having passed away before she was born. The passive language of the final sentence of the passage appears to imply that she was not involved in the fetus' death. She does the discursive labor to deny her abortion, meaning-making that went beyond moral boundary work.

Carrie from Indiana's birth/abortion narrative also reflected familiar cultural birth stories,

including details such as waiting for her cervix to gradually become dilated, using centimeters as a familiar measuring stick, and conveying the time of birth:

> "So I took the oral medicine the day before, and then I took the-- they started giving me the vaginal medicine on Tuesday, and I was only one centimeter dilated after 12 hours, by 7:00 pm that night. So I didn't give birth until 1:00 in the morning on the 3rd. So I mean, it was just a lot of a lot of downtime that day, and just waiting… I found out that she did not survive birth."

Similar to Michelle, Carrie's final sentence took a great deal of deflection to manage. She describes "finding out" that her daughter did not survive. By framing the story in this way, she transitions the death of her fetus away from human intervention and towards natural death. She incorporates natural death, and its culturally bestowed morality, into her narrative. But beyond that, she makes an implied argument that her experience was not an abortion at all.

In sum, women used the discourse of naturalization to draw symbolic moral boundaries between natural birth (good), natural death (good) and abortion (bad). They rejected the grotesqueness they associated with the intervention of abortion and embraced positive associations with both natural birth and natural death. In addition, some denied their abortions outright, turning their abortion narratives into birth and/or death narratives where the technological circumstances allowed. The discursive result of this work resulted in an alignment with those they considered to be a morally unpolluted group of bereaved parents.

Denial: What counts as a 'real' abortion?

Some participants ultimately rejected the label of abortion not by medicalizing or naturalizing their experiences, but by basing their explanations on contextual issues. These women implied that the reason or circumstances surrounding an abortion help to define what is and isn't a 'real' abortion – the killing of an unwanted child expected to live beyond infancy. For example, Amelia from California argued that since she had a wanted pregnancy, it was

inappropriate to call her procedure an abortion.

> Interviewer: "In your mind and how you're thinking about it, what made it different from-- why not call it an abortion? Or what was different about it?"
> Amelia: "I feel like abortion is always a child you don't want at all. He was definitely wanted. He was wanted not only by his parents, but he was wanted by an entire family. 50 people who almost-- he was wanted by about 50 people. He was already well loved. I already have gifts and things that are sitting around the house that we're going to keep because he was someone. We wanted him. We loved on him already so much."

Amelia's poignant argument hinged upon constructing her experience as something entirely different from abortion and more similar to the birth of a child. She states that her son was wanted, loved, and owned material objects, all things that are missing from dominant cultural narratives of abortion. Therefore, narratively at least, she was able to reject or deny the idea that she had an abortion at all.

Elena from California's response was similar to Amelia's. She invokes the association between abortion and unwanted pregnancy in order to explain how and why her experience was substantively different:

> Interviewer: "Did you think about it as abortion? Or did it feel different in any way?
> Elena: "It absolutely felt different because we know people who have had abortions because they had unwanted pregnancies. We felt it was absolutely different because we had wanted this so badly and we had tried for so long and so hard to get there that it just-having to use the word abortion, even though I get that that's the medical term for it, it makes it so much harder."
> Interviewer: "Did you refer to it in any other way?"
> Elena: "I want to say what we ended up telling people was just that she wasn't going to make it. And so we had to end the pregnancy."

Elena puts her decision in the context of a wanted pregnancy and uses the alternative language of "she wasn't going to make it" and "end the pregnancy" to put her experience in what she feels is a more fitting social context. Another participant, Shania, put her current abortion into context by comparing it to a previous abortion, or what she calls "an actual abortion":

> "I had an actual abortion [last] February. I knew that I could not-- I couldn't have a child with that person. I knew that I wasn't in a place to provide for two children and they both

> have a fair life. And then moving forward to this experience, I didn't look at it as an abortion per se, but it's hard. I don't really know what you call it." (Shania, 29, indigenous, Missouri)

Shania gives context to her previous abortion by using a familiar cultural narrative – choosing to have an abortion due to an unsuitable partner. She finds it difficult to see a parallel between that previous experience and her current one, yet a replacement for the word "abortion" eludes her. She is forced to sit with her ambivalence and is unable to draw a firm boundary between these two abortions.

Jamie from Missouri struggled with, but ultimately accepted, her experience as an abortion. She was able to accept belonging in the category of people who have abortions, yet she still maintains that there is a difference between her own abortion and others':

> "First when they would say 'termination', it sounds better, I guess. But then once I realized, I guess I didn't even really realize it at first, that I was aborting my baby. That's so naive. But at the beginning of all of this, it was just-- I don't know. It just didn't feel like that. I don't know. I guess I use them interchangeably now because it's one of the same. One is just a little bit more, I don't know, society friendly than the other, but they mean the same thing."

Jamie describes the experience of coming to understand her procedure as an abortion yet explains that "it doesn't feel like that". She finds herself able to switch back and forth between "abortion" and "termination" depending on her audience, perhaps using "termination" strategically to categorize her experience as a "society friendly" one. Internally though, she is unable to achieve a firm or clear moral limit.

The narratives of Amelia, Elena, Shania, and Jamie illustrate the messy work of rejecting and redefining abortion. When boundary marking between 'good abortions' and 'bad abortions' felt insufficient to describe their experiences, they tried, to the extent that language allowed, to deflect their experiences based on the contextual factors in which the abortion decision took place. A discourse of moral boundaries between abortions gave way to boundaries between real

or actual abortions and non-abortions.

Discussion

This study explores how people who have abortions in cases of life-limiting fetal conditions talk about the morality of their abortions. I find that as part of managing abortion stigma and constructing positive moral identities, women make claims of moral worth by comparing their experiences to imagined others who have abortions for different reasons. I identify various approaches relied upon to manage abortion stigma. First, in gendered moral boundary work, subjects emphasize traits of ideal womanhood such as care, self-sacrifice, and maternity as destiny. Equally important, they contrast their experiences with the women they are not: 'bad mothers' who reject motherhood by having abortions for personal reasons or showing a lack of care for their pregnancy. Second, subjects used medical and natural discourses as moral boundary work. Some contrasted their 'medically necessary' abortions with 'non-medical' abortions or used terms like 'termination' and 'induction' rather than 'abortion'. Others described their abortions as similar or equivalent to other naturally occurring events such as giving birth or dying of natural causes. Finally, subjects rejected and denied the abortion label itself by defining abortion based on its medical and social contexts. Importantly, when the moral distinction between 'good' and 'bad' abortions felt insufficient to describe their lived experiences, subjects moved beyond moral boundary work to the work of abortion denial and deflection.

The findings of this paper are supported by previous scholarly work. Prior research has demonstrated that the moral acceptability of reproductive choices often hinges on whether ideal womanhood, itself a racialized and classed concept, is perceived as being embraced or rejected (Becker 2019; Cockrill and Nack 2013; Combellick 2023; Czarnecki 2022; Jones et al. 2008).

Moreover, the relationship I observed between morality and medicalization discourses contain elements that have been previously theorized. The social construction of biomedicine involves the doctor as both a technical and moral authority (Foucault 1973; Starr 1982; Zola 1972). This, combined with the fact that abortion is already medically marginalized (Freedman 2010; Joffe 1996), allows space for an argument to be made that the medical necessity of abortion for a serious fetal diagnosis makes it morally superior to other abortions. In this study, even the physical boundaries between clinic and hospital environments became closely entwined in the moral boundary between 'good' and 'bad' abortions.

This research also contains a number of novel findings of potential empirical and theoretical interest, including the mobilization of medical and natural discourses to claim moral worth. A novel finding in the present case is that individuals use medicalized discourse to claim a moral status in a highly contested decision-making context. Medicalization became a discursive resource for asserting moral worth and a symbolic boundary between oneself and others. These results suggest an intervention in the literature on the medicalization of deviance – not only is the transition 'from badness to sickness' an institutional one, but it is also produced at the level of social interaction. In an unexpected discovery, I found that demedicalization, or naturalization, can also function as moral boundary work in nearly the same way. Claiming one's abortion as proximate to nature can be used as a discursive tool that separates oneself from a morally subordinate group.

These findings also make clear that sometimes the moral boundaries between 'good' and 'bad' feel insufficient to effectively dispel stigma. In these cases a strategy of stigma deflection (Thoits 2011, 2016) may be necessary to construct a positive moral identity. Identity deflection as a form of stigma resistance has been identified in studies of personal experiences of mental

illness (Thoits 2011, 2016) and harmful drinking (Morris et al. 2022). This may indicate a potentially rich area for further research. It seems important to probe where the "boundaries" between boundary work and other discursive elements begin and end. When and under what conditions does boundary work end and deflection begin? Or is deflection itself a form of boundary work that is necessary under certain conditions? And most importantly, what are the alternatives to boundary work? It may be possible that under some circumstances, the individuals who are located in the privileged corners of a stigmatized experience are in a unique position to push back against that stigma on behalf of the larger group.

It is important to acknowledge the scope limitations of this small qualitative study. It is limited in representation from states that are considered politically moderate towards abortion rights. We recruited fewer participants from states that were categorized in 2019 as "middle-ground" compared with "supportive" and "hostile" which may have influenced the findings. We also do not know why there were no significant differences in the boundary work of participants in different states, but it suggests that abortion stigma and its management does not always circulate in a predictable red state/blue state pattern. Additionally, participants interviewed predominantly identified as non-Hispanic, white. This resulted in less representation from participants of other ethnic and racial backgrounds and likely represents a limited perspective. Future research on abortion morality should include attentiveness to the many minoritized voices in abortion research, including integrating the voices of transgender and gender-expansive people who have abortions.

In terms of scope conditions, the fact that abortion providers in academic settings, and not a more general group of providers, were targeted as recruitment sites may be significant. First, receiving abortion care in the hospital setting, typically in the labor and delivery department,

meant receiving care in closer proximity to birthing people than to those having 'ordinary' abortions. It may be easier to construct similarities with groups one has received care with side-by-side, and to construct distinctions from groups one has not. Second, receiving abortions in hospitals may have made medical discourse more readily available to these subjects than others having abortions in independent clinics. Questions remain about who participates in boundary work or deflection through medical discourse. Is the language used by patients constructed independently, is it influenced by the language abortion providers use, or is it from another source?

Like many studies of abortion in the United States, this research may have practical applicability to the politics of reproductive rights. My findings raise questions about the efficacy of political messages that emphasize abortions for fetal health reasons, the stories that are often elevated in pro-abortion rights discourse. These individuals have experienced tragic circumstances that rightfully deserve sympathy; however, their specific definitions of appropriate morality may indirectly subjugate the moral authority of the vast majority of Americans who have abortions. When abortion rights advocates center the abortion narratives of people who don't actually consider what they did to be abortion, there can be unintended consequences, in which reproductive rights discourse focuses on exceptions to abortion restrictions, rather than reproductive autonomy for all people.

References

Abrams, Paula. 2015. “The Bad Mother: Stigma, Abortion and Surrogacy.” *Journal of Law, Medicine & Ethics* 43(2):179–91.

Almeling, Rene. 2011. *Sex Cells*. University of California Press.

Anspach, Renee. 1993. *Deciding Who Lives: Fateful Choices in the Intensive-Care Nursery*. University of California Press.

Barker, Kristin K. 1998. “A Ship upon a Stormy Sea: The Medicalization of Pregnancy.” *Social Science & Medicine* 47(8):1067–76.

Becker, Andréa. 2019. “‘My Abortion Made Me a Good Mom’: An Analysis of the Use of Motherhood Identity to Dispel Abortion Stigma.” Pp. 219–40 in *Reproduction, Health, and Medicine (Advances in Medical Sociology, Vol. 20)*. Emerald Publishing Limited.

Bell, Ann V. 2009. “‘It’s Way out of My League.’” *Gender & Society* 23(5):688–709.

Biggs, M. Antonia., Ushma D. Upadhyay, Julia R. Steinberg, and Diana G. Foster. 2014. “Does Abortion Reduce Self-Esteem and Life Satisfaction?” *Quality of Life Research* 23(9):2505–13.

Biggs, M. Antonia, Ushma D. Upadhyay, Charles E. McCulloch, and Diana G. Foster. 2017. “Women’s Mental Health and Well-Being 5 Years after Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study.” *JAMA Psychiatry* 74(2):169–78.

Blum, Linda. 2000. *At the Breast: Ideologies of Breastfeeding and Motherhood in the Contemporary United States*. Beacon Press.

Bröer, Christian, and Broos Besseling. 2017. “Sadness or Depression: Making Sense of Low Mood and the Medicalization of Everyday Life.” *Social Science & Medicine* 183:28–36.

Chambliss, Daniel F. 1996. *Beyond Caring: Hospitals, Nurses, and the Social Organization of Ethics*. University of Chicago Press.

Cockrill, Kate, and Tracy A. Weitz. 2010. "Abortion Patients' Perceptions of Abortion Regulation." *Womens Health Issues* 20(1):12–19.

Cockrill, Kate, and Adina Nack. 2013. "'I'm Not That Type of Person': Managing the Stigma of Having an Abortion." *Deviant Behavior* 34(12):973–90.

Cockrill, Kate, Ushma Upadhyay, Janet Turan, and Diana Greene Foster. 2013. "The Stigma of Having an Abortion: Development of a Scale and Characteristics of Women Experiencing Abortion Stigma." *Perspectives on Sexual and Reproductive Health* 45(2):79–88.

Colen, Shellee. 1995. "'Like a Mother to Them': Stratified Reproduction and West Indian Childcare Workers and Employers in New York." Pp. 78–102 in *Conceiving the New World Order: The Global Politics of Reproduction*, edited by F.D. Ginsburg and R. Rapp. University of California Press.

Combellick, Sarah Larissa. 2023. "'My Baby Went Straight to Heaven': Morality Work in Abortion Online Storytelling." *Social Problems* 70(1):87–103. doi: 10.1093/socpro/spab033.

Conrad, Peter. 1975. "The Discovery of Hyperkinesis: Notes on the Medicalization of Deviant Behavior." *Social Problems* 23(1):12–21.

Conrad, Peter. 1979. "Types of Medical Social Control." *Sociology of Health & Illness* 1(1):1–11.

Conrad, Peter. 1992. "Medicalization and Social Control." *Annual Review of Sociology* 18(1):209–32.

Conrad, Peter. 2006. *Identifying Hyperactive Children: The Medicalization of Deviant Behavior*. Ashgate Publishing, Ltd.

Conrad, Peter, and Joseph Schneider. 1980. *Deviance and Medicalization: From Badness to Sickness*. Temple University Press.

Czarnecki, Danielle. 2022. "'I'm Trying to Create, Not Destroy': Gendered Moralities and the Fate of IVF Embryos in Evangelical Women's Narratives." *Qualitative Sociology* 45(1):89–121.

Davis-Floyd, Robbie. 2022. *Birth as an American Rite of Passage*. Taylor & Francis.

De Zordo, Silvia. 2018. "From Women's 'Irresponsibility' to Foetal 'Patienthood': Obstetricians-Gynaecologists' Perspectives on Abortion and Its Stigmatisation in Italy and Cataluña." *Global Public Health* 13(6):711–23.

Fielding, Stephen L., Emme Edmunds, and Eric A. Schaff. 2002. "Having an Abortion Using Mifepristone and Home Misoprostol: A Qualitative Analysis of Women's Experiences." *Perspectives on Sexual and Reproductive Health* 34(1):34–40.

Flavin, J. 2008. *Our Bodies, Our Crimes: The Policing of Women's Reproduction in America*. New York: New York University Press.

Foster, Diana G., Julia R. Steinberg, Sarah CM Roberts, John Neuhaus, and M. Antonia Biggs. 2015. "A Comparison of Depression and Anxiety Symptom Trajectories between Women Who Had an Abortion and Women Denied One." *Psychological Medicine* 45(10):2073–82.

Foucault, Michel. 1973. *The Birth of the Clinic*. Routledge.

Freedman, Lori. 2010. *Willing and Unable: Doctors' Constraints in Abortion Care*. Vanderbilt University Press.

Gelman, Amanda, Elian A. Rosenfeld, Cara Nikolajski, Lori R. Freedman, Julia R. Steinberg, and Sonya Borrero. 2017. "Abortion Stigma Among Low-Income Women Obtaining Abortions in Western Pennsylvania: A Qualitative Assessment." *Perspectives on Sexual and Reproductive Health* 49(1):29–36.

Ginsburg, Faye D. and Rayna Rapp. 1995. *Conceiving the New World Order: The Global Politics of Reproduction*. University of California Press.

Guttmacher Institute. 2019. *State Abortion Policy Landscape: From Hostile to Supportive*.

Halfmann, Drew. 2012. "Recognizing Medicalization and Demedicalization: Discourses, Practices, and Identities." *Health:* 16(2):186–207.

Halfmann, Drew. 2019. "Political Institutions and the Comparative Medicalization of Abortion." *Journal of Health and Social Behavior* 60(2):138–52.

Hanschmidt, Franz, Katja Linde, Anja Hilbert, Steffi G. Riedel-Heller, and Anette Kersting. 2016. "Abortion Stigma: A Systematic Review." *Perspectives on Sexual and Reproductive Health* 48(4):169–77.

Hanschmidt, Franz, Michaela Nagl, Johanna Klingner, Holger Stepan, and Anette Kersting. 2018. "Abortion after Diagnosis of Fetal Anomaly: Psychometric Properties of a German Version of the Individual Level Abortion Stigma Scale." *PLOS ONE* 13(6):e0197986.

Harris, Lisa H., and Taida Wolfe. 2014. "Stratified Reproduction, Family Planning Care and the Double Edge of History." *Current Opinion in Obstetrics and Gynecology* 26(6):539–44.

Harris, Lisa H., Lisa Martin, Michelle Debbink, and Jane Hassinger. 2013. "Physicians, Abortion Provision and the Legitimacy Paradox." *Contraception* 87(1):11–16.

Harris, Lisa H., Michelle Debbink, Lisa Martin, and Jane Hassinger. 2011. “Dynamics of Stigma in Abortion Work: Findings from a Pilot Study of the Providers Share Workshop.” *Social Science & Medicine* 73(7):1062–70.

Harvey, Janet. 1997. “The Technological Regulation of Death: With Reference to the Technological Regulation of Birth.” *Sociology* 31(4):719–35.

Harvey, S. Marie, Linda J. Beckman, and Sarah J. Satre. 2001. “Choice of and Satisfaction with Methods of Medical and Surgical Abortion among U.S. Clinic Patients.” *Family Planning Perspectives* 33(5):212–16.

Hays, Sharon. 1996. *The Cultural Contradictions of Motherhood*. Yale University Press.

Hoggart, Lesley. 2017. “Internalised Abortion Stigma: Young Women’s Strategies of Resistance and Rejection.” *Feminism and Psychology* 27(2):186–202.

Honkanen, Helena, and Helena von Hertzen. 2002. “Users’ Perspectives on Medical Abortion in Finland.” *Contraception* 65(6):419–23.

Janiak, Elizabeth Alisa B. and Goldberg. 2016. “Eliminating the Phrase ‘Elective Abortion’: Why Language Matters.” *Contraception* 93:89–92.

Joffe, Carole. 1986. *The Regulation of Sexuality: Experiences of Family Planning Workers*. Temple University Press.

Joffe, Carole. 1996. *Doctors of Conscience: The Struggle to Provide Abortion before and after Roe v. Wade*. Beacon Press.

Jones, Rachel, Lori Frohwirth, and Ann Moore. 2008. “‘I Would Want to Give My Child, Like, Everything in the World’: How Issues of Motherhood Influence Women Who Have Abortions.” *Journal of Family Issues* 29(1):79–99.

Jozkowski, Kristen N., Brandon L. Crawford, and Mary E. Hunt. 2018. "Complexity in Attitudes Toward Abortion Access: Results from Two Studies." *Sexuality Research and Social Policy* 15(4):464–82.

Keefe-Cooperman, Kathleen. 2005. "A Comparison of Grief as Related to Miscarriage and Termination for Fetal Abnormality." *OMEGA-Journal of Death and Dying* 50(4):281–300.

Kersting, Anette, Michaela Dorsch, Carmen Kreulich, M. Reutemann, P. Ohrmann, E. Baez, and V. Arolt. 2005. "Trauma and Grief 2–7 Years after Termination of Pregnancy Because of Fetal Anomalies–a Pilot Study." *Journal of Psychosomatic Obstetrics & Gynecology* 26(1):9–14.

Kersting, Anette, Kristin Kroker, Johannes Steinhard, Isabell Hoernig-Franz, Ute Wesselmann, Katharina Luedorff, Patricia Ohrmann, Volker Arolt, and Thomas Suslow. 2009. "Psychological Impact on Women after Second and Third Trimester Termination of Pregnancy Due to Fetal Anomalies versus Women after Preterm Birth—a 14-Month Follow up Study." *Archives of Women's Mental Health* 12(4):193–201.

Kimport, Katrina. 2022. "Choosing Abortion for a Serious Fetal Health Issue: From Medical Information to Values." Pp. 91–118 in *Facing Death: Familial Responses to Illness and Death*. Vol. 19, *Contemporary Perspectives in Family Research*, edited by C. L. Scott, H. M. Williams, and S. Wilder. Emerald Publishing Limited.

Kimport, Katrina, Tracy A. Weitz, and Lori Freedman. 2016. "The Stratified Legitimacy of Abortions." *Journal of Health and Social Behavior* 57(4):503–16.

Korenromp, Marijke J., Godelieve CML Page-Christiaens, Jan van den Bout, Eduard JH Mulder, and Gerard HA Visser. 2009. "Adjustment to Termination of Pregnancy for Fetal

Anomaly: A Longitudinal Study in Women at 4, 8, and 16 Months." *American Journal of Obstetrics and Gynecology* 201(2):160-e1.

Kumar, Anuradha, Leila Hessini, and Ellen Mitchell. 2009. "Conceptualising Abortion Stigma." *Culture, Health, and Sexuality* 11(6):625–39.

Lafarge, Caroline, Kathryn Mitchell, and Pauline Fox. 2014. "Termination of Pregnancy for Fetal Abnormality: A Meta-Ethnography of Women's Experiences." *Reproductive Health Matters* 22(44):191–201.

Lamont, Michèle. 1992. *Money, Morals, and Manners: The Culture of the French and the American Upper-Middle Class*. University of Chicago Press.

Lamont, Michèle. 2009. *The Dignity of Working Men: Morality and the Boundaries of Race, Class, and Immigration*. Harvard University Press.

Lareau, Annette. 2011. *Unequal Childhoods*. University of California Press.

Lee, Ellie. 2003. *Abortion, Motherhood, and Mental Health: Medicalizing Reproduction in the United States and Great Britain*. Transaction Publishers.

Ludlow, Jeannie. 2008. "The Things We Cannot Say: Witnessing the Traumatization of Abortion in the United States." *Women's Studies Quarterly* 36(1/2):28–41.

Luker, Kristin. 1984. *Abortion and the Politics of Motherhood*. University of California Press.

Maguire, Marguerite, Alexis Light, Miriam Kuppermann, Vanessa K. Dalton, Jody E. Steinauer, and Jennifer L. Kerns. 2015. "Grief after Second-Trimester Termination for Fetal Anomaly: A Qualitative Study." *Contraception* 91(3):234–39.

Malacrida, Claudia, and Tiffany Boulton. 2012. "Women's Perceptions of Childbirth 'Choices': Competing Discourses of Motherhood, Sexuality, and Selflessness." *Gender & Society* 26(5):748–72.

Martin, Emily. 2001. *The Woman in the Body: A Cultural Analysis of Reproduction*. Beacon Press.

Martin, Lisa A., Jane A. Hassinger, Michelle Debbink, and Lisa H. Harris. 2017. "Dangertalk: Voices of Abortion Providers." *Social Science & Medicine* 184:75–83.

Mastey, Namrata, Sarah L. Combellick, Mitchell D. Creinin, E. Bimla Schwarz, and Melissa J. Chen. 2023. "Perinatal Palliative Care and Abortion for Life-Limiting Fetal Conditions: A Qualitative Study." *Under Review.*

McCoyd, Judith L. M. 2010. "Women in No Man's Land: The Abortion Debate in the USA and Women Terminating Desired Pregnancies Due to Foetal Anomaly." *The British Journal of Social Work* 40(1):133–53.

Millar, Erica. 2020. "Abortion Stigma as a Social Process." *Women's Studies International Forum*. 78:102328.

Morris, J., A. C. Moss, I. P. Albery, and Nick Heather. 2022. "The 'Alcoholic Other': Harmful Drinkers Resist Problem Recognition to Manage Identity Threat." *Addictive Behaviors* 124:107093.

Murray Milner. 2020. "Status Distinctions and Boundaries." Pp. 295–304 in *Routledge Handbook of Cultural Sociology*, edited by L. Grindstaff, M.M. Lo, and J.R. Hall. Routledge.

Nickerson, A., R. Manski, and A. Dennis. 2014. "A Qualitative Investigation of Low-Income Abortion Clients' Attitudes toward Public Funding for Abortion." *Women Health* 54(7):672–86.

Norris, Alison, Danielle Bessett, Julia Steinberg, Megan Kavanaugh, Silvia De Zordo, and Davida Becker. 2011. "Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences." *Womens Health Issues* 21(3 Suppl):S49-54.

O'Connor, Bonnie B. 1993. "The Home Birth Movement in the United States." *The Journal of Medicine and Philosophy* 18(2):147–74.

Ortiz, Selena E., Ichiro Kawachi, and Angie M. Boyce. 2017. "The Medicalization of Obesity, Bariatric Surgery, and Population Health." *Health:* 21(5):498–518.

Rapp, Rayna. 2004. *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America*. Routledge.

Reich, Jennifer A. 2014. "Neoliberal Mothering and Vaccine Refusal: Imagined Gated Communities and the Privilege of Choice." *Gender & Society* 28(5):679–704.

Rich, Adrienne. 2021. *Of Woman Born: Motherhood as Experience and Institution*. WW Norton & Company.

Riessman, Catherine Kohler. 1983. "Women and Medicalization: A New Perspective." *Social Policy* 14(1):3–18.

Roberts, Dorothy E. 1999. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. Vintage.

Rossol, Josh. 2001. "The Medicalization of Deviance as an Interactive Achievement: The Construction of Compulsive Gambling." *Symbolic Interaction* 24(3):315–41.

Russo, Nancy. 1976. "The Motherhood Mandate." *Journal of Social Issues* 32(3):143–53.

Salvesen, K\AA, L. Øyen, N. Schmidt, U. F. Malt, and S. H. Eik-Nes. 1997. "Comparison of Long-Term Psychological Responses of Women after Pregnancy Termination Due to Fetal Anomalies and after Perinatal Loss." *Ultrasound in Obstetrics and Gynecology:*

The Official Journal of the International Society of Ultrasound in Obstetrics and Gynecology 9(2):80–85.

Schneider, Joseph W. 1978. "Deviant Drinking as Disease: Alcoholism as a Social Accomplishment." *Social Problems* 25(4):361–72.

Seymour, Jane Elizabeth. 2000. "Negotiating Natural Death in Intensive Care." *Social Science & Medicine* 51(8):1241–52.

Sheldon, Wendy R., Meighan Mary, Lisa Harris, Katherine Starr, and Beverly Winikoff. 2020. "Exploring Potential Interest in Missed Period Pills in Two US States." *Contraception* 102(6):414–20.

Simonds, Wendy, Barbara Katz Rothman, and Bari Meltzer Norman. 2007. *Laboring on: Birth in Transition in the United States*. Taylor & Francis.

Skeggs, Beverley. 1997. *Formations of Class & Gender: Becoming Respectable*. Sage.

Smith, Tom, and Jaesok Son. 2013. *General Social Survey 2012 Final Report: Trends in Public Attitudes Towards Abortion*. NORC at the University of Chicago.

Solinger, R. 2005. *Pregnancy and Power: A Short History of Reproductive Politics in America*. New York University Press.

Starr, Paul. 1982. *The Social Transformation of American Medicine*. Basic Books.

Steinberg, Julia R. 2011. "Later Abortions and Mental Health: Psychological Experiences of Women Having Later Abortions—a Critical Review of Research." *Women's Health Issues* 21(3):S44–48.

Thoits, Peggy A. 2011. "Resisting the Stigma of Mental Illness." *Social Psychology Quarterly* 74(1):6–28.

Thoits, Peggy A. 2016. "'I'm Not Mentally Ill': Identity Deflection as a Form of Stigma Resistance." *Journal of Health and Social Behavior* 57(2):135–51.

Thompson, Charis. 2001. "Strategic Naturalizing: Kinship in an Infertility Clinic." Pp. 175-202 in *Relative Values: Reconfiguring Kinship Studies*, edited by S. Franklin and S. McKinnon. Duke University Press.

Thompson, Charis. 2005. *Making Parents: The Ontological Choreography of Reproductive Technologies*. MIT press.

Timmermans, Stefan, and Iddo Tavory. 2012. "Theory Construction in Qualitative Research." *Sociological Theory* 30(3):167–86.

Watson, Katie. 2018. *Scarlet A: The Ethics, Law, and Politics of Ordinary Abortion*. Oxford University Press.

White, Karolyn. 2002. "Nursing as Vocation." *Nursing Ethics* 9(3):279–90.

Wilkinson, D.J.C., P. Thiele, A. Watkins, and L. De Crespigny. 2012. "Fatally Flawed? A Review and Ethical Analysis of Lethal Congenital Malformations." *BJOG: An International Journal of Obstetrics & Gynaecology* 119(11):1302–8.

Wool, Charlotte. 2011. "Systematic Review of the Literature: Parental Outcomes after Diagnosis of Fetal Anomaly." *Advances in Neonatal Care* 11(3):182–92.

Zola, Irving Kenneth. 1972. "Medicine as an Institution of Social Control." *The Sociological Review* 20(4):487–504.

Zussman, Robert. 1992. *Intensive Care: Medical Ethics and the Medical Profession*. University of Chicago Press.

3. Stigma as a multi-level social process: The case of abortion for severe fetal diagnosis

Abstract

Recent scholarship on the concept of stigma promotes a reconceptualization of stigma beyond Goffman's classic social interactionist definition and toward an understanding of stigma as a social process informed by relations of power and inequality. The scholarship on abortion stigma has yet to fully embrace this theoretical framework, relying on a popular definition of stigma as an individual attribute that signals a failure to embrace the norms of womanhood. This study examines abortion stigma among people who receive abortions in the context of a fatal fetal diagnosis. I question why, despite an unambivalent embrace of motherhood ideals and fatal fetal diagnoses, this group of women experienced abortion stigma. I find that answering this question requires a theoretical re-orientation toward defining abortion stigma as a multi-level social process embedded in existing structures of power and inequality. The participants in this study encountered some abortion stigma at the interpersonal level, but also at three additional levels of society: the organizational/institutional level of the hospital, the cultural/mass discourse level of missing information and misinformation, and the structural level of state governments. Navigating a fetal diagnosis and needed abortion care required interactions with stigma at all of these levels. Processes of meso- and macro-level abortion stigma, controlled by powerful individuals and social groups, worked to produce individual-level stigma, which was then embodied and expressed through acts of secrecy or internalized as feelings of shame. Abortion stigma had more adverse consequences for women who were already marginalized due to their social location. These findings have implications for the study of abortion stigma and raise questions about best practices for ameliorating such stigma.

Keywords

abortion, fetal diagnosis, stigma, organizational-level stigma, structural-level stigma

Recent scholarship on the concept of stigma promotes a reconceptualization of stigma beyond Goffman's classic definition of stigma as an individual attribute (Goffman 1963) and toward an understanding of stigma as a social process informed by relations of power and inequality. The subfield of abortion stigma has followed this trend, although to a lesser extent and with an absence of empirical research on the subject. The most common definition of abortion stigma originated with a 2009 article as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood" (Kumar, Hessini, and Mitchell 2009:628). According to this conceptualization, while cultures vary in their specific definitions of womanhood ideals, people seeking abortions are assumed to be challenging gender essentialism (Kumar et al. 2009). Some scholars have critiqued this conceptualization of abortion stigma as too individualistic and urge those who study abortion to adopt a more expansive definition that considers abortion stigma as a phenomenon that manifests beyond the individual (Hessini 2014) and as part of a wider and more complex social process (Millar 2020).

This research examines abortion stigma among people who receive abortions in the context of a fatal fetal diagnosis. An empirical and theoretical puzzle emerged from a qualitative study of eighteen cisgender American women who were interviewed about their abortion experiences. The women in the study had highly desired pregnancies and were excited to become mothers. They also had severe fetal diagnoses – cases in which an infant would likely not survive long after birth. They unequivocally embraced motherhood and told highly sympathetic stories of maternal grief and loss. Even the most strident anti-abortion activist would be hard pressed to describe the behaviors of the women of this study as inferior to the ideals of womanhood. And yet, they still experienced abortion stigma within their social networks and the organizations and

institutions they had to navigate to obtain abortion care. This led to the question of why, despite an unambivalent embrace of motherhood ideals and fatal fetal diagnoses, did this group of women experience abortion stigma?

Upon review of the data and associated scholarly work in this area, I find that answering this question requires a theoretical re-orientation of abortion stigma away from definitions that rely on stigma as an individual attribute, and toward an appreciation of stigma as a multi-level social process embedded in existing structures of power and inequality (Millar 2020). This framework allows for an understanding of abortion stigma as multidimensional and variable, distributed alongside multiple structures of inequality. The participants in this study experienced some abortion stigma at the interpersonal level, but also at the meso-level of organizations, such as hospitals, the cultural level of mass discourses, and the structural level of state governments. Obtaining abortion care required navigating these stigmatized organizations and institutions and often produced individual-level stigma resulting in stigmatized behaviors and emotions. This stigma was exacerbated by existing inequality structures such as institutional racism and financial hardship.

The findings of this research are meaningful for a number of reasons. I suggest that a theoretical re-orientation of abortion stigma opens new pathways for scholarship and may inform the implementation and evaluation of interventions to decrease or eliminate abortion stigma. Furthermore, there are implications for the field of stigma research more broadly. I concur with previous scholars (e.g., Link and Phelan 2014; Tyler and Slater 2018) that stigma research must move beyond the limitations of post-Goffman conceptual understandings to develop research that investigates how stigma functions as a form of social power.

Abortion Stigma in Cases of Fetal Diagnosis

Recent advances in prenatal diagnostics allow for an increasing number of fetal anomalies to be diagnosed, and many women who receive a diagnosis of fetal anomaly decide to have abortions to end their pregnancies. While the vast majority of people who have abortions for fetal anomalies believe that their decision to terminate the pregnancy is right, the decision is frequently marked by grief, emotional distress, and poor psychological functioning (Keefe-Cooperman 2005; Kersting et al. 2005, 2009; Lafarge, Mitchell, and Fox 2014; Steinberg 2011; Wool 2011). Abortion in the context of a fetal anomaly is generally experienced differently from other abortions - abortion in the context of other circumstances does not harm patients' mental health (Biggs et al. 2014, 2017; Foster et al. 2015). The range of emotions and experiences generated by pregnancy termination for fetal anomalies goes beyond what Lafarge and colleagues call the "abortion paradigm" (Lafarge et al. 2014). It differs from other abortions in that most pregnancies are desired by the parents, differs from other perinatal losses which do not arise from a woman's decision, and differs from other types of bereavement in that the loss is stigmatized. (Lafarge et al. 2014).

The scholarly literature addressing abortion stigma among patients with fetal diagnoses is limited (Hanschmidt et al. 2018; Maguire et al. 2015; McCoyd 2010). Qualitative research suggests that stigma surrounding abortion for fetal abnormality leads to self-censorship and social isolation (Lafarge et al. 2014), and that the social isolation caused by abortion stigma intensifies the grieving process (Maguire et al. 2015). In one study, women reported being cut off from receiving social support due to their feeling that they could not be open about their abortions (McCoyd 2010). I identified only one quantitative study on the subject (Hanschmidt et al. 2018), which compared the scores reported by women having abortions for various reasons in

the original ILAS abortion stigma scale development study (Cockrill et al. 2013) to women having abortions for fetal anomalies in a German sample. The German fetal anomaly sample reported lower levels of abortion stigma from the American general sample. However, the two samples were very different in terms of political, cultural, and socio-legal context. In summary, it appears that people terminating pregnancies in cases of fetal diagnosis experience abortion stigma, at least to some extent, but that more empirical research is needed to fully understand the experiences of this group.

Conceptualizing Stigma

Understanding abortion stigma requires acquaintance with the scholarly debate surrounding how to conceptualize stigma more generally and the question of whether stigma is an individual attribute or a social process. Goffman first described stigma as an "attribute that is deeply discrediting" and that reduces the bearer "from a whole and usual person, to a tainted, discounted one." (Goffman 1963:3). Later scholars elaborated on how this attribute manifested as a specific typology of individual-level stigma. Scambler and Hopkins, scholars of epilepsy, introduced the conceptual difference between 'enacted' and 'felt' stigma: Enacted stigma referred to instances of discrimination against people on the grounds of their perceived unacceptability or inferiority, while felt stigma was the fear of enacted stigma and associated secrecy and shame (Scambler and Hopkins 1986). The authors argued that felt stigma is more common and causes more unhappiness and anxiety than enacted stigma. Steward and colleagues added a third type of individual-level stigma in their study of HIV-related stigma (Steward et al. 2008). They argued that 'internalized' stigma happened when the stigmatized person accepted the stigma as legitimate. The individual's self-concept became congruent with the stigmatizing responses of others, and so they accepted their discredited status as valid.

More recently, scholars have questioned whether Goffman's conceptualization of stigma was too simple or narrow. Link and Phelan expanded upon Goffman's definition to outline stigma as a social process of distinguishing and labelling human differences, linking labels to negative stereotypes, and separating the labelled person from the group, resulting in in status loss and discrimination (Link and Phelan 2001). Later they expanded on this model, elaborating on the power differential between the perpetrators and targets of stigma and explaining three functions of stigma and prejudice: exploitation and domination (keeping people down); norm enforcement (keeping people in); and disease avoidance (keeping people away) (Phelan, Link, and Dovidio 2008). They developed the concept of 'stigma power', a form of symbolic capital that helps stigmatizers achieve their goals in covert but powerful ways (Link and Phelan 2014).

Scambler argued that Goffman's legacy is that of a personal tragedy/deviance model of health-related stigma, which limits the focus of research to social interactionist analysis. Scambler argued that a post-Goffman sociology of stigma relations must accept that individuals are part of a more expansive nexus of social and structural contexts (Scambler 2009). Similarly, Parker and Aggleton critiqued how Goffman's approach to stigma had been used in HIV/AIDS research (Parker and Aggleton 2003). They posited that classifying stigma as a static characteristic or feature, or as an individualized social process (i.e., what some individuals "do" to other individuals) was overly simplistic. Herek highlighted the importance of structural-level stigma, maintaining that embedding stigma in society's institutions, including religion, the law, and medicine, ensures that stigmatized individuals have less power than the non-stigmatized (Herek 2009).

Tyler and Slater expanded on these critiques, contending that studies of stigma frequently neglect to address structural questions about the social and political function of stigma as a form

of power (Tyler and Slater 2018). They problematize an understanding of stigma as something that can be ameliorated either through education about particular stigmatized conditions or by "schooling the stigmatized (729)" to better manage their differences. Tyler and Slater developed a Foucauldian conceptualization of stigma as a social process linked to the reproduction of power, inequality, and exclusion. They contextualize the concept of stigma power within an understanding of power as "motivated by institutions and states within a broader political economy of neoliberal capitalist accumulation" (Tyler and Slater 2018:16).

Abortion Stigma as a Social Process

Kumar and colleagues (Kumar et al. 2009) developed an operational definition of abortion stigma informed by Goffman's theory. The authors suggested abortion stigma is a social phenomenon that is constructed and reproduced locally through various pathways and defines abortion stigma as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood (628)." They maintain that a person who seeks an abortion is inadvertently challenging widely held assumptions about the essential nature of women. Others have discussed the role of non-maternal aspects of abortion stigma: its status as "dirty work" (Joffe 1986), grotesque (Halfmann and Young 2010), or disgusting (Kumar 2018); its association with death (Kumar 2013); the pervasive ideology of fetal personhood (Cockrill and Hessini 2014; Hoggart 2017; Norris et al. 2011), religion (Hoggart 2017; Sorhaindo et al. 2014), and anti-abortion discourses (Cockrill and Hessini 2014; Norris et al. 2011).

A number of empirical studies use an individual-level conceptualization of abortion stigma to inform their questions and analysis. These studies have explored personal experiences of abortion stigma in the United states and abroad (Astbury-Ward, Parry, and Carnwell 2012;

Cockrill et al. 2013; Cockrill and Nack 2013; Cowan 2017; Major 1999; Shellenberg et al. 2011; Shellenberg and Tsui 2012; Sorhaindo et al. 2014) and the psychosocial consequences of abortion stigma for patients (Astbury-Ward et al. 2012; Biggs, Brown, and Foster 2020; Cockrill et al. 2013; Cockrill and Nack 2013; Herold, Kimport, and Cockrill 2015; Shellenberg et al. 2011; Shellenberg and Tsui 2012). Notably, interventions to lessen abortion stigma have focused on changing individual-level attitudes toward people who have abortions or to reduce felt and internalized stigma among people with an abortion history (Belfrage, Ortíz Ramírez, and Sorhaindo 2020; Biggs et al. 2020; Littman, Zarcadoolas, and Jacobs 2009; Sorhaindo and Loi 2022), despite the existence of multi-level interventions to interrupt the process of health stigma (Stangl et al. 2019).

In a systematic review of abortion stigma published in 2016, the authors found that studies did not differentiate among reasons women gave for their abortion, which might have masked variations in experiences of abortion stigma (Hanschmidt et al. 2016). Knowing that some reasons for having an abortion are more socially acceptable than others, women's perception of stigmatization from others might also depend on the reason why they choose to terminate their pregnancy.

Some scholars have begun to critique and/or expand upon the interactional definition of abortion stigma used by most scholars. One of the authors of the original paper later explicated a framework for understanding abortion stigma as a multi-level model (Hessini 2014). This model includes the individual level, community level, the organizational/institutional level, the government/structural level, and framing discourses/mass culture (Hessini 2014). The model explicates a number of empirical questions to be answered about each level of stigma. Yet, almost a decade later, the vast majority of abortion stigma scholarship still focuses on individual-

level stigma. Efforts to reduce abortion stigma could draw upon a broader health stigma framework and benefit from shared concepts, tools, indicators and outcomes (Stangl et al. 2019).

Most recently, Millar advocated for a theoretical re-orientation of abortion stigma away from Goffman to "a Foucauldian appreciation of the power relations that are reproduced and legitimated in normative modes of difference" (Millar 2020:1). Millar argues that abortion stigma is multidimensional and variable, distributed alongside multiple structures of inequality. The framing of abortion stigma as an individual phenomenon fails to capture this complexity and may serve to reinforce an "autonomous neoliberal subject, erasing the forms of inequality that position us differentially in relation to reproductive choices and outcomes" (Millar 2020:6). Millar argues that this framework allows for the study of the stratification of stigma and its material effects as well as an examination of situations in which individuals resist or reject stigma. This framework is supported by research that finds that when women talk about their abortions they actively construct positive identities despite being subjected to stigma (Beynon-Jones 2017; Combellick 2023).

In summary, using a Goffman style approach to define abortion stigma may be limiting our understanding of the phenomenon. A broadened understanding of abortion stigma as a multi-level process embedded in structures of power and inequality may allow for a more sophisticated appreciation for how it operates in society and aligns with more contemporary social theory. The present research explores the experience of abortion for fatal fetal indications through this theoretical lens.

Methods

The data for this analysis were generated in the course of a larger study of perinatal palliative care to support people terminating pregnancies in cases of life-limiting fetal anomalies

(Mastey et al. 2023). This qualitative study aimed to interview a diverse group of patients throughout the United States in the weeks following their abortions. Our study team conducted semi-structured interviews with eighteen cisgender women. The University of California, Davis Institutional Review Board approved the study and all study documents.

Potential participants were identified and referred by their abortion providers. They were approached if they were age 18 or older, English-speaking, and choosing to end a pregnancy with one or more life-limiting fetal conditions. While no consensus exists within the perinatal literature on what diagnoses are always considered "life-limiting", the most straightforward definition has been described as "a condition incompatible with survival beyond the newborn period" (Wilkinson et al. 2012). For this study, diagnoses were classified as "life-limiting" if the condition was described as "lethal" in the medical literature (Wilkinson et al. 2012) or if survival past the neonatal period would require continuous and often futile advanced medical intervention. We contacted participants to ask if they were interested in participating in an interview about their experience from the time of fetal diagnosis to the weeks after the abortion. For those who met entry criteria and gave informed consent, we scheduled the interview two to eight weeks post-abortion. We conducted interviews between April 2020 and March 2021. Due to COVID-19 restrictions as well as geographic distance, we conducted all interviews via telephone. Interviews were audio recorded and transcribed verbatim by a professional transcriptionist.

Knowing that structural conditions affect individual experience, information from the Guttmacher Institute was used to target states with varying levels of abortion access. The Institute categorizes each of the 50 states as *supportive, middle ground, or hostile* to abortion rights, and we sought representation from all three types (Guttmacher Institute 2019). The

abortion political landscape has changed dramatically since the Dobbs decision that no longer guarantees the right to legal abortion in the United States. However, the categories used for this research used the Guttmacher Institute's classifications from 2019. The four states of recruitment were California (supportive), Nevada (middle ground), Indiana (hostile), and Missouri (hostile).

The in-depth interviews covered women's general personal and social experiences of abortion. The semi-structured interview guide covered topics such as pregnancy and fetal diagnosis experiences, the process of labor induction or surgery, social support, and emotions experienced since the abortion. We also asked participants how they felt about abortion more generally and whether and to what extent the current experience changed their attitudes about abortion and the people who obtain them. We continued recruitment until thematic saturation was reached for the original research question.

I analyzed the data using QSR NVivo 12 software. My analysis was theoretically informed by the abductive approach to qualitative analysis based on "the ability to recognize a finding as surprising in light of existing theories" (Timmermans and Tavory 2012:169). The recursive and iterative nature of abductive analysis allows the analyst to look for good and poor "fits" between the data and any number of existing theories. Instead of theories emerging from data as in traditional grounded theory, existing theoretical concepts can be further developed or revised based on puzzling empirical materials. I subjected the data to multiple rounds of coding. In open coding, I identified any and all themes of interest (e.g., grief and loss, social support, feelings about abortion) to begin specifying the points of view of the subjects and how they described and evaluated their situations and activities. Participants were not asked directly about abortion stigma; the topic emerged as a recurrent theme in open coding and I elected to explore this new research question in second and higher rounds of focused coding. In focused coding, I

re-read and re-coded stories after having decided on core categories and the most relevant theoretical work (e.g., levels of stigma, shame and judgement from others, exacerbating factors). Throughout the coding process, I wrote reflections in the form of analytic memos about salient themes and topics and integrative memos that further elaborated, extended, and integrated themes. These memos served as the starting point for the text of the article.

Findings

Description of sample

Selected demographic and reproductive characteristics of the sample are summarized in **Table 1**. All participants identified as cisgender women. The participants' ages ranged from 19-40 with a mean age of 32. Half of the sample (n=9) had previously given birth. Thirteen out of eighteen participants described their pregnancies as planned; all participants described their pregnancies as desired/wanted. Thirteen participants described their race as white, two as black, one as indigenous, and two as mixed race. Four out of eighteen identified their ethnicity as Hispanic.

Most women were between 20 and 23 weeks pregnant at the time of their abortions (n=16). The distribution of the states of referral was not uniform due to unpreventable local recruitment barriers. There were fewer participants from states categorized as middle-ground (n=1) compared with supportive (n=10) and hostile (n=7). Interviews took place an average of 28 days after the abortion.

Contextual Observations: Identification with Ideal Motherhood

The women in this study identified as mothers, identified their fetus' as their children, and whole-heartedly embraced the ideals of motherhood. Nearly universally, participants began developing personal motherhood identities early in pregnancy and by the time of their diagnosis,

the pregnant women had taken concrete steps to prepare for the baby's arrival. This involved planning for the future (e.g., moving to a larger house, planning a baby shower), purchasing/acquiring material items for the baby, and imagining a future life with the baby. Passing milestones such as the first trimester or the first round of genetic testing allowed the expectant women to build confidence in their paths to becoming mothers. By the time they received their diagnoses mid-pregnancy, they had fully adopted motherhood identities. The interruption of this identity caused significant emotional difficulty associated with the diagnosis and the abortion.

Michelle is a 32 year-old white woman from California who had been expecting her first child. Michelle described her grief in response to losing the motherhood identity she had developed:

> "It's just hard. When you're just like looking forward to something so much and when you feel like you'll have the opportunity to be a mom and give-- I just wanted to be able to provide them love and care that I didn't have from my mom. And I just knew that I had a lot of love to give. That's all."

Later in the interview Michelle mentions that deciding to have the abortion made her feel like she was a bad person. When asked why, she responded:

> "I don't know. It just seems like even though I know her situation was obviously not something that she can come up from, I just felt like it was me, in other words, giving up on her in a way. And that is the hardest part even if you know that she's not going to make it. It's so hard as a mom."

Michelle recognized that her daughter's diagnosis was fatal, yet she felt like, as a mother, the decision to end her daughter's life meant giving up on her. Carrie, a 40 year-old white mother of one from Indiana, had a slightly different perspective, where she decided that in her role as the fetus' mother, it was her obligation to end the pregnancy to take on the suffering for herself:

> Interviewer: "You were mentioning suffering and [not being promised no suffering?]. Did that thought kind of play a role in deciding to stop the pregnancy?"

> Carrie: "Yes. Because I could take on the suffering and then my daughter didn't have to suffer."

Jessica, a 33 year-old white mother of one from California, similarly talked about how ending the pregnancy would relieve the child of any suffering after learning about what their life would be like after the birth:

> "And, as hard as it is to hear, nobody, especially my baby, should not have to live like that. And what [the doctor] said that just resonated with us is 'there's mercy in not making her have to try'…. there's mercy in not having her try to do these things that she wasn't made to do. And she mattered and, because she matters, we chose to not make her have to suffer or hurt and not to be able to tell us that she hurts, and she mattered. She matters too much."

Other participants echoed the sentiment that they developed a motherhood bond with their fetus during pregnancy and that was what made the diagnosis, and the subsequent decision to end the pregnancy, so painful:

> "And over time, when you carry the child long enough you grow this bond with him, and that's the bond that grew with my son."
> -- Tameka, 19 years old, black, California

> Amelia: "I've lost a sibling before, yeah."
> Interviewer: "How does this compare to that?"
> Amelia: "Oh, it's totally different. And it doesn't mean that I didn't love my sibling or anything, but I feel like I lost a piece of me, losing [my baby]."
> –36 years old, multi-racial, California

This context, that women had personally and socially constructed a motherhood identity before the diagnosis, is significant given the common definition of abortion stigma as a rejection of femininity and motherhood (Kumar et al. 2009).

Social Support and Individual-Level Stigma

Most participants received positive social support from the friends and family they chose to disclose their abortions to. Some participants were relieved and even surprised to receive this support from loved ones who were known to be deeply religious or hold anti-abortion views.

Jamie, a 35 year-old white mother of one from Missouri, revealed that her 'pro-life' friend supported her decision and even expanded her views on abortion after learning about her diagnosis:

> "I have a friend …who had voted for Trump in the first go around…and her rationale was, 'Well, the only reason why I voted for him is because he's pro-life'… and finally, I just texted her and it was like, 'Look, man, I'm going through the hardest thing in my life and I can't talk to you about it because I know where you stand on this issue.' And to which she responded, 'What you're going through is unreal. And I would hope that you would know that I am your friend and I'm here. And whatever I thought I knew about life, I didn't know. And I'm sorry that you would feel that you couldn't come to me because of things I've said before. I just didn't know.' And we've talked at length about it since then. And she's just like, 'I just didn't know this is the way it could be for people.'"

Similarly, Carrie from Indiana received encouragement from her parents, who despite being deeply religious, supported her decision:

> People were really supportive on the whole. My parents are both extremely fundamentalist and religious and anti-abortion. And I honestly had no idea what their reaction was going to be… When they found out the severity of what was happening, they both were 100% supportive of whatever we would decide, which was honestly shocking.

In these cases, the reason for the participant's abortion (a fatal fetal diagnosis) appeared to insulate them from the interpersonal stigma they may have otherwise faced from these significant others.

In addition to family and friends, participants generally described positive and affirming experiences with health care providers, including their prenatal care team, specialists, and abortion providers. Marisa, a 22 year-old Latinx woman from California spoke about the surprise and relief she felt when she had nonjudgmental interactions with her health care team:

> "Actually, everyone was really friendly. I was kind of afraid that they might think I was doing something wrong, but they were actually very friendly."

Lauren, a 32 year-old white woman from California, described similar positive interactions with

her health care providers, in spite of concerns that she might face anti-abortion stigma from them.

> "I think I just kind of want to reiterate how wonderful the staff were. Just the surgeons and the nurses and the doctors, everyone was so kind. And it's an abortion. It's a late-term abortion. And that can make people really upset. And there wasn't any bias or anything like that. Everyone just, I don't know. I just…we both felt very well cared for. And we really appreciate it. And so, that really helped us a lot."

Despite overall strong social support, some participants also experienced individual-level abortion stigma. Emma, a 33 year-old white woman from California, described her late realization that the procedure she was having was an "abortion" and described the stigma she felt when the word was used:

> "I think there were a few things really like, when I was going through all of the paperwork, I didn't realize at that time that it was an abortion that I was having an abortion, you know, and there's so much like stigma around the word and, you know, I'm not someone who would ever get pregnant and have an abortion… if there wasn't a medical reason. You know, kind of hearing that was, you know, it's just difficult that part. I just didn't know until that moment - I didn't realize until that moment."

Emma's slow realization and identification with abortion was personally distressing to her, despite a supportive health care and family environment and supportive political environment.

A small number of participants had already internalized abortion stigma before the need for the termination. For Elena, a 29 year-old Hispanic woman from California, she and her partner's internalized abortion stigma contributed to the emotional difficulty they both experienced around the decision:

> Interviewer: "And when they told you that most women choose to terminate the pregnancy in this circumstance, what was that-- hearing that like?"
> Elena: "That was rough. My husband and I are both Christian and grew up thinking abortion is bad. We don't do that. And while we've never judged people for making that decision, we also never thought it would be a decision that we would have to make. So that was really difficult to realize that because of this, we were going to be that statistic as well."

In a small number of cases, participants were targeted with direct, face-to-face stigma from interpersonal encounters, also called enacted stigma (Herek 2009; Scambler and Hopkins 1986; Steward et al. 2008). A friend's lack of support for her abortion decision was upsetting for Lauren from California, who expressed anger that another person was trying to persuade her from their own religious perspective.

> Lauren: "Everyone was really shocked because they weren't expecting us to terminate. I think they were trying to be supportive without sharing how they truly felt about it. One of my friends… they were really against us terminating."
> Interviewer: "How did that make you feel, hearing about that?"
> Lauren: "It made me kind of angry because every situation is different. And I'm not religious, and I don't really believe in all of that, and they are, and I thought-- I don't know. I guess I was just angry about everything."

Jamie from Missouri described having a supportive maternal-fetal medicine specialist in a politically hostile state. However, her provider's well-intentioned advice still enacted stigma upon Jamie who was made to feel that she needed to keep her abortion a secret:

> "And it was -- 'You don't have to tell people the full story. It's no one's business.' And I know she was trying to be supportive in saying that. I get that. But then it just, it makes you feel like you just did something really wrong… I don't think it came from any judgment from her. She wasn't being mean or rude or anything like that. I think it came from a caring place. But it just leaves this feeling of, you just did something really wrong. that they don't think is wrong, but everyone else thinks it's wrong."

Felt stigma, identified in previous literature as the fear of discrimination or condemnation based on stigma and/or a feeling of shame associated with stigma (Herek 2009; Scambler and Hopkins 1986; Steward et al. 2008), is commonly reported among the general population of people receiving abortions (Cockrill et al. 2013; Cockrill and Nack 2013). This type of individual-level stigma was common among this sample of women as well. In some cases, felt stigma prevented participants from disclosing their abortion experiences to a wider audience. Ashley, 25 year-old white woman from Indiana, was one of several participants who described being very deliberate with what they posted on social media regarding the abortion:

> "I told you earlier that we did post the news that we were pregnant to Facebook. So, I decided that we needed to post that we lost the baby, just so, I didn't want people asking when we're out in public. So, I posted a very vague post, just saying that we lost the baby. I did not put any details about what we chose to do, just because I feel like there probably are people out there that would hold some judgment against us and people that do see black and white."

Elizabeth, a 30 year-old white mother of one from Indiana, was similarly measured about what parts of her experience she was willing to share with others. She said:

> We honestly haven't told anybody but our parents the whole story. Everybody else just knows we had a miscarriage because I don't want to hear anybody's opinion. That's [inaudible] but it wasn't your life. It wasn't your baby. You didn't have to live through that, or you wouldn't have had to live through that had she made it that far. So, it's not up to you."

In response to felt stigma, both Ashley and Elizabeth used partial secrecy to mitigate what they felt would be shame and judgement from others.

In summary, the women of this study had experiences and attitudes that aligned well with the norms of ideal womanhood. They had planned and/or wanted pregnancies, they felt bonded to their fetuses during pregnancy, and they had well-developed motherhood identities. Upon discovering their fetuses had anomalies that were inconsistent with life after birth, the women did what they described as being in the best interests of the potential child by eliminating their suffering. They described their own experiences of grief after losing the potential child similarly to other bereaved parents. There was no evidence that these participants rejected idealized motherhood; in fact, they wholly embraced it. However, they were not invulnerable from experiencing abortion stigma. The next sections of this paper explore how and why this was the case, and in the process provides insights into how to conceptualize abortion stigma in future scholarship.

Participants' experiences of individual-level stigma were not explained by theorizing stigma as an individual attribute but may be partially explained by expanding the

conceptualization of abortion stigma beyond the interpersonal level to meso- and macro-levels of analysis. For this next analysis I look at abortion stigma at three levels conceptualized by Hessini (2014): 1) Organizational/institutional, 2) framing discourses/mass culture, and 3) government/structural.

Organizational/Institutional stigma: Encounters with Hospitals

Stigma was embedded in the organizations participants were forced to navigate in order to receive abortion care. Understanding organizational stigma requires an analysis of the health care systems where the women received care. Many received prenatal care, diagnosis, and (sometimes) their abortions within a larger hospital system, each with its own norms, regulations, and policies. As forward facing staff, health care providers acted as agents of their larger health care organization. Abortion stigma affected the communication between patients and their health care providers, particularly in cases where it appeared the hospital restricted what providers could discuss with their patients. This sometimes made it difficult to have even basic informational clarity from health care providers. For example, Ashley from Indiana received her diagnosis from a provider in a Catholic hospital, and she believed that the doctor was made to withhold information about the fetus' chances of survival if carried to term:

> "You could just tell from the way the doctor was speaking to us. He was like, 'Whatever you choose to do, my heart is with you.' But you could just tell by the way he was looking at us, I think he knew that the baby wasn't going to live. And I mean obviously there are Catholics there too, so they can't actually be like, 'I'd really recommend the abortion.' But that's basically the option they gave us."

Anna, a 40 year-old mother of one from Indiana, told a story about her inability to get any information from her health care providers about the need for abortion. She also believed that this was because they were prohibited by their organization to do so:

> "So, with all of this little information that they gave me, they gave me the hope that the baby can be healthy because as I understand, they actually may be not even allowed to

> talk about abortions since it's prohibited in our state [at later gestations] … They probably didn't even know what to do with this. Because when I emailed my doctor saying, 'hey, how can I make an abortion [appointment]?' he emailed me back saying, 'oh, I'm sorry for all that you're going through.' That's all his answer was. He didn't even say anything about how to do that because, like I said, I have a suspicion they are not allowed to talk about this."

Later Anna spoke more about the diagnosis and her belief that she was misled by her providers:

> "I don't know what their plan was. I think what she said is, 'we don't know how severe it's going to be until [after] the baby's born.' Something like that she told me. I'm like, okay, but then I guess it wasn't true because if the brain was already affected, that was already severe enough. I didn't understand how-- like I said, they were trying to cover this up for me and make it kind of look not as bad, but I don't think that's a good thing to do in situations like that. You need to know the truth."

Anna's and Ashley's experiences illustrate how when stigma is embedded within a health care organization, the consequences can be confusion, lack of information, and even misinformation, leading to adverse health care experiences with serious implications for ethics and informed consent.

Jamie's experience in Missouri involved an internal ethics board that made decisions about whether or not any particular abortion was allowed to be performed within the hospital. She described her feelings after finding out the ethics board rejected her request despite her serious diagnosis:

> It was really hard, like I said, it was a huge blow once I found out that my hospital here was out of the question, and then to find out that was because an ethics board decided… it wasn't ethical. Because then it made me feel like I wasn't ethical…. And I just felt like, 'Can I go talk to them? Who is making these decisions? You're not here. You're not in this. Do you know the ins and outs of this?'… It just was unsettling. Like I said, it just made me feel like then we're making the wrong choice here… But I have a [living] son that counts on me that I have to be here for too. And be semi-okay for. And those are things that the ethics boards don't take into consideration. So, I can't necessarily say that they shouldn't be there, but at the same time, it's 'how do you make these life altering decisions when you don't know anything about the life that you're deciding upon?'"

Jamie's experience illustrates how stigmatizing practices within an organization can be associated with shame about the abortion and even second-guessing of a decision. Despite

having a strong ethical argument in support of her decision (that carrying the pregnancy to term would interfere with her ability to parent an existing child), Jamie questioned her own identity as an ethical person after being regarded as unethical by the invisible agents of a powerful organization. The organizational stigma seemingly transferred to her as felt stigma. This process will be analyzed further in the following sections.

Cultural Stigma: Encounters with Misinformation and Missing Information

The secrecy and silence produced by abortion stigma leaves a dearth of accurate information on the internet, where many people search for information about health topics. Often, where there is a lack of information online, gaps in knowledge are filled in with misinformation, which can make researching medical options difficult. In the case of abortion, there is evidence of online misinformation about the safety and ethics of abortion produced by well-resourced anti-abortion organizations (Dodge et al. 2018; Han et al. 2020). Elena from California spoke about accidently coming across such a group when trying to gather information about her abortion procedure. She remarked:

> "There's not very much readily available information from hospitals. And so that was tough because you would click on one [website] because you're like, 'oh this looks informative.' And then it would end up being an anti-abortion site calling us murderers and saying we're going to hell and all of these insane things. We had to kind of get offline for a while. But it was definitely frustrating not being able to find any more information about what a second trimester termination would look like from a hospital site or the CDC or something like that."

Elena's experience demonstrates how abortion stigma can leave gaps in information, and that savvy anti-abortion groups are skilled at filling in those gaps with information that produces even more stigma.

Missing information and misinformation, along with general stigma about abortion providers as unskilled, duplicitous, or unsafe, led to (often unnecessary) fear of the abortion

procedure itself. Several participants described concerns about being able to access safe abortions at some point in their experiences:

> "And so, I just hate to think if that was something we had to do, if we had to go out of state and go to a sketchy clinic or something, that's not something I would want to do."
> --Ashley (Indiana)

> "[After the procedure] I was happy, especially to see my mom because, yeah, I was really scared of like not waking up [from] the procedure, like something bad happening, so I was really excited to see my mom."
> --Marisa (California)

> "It went better than I thought. Because the day before I went in, I'm thinking, 'Is something going to happen that's going to make me and my son pass away at the same time?' or, 'Am I going to wake up?' or, 'Who's going to be there?' And it boggled my mind to the point where I couldn't sleep at all.
> --Tameka (California)

Abortion stigma in the broader culture of the United States promotes myths about abortion as dangerous. Ashley's fears of ending up at a "sketchy clinic" and Marisa's and Tameka's fears of "something bad happening" stem directly from these myths. This process exemplifies how, even without being labelled with the individual attribute of abortion stigma, the stigma from broader levels of society can shape an individual's experience.

Structural Stigma: Encounters with the State

At its most structural level, abortion stigma becomes enshrined and institutionalized in government laws, policies, and regulations. Structural-level stigma negatively affected participants recruited from politically hostile states, who were already suffering with grief, loss, and some individual-level abortion stigma. Many women described an affective process whereby state-level abortion restrictions, rooted in abortion stigma, became internalized as feelings of self-stigma or shame around the abortion itself. Jamie from Missouri described feelings of shame around being forced to travel out of state to receive her abortion:

> "First of all, to even have to go out of state, makes you feel like you're doing something wrong, you have to find somewhere where it's deemed okay what you're doing because the majority of the world thinks it's wrong or whatever."

Later in the interview, Jamie re-visited these humiliating feelings:

> "Worst case scenario, we'll have to…go out of state. And I don't know why the feeling of having to go out of state, it felt so shameful, like, 'I'm leaving to go, god, go terminate my child.'"

Several participants described feeling stigmatized by the state-mandated informed consent process, which included shameful language about abortion. Colette, a 19 year-old white woman from Indiana stated:

> "The paperwork was brutal, in general, for the state. We sat there and read, 'This is what you're doing, and you're --- like the lethal and the non-lethal and all of these things we were told, like what we're doing is justified or not and whatever. [It] was just a lot, I think, to process, in general, for the paperwork. And then it's called an abortion, regardless. I guess that's how-- I guess that's the medical term for it, and I think-- I guess I don't understand it, but I guess I can say I understand the terminology because that's the term."

Colette reported emotional difficulty after reading language that she found to be judgmental. She also had difficulty with the word "abortion" being used to describe a procedure that felt, in her experience, different. Simply reading the word bothered Colette, suggesting how deeply embedded in stigma the word "abortion" is. Carrie from Indiana described similar feelings of discomfort with the state-mandated paperwork she was made to read and sign before her abortion:

> "I don't have a word to describe it other than awful. The paperwork itself was absolutely ridiculous. And meant to basically shame anyone who's having a pregnancy termination. And it was really bad. First of all, it was a wanted pregnancy. And so, I felt like all this paperwork was being provided for me that didn't even apply to me. And I felt like the doctor's hands were tied because they have this law that it's not up to them to make sense of it. It's up to them to not lose their license. So, it's awful. It continues to haunt me, to be honest."

Jamie's experience of the informed consent process involved receiving false information about

the mental health effects of abortion:

> "They have to go through all of that information with you and talk about the long term psychological effects and how this harms you. And they try to do their best to be like, 'This is what we have to do because of state law. But you're doing what you need to do.' But even that kind of language is hard because it just makes it feel like it's something you're making happen."

She continued:

> "And then they have to have their attending physician come in and go over all of it again. And that's so traumatic and you're signing off on all this paperwork. And then we do the same thing for the labor and induction, and then somebody comes in and goes over all of it again and you sign off. 'Sign my name to go to hell now.'"

Colette's, Carrie's, and Jamie's experiences with state informed consent policies illustrate how powerful individuals and groups produce and reproduce abortion stigma by embedding it within laws and policies. Structural-level stigma affects all people seeking abortion in the state, regardless of whether each individual displays attributes that suggest social deviance.

Indiana has a unique law that when an abortion is performed after 20 weeks, the person who has the abortion must take care of the fetal remains in the same way as they would a baby who dies. This involves making funeral arrangements for fetal remains, which for these participants caused emotional distress as well as administrative and financial burdens. Ashley spoke about the material burdens of being forced to deal with a funeral home because her gestation at the time of the abortion was beyond 20 weeks.

> "I mean, if we would've been under 20 weeks, the hospital would have taken care of it, and that's what I would have-- I would have just let them take care of it because, for one, that's another financial expense… And that's one thing I wish that we could've caught this sooner [sic] because the funeral home thing was just one more thing that we had to take care of… you have to go sign paperwork to sign off on the [cremation] and all this sort of stuff."

Elizabeth discussed how after being forced to make a distressing decision about her abortion, she wanted the experience to be over as quickly as possible. Yet was made to comply with Indiana's

funeral procedures law instead:

> "So, I, again, in my mind, when she was in my belly she was perfect, and to choose to not continue with the pregnancy I just wanted it to be over. That sounds really bad, but I wanted it to be over. So, to have to deal with the funeral home afterward just sucked because you had to make the arrangements, you then have to pay, you have to go pick her up... So, to extend that afterward [was] just not my favorite."

Ashley and Elizabeth described their negative experiences, which already included a devastating fetal diagnosis, a stressful decision-making period, and the medical requirements of an abortion, being unnecessarily prolonged and exacerbated by the funeral law. The law, which did not serve any health or sanitation purpose, seemed designed solely for punitive reasons, to make the experience of later abortion more difficult for Indianans.

In a concluding passage, Jamie was able to illuminate the cumulative effects of multiple Missouri abortion restrictions and the process by which they affected her abortion experience. She points to the power dynamics in play when policy makers use laws to purposefully enact stigma on women seeking abortions:

> "And I think back to when they were-- part of what they have to go over with you is that severe psychological harm can come to you from having an abortion. And I just want to be like, 'Yeah, because you guys design it that way.' Not the doctors, but the policy makers in Missouri absolutely make it so that it hurts as much as it possibly can. And every step is so f---ing painful for something that already is super painful…. There was nothing peaceful or at peace with any of that. Nothing. And I feel if more was done to not make it so abrasive, it may not be so damaging… I would give anything to go back and be able to make her be alive and make her be okay. But I couldn't. But then you didn't have to make it so bad… It's just, there's got to be stuff that can be done to make it just not so harsh."

The experiences of the women in this study, including Jamie's articulate description above, demonstrate how meso- and macro-level stigma helped produce the experience of individual-level stigma. Powerful institutions and organizations manipulate the feelings of less powerful individuals so that they are subjected to fear, shame, confusion, and discrimination, regardless of their individual circumstances and behavior.

Stigma, Social Location, and Social Inequality

Scholars have theorized that reimagining stigma as a multi-level social process includes understanding stigma as used by individuals, communities, and the state to produce and reproduce existing social inequalities (Tyler and Slater 2018). On the whole, this was a highly privileged sample of women who had access to significant forms of social capital and economic power. They were able to leverage that power to mitigate some of the worst impacts of stigma. Shania's story offers a glimpse into how diminished social and economic power exacerbated abortion stigma and made its consequences more difficult to manage. Shania, a twenty-nine year old indigenous mother of one from Missouri, described having limited options for where she could receive abortion care and being forced to seek care at an organization known for racism and discrimination:

> Shania: "And then at this particular hospital… it's known to have very, very racist and prejudiced processes towards women of color. It's a hospital that you don't really hear good things about when it comes to people of color and indigenous backgrounds. It's a hospital that I never wanted to deal with…. So, I'm also feeling fear in a sense of am I going even be able to have the best care. And so, it was a-- it was even more [inaudible] of the fact that this is the only hospital that I can really go through to get the care that I need."
> ….
> Interviewer: "Did you share with them specifically that-- the fear of being a woman of color in the medical system?"
> Shania: "I mean, yeah, I did mention my experience with [the hospital]. I will say the people I spoke with in my experience are well aware of the history-- the racial history with [the hospital] and women of color and people of indigenous backgrounds."

The limited number of abortion providers in hostile states is a phenomenon that itself is rooted in abortion stigma – fewer providers in these areas feel comfortable providing abortions and fewer institutions are willing to allow abortions to be performed (Freedman 2010). This lack of options made Shania more vulnerable to institutional racism.

Shania also experienced a lack of support from her workplace in regard to the abortion.

She was not given as much time off as she needed to emotionally process her experience and was unable to afford the economic expense and risk to her employment to take extra time off. She describes:

> "It was a lot to handle so, I feel like I probably could've taken off work sooner if I really was adamant about it, but I really didn't want to push myself to potentially lose my job or forfeit any fair amount of pay that I could receive before just leaving. Because if I probably would've taken off before the surgery had happened, I most likely probably wouldn't have been able to get… maternity leave. So…I still had to work."

She continued to describe the additional distress of being required to work before having the opportunity to heal from a stigmatizing and traumatic event:

> "Not having to worry about working… probably could've made it easier. Because me finding out information like that, it's kind of unfair to just expect somebody to just work through it…I would say if there was some kind of…support like… 'Hey, we have this emotional support disability for you. You've endured something really traumatic. Here, here's your allotted time off on top of whatever else you may have…'"

Shania's experience at work is indicative of a rigid system of employment that is ill-equipped to handle employees' nuanced experiences of reproductive loss. Her management of abortion stigma was exacerbated by the structural conditions she was subjected to as a working-class woman of color. Shania's case illustrates how stigma reproduces existing inequalities.

Discussion

This study investigated the experiences of abortion stigma among a unique group, cisgender women who have abortions for severe fetal anomalies. This group of women had highly desired pregnancies and told sympathetic narratives of reproductive loss. They embodied and expressed motherhood identities and maternal-fetal bonding that matched social expectations of pregnant women under a framework of ideal motherhood. Their narratives directly conflicted with a definition of abortion stigma as an attribute that would mark them as inferior to the ideals of womanhood (Kumar et al. 2009). However, a multi-level analysis involving a framework of

stigma as a social process revealed that the participants did indeed experience and suffer the consequences of abortion stigma.

In this study, stigma was experienced beyond the interactional level. Organizations and institutions, controlled by powerful individuals and social groups, produced and reproduced stigma. A "political economy of stigma" (Tyler and Slater 2018:736) was observed: macro-level structures and forces shaped the experience of abortion stigma and shaped its consequences. Examples included hospital administrations restricting what and how much information their providers were allowed to give about diagnoses and termination options, and a hospital ethics board turning down a patient's abortion request. Likewise, stigma at the level of culture/mass discourses left a vacuum of information about abortion, allowing anti-abortion groups to spread misinformation online, leading to safety fears and confusion about diagnoses. State abortion laws, i.e., structural-level stigma, regulated and complicated informed consent processes and funeral procedures resulting in feelings of internalized stigma and shame among participants. State-controlled gestational age limits and insurance regulations produced not only shameful emotions but material burdens as well. While participants often described how these issues affected them at the personal level (e.g., an abortion restriction making them feel ashamed, as if they were doing something wrong), these stigmatizing experiences were in fact manipulated by powerful social forces as a form of domination and a driver of the reproduction of social inequality. These meso- and macro-level forces "deliberately activate[d] stigma to 'nudge' people into desired patterns of behavior" (Tyler and Slater 2018:732).

It is important to consider not only the ways stigma is produced at each level of social analysis but also the interactions between levels. Individual-level stigma – marked most often in this study by shame and/or compelled secrecy - is the most visible form of stigma but is often the

proverbial tip of the underground iceberg. Higher level processes of stigma, controlled by powerful individuals, institutions, and social groups produce stigma, which is then expressed and internalized individually. In other words, the effects of stigma power become embodied by less powerful individuals. And importantly, individuals all have some capacity to resist that power/stigma, although the strength of this capacity often depends on social location and other social characteristics.

Often stigma manifests not only by what stigmatizers do, but also by a lack of action by the institutions that have the power to mitigate it. It is notable that the narratives in this study lack any mention of government intervention in support of abortion access. One can imagine that if abortion stigma were absent at the federal level there would be readily available and transparent information about prenatal diagnoses and termination options on the CDC and other federal websites, diverting internet traffic from sites created by anti-abortion groups. If congress passed bills ensuring access to abortion and codifying abortion rights into federal law, the participants in this study would be less likely to experience the emotional and material difficulty of navigating state-level restrictions. Stigma breeds not only action on the part of stigmatizers, but inaction on the part of individuals and groups unwilling to intervene in stigmatizing processes.

Interpretative methods of social inquiry require a critical analysis of alternative explanations for social phenomena. There may be other reasons why this sample experienced higher levels of stigma that current theoretical frameworks would suggest. Due to how and when they received their fetal diagnoses, this sample accessed abortions at later gestations than average for the United States. It is possible that the stigma they experienced was reflective of their later gestations and that the strength of the stigma of later abortion is more powerful than the stigma

of having an abortion for non-medical reasons. Furthermore, this group had less control over secrecy and the disclosure of the abortion to others, having already disclosed the pregnancy to most of their social network, needing to navigate gestation-related abortion restrictions, and the need for more complex medical interventions for later pregnancies. Secrecy is a widely documented stigma-management strategy that this unique sample had diminished access to. Further research is needed to unpack the relative impacts of these different social and medical circumstances; however, that need does not preclude or contradict a theoretical re-orientation toward stigma as a multi-level social process.

These case findings have implications for abortion stigma more generally. The vast majority of people having so-called "elective abortions" (Janiak 2016)" or "ordinary abortions" (Watson 2018) do need to contend with social accusations of failure to embrace feminine ideals. However, the expression of that stigma through internalized guilt or shame, secrecy, or direct discrimination may be exacerbated and compounded by meso- and macro-level stigma as they navigate health care organizations and social and legal institutions. Scholars of abortion stigma are encouraged to consider the nuances of this social process, particularly when developing ways to measure abortion stigma or when planning interventions to dispel it. Moreover, these findings align with scholars of stigma more generally who call for a theoretical orientation beyond Goffman's social-interactional approach and toward a framework of stigma as a multi-level social process embedded in structures of power and inequality.

When stigma is conceptualized as embedded in social structures, as opposed to an individual attribute assigned to particular people, it casts a wide net. In the case of abortion stigma, the ability to delineate who exactly can be assigned to be embracing or rejecting motherhood becomes very muddled. Abortion stigma affects all people who have abortions –

including those who are not perceived as violating motherhood norms. This can be explained by expanding upon and reconceptualizing current theories and definitions of stigma. We can more fully understand the concept of abortion stigma and its real-world implications by envisioning a multi-dimensional and variable concept based on complex structures of power and inequality. An enhanced understanding of this phenomenon can support the growth of scholarship in novel and significant ways.

References

Astbury-Ward, Edna, Odette Parry, and Ros Carnwell. 2012. "Stigma, Abortion, and Disclosure—Findings from a Qualitative Study." *The Journal of Sexual Medicine* 9(12):3137–47.

Belfrage, Madeleine, Olivia Ortíz Ramírez, and Annik Sorhaindo. 2020. "Story Circles and Abortion Stigma in Mexico: A Mixed-Methods Evaluation of a New Intervention for Reducing Individual Level Abortion Stigma." *Culture, Health & Sexuality* 22(1):96–111.

Beynon-Jones, Siân. 2017. "Untroubling Abortion: A Discourse Analysis of Women's Accounts." *Feminism & Psychology* 27(2):225–42.

Biggs, M. Antonia, Ushma D. Upadhyay, Julia R. Steinberg, and Diana G. Foster. 2014. "Does Abortion Reduce Self-Esteem and Life Satisfaction?" *Quality of Life Research* 23(9):2505–13.

Biggs, M. Antonia, Katherine Brown, and Diana Greene Foster. 2020. "Perceived Abortion Stigma and Psychological Well-Being over Five Years after Receiving or Being Denied an Abortion." *PloS One* 15(1):e0226417.

Biggs, M. Antonia, Ushma D. Upadhyay, Charles E. McCulloch, and Diana G. Foster. 2017. "Women's Mental Health and Well-Being 5 Years after Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study." *JAMA Psychiatry* 74(2):169–78.

Cockrill, Kate, and Leila Hessini. 2014. "Introduction: Bringing Abortion Stigma into Focus." *Women & Health* 54(7):593–98.

Cockrill, Kate, and Adina Nack. 2013. "'I'm Not That Type of Person': Managing the Stigma of Having an Abortion." *Deviant Behavior* 34(12):973–90.

Cockrill, Kate, Ushma Upadhyay, Janet Turan, and Diana Greene Foster. 2013. “The Stigma of Having an Abortion: Development of a Scale and Characteristics of Women Experiencing Abortion Stigma.” *Perspectives on Sexual and Reproductive Health* 45(2):79–88.

Combellick, Sarah Larissa. 2023. “‘My Baby Went Straight to Heaven’: Morality Work in Abortion Online Storytelling.” *Social Problems* 70(1):87–103.

Cowan, Sarah K. 2017. “Enacted Abortion Stigma in the United States.” *Social Science & Medicine* 177:259–68.

Dodge, Laura E., Sharon J. Phillips, Dayna T. Neo, Siripanth Nippita, Maureen E. Paul, and Michele R. Hacker. 2018. “Quality of Information Available Online for Abortion Self-Referral.” *Obstetrics & Gynecology* 132(6):1443.

Foster, Diana G., Julia R. Steinberg, Sarah CM Roberts, John Neuhaus, and M. Antonia Biggs. 2015. “A Comparison of Depression and Anxiety Symptom Trajectories between Women Who Had an Abortion and Women Denied One.” *Psychological Medicine* 45(10):2073–82.

Freedman, Lori. 2010. *Willing and Unable: Doctors’ Constraints in Abortion Care*. Vanderbilt University Press.

Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity*. Simon and Schuster.

Guttmacher Institute. 2019. *State Abortion Policy Landscape: From Hostile to Supportive*.

Halfmann, Drew, and Michael Young. 2010. “War Pictures: The Grotesque as a Mobilizing Tactic.” *Mobilization: An International Quarterly* 15(1):1–24.

Han, Leo, Emily R. Boniface, Lisa Yin Han, Jonathan Albright, Nora Doty, and Blair G. Darney. 2020. “The Abortion Web Ecosystem: Cross-Sectional Analysis of Trustworthiness and Bias.” *Journal of Medical Internet Research* 22(10):e20619.

Hanschmidt, Franz, Linde, Anja Hilbert, Steffi Riedel-Heller, and Anette Kersting. 2016. “Abortion Stigma: A Systematic Review.” *Perspectives on Sexual and Reproductive Health* 48(4):169–77.

Hanschmidt, Franz, Michaela Nagl, Johanna Klingner, Holger Stepan, and Anette Kersting. 2018. “Abortion after Diagnosis of Fetal Anomaly: Psychometric Properties of a German Version of the Individual Level Abortion Stigma Scale.” *PLOS ONE* 13(6):e0197986.

Herek, Gregory. 2009. “Sexual Stigma and Sexual Prejudice in the United States: A Conceptual Framework.” Pp. 65–111 in *Contemporary Perspectives on Lesbian, Gay, and Bisexual identities*, edited by D. Hope. Springer.

Herold, Stephanie, Katrina Kimport, and Kate Cockrill. 2015. “Women’s Private Conversations about Abortion: A Qualitative Study.” *Women & Health* 55(8):943–59.

Hessini, Leila. 2014. “A Learning Agenda for Abortion Stigma: Recommendations from the Bellagio Expert Group Meeting.” *Women & Health* 54(7):617–21.

Hoggart, Lesley. 2017. “Internalised Abortion Stigma: Young Women’s Strategies of Resistance and Rejection.” *Feminism and Psychology* 27(2):186–202.

Janiak, Elizabeth; Alisa B. Goldberg. 2016. “Eliminating the Phrase ‘Elective Abortion’: Why Language Matter.” *Contraception* 93(2):89–92.

Joffe, Carole. 1986. *The Regulation of Sexuality: Experiences of Family Planning Workers*. Temple University Press.

Keefe-Cooperman, Kathleen. 2005. “A Comparison of Grief as Related to Miscarriage and Termination for Fetal Abnormality.” *OMEGA-Journal of Death and Dying* 50(4):281–300.

Kersting, Anette, Michaela Dorsch, Carmen Kreulich, M. Reutemann, P. Ohrmann, E. Baez, and V. Arolt. 2005. “Trauma and Grief 2–7 Years after Termination of Pregnancy Because of Fetal Anomalies–a Pilot Study.” *Journal of Psychosomatic Obstetrics & Gynecology* 26(1):9–14.

Kersting, Anette, Kristin Kroker, Johannes Steinhard, Isabell Hoernig-Franz, Ute Wesselmann, Katharina Luedorff, Patricia Ohrmann, Volker Arolt, and Thomas Suslow. 2009. “Psychological Impact on Women after Second and Third Trimester Termination of Pregnancy Due to Fetal Anomalies versus Women after Preterm Birth—a 14-Month Follow up Study.” *Archives of Women’s Mental Health* 12(4):193–201.

Kumar, Anuradha. 2013. “Everything Is Not Abortion Stigma.” *Women’s Health Issues* 23(6):e329–31.

Kumar, Anuradha. 2018. “Disgust, Stigma, and the Politics of Abortion.” *Feminism & Psychology* 28(4):530–38.

Kumar, Anuradha, Leila Hessini, and Ellen Mitchell. 2009. “Conceptualising Abortion Stigma.” *Culture, Health, and Sexuality* 11(6):625–39.

Lafarge, Caroline, Kathryn Mitchell, and Pauline Fox. 2014. “Termination of Pregnancy for Fetal Abnormality: A Meta-Ethnography of Women’s Experiences.” *Reproductive Health Matters* 22(44):191–201.

Link, Bruce G., and Jo Phelan. 2014. “Stigma Power.” *Social Science & Medicine* 103:24–32.

Link, Bruce, and Jo Phelan. 2001. “Conceptualizing Stigma.” *Annual Review of Sociology* 27:363–85.

Littman, Lisa L., Christina Zarcadoolas, and Adam R. Jacobs. 2009. “Introducing Abortion Patients to a Culture of Support: A Pilot Study.” *Archives of Women’s Mental Health* 12(6):419–31.

Maguire, Marguerite, Alexis Light, Miriam Kuppermann, Vanessa K. Dalton, Jody E. Steinauer, and Jennifer L. Kerns. 2015. “Grief after Second-Trimester Termination for Fetal Anomaly: A Qualitative Study.” *Contraception* 91(3):234–39.

Major, Brenda and Richard H. Gramzow. 1999. “Abortion as Stigma. Cognitive and Emotional Implications of Concealment.” *Journal of Personality and Social Psychology* 77(4):735–45.

Mastey, Namrata, Sarah L. Combellick, Mitchell D. Creinin, E. Bimla Schwarz, and Melissa J. Chen. 2023. “Perinatal Palliative Care and Abortion for Life-Limiting Fetal Conditions: A Qualitative Study.” *Under Review.*

McCoyd, Judith L. M. 2010. “Women in No Man’s Land: The Abortion Debate in the USA and Women Terminating Desired Pregnancies Due to Foetal Anomaly.” *The British Journal of Social Work* 40(1):133–53.

Millar, Erica. 2020. “Abortion Stigma as a Social Process.” “Abortion Stigma as a Social Process.” *Women’s Studies International Forum*. 78:102328.

Norris, Alison, Danielle Bessett, Julia Steinberg, Megan Kavanaugh, Silvia De Zordo, and Davida Becker. 2011. “Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences.” *Womens Health Issues* 21(3 Suppl):S49-54.

Parker, Richard, and Peter Aggleton. 2003. “HIV and AIDS-Related Stigma and Discrimination: A Conceptual Framework and Implications for Action.” *Social Science & Medicine* 57(1):13–24.

Phelan, Jo, Bruce G. Link, and John F. Dovidio. 2008. “‘Stigma and Prejudice: One Animal or Two?’” *Social Science & Medicine (1982)* 67(3):358–67.

Scambler, G. 2009. “Health-Related Stigma.” *Sociology of Health and Illness* 31(3):441–55.

Scambler, Graham, and Anthony Hopkins. 1986. “Being Epileptic: Coming to Terms with Stigma.” *Sociology of Health & Illness* 8(1):26–43.

Shellenberg, Kristen M., Ann M. Moore, Akinrinola Bankole, Fatima Juarez, Adekunbi Kehinde Omideyi, Nancy Palomino, Zeba Sathar, Susheela Singh, and Amy O. Tsui. 2011. “Social Stigma and Disclosure about Induced Abortion: Results from an Exploratory Study.” *Global Public Health* 6(sup1):S111–25.

Shellenberg, Kristen M., and Amy O. Tsui. 2012. “Correlates of Perceived and Internalized Stigma among Abortion Patients in the USA: An Exploration by Race and Hispanic Ethnicity.” *International Journal of Gynecology & Obstetrics* 118:S152–59.

Sorhaindo, Annik, and Ulrika Rehnstrom Loi. 2022. “Interventions to Reduce Stigma Related to Contraception and Abortion: A Scoping Review.” *BMJ Open* 12(11):e063870.

Sorhaindo, Annik M., Clara Juárez-Ramírez, Claudia Díaz Olavarrieta, Evelyn Aldaz, María Consuelo Mejía Piñeros, and Sandra Garcia. 2014. “Qualitative Evidence on Abortion Stigma from Mexico City and Five States in Mexico.” *Women & Health* 54(7):622–40.

Stangl, Anne L., Valerie A. Earnshaw, Carmen H. Logie, Wim van Brakel, Leickness C. Simbayi, Iman Barré, and John F. Dovidio. 2019. “The Health Stigma and Discrimination

Framework: A Global, Crosscutting Framework to Inform Research, Intervention Development, and Policy on Health-Related Stigmas." *BMC Medicine* 17(1):31.

Steinberg, Julia R. 2011. "Later Abortions and Mental Health: Psychological Experiences of Women Having Later Abortions—a Critical Review of Research." *Women's Health Issues* 21(3):S44–48.

Steward, Wayne T., Gregory M. Herek, Jayashree Ramakrishna, Shalini Bharat, Sara Chandy, Judith Wrubel, and Maria L. Ekstrand. 2008. "HIV-Related Stigma: Adapting a Theoretical Framework for Use in India." *Social Science & Medicine* 67(8):1225–35.

Timmermans, Stefan, and Iddo Tavory. 2012. "Theory Construction in Qualitative Research." *Sociological Theory* 30(3):167–86.

Tyler, Imogen, and Tom Slater. 2018. "Rethinking the Sociology of Stigma." *The Sociological Review* 66(4):721–43.

Watson, Katie. 2018. *Scarlet A: The Ethics, Law, and Politics of Ordinary Abortion*. Oxford University Press.

Wilkinson, D.J.C., P. Thiele, A. Watkins, and L. De Crespigny. 2012. "Fatally Flawed? A Review and Ethical Analysis of Lethal Congenital Malformations." *BJOG: An International Journal of Obstetrics & Gynaecology* 119(11):1302–8.

Wool, Charlotte. 2011. "Systematic Review of the Literature: Parental Outcomes after Diagnosis of Fetal Anomaly." *Advances in Neonatal Care* 11(3):182–92.

Tables

Table 1. Perinatal palliative care study: Selected demographic and reproductive characteristics and history.

Characteristics	*n (%) or Median (range)*
Age	32 (19-40)
Race	
White	13 (72)
Black	2 (11)
Indigenous	1 (6)
Mixed Race	2 (11)
Hispanic Ethnicity	
Yes	4 (22)
No	14 (78)
Previous Births	
0	9 (50)
1-2	9 (50)
Gestational Age at time of termination (days)	159 (117-191)
Referring state hostility towards abortion	
Supportive (California)	10 (56)
Middle ground (Nevada)	1 (6)
Hostile (Indiana and Missouri)	7 (39)
Days elapsed between termination and interview	28 (15-50)