

Stigma Theory and Reproductive Health: A Literature Review

Disciplinary Honors

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Stigma is a known quantity. Even if an academic definition does not come to mind, everyone at one point or another has felt stigma, can describe stigma, and can discuss what various stigmas look like. Stigma can be very simple or very complex and often swings from one side to the other. While everyone can feel stigma, not everyone can reduce it. Stigma reduction is the school of thought that aims to stop the perpetuation of misconceptions that create stigma. When there are situations that are deemed as separate from the collective narrative or experience, such as abortion, those who find themselves in this situation experience an alienation that is unnecessary and, frankly, a false narrative. When abortion stigma is felt and perpetuated, it can have a physical and mental ripple effect on the human body in the moment and into the future. To understand how abortion stigma is felt and its repercussions, this paper will first focus on stigma theory and the components that uphold the theory, how stigma can be used to perpetuate dominant narratives, and how those same narratives can be challenged, unpacked, and rewritten.

Stigma is the way descriptors are attributed to individual behaviors, attributes, or identities that can be discrediting for the individual overall, reducing “the individual from a whole person to a tainted, discounted one” (Nixon et al., 2018). Stigma is not just name calling, or a group shun, as in the Salem Witch Trials. It is that and so much more: it is everything from someone turning their back to another all the way up to policies and laws enacted due to falsehoods or misconceptions about marginalized groups. Stigma can be broken down into eight different types: public, self, label avoidance, courtesy, stigma power, automatic stigma and double or multiple stigmas (Sheehan et al., 2016). Sheehan et al., can be the authority on two of the definitions used in this paper, the first being structural stigma: “the public and private sector policies that unintentionally restrict the opportunities of the minority group,” and the second being the definition for public stigma: “public endorsement of prejudice and discrimination towards a minority group” (2016). Public stigma can be felt on the interpersonal level from friends, family, peers, and virtually anyone who an individual has a close interpersonal relationship with, but also felt from the community (and communities) they belong to. This community-based

stigma can present in the forms of internalized fear, community norms and values that individuals are aware of, and mass statements of expectations and consequences. Often, stigma is felt as multiple types; an individual can experience community, self, and courtesy stigma all at the same interaction. This is called intersectional stigma. So, a woman trying to obtain an abortion and reproductive care services has the potential to be stigmatized by friends, family, her community, and have medical barriers in place which limit her ability to receive an abortion. While experiencing any type of stigma while receiving healthcare is abominable, the focus of this paper will be about community, interpersonal, and structural stigma in reproductive healthcare.

The application of stigma theory to abortion and reproductive healthcare births abortion stigma. Abortion stigma is understood as the “shared understanding that abortion is morally wrong and/or socially unacceptable” (Nixon et al., 2018). For those who are being stigmatized, abortion stigma can be felt from family, friends, community norms and beliefs, and can also present as structural barriers. These interactions will be the focus of this paper. When abortion stigma is felt on these three levels, it creates effects in women that affect their well-being beyond the actual healthcare services: women can experience negative physiological consequences, and will often forgo reproductive care (Cook & Dickens, 2014; Turan & Budhwani, 2021). This is not because women are stigmatized for seeking reproductive care itself, but rather because abortion stigma manifests as negative stereotypes, prejudice and discrimination. By avoiding reproductive healthcare, women evade these stigmatizing components. This aversion due to fear of judgement can result in devastating health consequences for the individual unrelated to abortion and abortion related care. Stigma can take a physical and mental toll on an individual. The outcomes of deteriorating social well-being and health are often experienced through prejudice and discrimination which create daily stress and psychological distress (Turan & Budhwani, 2021). “There is evidence that people who perceive themselves as demeaned by stigma often undergo a chronic physiological stress response, affecting for instance their cardiovascular health” (Cook & Dickens, 2014). Creating unnecessary stress around a safe procedure does nothing except create health complications for the individual to deal

with on their own. This leaves the stigmatizer feeling good about their actions, even though they have created health problems that can be larger than the necessity of an abortion.

Abortion stigma using the three piece framework of stereotypes, prejudice, and discrimination has some specific examples of how they are projected and experienced. For example, stereotypes can manifest as the classification of women who seek abortion services as “irresponsible,” “immoral,” or “selfish,” while discrimination would be the action of making abortion services hard to access or completely inaccessible to some or all—it is the physical manifestation of the prejudice and stereotypes (Smith et al., 2016). An individual experiences prejudice, stereotypes, and discrimination on a repeated basis. Stereotypes are shortcuts that provide social information in culture but are not often based in truth, stereotypes are thoughts based on public opinion (Sheehan et al., 2016). Prejudice is when those thoughts are endorsed by individuals and experience negative reactions to the stigmatized individual (Sheehan et al., 2016). Discrimination are the overt behaviors that reflect stereotypes and prejudice in ways that limit or devalue the stigmatized person or group (Sheehan et al., 2016). Stereotypes do not always preface discrimination: prejudice is the link between the marginalizing, stereotypical thoughts and feelings and the discriminatory behavior (Sheehan et al., 2016). When these three pieces cumulate into abortion stigma, then women are unable to access critical healthcare and unable to do so without fear of criticism, repercussions, or pushback.

So, how does a medical procedure get to the point where it is labeled taboo? By labeling women who have abortions as “other” and creating an “us versus them” divide amongst women who have had an abortion and those who have not. A study in Birmingham, Alabama asked participants about the prevalence of abortion in their area; it was found that abortion was perceived as far less visible than parenting as a young woman in this community (Smith et al., 2016). Distancing the prevalence of abortion from any community creates a gap that stigma fills. One of the ways that this distancing is used is by politicians and political parties. Culter et al. found “That attitudes about abortion policy are highly related to political identity is consistent with existing public

opinion research” (2021). This study found that this connection between abortion policy and political identity was consistent with validated measures of community level abortion stigma (Cutler et al., 2021). The “other” label placed upon women who have had an abortion, reinforces structural and community stigma within politics with the hope of creating a negative emotional response from that label. One such emotional response would be disgust, a communicable emotion, to move the emotional reaction to a political action (Kumar, 2018). Although abortion stigma’s connection to political identity and further, political action, can impact community members, it’s effects can be mitigated. An example of mitigating community level abortion stigma is knowing someone who had an abortion: “knowing someone who had an abortion was associated with lower stigma on CASS, CLASS, and polling questions on general support for abortion access” (Cutler et al., 2021)” This extends research by Cockrill and Biggs, whose 2017 research demonstrated that direct contact with individuals who disclosed an abortion experience could result in a “warming effect” of attitudes towards abortion care and those who have had one (Cutler et al., 2021).

Abortion stigma can be thought of as analogous to the Social Ecological Model, except in addition to the outermost ring is framing discourse: communication with the intent to shape public opinion (Kumar et al., 2009). Within structural stigma there is an undercurrent of politicians and media presenting abortion narratives to create political action, such as retributive stigma: naming offenders based off of their crime: a “murderer” commits murder and an “abortionist” has an abortion (Cook & Dickens, 2014).

Abortion stigma is not just conjured up out of thin air; it is a learned state of mind that is perpetuated by the stigmatizing groups. The way to create narratives by the stigmatizing group, using media to push the dominant view of a stigmatized topic, is called framing. “Framing” refers to how an issue is portrayed and understood and involves emphasis on certain aspects of identity and the exclusion of others. Frames can either enforce or reduce stigma surrounding an issue, and abortion is more often presented as a political issue rather than a health issue (Nixon et al., 2016). Nixon et al.,

looked at what is being presented by the media surround abortion and what is not being presented (2018). The researchers looked at what was being pushed as “normative” abortion stories and what there was an absence of. There was an absence of first person accounts, public health information and social context (more of an absence and a vacuum effect rather than covering something bad, but then again, read what we see) in the data set of collected articles. In an overwhelming majority, the articles most often presented policies to restrict abortion rights. It was also found that the more often an article mentioned abortion, the more likely they were to have a stigmatizing statement. Finally, there was an absence of positive and/or neutral mentions of abortion, services, or first hand accounts, and that this absence leaves the public to infer misinformation about abortion (Nixon et al., 2018).

Framing can be used to identify and perpetuate a dominant narrative surrounding abortion, like the idea that women who have an abortion regret their decision. For many women, abortion is a life changing event. Many health experts argue that experiencing negative emotions or believing that abortion was not the right decision are not mental health problems, but rather an expected reaction to a significant event and “inevitable among individuals making medical and life decisions” (Rocca et al., 2020).

One study looked at participants of the Turnaway study, a study comparing the outcomes of women obtaining first trimester abortions at their facility, women who were having later term abortions, and women who were too far along to have an abortion at that same facility—the *turnaway* group (Rocca et al., 2020). The researchers were following up with the women of the Turnaway Study to ask them about the rightness of their decision to have an abortion, taking into account different types of stigma. They found that decision difficulty increased with higher levels of perceived abortion stigma in their community: among those reporting the decision was very difficult, 45% perceived high levels and 26% perceived no stigma; these figures were 24% and 46%, respectively, among those having no difficulty (Rocca et al., 2020). The decision made by these women to have an abortion was not inherently difficult, but was made to be a difficult decision by the attitudes and beliefs of their communities.

Feeling the effects of community, structural and interpersonal stigma does not have to be a static event present in every woman's life. Stigma can be reduced, and there are many avenues to achieve the goal of reducing abortion stigma. If reproductive healthcare is a right, then it needs to be treated as such and then the responsibility is to push against and disrupt the dominant discourse surrounding perpetuated abortion stigma.

One such way to engage with truthful stories is via interactive narratives. Interactive narratives are stories in which the reader is an active participant and has opportunities to decide the direction of the narrative, often at a key plot point (Green & Jenkins, 2014). The degree of influence the reader has on the outcome differs from narrative to narrative depending on the author's goals for the project. Some researchers look to increase positive attitudes and beliefs about populations and demographics. This is something that Parrott et. al looked at in their study about Mexican immigrants and associated social services (2017). This group wanted to interrogate the "us versus them" mentality surrounding Mexican immigration to the US, and used a technique called "perspective taking" in their interactive narrative. This is a technique that allows the individual to take the perspective of another, most often as someone from the stigmatized group, to increase positive attitudes and beliefs towards the group labeled "other" (Parrott et al., 2017). After allowing participants to play through the narrative, Parrot et. al found that it was simply exposure to the narrative that increased participant's positive attitudes and beliefs towards Mexican immigrants and immigration.

Perspective taking isn't the only way interactive narratives can be used to combat stigma. Participant control of the narrative and investment in the character's plot arc are two additional methods used by researchers in interactive narratives. By identifying key narrative elements of abortion stories, they can be used to give the participant maximum control and investment in the narrative. This investment, with proper immersion and perspective taking, can put the participant in a position to have to make the sometimes difficult decisions that women seeking abortion services are presented with. Using the branched plot points of an interactive narrative structure shows the participant the very real consequences of those decisions. By utilizing the most common forms of prejudice,

stereotypes, and discrimination that women experience when seeking an abortion, the immersion and perspective taking of interactive narratives present a unique opportunity to rewrite the way in which abortion is presented.

Creating a truthful narrative would use first hand accounts from women who have had an abortion. Abortions are a part of healthcare. When there are laws and policies put in place to prevent or restrict abortion, the rates of abortion do not go down. Rather, the rates of *unsafe* abortions go up. To combat the stigma that permeates all levels of abortion, but in particular, interpersonal, community, and structural stigma, the creator would focus their efforts on accounts that reflected these three types of stigma in their interactive narrative. These stigma highlights, coupled with perspective taking, immersion, and investment can rewrite a highly politicized topic back to its origin as a healthcare procedure. Interactive narratives using firsthand abortion stories to create a story has the potential to create change in the attitudes and beliefs that individuals hold towards abortion and those who seek and receive one.

Interactive narratives are a relatively new approach to stigma reduction, and are not the only technique that can be used to mitigate stigma surrounding abortion. When looking to correct and minimize this kind of stigma, researchers and health care workers must remember to ground their approach in evidence-based practice of stigma reduction, otherwise there is a risk of further perpetuating stigma and all its components, rather than mitigating stigma. Roberts et al., have started this work by taking the CDC's Essential Public Health Services and applying them to abortion (2017). This work is being done to guide how public health departments should engage with abortion, and it "describes what health department activities related to abortion might look like if health departments were to use an accepted public health framework to guide their abortion-related activities rather than focus primarily on enforcing abortion-related laws" (Roberts et al., 2017). Some of these framework based activities would include researching barriers to abortion access in the state that the health department is responsible for, and promoting the use of scientific evidence in abortion-related laws (Roberts et al., 2017).

Other recommendations are a little more broad, and deal with how abortion and abortion stigma are *seen*. One such recommendation is to include basic public health information about abortion in news and mass media: information about prevalence, safety, and public opinion can go a long way to reconstruct policymaker and constituent's opinions about abortion that can be reflected in their policy (Nixon et al., 2018). Reporters can also expand coverage on abortion to be more centered on abortion facts: include more firsthand accounts that are not just from young, childless, white women, as most abortions are had by women of minority groups and by women who are already mothers (Nixon et al., 2018). Further recommendations build on the fact that abortion is a part of healthcare and is not political, nor is its necessity up for debate. A more long term goal related to this fact would be that public health departments can spearhead programs that reclaim abortion as a part of reproductive healthcare that would be supplemented and broadcasted by reporters and media. This would include public health departments making a conscious effort to integrate abortion-related activities and policies aligned with accepted public health framework (Roberts et al., 2017).

At the end of the day, abortion is a medical procedure and women have a right to medical procedures. Reproductive health stigma permeates individual lives at varying degrees and levels: some days it may only be structural barriers that are prevalent, and some days it may feel like everyone is talking about abortion but no one is explicitly naming it. Abortion stigma can be a powerful motivator that is used to prevent women from accessing critical medical care—whether that causes women to disengage from care due to perceived stigma or people to cast votes in favor of stricter policies, stigma can create real and tangible consequences.

All hope is not lost, for as debilitating as stigma can be, stigma can be reduced and reversed. In the hands of public health professionals, interactive narratives have the power to reduce the perpetuation of community, interpersonal, and structural stigma. Through the use of abortion related interactive narratives, there is a power there to create and change individual's beliefs and attitudes towards abortion to a more positive one.

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