Abortion stigma in Sweden
An explorative study and analysis of women’s personal experiences

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Abstract

Abortion stigma has been identified as a harmful social phenomenon with severe consequences for women all over the world. Recent conceptualizations within the emerging field of abortion stigma suggest that the production of stigma is profoundly local. The aim of this study is therefore to provide an indication of how individual level abortion stigma is constructed within a Swedish context. Conceptual frameworks of individual level abortion stigma have informed the interview design and provided a link to concepts within stigma theory and gender analyses of sexuality and biopower. Data was collected through five in-depth qualitative interviews with women with personal experiences of abortion, and analyzed through content analysis with guidance from the conceptual framework. The result indicates that abortion stigma is experienced in various ways and to different extents, both in relation to the abortion decision as well as the unintended pregnancy. All three manifestations of stigma (internalized, felt and enacted) could be identified and have caused consequences for these women. Important elements of abortion stigma found in the result were: over-simplifications, misconceptions and lack of awareness surrounding abortions, feelings of shame and guilt, and the women’s reactions to abortion stigma. The study concludes that abortion stigma in Sweden seems to be built upon the same gendered normative ideals that have been identified in previous research, with a possible additional focus on the ideal of not getting unintentionally pregnant. It is further concluded that the existence of abortion stigma in Sweden can be linked to concepts of biopower, heteronormativity and the discourse of modern sexuality.
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1. Introduction

Abortion is a health and rights issue and a controversial topic world-wide (Berer, 2002). About 25% of the world’s population live in countries where abortion is illegal or allowed only if the woman’s life is threatened (Center for Reproductive Rights, 2014). This results in the deaths of 47,000 women every year as a consequence of unsafe abortions (WHO & Guttmacher institute, 2012). Women’s sexual and reproductive health is integral to several human rights, such as the right to life, health, privacy, education, freedom from torture and prohibition of discrimination (OHCHR, n.d.). Article 16 in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) guarantees women’s right to decide “freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights” (OHCHR, n.d).

Unwanted pregnancies and abortions have existed since the beginning of history and a safe abortion is nowadays a common and simple medical procedure (Kumar, Hessini & Mitchell, 2009). About one in four pregnancies world-wide is terminated and the annual number of abortions were 56 million between 2010 and 2014 (Sedgh et al., 2016, p. 263). However, despite abortion being common, scholars conducting studies on abortion have identified a far-reaching abortion stigma world-wide (Shellenberg et al., 2011). In some contexts, this stigma is directly harmful, if not lethal, to women who undergo the procedure and in other contexts it is considered to constitute impediments of various levels and in various ways (Shellenberg et al., 2011; Sedgh, et al., 2016; Kumar et al., 2009). The production and re-production of this stigma is however poorly understood (Kumar et al., 2009; Norris, Bessett, Steinberg, Kavanaugh, Zordo, Becker, 2011).

Sweden is sometimes described as one of the most culturally distinguished countries in the world, and scores high on secular and self-expressive values charts (World Values Survey, n.d.). The same findings suggest that Sweden could also be considered as the most accepting country in the world as to whether abortion is justified or not. Despite this, I have not come across any research on abortion stigma in Sweden. Several studies conducted on abortion in Sweden mention stigma as either inherent and natural to the issue, or describe it as something problematic but without analyzing it further (Kero, 2002; Stålhandske, Makenzius, Tydén, & Larsson, 2012; Andersson & Larsson, 2010). As the growing research field of abortion stigma has found, the topic often is
highly contextual as well as concealed. The question remains as to in what way abortion stigma is constructed in a context of an accepting attitude towards abortion and liberal abortion laws.

Stigma research suggests that stigma in abortion related issues serves to re-create the misconception that the procedure is uncommon. This fuels societal norms that mark abortions and women who have had them as non-normative, which in turn results in discriminative laws, unjust resource distribution and an even stronger taboo (Kumar et al. 2009). Abortion stigma can therefore be understood from Michael Foucault’s (2002) term biopower that emphasizes non-centralized forms of power that are exercised through social relationships and are practiced rather than possessed. The choice to have an abortion can further be seen as a way for women to express their moral independence and agency as it challenges narrow conceptions of gender roles, female sexuality and motherhood (Kumar, 2009). Cockrill and Nack (2013) argue that women have the possibility to transgress these narrow conceptions at different points throughout their life, abortion being one of them. Moreover, since abortion is a concealable type of stigma, women can most times choose when and to whom they wish to disclose it (Cockrill & Nack, 2013).

Abortion stigma has been theorized to exist at several levels. Individual level abortion stigma could, from Kumar et al.’s (2009) conceptualization, be described as manifestations of abortion stigma within the psyche of individual persons. Individual level abortion stigma has further been divided into three separate manifestations: internalized, felt and enacted (Cockrill & Nack, 2013). These have been used to understand and make sense of women’s experiences of abortion stigma in contexts outside of Sweden.¹

2. Aim of study

The general aim of the study is to provide an indication of how individual level abortion stigma is constructed within a Swedish context. This has been divided into two more specific aims:

The first aim of this study is explorative - to examine how women in Sweden experience individual level abortion stigma and what elements of abortion stigma can be identified from their experiences. The second aim of this study is to systematize and theoretically analyze how

¹ This introduction was written as part of the course GS1311 Methodology in Global Studies, Autumn 2016.
their experiences relate to local and global forms of power by using conceptualizations of stigma, sexuality and theories of power.

3. Research questions

The research questions therefore consist of one general question that will be answered through three sub-questions:

How is individual level abortion stigma constructed within a Swedish context?

- How are the three manifestations of abortion stigma (internalized, felt and enacted) experienced by women with personal experiences of abortion?
- What elements of abortion stigma can be identified from women’s personal experiences?
- How do the manifestations and elements of abortion stigma relate to local and global conceptions and theories of stigma, sexuality, and biopower?

4. Delimitations

The workings of stigma are contextual, and part of a normative system that is constantly changing (Goffman & Matz, 2014, pp. 9-10). Because of this, my study will be an insight into how abortion stigma might be constructed in one specific context at a given time in history, and the potential to gain insights about other contexts is therefore limited (Danermark, Ekström, Jakobsen, Karlsson, 2003, pp. 49-62).

By focusing solely on women with personal experience of abortion(s), I exclude a significant amount of people that might also have important perspectives regarding this issue. Especially important to note here are: men, as well as women without personal experience of abortion. Research on men’s experience of abortion is a highly under-researched subject in urgent need of future attention (Kero, 2002). Consequently, men’s relation to abortion stigma is unfortunately not researched well enough for me to be able to further study it in this thesis. Similarly, the existing conceptualizations and measurements are mainly from studies on women with personal experience of abortion, and not on women in general. Furthermore, Kumar et al. (2009), state that

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2 Hereby abortion(s) will be referred to in singular unless for a specific reason, despite multiple abortions being common.
stigma research has mostly focused on individuals and therefore argue that abortion stigma should be studied with the community level as the central locus. This would, however, require resources not available for this thesis. The thesis is thus focused on women’s experiences of individual level abortion stigma.

It is also important to note that I use the concepts and dichotomy of man – woman throughout the thesis. I am aware that this is a highly simplified depiction of gender identities. Using the category ‘woman’ might therefore be problematic, especially since it is integral to the topic and my analysis. However, I believe that avoiding this category would have required another set of theory essentially different from the aim of this thesis and different from the theory used by the few available studies on abortion stigma. Because of this, I chose to give all respondents the chance to define their gender themselves prior to participating in the study.

I aimed to limit the sample to women who are between 20 and 30 years old. Four out of five respondents fit these criteria. By mostly focusing on young women, the study was able to discuss the issues with them only a few years or less after their abortion. Most abortions in Sweden occur among women between 20-24 years old, and the age group with the second most abortions is 25-29 (Socialstyrelsen, 2015). Even though the risk of experiencing stigma may prevail throughout a woman’s life, several studies have shown that women experience the most stigma around the time of their abortion (E.g. Cockrill & Nack, 2013).

Another delimitation I made in the beginning of the study was to only include respondents who had lived in Sweden for most of their life. This delimitation was made from the assumption that respondents with the most ‘experience’ of a culture will facilitate for the study to generate insights into how abortion stigma in Sweden is constructed (Esaiasson, Gilljam, Oscarsson & Wängnerud, 2012, pp. 258-262). It does however pose a substantial limitation to the possibility of understanding the construction of abortion stigma in Sweden as a whole (Esaiasson et al., 2012, pp. 188-192). Later in the study, I therefore found that this delimitation may not be particularly relevant. Lastly, by reaching out to women currently living in Gothenburg, the interviews could in four out of five cases (one phone interview) be held face to face, which facilitates a constructive and perceptive conversation (McCracken, 1988, pp. 16-22).
5. Methodological considerations

Because of the explorative nature of the first research question, a deductive approach was applied. Therefore, prior to data collection, theoretical constructions and conceptualizations were examined and specific theoretical themes formed the basis for the interview guide (Danermark et al., 2003, pp. 170-174). The explorative aim of this study enables for future research to collect inspiration or insights, even though the external validity of this study is low (Esaiasson et al. 2012, p. 58).

5.1 Data collection and validity

This study is based on qualitative primary data collected through five semi-structured interviews conducted in Gothenburg and over the phone during May and June 2017. The interviews were conducted in Swedish, and recorded after obtaining consent from the respondents to record. The material was transcribed and analyzed in chronological order, and the systematized themes were translated into English. During the translation process, the respondent’s meaning of each utterance was prioritized as opposed to a more literal ‘word-for-word’ translation.

Interviews were considered to be a suitable choice of method because of the large variation between women’s experiences of abortion. The intention was that the different stories and experiences would provide a result as close to “the whole story” as possible (Sprague, 2005, p. 47). It also suits the explorative aim of the study. Alternative methods considered were surveys, and discourse analysis (Esaiasson et al., 2012). A survey could reach a large number of respondents and provide interesting insight into how often women choose to disclose their abortion. However, it does not give much room for complex answers, as the dynamic character of semi-structured interviews does (McCracken, 1988, pp. 18-20). Since the field is relatively uninvestigated, the first step would be to get an overview of themes and concepts (Esaiasson et al., 2012, p. 253). Discourse analysis could have provided insights on the relation between abortion stigma and how abortions are described in general media and public opinion. However, as stated above, the aim is to explore women’s lived experiences of individual level abortion stigma and thus, semi-structured interviews were considered to be the most suitable method.

Conceptualizations of abortion stigma are largely based on interview-oriented studies. Thus, this study aims to provide insights into a Swedish context by using similar methods as have been
employed when creating the conceptualizations. The framework for developing the interview guide was Cockrill and Nack’s (2013) conceptual model of three types of abortion stigma: internalized, felt and enacted. This was chosen to enhance the content validity of the study (Esaiasson et al., 2012, p. 60). After the development of the interview guide, five individual semi-structured in-depth qualitative interviews were conducted at different locations in and around Gothenburg. The time and place for the interview was decided together between the researcher and the respondent, with emphasis put on convenience for the respondent. One interview was conducted over the phone for this reason. Throughout the study, a few questions were added in order to follow up on interesting aspects brought up in the first interviews. Some questions have also been clarified and adjusted to be more tangible.

One issue when studying stigma is that many scientists are not part of the stigmatized group (Link and Phelan, 2001). Because of this, I view my own experiences of abortion and abortion stigma as a vantage point that gives me the possibility to get closer access to the workings of the stigma. On the other hand, this can also constitute a disadvantage. I view my own understanding of abortion stigma as partial and socially constructed (Sprague, 2005, pp. 32-41) which was another reason for choosing semi-structured interviews with women with different experiences of abortion stigma. McCracken (1988, pp. 22-28) argues that when conducting interviews is it an advantage to be part of the ‘culture’. However, it is also important to defamiliarize oneself with the issue in order to conduct a professional study. Before designing the interview guide, I therefore did a close examination of my own perspectives and beliefs, while studying previous literature.

5.2 Sampling method and target group

This study used non-probability sampling through utilizing personal networks and snowball sampling. Non-probability sampling was deemed suitable because of the explorative nature of this study. The choice of target group has been guided by the conceptual framework on abortion stigma and constitutes one of Norris et al.’s (2011) three affected groups: women who have abortions, abortion care workers and supporters of women who have abortions, for example partners or family. The deductive approach opens up for conclusions being derived from given premises. However, the non-probability sampling prevents it from making generalizations to a larger population. Utilizing personal networks and snowball sampling can further be criticized for
portraying only a fraction of the analytical unit and thus the result can be seen as distorted (Esaiasson et al., 2012, pp. 188-192). This was however, deemed to be the most appropriate and accurate sampling method available with given resources. A positive effect could be that these two sampling methods generate respondents with more experience on abortion stigma, thus making the result more ‘intense’ (Esaiasson et al., 2012, pp. 258-262).

Sampling method was one of the study’s most complex issues from the start. Since abortion can be a sensitive topic for some women, consideration was put into making sure that no respondent felt obliged to participate but instead could participate entirely on their own terms. I first reached out to organizations and volunteer networks. The aim was to reach people with whom I would have a personal connection, such as a shared interest, (i.e. to establish trust) but that I had never met in person (McCracken 1988, p. 37). This did however not generate any respondents and instead I turned to personal networks to try to reach respondents through common friends. The issue of trust versus stranger was more complex here since the common friend also had to be comfortable enough with both of us in order to talk about this issue. Social media helped in reaching a few respondents. After the first interviews had been conducted, snowball sampling was used by asking respondents to spread the word about the study.

A relatively low number of respondents was chosen because of the limitations in time and resources. The respondents are Andrea, Claudia, Elisabeth, Julia and Miriam. Four out of five respondents live in or around Gothenburg.

5.3 Method of analysis

The analytical process is characterized as a latent content analysis and has followed the five-stage model presented by McCracken (1988, pp. 29,42-46) with guidance from the theoretical framework. The five-stage model constitutes McCracken’s fourth and last step when planning and conducting qualitative interviews. The aim is to “determine the categories, relationships, and assumptions that inform the respondent’s view of the world in general and the topic in particular” (McCracken, 1988, p. 42). Each stage of the model develops the result closer towards generality and systematization. The purpose of the first stage is to judge utterances individually and look for assumptions and beliefs behind them with help from the literature review and one’s own associational capacity. The second stage starts looking for relationships between utterances, both similarities and contradictions. Stage three organizes patterns and themes, and clarifies the
general outlines of the interview. In the fourth stage, decisions are made on the relationship between the themes, whether they are essential or not, and how the hierarchy of themes should be organized. The last stage reviews the conclusions made from all interviews and analyses them into general theses.

By carefully moving from utterance to general themes, this model lets the perspectives and opinions that the respondents express be the outset for the analysis. It follows a certain logic and model that could be repeated while the process remains open for unexpected results (McCracken, 1988, p. 41). Since women’s experiences of abortion are highly varied, nuances and exceptions have been pursued in the analytical process. This is important in order not to re-create the over-generalizations surrounding abortion (Kumar et al. 2009). It is also an important approach in order to answer the explorative research question and provide as exhaustive an indication of the construction of stigma as possible.

The implementation of the five-stage model was facilitated through note-taking and several different documents (McCracken, 1988, p. 47). Throughout the entire process, but especially in the first stage, conceptualizations of abortion stigma were used as templates that helped systematize the data. One aspect that was reflected upon was the consequences that the stigma itself might have on the empirical data. As a stigmatized issue by definition is fully or partly socially unacceptable (Goffman & Matz, 2014) it might be difficult to attain authentic and comprehensive answers. This was managed by carefully considering the manifestations of stigma that has been identified in previous studies. Another critique that can be directed to the method of analysis is the risk of simplifying the women’s experiences when categorizing them into manifestations and elements. This has nevertheless been done in order to follow the conceptualizations that are central to this study.

5.4 Ethical considerations

Since abortion can be a sensitive topic for some women, the interviews were designed and conducted with care. The possible positive contributions of the study to society have been weighed against individuals’ right to privacy and integrity (Vetenskapsrådet, 2002). As a result, some questions have not been asked, since they could be considered a too big violation into the integrity of the respondents. For instance, no questions regarding the reason behind the pregnancy or reasons for choosing to have an abortion were asked. All respondents were also informed
about this before agreeing on an interview. However, several respondents provided information on these issues anyway. The interviews were conducted with a balance between formal and informal approach. The aim was to provide a feeling of confidentiality by being formal in tone and have a clear setup for the interview. This was mixed with an informal approach to create a feeling of openness and closeness. Where it was deemed suitable, the researcher’s own personal experiences of abortion were mentioned shortly before the interview started, with the aim of establishing an open and trusting atmosphere.

All respondents were informed about the conditions for their participations: the scientific use of the results, voluntary participation (i.e. free to avoid certain questions or cancel their participation entirely) and anonymous participation. This information was provided at first contact with the respondents, as well as in the beginning of the interview. All respondents were then asked if they consented to this. They were also asked if they were comfortable with the study using the pronoun ‘women’ for them in the study, and all consented to this. The risks for uncomfortable questions could be considered to have been accounted for, since it was made clear that the interview would include personal experiences regarding abortion. It should also be noted that all respondents have contacted the researcher voluntarily and that they had no personal attachment to the researcher, thus the risk for them to feel obliged to participate is very small. The thesis has been written in such a way that it would be very difficult for anyone else than the researcher and the respondent to know which of the answers they have given. Information on age of the respondents were collected during the interviews but excluded after considering the risk that it could make it possible for a third party to identify a specific respondent. Pseudonyms have replaced the names of the respondents in all documents throughout the study. All respondents were asked if they wanted to read the thesis before final due date; and those who requested this have read and consented to the interpretations of their answers.

6. Theoretical considerations

This section aims to relate the study to previous literature as well as discuss concepts central to the analysis of the result. Not all concepts will therefore be directly related to the result but instead serve to put the study in perspective.
Theory in this study is understood and used mainly as a cluster of separate concepts with explanatory and systemizing potential. The concepts will be linked to and facilitate the analysis of the material. They do not aim to provide an exhaustive “grand theory” explanation, but are all relevant to the explorative examination of the data. Some of them are more central than others. Kumar et al. (2009), Shellenberg et al. (2011), Link & Phelan (2001) have served as the foundation for understanding and defining individual abortion stigma. Cockrill and Nack’s (2013) socio-psychological framework of three manifestations of abortion stigma: internalized, felt and enacted have informed the basic theorization and the interview guide. These authors’ analysis of the issue provides an entranceway to several concepts within stigma theory, gender analyses of sexuality and biopower. The linking aspect of all concepts is power in different forms. I do not seek to define power relations, but instead explore if and how these concepts could be used to understand parts of how abortion stigma is constructed in Sweden. Thus, postmodern power concepts inspired by Foucault are useful since they open up several possibly conflicting directions of power and put emphasis on discourses and non-centralized forms of power exercised through social relationships (Boyle, 1997).

6.1 Previous research on abortion in Sweden

Almost half of all women in Sweden will have one or a few abortions throughout their life. It is thus a common phenomenon and a standard medical procedure (Söderlund Leifler, 2015). The abortion rate among women between 15-44 years of age has according to Anneli Kero (2002) remained relatively unchanged since the law was changed in 1975. It has stayed at about 17-21 abortions per 1000 women per year and was calculated to 20.8 abortions per 1000 women in 2016 (Socialstyrelsen, 2017). The amount of abortions carried out before week 7 (53 % in 2016) have increased since the 1990s and the number of abortions during week 9-11 have declined. 94 % of all abortions in Sweden are carried out before week 12 (Socialstyrelsen, 2017). Forty-two percent of all abortions in 2014 were repeat abortions (Socialstyrelsen, 2015). Kero (2002) states it is important to note here that people in Sweden are very successful in preventing unwanted pregnancies.
6.1.1 The abortion experience

Women’s experiences of abortion vary substantially; the general perceptions of abortion, however, are often simplified in various ways. Kero (2002, p. 25) has found that women in “all possible contexts” in Sweden have abortions, including married and single women, in all reproductive ages, with and without previous children and/or previous experience of abortion, with good and poor finances and in all social classes. Another study has found that abortion rates are higher in socially vulnerable areas (Söderberg, Andersson, Janzon & Sjöberg, et al., 1993). In Kero’s (2002) study, the two main motives for abortion were lack of a relationship with a stable partner, and the desire to postpone childbirth or limit the number of children. Other reasons mentioned were: economic factors, age, giving priority to work, lack of time and energy for another child and heavy workload.

Women often find themselves knowing what they want already when they find out about the pregnancy. In Kero, Högberg, Jacobsson and Lalos (2001, p. 1484) study, 92 % of the women interviewed (n=211) had decided to have an abortion before they contacted the health care system, and a third had known even before they got pregnant what their decision would be. This has been shown by other studies as well (Törnbom, Ingelhammar, Lilja, Svanberg, & Möller, 1999). Kero (Bengtsdotter 2017, pp. 63-65) states that since the public conversation about abortion often address it as a difficult decision, many are surprised by how easy it was for them to make the decision and sometimes start doubting themselves for not being sad. Kero brings up the ability to feel mixed emotions and that the decision might be right from one perspective and wrong from another. The decision has many levels and is a solution to a practical problem, as well as a matter of life and death, she argues (Bengtsdotter 2017, pp. 63-65).

Mixed emotions in relation to the abortion decision as well as afterwards are common in several studies but few women experience severe psychological consequences (Kero, 2002; Wallin Lundell et al., 2013; Lennerhed, 2011). In Wallin Lundell et al.’s (2013) study, few women developed posttraumatic stress disorder and the majority of them did so because of experiences unrelated to the abortion. Even though the abortion experience can be a stressful event, Kero (2002) as well as Stålhandske et al. (2012) emphasizes that feelings of relief and reduced

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3 ‘The abortion experience’ refers here to the experience as a whole, including: finding out about the pregnancy, the abortion decision, the procedure as well as the time afterwards.
emotional stress occur for most women. In other words, it could be understood as that abortion for most women is a solution to the problematic pregnancy.

Kero believes that there is a need for a nuanced description of the feelings surrounding an abortion for the sake of the debate and women’s emotional process of the abortion. There is a reluctance of talking about positive as well as negative emotions surrounding the abortion, because of the fear that opponents of abortion will use these stories to strengthen their simplified rhetoric (Bengtsdotter, 2017, pp. 65-66). In this logic, sad emotions in relation to the abortion are equal to abortion being morally wrong. Løkeland (2004) argues that the moral right to have an abortion in Norway has not yet been established. Her study shows that women are expected to feel sorrow, shame and guilt for many reasons concerning their sexuality, and even more so for getting pregnant unintentionally.

Studies have shown that women take well-thought through and rational decisions; and they are concerned about both their own well-being and the well-being of others (Stålhandske et al., 2012; Kero, 2002). According to Kero there is an idea of women as influenced by hormones and rampant emotions, thus not able to take rational decisions based on complicated emotions (Bengtsdotter, 2017, pp. 63-64). Kero further states that the predominant construction of women as first and foremost taking care of others does not match the idea of women who have abortions. Løkeland (2004) brings up the still existing moral pressure for a woman to want to have children. She gives the example of how most people in Norway understand that a teenager, without education, job or a steady partner would not want to have a child, but have difficulties accepting that women in their late 20s, with job and partner still does not want to become a mother. When women in Norway disclose their abortion to others, they often start by explaining why they took the decision, as a result of the perceived risk for negative reactions (Løkeland, 2004).

6.1.2 Abortion and society

The right to abortion is supported by law and by general public opinion in Sweden (Center for Reproductive Rights, 2014; World Values Survey, n.d). However, no prior research on abortion stigma in Sweden was found in the literature review for this thesis. Studies on abortion sometimes mention stigma but without analyzing it further (Kero, 2002; Stålhandske et al., 2012, Andersson & Larsson, 2010).
Abortion has been regulated by legislation in Sweden since the 13th century, and has since then been punishable in various degrees (Kero, 2002). During the 18th century, the punishment for having an abortion was death. This gradually became more permissive and in 1975 a radical law was enforced that left the decision entirely to the woman until the end of the 18th week of pregnancy (Kero, 2002). After this, abortion has to be admitted by the National Board of Health and Welfare (Socialstyrelsen, 2015). The 1980 committee on abortion emphasizes the importance of lowering the number of abortions, and states that abortion is regarded as “a last resort” when other contraceptive methods have failed (SOU 1983:31, p. 41).

Lena Lennerhed has argued that we are historical beings, perceiving previous societies’ norms and ideas and preserving them in our own time (Bengtsdotter, 2017, p. 91). Processes of change takes time, we are still affected by norms and perceptions of how we are supposed to feel about abortion. Even if we do not share the opinions of abortion opponents in Sweden and elsewhere, we are affected by them. In addition, Lennerhed states that a woman has to relate to the idea of motherhood before she even has anything to be mother for. If she terminates the pregnancy, she might be perceived as a ‘cold-hearted mother’. Women are supposed to care for life, and it is shameful to do the opposite (Bengtsdotter, 2017, pp. 88-96). It is interesting to note that Kero (Bengtsdotter, 2017, pp. 98-99) has found that men more often view the abortion as a responsible act than women.

Ingrid Frisk argues that the stigma of having an abortion is strong (Bengtsdotter, 2017, p. 82). There is a silence surrounding it and abortion is not something that one would talk casually about. It is expected to be embarrassing and “slutty” for a woman to sleep with many partners and get pregnant, Frisk says. This may cause feelings of judgment from health care personnel, since every shift in tone is registered and can be interpreted as “I should be ashamed” (Bengtsdotter, 2017, p. 82). Løkeland (2004) states that abortion in Norway is often only talked about in private conversations and that many only tell their closest family or friends about it or no one at all. Silence surrounding abortion experience in turn perpetuates the stigma (Shellenberg et al., 2011).

According to Lennerhed, feelings of shame are not so much about the abortion, but that one has become pregnant unintentionally. These are feelings of failure; to have been careless, bad and improper (Bengtsdotter, 2017, p. 88). I understand her argument as relevant no matter what the reason behind the pregnancy is. Lennerhed reasons that it is human to make mistakes, especially
in sexual relations where strong emotions are at work. Thus, there is an uncompromising ideal of not getting unintentionally pregnant, causing shame which is mixed together with the shame of having an abortion. A “big and undefined shame-cloud” is formed and it can be hard to separate what feelings that caused it (Bengtsdotter, 2017, p. 89). Shame in relation to abortion is thus broader than just the issue of whether is right or wrong to have an abortion.

Lennerhed (2000) has analyzed the development of what she termed the “modern sexuality” in Sweden. She argues that the modern sexuality is rational and healthy, child rearing is planned and pregnancies as well as STD’s are avoided through education and medicine. Moreover, it is equal in the sense that everyone should be able to control their lives and embrace their sexuality. Lastly, it is directed towards pleasure which has replaced requirements of reproduction, marriage with new requirements of lust. She further links this to the development of modernity in general and the belief that most problems can be solved by science which in turn is related to a “radical rationality” and the will to regulate and plan (Lennerhed, 2000, p. 144).

Scholars have further identified several myths and misconceptions surrounding abortion (Løkeland, 2004; Bengtsdotter, 2017). One such misconception is the idea of abortion as a long term physical strain on the body, and the belief that legal and safe abortion can cause sterility (Shellenberg et al. 2011; Familjeliv.se, 2011). According to the Swedish county councils and regions Healthcare Guide, abortion does not pose any risk to the woman’s reproductive ability (1177 Vårdguiden, 2015). Another misconception is that abortion is being used as a contraceptive by some women (Bengtsdotter, 2017, p. 98). There is however no evidence that women use abortion as a contraceptive in Sweden today. Lennerhed argues that if that was the case, it would be visible in the abortion statistics instead of the current numbers showing that women have one or a few abortions. Lennerhed (Bengtsdotter, 2017, p. 97) mentions that many people consider one abortion in a woman’s life-time to be acceptable. More than one is however considered to be a problem since then the woman has not understood her responsibility. The alternative, to keep the child, would not be considered entirely acceptable either, since there are also societal norms surrounding how and when to have children (Bengtsdotter, 2017; Ekstrand, Tydén, Darj & Larsson, 2009).

An influential myth is the Post-abortion syndrome (PAS). It does not exist as a recognized medical diagnosis but is often put forward as a common psychological consequence of abortion.
by abortion opponents (Bengtsdotter, 2017, pp. 67-68). Lennerhed explains that the concept originates from the US and describes this as a new adapted message, formulated in a scientific way and packaged in a modern form. Focus is no longer put on the fetus as means to protecting the unborn life, but instead to protecting women from negative psychological effects of abortion. Even though it is not as established in Sweden, there is an idea of abortion as often causing severe psychological problems and the discussion surrounding abortion has not succeeded in separating the myth of PAS from feelings of sorrow (Bengtsdotter 2017, pp. 67-68). This could be linked to Kumar et al.’s (2009) example of how abortion opponents often seek to remove women’s moral agency and portray them as victims.

6.2 Stigma

6.2.1. Conceptualizations on stigma

According to Erving Goffman, the context of every specific society determines what social categories are developed within it, and what characteristics the members of each category naturally have (Goffman & Matz, 2014, pp. 9-10). Members of the society can navigate within the categories without having to think too much about who they are and who they will meet. New persons are ascribed a social identity that comes with normative expectations, and awareness of these expectations might not be acquired until there is a risk they might not be fulfilled. An unexpected and undesirable attribute constitutes a discrepancy between the person’s virtual and actual identity. As a result, the person is reduced to an incomplete, non-normative person, or reclassified into another category. The social labelling of persons into negative attributes is a stigma (Goffman & Matz 2014, pp. 9-10).

Cockrill and Nack (2013) argue that all stigmas are rooted in socially constructed ideas of specific negative attributes. Link and Phelan’s (2001, p. 375) make a similar point when they argue that power cannot be separated from the production of stigma and state that “it takes power to stigmatize”. They argue that the discriminative aspect should not be left out of our understanding of stigma and put forward four steps in how we create a stigma and discriminative behavior: human differences are distinguished and labeled, dominant cultural beliefs link the labeled persons to undesirable characteristics (negative stereotypes), labeled persons are placed in distinct categories so as to accomplish some degree of separation between “us” and “them”, and lastly, labeled persons experience status loss and discrimination (Link and Phelan, 2001, p. 367).
Deacon (2006) argues however that a stigma can have negative impact on the self-conception and actions of people who are subject to stigmatization, even though active discrimination is absent.

Goffman & Matz (2014, pp. 51-52) separates between persons who are stigmatized in a way that one would notice at first sight, or perhaps even before that by acquiring knowledge of that person, and persons who are stigmatized in such a way that is it possible for them to conceal it. The issue that arises for persons with a concealable type of stigma is not to avoid the tensions that emerge during social contact with others, but to avoid that the flaw is discovered at all. The person faces a choice of whether to disclose the attribute or lie and pretend they are ‘normal’. They also face the choice of deciding who, how, where and when they will do it (Goffman & Matz 2014, p. 51). In addition, Goffman and Matz (2014, p. 63) argues that the consequences of stigma are active both among strangers as well as friends and family. People with a concealable type of stigma may be even more at risk to experience uncomfortable reactions when disclosing the stigmatized attribute. Friends and family can also sometimes be the main persons a discreditable person is trying to hide the stigmatized attribute from (Goffman & Matz, 2014, p. 63).

Cockrill and Nack (2013) build on Goffman’s theory of information control when discussing abortion stigma, which in most cases is concealable. The nature of a concealable type of stigma, such as abortion stigma, enables women to decide whether to disclose the stigmatized attribute to others or not. Women often weigh upsides and downsides before taking the decision to tell others. The amount of distress they experience depends on how central the stigma is to one’s individual identity and how salient it is at a given time (doctor’s appointments etc). Thus, they argue that experiences of abortion stigma can change over time (Cockrill and Nack, 2013). Goffman & Matz (2014, p. 52) argues that a person with a concealable type of stigma does not necessary experience prejudices, but has to count on the risk that people in their surroundings have prejudices against the stigmatizing attribute they have. The actions by surrounding people are thus based on a false perception of them.

**6.2.2 Previous research on abortion stigma**

Cockrill and Nack (2013, p. 974) argue “[a]ll stigmas stem from shared, socially constructed knowledge of the devaluing effect of particular attributes”. Similarly, Kumar et al. (2009) explain abortion stigma as a socio-interactional phenomenon and argue that all stigmas are created
through over-simplifications of complex situations. Norris et al. (2011) too describe abortion stigma as a dynamic social process and emphasize the contextual aspect. It has further been theorized that stigma is dependent upon context specific factors. Abortion stigma in different contexts can share common traits and outcomes, but the production of stigma takes place in local social relationships and cultural constructs (Kumar et al., 2009). In this study I will use Kumar, et al.’s (2009, p. 628) definition of 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.”

Several consequences of abortion stigma have been identified. These are for example: “selfprotective secrecy, the stereotyping of women and providers, discriminatory policy, and the marginalization of abortion as a medical practice” (Cockrill & Hessini, 2014, p. 593). Shellenberg et al. (2011, pp. 113-114) bring up issues of: rejection, exclusion, discrimination or “physical, verbal or emotional abuse, being devalued as a wife or mother, being mistreated at home and/or community setting and denial of health care services”. In addition, Cockrill & Nack (2013) bring up feelings of shame and guilt, isolation from others who might understand and losing the chance of therapeutic disclosure.

Similar to Link and Phelan’s (2001) point that the creation of stigma is closely connected to workings of power, Kumar et al. (2009) argue that abortion stigma is a compound stigma. In other words, it is based on multiple forms of structural injustices and discrimination. Cockrill and Nack (2013, pp. 274-275) put forward that “[a]bortion stigma is rooted in narrow, gender-specific archetypes that inform cultural meanings of pregnancy termination,” including archetypal constructs of the ‘feminine,’ of procreative female sexuality, and of women’s innate desire to be a mother. To have an abortion signals multiple transgressions of these archetypes in various ways such as: “sex without a desire for procreation, an unwillingness to become a mother, and/or a lack of maternal-fetal bonding” (Cockrill & Nack, 2013, p. 975). Kumar et al. (2009) state that abortion stigma is often described as maintained through systems of unequal access of power, resources, narrow and rigid gender roles and systematic attempts to control female sexuality. They further link this to ideological struggles concerning the purpose of family, motherhood and sexuality. Shellenberg (2011) argue that abortion stigma often fall under Deacons’ (2006) conceptualization where the workings of stigma negatively affect and exercise power over stigmatized persons without direct discrimination. Women’s individual management strategies,
i.e. reactions to and ways to handle stigma, too have consequences for their surroundings. Cockrill and Nack (2013, p. 974) state that these strategies have “social, cultural and political implications”.

Along the line of thought that abortion stigma is closely related to societal factors and structural injustices, the manifestations of stigma have been theorized to exist at several different levels in society. These are: individual level, community level, organizational/institutional level, governmental/structural level, framing discourses and mass culture level (Kumar et al., 2009). At individual level, which Kumar et al. (2009) describe as perhaps the most destructive locus of abortion stigma, three separate manifestations have been identified: internalized, felt, and enacted (Cockrill & Nack, 2013). Internalized stigma is the woman’s acceptance of negative cultural valuations of abortion. Felt stigma is her assessment of others’ abortion attitudes and expectations of how they will act. Enacted stigma is her experience of clear or subtle actions that reveal prejudice. Kumar et al. (2009) put forward that shame and guilt are the most common manifestations of internalized abortion stigma, and bring up issues of women feeling selfish or immoral.

Abortion stigma can vary over time. In Cockrill’s and Nack (2013) study, internalized and felt stigma was experienced mainly around the time of the abortion, but felt stigma was experienced afterwards as well. Enacted stigma was experienced around social interactions. As time passes, the need for therapeutic disclosure may diminish, while the risk of experiencing stigma may stay the same. This decreases the likelihood that women disclose their abortions, leading to what Cockrill and Nack call a re-creation of the collective social silence. Thus the collective social silence around abortion could in part be understood as an unintended consequence of successful individual stigma management. As a consequence women who have had an abortion are often isolated from women who might understand. It is interesting to note here that many women stay silent even though they feel good about their decisions (Cockrill & Nack, 2013).

There is a private dimension to abortion that is potentially interesting to discuss when analyzing abortion stigma. Cockrill and Hessini (2014) mention that the perception of abortion as a private experience is justified by its sexual and reproductive nature. It is however, as Boyle (1997, p. 9) has argued, important to understand that wider social meanings are central to individual women’s experience of abortion. She further brings up the issue that discourses during the past two centuries have been characterized by “political and social practices of excluding or attempting to
exclude women from public life” (Boyle, 1997, p. 8). Several scholars that have analyzed abortion also state that women’s personal stories are in large parts absent in the public debate (Løkeland, 2004; Bengtsdotter, 2017).

6.3 Gender and sexuality

Stigma is built upon socially constructed categories that create normative expectations, or ideals (Goffman & Matz, 2014). Similarly, Kumar et al. (2009) emphasize ideals of womanhood in their definition stated above. They put forward that while definitions of the ‘essential nature’ of women vary between cultures and histories, an abortion defends women’s moral autonomy and opposes current perspectives of women as of women as perpetual life givers (Kumar et al., 2009). They propose three archetypal constructs of the ‘feminine’ that could be transgressed when having an abortion: “female sexuality solely for procreation, the inevitability of motherhood and instinctual nurturance of the vulnerable” (Kumar et al., 2009, p. 628). Thus abortion stigma could be said to build upon socially constructed archetypes, or ideals, closely related to gender and sexuality.

Several scholars have theorized the social construction of gender and sexuality, many building on Judith Butler’s theories. Butler argues that these are not absolute categories but social constructions (Butler, Rosenberg, & Lindeqvist, 2005, pp. 9-10). The categories cannot be derived to any ‘natural’ differences between women and men, and are not created by just people’s ‘being’ but instead by people’s ‘doings’. She also criticizes the heteronormative definition of women and men that links femininity to women and masculinity to men (Butler, Rosenberg, & Lindeqvist, 2005, p. 10).

Heteronormativity is therefore a useful concept when analyzing social constructions of gender and sexuality (Wasshede, 2010, pp. 26-27). Heteronormativity is the normative forces that privileges heterosexuality and marginalizes as well as stigmatizes deviations. It naturalizes our expectations of heterosexuality and prevents the creation of alternative categories (Wasshede, 2010, pp. 26-27). Central to this study is the assumption that the heteronormative discourse does not only include heterosexuality, but also that sexuality should be a specific way: monogamous, reproductive etc. (Wasshede, 2010, p. 293). Liljeström (1990) argues that the way heterosexuality

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4 I am using the term ‘sexuality’ in a general way, since a precise definition could interfere with the concepts within the conceptual framework. Instead I refer to Wasshede’s (2010) discussion of sex and sexuality.
is naturalized is related to biological reproduction. The genital correspondence is combined with the heterosexual intercourse’s potential or real result, i.e. children. Biological reproduction is therefore a fundamental factor in maintaining the heteronormative discourse she argues (Liljeström 1990; see also Wasshede 2010, p. 37).

It is thus crucial to problematize gender and sexuality in order to understand the production of abortion stigma (Kumar et al., 2009). The social construction of gender and sexuality, gendered archetypal constructs of the ‘feminine’, and heteronormativity are all important concepts when starting to theorize the construction of abortion stigma in Sweden.

### 6.4 Biopower

Foucault’s (2002, p.141) term biopower puts emphasis on non-centralized forms of power that are exercised through social relationships and practiced rather than possessed (Boyle, 1997, p. 7). According to Foucault (2002, p. 56), there are multiple ways we speak about sex. Together the ways we speak about sex form discourses that have multiplied “in the very space [of power] and as the means of its exercise (Foucault, 1978, p. 32). He further reasons that the discourses created as a result work in accordance with political and economic interests such as maintaining the stability of society and re-creating a healthy work force (Foucault 2002, pp. 59,121). These interests need power mechanisms that are normative, regulating and corrective, instead of ‘killing’ (Foucault, 2002, pp. 141-145). The power’s most important function is thus to appropriate life from the beginning until its end. This way, biopower is created (Wasshede, 2010, pp. 28-29).

Butler (1997, p. 274) links this reasoning to the biological reproduction in the heterosexual family and the re-creation of heterosexuality: “the economic, tied to the reproductive, is necessarily linked to the reproduction of heterosexuality”. This corresponds well with Foucault’s argument of the perverse implantation. He puts forward that the discourses surrounding sex are linked to the task of expelling the forms of sexuality that are not reproductive: “…to say no to unproductive activities, to banish casual pleasures, to reduce or exclude practices whose object was not procreation” (Foucault, 1978, p. 36).

Foucault argues that the power’s speech about sex disciplines the bodies and regulates the population (Foucault, 2002, pp. 140-141). Wasshede (2010, pp. 29-30) links this to
heteronormativity and argues that by being defined as a woman, one get assigned to an identity, but that identity also means that you are forced into a category, and therefore more easily can be controlled. Boyle (1997, p. 10) argues that women’s bodies and reproductive processes are “one of the most salient and contested sites for the operation of bio-power.” Moreover, the boundaries surrounding identities mean that there are things you cannot apply, that don’t belong in that category (Wasshede, 2010, pp. 29-30). Central to the concept biopower is however the possibility of resistance, from all parties and in complicated and sometimes conflicted ways (Foucault, 2002, p. 111).

7. Result and analysis

The presentation of result and analysis below constitutes the answer to the explorative aim of this study - to examine how women in Sweden experience individual level abortion stigma and what elements of abortion stigma can be identified from their experiences. It also constitutes the answers to the first and second research question. Generally the stigma was experienced in large variations. It is however possible to find support for all three of Cockrill and Nack’s (2013) manifestations of individual level abortion stigma: internalized, felt and enacted.

Variations were visible in several ways. For example, the number of people to whom the respondents had disclosed their abortions to varied from 4 to 30 people. Some had planned to whom and how they will disclose it carefully; others have done it spontaneously. One respondent, Julia, has disclosed her abortion on social media. Several aspects were, however, shared between the respondents. All respondents have told one or several significant others, such as friends, family or partners, about their abortion. No respondent had told anyone that they did not know previously. Four of the respondents have had a deeper conversation about it with five persons. Miriam has had a deeper talk with one person. Lastly, four of the respondents stated they have reflected upon how the information will be received and what kind of reaction they should expect from at least two persons.

A common reason for telling others about their abortion was need of support. Julia, for example, found it quite easy to tell people about her abortion and she has received support from friends, family, partner, and colleagues. As she was feeling physically unwell before and after the abortion, she explained her behavior partly by telling others about the abortion. The topic also
came up naturally with colleagues who were also pregnant at the time. Claudia did not express experiencing any felt stigma and received the support she needed at the time from family and friends. She does however feel that abortion never has been the main topic of conversation, but rather only mentioned in the passing. Andrea has sometimes worried about how people would react, but nevertheless expected to receive support, which she did. Miriam feels she did not receive the support she was looking for when disclosing her abortion, except for when telling her current partner. She explains her need for support this way:

Sometimes you have to share your thoughts with someone else for a moment. It’s the same thing here, this is an experience and I haven’t had anyone to talk with, […] I have to talk to someone, I can’t just be quiet.

The following presentation of result and analysis aim to give an account for the variations of women’s experiences, as well as identify common denominators.

### 7.1 Manifestations of individual level abortion stigma

The following sections aim to answer the first research question: *How are the three manifestations of abortion stigma (internalized, felt and enacted) experienced by women with personal experiences of abortion?*

#### 7.1.1 Internalized stigma

Internalized stigma - “a woman’s acceptance of negative cultural valuations of abortion” (Cockrill & Nack, 2013, p. 974) occurred among the respondents to a limited extent and mostly consisted of negative valuations regarding the unintended pregnancy rather than the abortion.

Acceptance of the negative cultural valuations of the pregnancy was expressed to various extents. Elisabeth experienced feelings of shame for getting accidentally pregnant again and having a second abortion. She felt careless and a bit irresponsible: ”This time I felt more shame for having the abortion [compared to the first time], not in the way that I’m ashamed before others, but rather towards myself, that I feel more guilty […]. I was a bit ashamed for being a bit irresponsible”. Miriam and Andrea both expressed they had previous prejudices against people who get accidentally pregnant. Before Miriam got pregnant she explained thinking that people who get accidentally pregnant do not make the effort to use contraceptives or deliberately use
abortion as a contraceptive. Andrea knew of a few people who had had abortions, one of whom told her when they were teenagers: “I believe I remember thinking that, especially with this one friend, sort of ‘oh, how did this happen?’ Since she was it [pregnant] several times. Perhaps a little, not judgmental but like, ‘Why aren’t they more careful?’”

The respondents who had talked to people about abortion before, in a more thorough way than a mere mentioning of its occurrence, expressed less or none internalized stigma. Julia for example, expressed little internalized stigma and knew about 5-6 people before who had had abortions: “It [the topic] has come up… when you meet up. One person I lived with and well, everyday conversations.” Claudia too expressed little internalized stigma. She felt that abortion was fairly easy to talk about among her friends since many of them do not want to have children:

Among friends people have brought it up like ‘yes I’ve done that’ and ‘yes me too’. And then you’ve discussed similarities and thoughts. But I think that, I don’t know, there are so many among my friends who don’t want kids. So then abortions have become a fairly natural topic as well.

### 7.1.2 Felt stigma

Felt stigma – “assessments of others’ abortion attitudes, as well as her expectations about how attitudes might result in actions” (Cockrill & Nack, 2013, p. 974) was experienced by most of the respondents and sometimes to a large extent. Several respondents have imagined negative reactions and some have, as a result, carefully planned who they disclose it to and how they do it. Experiences of felt stigma seem to be oriented both towards the abortion decision as well as the unintended pregnancy. The result further indicates that internalized stigma can contribute to felt stigma. For example, Miriam explains that since she realized she had prejudices herself, she assumed her friends would have them too. Because of this she hesitated before telling them and she was not surprised when their reactions were negative.

Felt stigma was experienced in large variations. As seen in the quote above, Claudia has not been nervous before talking to people about it or worried about how people would react. Julia too has experienced little felt stigma. She has not worried about people’s reactions, except her grandmother and mother. Her grandmother is a practicing Christian and her mother is “pro-choice in theory” but believes it is a very difficult thing to go through. Thus, Julia did not want to

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5 A negative reaction is understood here as inconsiderate and/or judgmental.
have that discussion with her, and asked her sister to tell their mom instead. Several respondents expressed a similar kind of need to control how and when people find out. Elisabeth chose to tell her father over the phone while she was with her mother, since she worried about how he would react. She also stated that she would never tell anyone who she worried might be judgmental, unless she had to. Those who she was worried about how they would react, she has not told about the abortion. One such group is men:

I’ve heard guys bullshit about girls who get pregnant. That it’s irresponsible, that it’s the girl’s fault and not the guy’s responsibility. You know, like really foolish. And there’s still this talk about girls who sleep around as… disgusting. I think that still now when you’re older you hear that a lot. That girls are loose and stuff. So I’m just not as comfortable with telling guys I know as compared to girls I know.

Along with worrying about people’s reactions, several respondents also expressed a need of support. Miriam has often worried about how people will react, and has concealed her abortion in several situations: “There are many times I’ve thought that this would have been good to talk about. And then you hesitate and you don’t do it. I would have liked to tell my mom. But well, I can’t. I would have liked to tell my grandfather but that’s not an option.” Despite her worries, she has told a few friends since she believes she should not have to keep quiet: “I have a need to talk about things”. Andrea too found the situation a difficult process and felt a need to talk to people about it. She was a bit nervous before telling friends who wanted to have children of their own, and at first she was unsure whether to tell her parents or not. Apart from this, Andrea did not worry about what people would think about her decision, since everyone she knows are pro-choice, but rather what they would think about her unintended pregnancy:

… because I had those thoughts about being careless myself. So I think that always when telling another person… it’s related to each other. If you have an abortion, people will know you got pregnant. But I think for me it has always been this issue of carelessness that has been the most difficult. And it feels like it is related to the guilt, before… the responsibility is always mine, rather than the guy’s.

No respondents have told anyone that they did not know previously. Elisabeth feels like it is none of their business and she does not think they would be interested. She also mentions that perhaps because she knows everyone that she has told about the abortion quite well, she has received the reactions she expected (i.e. support and only one negative reaction that she anticipated).
Several respondents mentioned a silence that they felt surrounded the topic of abortion. For example, Claudia felt that abortion never has been the main topic of conversation, but rather only mentioned in the passing. Julia further stated that:

…it’s often like if you tell someone you have had an abortion then there are, at least among people I know, many who have done it too. But it’s not something that you would… in most cases it’s not something that would come up. And several persons I have spoken to have felt that it has been really difficult and very ‘hush-hush’ surrounding their abortions. It’s something they don’t want to be known.

7.1.3 Enacted stigma

Enacted stigma - “experiences of clear or subtle actions that reveal prejudice against those involved in abortions” (Cockrill & Nack, 2013, p. 974) too was experienced in large variations. All respondents have had at least one positive reaction and one respondent did not report any negative reaction at all. Four out of five respondents have however experienced enacted stigma to different extents. Most respondents have received the reactions they expected, irrespectively of whether they were positive or negative.

Negative reactions emerged both in relation to the abortion decision as well as the unintended pregnancy. Elisabeth, for example, experienced a negative reaction from her partner at the time: “He was like ‘are you serious?’, and almost got angry at me and you know… He said ‘you can’t have another abortion, it’s dangerous. You won’t be able to get pregnant when you’re older’”. Elisabeth knew that this is not true but said it still made her feel bad. Miriam feels that others look down upon her decision and has experienced strong judgments: “The first people I told, a few friends, thought it was insane. ‘How can you do that?’ ‘I would never have done that’. So then… you don’t tell anyone else”. Julia’s mom has reacted somewhat negatively, in the sense that she has worried about her health and asked such questions that lead Julia to believe her mom is afraid that she will regret her decision. This made it difficult for her to talk to her mom, which was complicated by the variances in hormone levels: “I had a lot of hormones so I could get very upset for anything. So then it sort of became a confirmation for her that it is really difficult. When really it’s not the decision that’s difficult but the whole situation.”

6 A positive reaction is understood here as considerate and without judgment
Miriam brings up the prejudice people show when finding out about her unintended pregnancy. She thinks they act on the idea of a simple solution to the problem: “Like, ‘why didn’t you just use contraceptives?’” When telling others about her pregnancy, she’s found that they assume she carried it to term. When they realize she didn’t, they change the topic or show in another way that they do not want to talk about it. Elisabeth has also experienced being questioned why she got pregnant a second time three years after her first abortion. Her boyfriend called it “disgusting” and told her to “tighten up”, and a health care worker questioned her second pregnancy and said “you can’t go on like this.” While she also received support from friends and her mom, they have questioned her as well: “… like ‘why do you get pregnant again?’ or ‘don’t you use protection’, ‘you’ve already been pregnant once’ sort of like that… And my mom said ‘from now on you really have to take this seriously’. ” Elisabeth thinks they react this way because they care about her and because they know that she has found the abortions quite difficult.

Most interactions with the health care system have been positive for the respondents. However, enacted stigma was also experienced from health care personnel. Julia faced a judgmental attitude when trying to book a time for abortion. The employee pressured her on contraceptives and told her that “you don’t want to end up here again”. Andrea also experienced a negative reaction when contacting the health center to book a time for insertion of an IUD after her abortion. The nurse criticized her unintended pregnancy and told her that “we barely have time for the pregnant women.” After Miriam’s abortion she faced severe complications and had to receive surgery several times. The first time she arrived at the hospital for surgery a nurse told her that she “doesn’t think anyone should have an abortion.”

Enacted stigma was experienced as a reaction to related issues as well. Julia does not want to have children and feels that abortion counters the dominant idea that everyone wants to have children: “… I’ve tried to say that ‘I don’t agree.’ But it’s a difficult discussion to engage in, people often get very upset […] they say ‘think about those who cannot conceive’.” She believes this is connected to the heteronormative idea of a relationship and growing up. Among her queer friends she does not feel the same pressure, she says.
7.1.4 Summary and discussion

This section aimed to answer the first research question: How are the three manifestations of abortion stigma (internalized, felt and enacted) experienced by women with personal experiences of abortion? The following section will conclude and discuss the findings.

The results could be understood as a clear indication of the prevalence of abortion stigma in Sweden. Just as women’s general experiences of abortion vary, as shown by Kero (2002), the women in this study experience abortion stigma to different extents and in various ways. The experiences are sometimes conflicting and complicated. A common feeling among several of them are, however, the simultaneous need of support and need to control if, how and when to disclose their abortions. In short, internalized stigma was experienced to a limited extent, and mostly in relation to the unintended pregnancy. Felt stigma was experienced to a fairly high extent, both in relation to the pregnancy as well as the abortion decision. Enacted stigma was experienced in large variations and sometimes to a high extent, both in relation to the pregnancy as well as the abortion decision.

An interesting aspect of the result was that the manifestations of stigma were focused on both the abortion decision as well as the unintended pregnancy. This could be seen as illustrating what Lennerhed (Bengtsdotter, 2017, p. 89) argues to be a “big and undefined cloud of shame.” The uncompromising ideal of not getting unintentionally pregnant causes shame which is mixed together with the shame of having an abortion. To have an abortion thus seem to carry two, potentially quite different but also closely related, stigmas: the unintended pregnancy as well as the abortion decision.

Another interesting finding was that some respondents who had been in contact with abortion or related issues before (such as LGBTQ identities or the preference to not have children) expressed less abortion stigma. This was the case especially for those social circles where the ‘deviant’ factor was present, which often were their friends groups. This goes in line with Kumar et al.’s (2009) conceptualization of abortion stigma as closely related to ideological struggles of family, motherhood and sexuality. In this reasoning, abortion is one way of many to transgress stated norms. This further goes in line with Julia’s experiences of enacted stigma when she has told others that she does not want to have children.
Negative cultural valuations of women who have had an abortion were present in the answers given by the respondents in several ways, for example by describing themselves and others as careless or irresponsible. It was sometimes described as prejudices by the respondents, for example as a few said they had to scrutinize themselves afterwards and realize they had previous prejudices. The respondents are aware of these prejudices and often act to avoid or counter them. Sometimes their worries about how others will react (i.e. felt stigma) are fulfilled (i.e. enacted stigma) and sometimes not.

Thus, the respondents are weighing upsides and downsides of disclosing their abortions for others. Cockrill and Nack (2013) have found a similar tendency and argue it is a part of the need to control if, how and when people find out. The fact that most respondents have received the reactions they expected indicates that their predictions of how people will react are accurate. It is thus likely the predictions are carefully thought through, and could be understood as another indication of the perceived need for information control. From the results it further seems like the need for information control may lead to losing the chance of therapeutic disclosure. This is illustrated by Miriam’s wish to be able to talk to her mom and grandfather about her abortion. Losing the chance of therapeutic disclosure may also lead to a re-creation of the collective social silence in society (Cockrill and Nack, 2013). Lastly, it is interesting to note that none of the respondents have told anyone they did not know previously. This is an indication of the perception of abortion as a private issue, as Elisabeth also stated.

### 7.2 Elements of abortion stigma

Apart from the three manifestations of stigma above, a few aspects that have been brought up in stigma research could be identified in this study as well: misconceptions and lack of awareness, and creation of shame and guilt. Lastly, the respondents expressed several reactions to the stigma such as reciprocal disclosure (mutual disclosure from someone who the respondent disclosed her abortion to) and taking action. Thus, the following section aim to provide an answer to the second research question: What elements of abortion stigma can be identified from women’s personal experiences?
7.2.1 Over-simplifications, misconceptions and lack of awareness

All respondents have brought up misconceptions or lack of awareness among others and themselves on abortion in general that has had a negative impact on their abortion experience. These have mostly been regarding: the prevalence of abortion in Sweden, who has an abortion and for what reason, as well as abortion’s physical and psychological impact before, during and after the procedure. For example, several respondents had at some point been told that abortion can cause sterility, or that abortion is being used as a contraceptive by some women. These misconceptions had also been internalized by a few of the respondents.

The idea that all women find abortion morally difficult caused several misconceptions. As mentioned above, Julia felt that her mother misunderstood her and strengthened her perception of abortion as morally difficult when Julia got upset because of the variances in hormone levels. She feels that many people focus too much on psychological distress of the abortion decision, and even though this is an issue for some, the other side of it (to find the abortion decision easy) is very seldom shown. She further states that society does not bring up the physical effects of pregnancy and abortion, for example the severe pain and complications that some women experience:

I think that it lacks nuances. [...] I think that there are two discourses that conflict each other a bit. One is that it can be difficult to have an abortion because maybe you wanted to keep the child [...] and on the other hand that it’s not very important with contraceptives since if anything happens you can always have an abortion. So then it’s like, if you don’t find it difficult psychologically, then it’s not an issue.

Miriam feels that abortion is regarded as an “easy way out” from a social perspective for women who get accidentally pregnant and do not want to “stand up for” their mistake: “It’s that people have so much prejudice, about everything [...] when you put blame on, like ‘why didn’t you just do it like this?’ Like there was an easy solution to it.” She therefore thinks it is important to spread knowledge of what abortion means, that it is not such an easy way out as people think, and awareness about how common it is, to lessen the shame that people feel.

On the other hand, Elisabeth thinks that abortions have become too normalized lately in comparison with when her mom was young: “…she said ‘I didn’t know anyone who had an abortion.’ So it was more like if you had a husband then you kept the baby. [...] so it’s difficult, since it dreadful to have like six abortions just because you don’t want children, while you don’t
care about taking the pills.” Since the abortion rate in Sweden has been relatively stable since the ‘70s, it is rather likely that Elisabeth’s mom did know some women who had had an abortion but kept it a secret. Elisabeth also stated that since abortion poses a strain to the body, and since it is dreadful to abort what could be a child, one should not consider abortion too easy: “I don’t think abortion is a contraceptive […]. I don’t think that is something you should do; I think you should be careful and take your pills.” The assumptions of abortion’s chronical strain on the body and of abortion being used as a contraceptive do not have any scientific support but are sometimes mentioned as common misconceptions (1177 Vårdguiden, 2015; Bengtsdotter, 2017).

Over-simplifications of women’s abortion stories had led to isolation for some respondents. After her abortion, Andrea faced a time of psychological distress and believes the abortion was a large component. This was something she was not prepared for and she felt alone in managing those feelings:

…I felt so stupid because I wanted to talk about it and I tried, since I’m that kind of person who can talk about things, I tried but it felt really wrong […]. Because I had made my decision and I shouldn’t feel like… I shouldn’t keep track of when the baby should have been born. But I did it anyway and I felt that I couldn’t talk about it. Because maybe they would think I regretted my decision.

Similarly, Claudia recently experienced new and mixed feelings about her abortion as she has started to consider having children. She stated that she would have liked people to ask her longer afterwards how she was feeling about it, even though it was the right decision in that situation and it felt very good and right at the time. As abortion research has found, to have mixed feelings after an abortion is very common. These are however aspects of people’s personal experiences of abortion that are seldom brought up in discussions on abortion (Bengtsdotter, 2017, p. 66).

### 7.2.2 Feelings of shame and guilt

Kumar et al. (2009, p. 633) have argued that “shame and guilt are the two most common manifestations of internalized abortion stigma.” In this study, feelings of shame and guilt were experienced in relation to the unintended pregnancy as well as the abortion decision.

Julia brings up the aspect of shame as a result of being in need of an abortion, and not so much of the abortion decision: “you have done something wrong in order to end up in that situation.” Since telling others that you are having an abortion inevitably also means telling them you are
pregnant, people would know you’ve been careless with contraceptives or “somehow it is your fault that you’ve ended up in a situation in which you need an abortion.” Thus she felt that the social component of being subject to shame for being in that situation is worse than the physical component. Miriam thinks the prejudices that people have makes others feel ashamed: “Like, ‘why didn’t you just use contraceptives?’ And you think ‘well, you don’t know everything because you didn’t ask’. […] I felt ashamed when people asked me that.” Miriam felt stupid and ashamed for getting pregnant even though they used contraceptives and she thinks it is because of the idea of women who get unintentionally pregnant as stupid:

…only those who go to the bar and sleep around get pregnant because they don’t have the sense to protect themselves, since only stupid people don’t protect themselves […] You know that people think that. It is some kind of invisible expectation.

She has had these thoughts herself before she got pregnant and stated that she afterwards had to scrutinize herself and realize that she was wrong. Andrea too brings up the issue of contraceptives, and criticizes that the responsibility to use contraceptives is always hers: “…some [guys] don’t even ask if you’re taking anything. So it feels like it is just expected of you.”

Elisabeth too thinks that abortion is considered shameful and has friends who feel that it is shameful to talk about. She links it to how young women are ashamed to say how many people they have had sex with. Elisabeth felt guiltier about her decision the second time, since her capacity to take care of a child was bigger, and also found it harder to talk about. She thinks that having a stable living situation would make the decision harder and that one would feel guiltier if you are capable but choosing to abort because you don’t want to have a child. The reasons behind her abortion are thus influencing her experience of stigma “…I don’t think what I did was wrong or anything, since I had my reasons. That were like, quite serious reasons.”

One unexpected aspect mentioned by several of the respondents has been the influence from school on forming ideas on abortion. Julia, for example, has experienced anti-abortion opinions from students and teachers at her school, who were arguing that it is morally wrong to have an abortion. Sometimes abortion would appear as a “moral issue” on exercises. Julia however believes that abortion is a natural right that should not be questioned. Andrea mentioned the impact of exercises in school such as biology lessons, argument exercises and discussion exercises in forming ideas about “killing a child.” Similarly, Miriam remembered discussion exercises with
questions such as “is abortion right or wrong,” “do you have the right to decide over someone else’s life?” She explains how these exercises have had an impact on her afterwards: “It’s these kinds of questions which you later, when you’re about to have an abortion, realize that: oh my god, someone once told me this, how difficult it got now.” She further stated that she thinks these kinds of discussions are unnecessary:

I feel like it is up to each and every person, since it is my body. Do I feel that it is alive in my body, or do I feel that it is a life I can’t contribute anything to and do I feel that it is not alive at all? […] I think it’s wrong for people to like, ‘well what do you think’ and it’s like, ‘you can’t tell, since it’s my body’.

7.2.3 Reactions to abortion stigma

Several respondents expressed that the abortion experience has also brought positive outcomes, such as personal development, mental growth, knowledge and awareness. The majority of the respondents also stated that the experience and reciprocal disclosure from others had made them realize how common abortion is.

There also seemed to be an awareness of the silence surrounding abortion, and all respondents criticized it in one way or another. They also expressed that the issue is important and should be talked about more often. Julia feels that there is a silence surrounding abortion: “I think it is something one should talk about, because… It shouldn’t be something that is silenced, but if you need to talk about it you should be able to do that without feeling shame.” She also called for more discussion on what the difference is between being pregnant when wanting to be it, and when not wanting to be it. Elisabeth compared it to standing up for how many people you’ve slept with: “…since then, if everyone would do that, no guy could tell you that you’re disgusting. Since then it would be like ‘alright,’ it would be ordinary, normal.” Miriam further compared abortion with women’s menstruations in that it is treated as a “women’s issue” hidden in a remote part of society instead of as a natural part of life. Julia decided to post a status about her abortion on social media at a time when there was a lot of debate surrounding abortion: “I wanted to share my perception of it.” Few of the respondents have, however, participated in any kind of discussion on abortion in general, despite feeling that it should be talked about more. A common remark among several of the respondents was that they would be happy to talk about it, if others approached them.
Several respondents had experienced reciprocal disclosure. Andrea has talked about her feelings afterwards with friends, despite feeling that it was difficult, and a few people have told her about their abortion experiences in return: “I’ve got the feeling that it is more common than you think […] And that it is a way for them to show that you’re not alone in this.” Miriam, however, has not experienced reciprocal disclosure from anyone. It feels strange, she says, and it makes her wonder if she has done something wrong, since others do not have the same experience. It thus contributes to the feeling of being stupid: “You feel a bit stupid I think […] who has an abortion, or even get pregnant at all because you know better, you’ve gotten all the information, you know how to protect yourself. It feels like people look down on you a bit. Some are like: ‘should you really…’ ‘is this good…?’”

Several respondents stated that they could tell more people in the future about their abortions. Nowadays Claudia feel that she would need more support, and therefore she will talk more about it. Miriam mentioned that as time passes and she gets more secure in herself she feels more comfortable in talking about her abortion as well as handling people’s reactions, and she believes that this will facilitate for her telling people in the future.

7.2.4 Summary and discussion

The section above aimed to answer the second research question: What elements of abortion stigma can be identified from women’s personal experiences? The following section will conclude and discuss the findings. In short, the elements of abortion stigma found here bring forth interesting indications of underlying reasons behind stigma and consequences for women and society at large.

The results under manifestations of stigma show that women’s general experiences of abortion vary, and can be complex and conflicting. This supports what has been found in several studies on abortion in Sweden and elsewhere (Kero, 2002; Bengtsdotter, 2017; Cockrill & Nack, 2013). However, the results also show how women meet a simplified perception of abortion. These simplified perceptions seem to originate from society at large, as well as friends and family and sometimes from the women themselves. The over-simplifications concerned: the prevalence (several respondents expressed realizing how common it is after experiencing it themselves), who has abortion and for what reason (the idea about ‘loose’ women who do not care about contraceptives), and abortion’s physical and psychological impact before, during and after the
procedure (that not all women feel that it is a difficult ‘moral’ decision, that mixed feelings are common even though you are happy with your decision, and that the procedure can cause severe physical pain). According to Kumar et al. (2009), the first stage of creating a stigma builds on over-simplification of complex situations.

Several consequences seem to emerge as a result of the stigma. In line with Lennerhed’s findings that women are supposed to care for life and it is shameful to do the opposite (Bengtsdotter, 2017, p. 96), shame and guilt were experienced in relation to the pregnancy and the abortion decision. Several of the women described themselves and others as careless or irresponsible. The results also indicate that stigma lead to isolation for some women, losing the chance of therapeutic disclosure as Cockrill and Nack (2013) have also argued. They felt isolated from others who might understand, i.e. significant others, or people with similar experiences. This goes in line with how the collective social silence surrounding abortions means that women stay silent about their experiences even though they feel good about it (Cockrill & Nack, 2013).

All respondents expressed awareness of the taboo, silence or misconceptions surrounding abortion. According to Lennerhed it is a good starting point to relate one’s experiences to the dominant perceptions and be aware of their incongruity (Bengtsdotter 2017, p. 89). Several respondents also criticized the perception of abortion that they had acquired in school when they were younger. The reactions to stigma such as talking about it with people they trust, or reciprocal disclosure, could also be seen as a way of breaking the collective social silence. However, only to a limited extent since no respondent had told anyone they didn’t know previously, few had participated in any discussion on abortion in general, and several mentioned that they would be happy to talk about it “if others approached them”.

8. Discussion of research findings

The general aim of this study was to provide an indication of how abortion stigma is constructed within a Swedish context. The summarized aspects from the first two questions, the manifestations and elements of the stigma, will be discussed below in order to answer the last question: How do the manifestations and elements of abortion stigma relate to local and global conceptions and theories of stigma, sexuality, and biopower?
As mentioned above, awareness of the normative expectations we put on people’s social identities might not be acquired until there is a risk they might not be fulfilled (Goffman & Matz 2014, pp. 9-10). In other words, normative ideals of ‘woman’ or ‘pregnant’ might not come to our awareness until they are transgressed by, for example, an abortion. I argue that the women in this study experience abortion stigma in Sweden. In other words, as previously stated, they are experiencing transgression of these ideals, or archetypal constructs (Cockrill and Nack, 2013). This was visible through the negative cultural valuations of women who have had an abortion and sometimes described as prejudices by the respondents. Perhaps the transgression of archetypes is the most visible when considering the exception: a few respondents expressed experiencing less stigma since they had already experienced similar transgressions of archetypes. Those respondents who knew several people before who had had abortions, who had LGBTQ friends, or friends who did not want to have children, could count on them to be accepting of their abortion. Thus, a normalization of transgressions of those ideals could perhaps be said to have taken place for those respondents. Or, in other words, perhaps the ideals had already been dismantled and/or changed. It is, however, important to note that experiences of stigma among women who have had an abortion should not be taken for granted. Instead, women’s individual experiences should be emphasized, especially since the large variations in the respondents testimonies show that experiences of stigma can vary substantially from one person to another.

Recurring concepts in literature discussing underlying reasons behind abortion stigma is gender and sexuality. Cockrill and Nack (2013, pp. 274-275) emphasize archetypal constructs of the “‘feminine’, of procreative female sexuality, and of women’s innate desire to be a mother”. Boyle too (1997, p. 7) argue that abortion has “strong and obvious links with female sexuality and motherhood.” Kero and Lennerhed both bring up aspects of abortion in a Swedish context that are closely related to these archetypal constructs. These include the public conversation about the difficult abortion decision, the idea of women as irrational, and first and foremost taking care of others (Bengtsdotter, 2017). As Lennerhed has argued, a woman has to relate to the idea of motherhood before she has anything to be mother for (Bengtsdotter, 2017, p. 96). Furthermore, feelings of shame and guilt occurred in relation to the unintentional pregnancy as well as the abortion decision. The result thus indicates that there is an uncompromising ideal of not getting unintentionally pregnant corresponding with what Lennerhed (2000) puts forward as the rational and healthy modern sexuality where child rearing is planned and pregnancies are avoided. This
is illustrated by the respondents who expressed feeling stupid or careless for getting pregnant. Having an abortion in Sweden could thus mark you as ‘deviant’ from these ideals, or norms, surrounding gender and sexuality.

According to Kumar et al. (2009), the first stage of creating a stigma builds on over-simplification of complex situations. In the findings, several over-simplifications and misconceptions surrounding abortion were prevalent. These could be grouped under three categories. Firstly, the prevalence of abortion in Sweden; several respondents expressed realizing how common abortion is after experiencing it themselves. Secondly, who has an abortion and for what reason, i.e. the idea about ‘loose’ women who do not care about contraceptives. Thirdly, abortion’s physical and psychological impact before, during and after the procedure; not all women feel that abortion is a difficult ‘moral’ decision, mixed feelings are common even though you are happy with your decision, and the fact that the procedure can cause severe physical pain. These misconceptions and over-simplifications correlate with what Kero and Lennerhed put forward regarding abortion in a Swedish context as stated above (Bengtsdotter, 2017).

If the social production of stigma is dependent on different forms of power, both obvious and subtle as Link and Phelan (2001) have argued, then it is relevant to analyze what such forms of power could be. Foucault’s term biopower puts emphasis on non-centralized forms of power that are exercised through social relationships and practiced rather than possessed (Boyle, 1997, p. 7). It may therefore be useful when trying to understand issues of individual level stigma where people’s thoughts and interactions with each other are central. These aspects are closely related to Foucault’s analysis of discourses surrounding sex, which in turn are linked to the pervasive implantation. I therefore argue that the findings discussed above are a part of a discourse that marks abortions as a form of perversion and women who have had them as deviant. The uncompromising ideal of not getting pregnant unintentionally could be interpreted as a result of the discourse on a rational and healthy modern sexuality, representing another direction within the multi-directional biopower. Thus, through the use of the concept biopower, one can problematize the discourses surrounding abortion and ask relevant questions about abortion stigma: What conditions fostered the emergence of abortion stigma? Which social practices are allowed, maintained or seem reasonable? Who is empowered to produce discourses on abortion stigma (Boyle, 1997)?
It is thus relevant to analyze the discourses surrounding abortion in the findings as normative forces with possible underlying interests and consequences. As Foucault proposes, it is possible that the objective of the discourses surrounding sexuality is to expel such practices that do not aim to be procreative. When Miriam says it would be more socially acceptable to be pregnant (and wanting to) than to have an abortion, when Elisabeth feels she is ashamed for having a second abortion, or when Julia receives the comment to ‘think about those who cannot conceive’ when stating her will to not have children could be seen as experiences of normative forces that privileges procreation. It is thus also an example of how the heteronormative discourse that naturalizes procreation, heterosexuality and monogamy, affects women in their everyday life. In this context it is especially interesting that the educational system in Sweden seem to have played a part in forming the respondents’ views on abortion. Disclosing your abortion to someone could, from the findings is this study, thus be seen as a way to resist the stigma and counter the normative forces.

Lastly, it is interesting to note that from the result it seems like abortion is considered a personal subject, while women also experience the public and political aspects of it. The main indication for it being considered a personal subject is the fact that none of the respondents have mentioned their abortion to anyone they don’t know. While this may be a personal preference, as Elisabeth pointed out: “It doesn’t feel like they have anything to do with that. […] They probably don’t care either,” it is interesting that none of the respondents have mentioned it irrespectively of how many people they have told or whether they found the abortion difficult or easy. No matter what the reason behind this is, it reinforces the collective social silence surrounding abortion, and the misconceptions surrounding abortion of how common it is and how women experience it. The prevalence of abortion stigma in Sweden shows that there is a connection between the individual and the social context. As Boyle (1997, p. 9) has also argued, it is important to understand that wider social meanings are central to individual women’s experience of abortion in order to deconstruct the social categories that stigma builds upon instead of treating them as a given. As Lennerhed argues, we are historical beings, detecting previous societies’ norms in relation to abortion (Bengtsdotter, 2017, p. 91). Boyle (1997, p. 8) further states that the discourses during the past two centuries have been characterized by “political and social practices of excluding or attempting to exclude women from public life.” The reasons for bringing forth women’s personal
experiences of abortion are many, and perhaps these need to be brought into the public sphere of society, in order to deconstruct the stigma.

9. Conclusion

This study provides an indication of how individual level abortion stigma is constructed within a Swedish context. Abortion stigma in this study is, just as abortion in general, experienced in various ways and to different extents by the women in this study. All three manifestations of stigma, internalized, felt and enacted, could however be found among their answers.

Abortion stigma was experienced in relation to the unintended pregnancy as well as the abortion decision. The women in this study face several consequences of abortion stigma such as feelings of shame and guilt, worrying about how people will react, having to face negative reactions, isolation from others who might understand, and/or losing the chance of therapeutic disclosure. All respondents did critique the stigma or consequences of stigma in one way or another. The results further indicate that over-simplifications and lack of awareness among the general public possibly contribute to the creation of stigma through working in accordance with gendered normative ideals that is the basic foundation for abortion stigma. From the women’s experiences, it can therefore be assumed that abortion stigma in Sweden is built upon the same gendered normative ideals that have been identified in previous research, including an uncompromising ideal of not getting unintentionally pregnant. Lastly it can be concluded that the women’s experiences of abortion stigma can be linked to concepts of biopower and the discourse of modern sexuality.

Deeper and more extensive research on abortion stigma in Sweden is necessary in order to get a clear understanding of stigma and identify the factors behind it. To begin with, quantitative as well as qualitative studies are needed looking at the extent to which women who have had an abortion experience abortion stigma. It is also relevant to look into what extent over-simplifications of abortions and of women who have had an abortion occur among the general public in Sweden. A related subject could possibly be the personal, public and political aspects of abortion and abortion stigma.
References


Appendix 1

Interview guide

Introduktion

- Presentation av studien (forskningssyfte, frivilligt och anonymt deltagande, frihet att avbryta, inspelning) samt säkerställande av samtycke.
- Inledande frågor: pronomen, ålder, antal aborter

Före aborten

- Hur många personer kände du till som hade gjort abort innan du blev gravid?
  o Hur kändes det när de berättade?
- Hade du pratat med någon annan om graviditet och abort innan du blev gravid? Kommer du ihåg hur du tänkte kring graviditet och abort då?

Att berätta

- I vilka situationer du har valt att berätta om din(a) abort(er)?
  o Hur kändes det att berätta?
  o Vem har du berättat för? (kön, ålder, bekant/främling)
  o Hur många personer har du berättat för, respektive haft ett djupare samtal med?
  o Varför har du berättat om din(a) abort(er)?
  o Hur kändes det att berätta om din abort, jämfört med att berätta om din oplanerade graviditet?

Reaktioner

- Om du tänker tillbaka på ett par situationer då du berättat för någon om din(a) abort(er).
  Vilka känslor skapade det hos dig?
  o Har du varit orolig för hur de ska reagera?
- Hur har de reagerat när du berättat om din abort?
  o Ev: Hur har andra reagerat på att du gjort fler än en abort?
  o Har de reagerat som du trodde?
  o Vilket stöd känner du att du har fått?
- Hur vill du helst att andra ska reagera?
- Hade du velat berätta för fler än du gjort?
- Kommer du att berätta för fler i framtiden?

Dig och din omgivning

- Vilken bild känner du att folk har av dig efter att du berättat?

7 All interviews were conducted in Swedish
8 Information om ålder togs senare bort för att skydda anonyemiteten hos respondenterna
Stämmer den bilden som andra har av dig överens med den du är?
Hur ser du på dig själv nu jämfört med tidigare?
- Hur tänker du kring abort generellt i samhället nu efter att du berättat för andra?
- Har din syn på din(a) abort(er) förändrats över tid?
- Om du tänker på en situation då abort har diskuterats i din närhet, hur upplever du det?
  (fysiskt, i media, på internet).
  - Brukar du ge dig in i diskussioner kring abortfrågan generellt?
  - Är det viktigt för dig att spreda kunskap/vetskap om detta?
- Om andra har berättat för dig om sin(a) abort(er), hur reagerar du då?
  - Vilken relation har du till andra som gjort abort?
- Vilken bild av abort tycker du förmedlas ifrån samhället?
  - Vilket stöd känner du att du fått från omgivande samhället (media, vården etc.)?

Avslutning

- Hur har du upplevt det här samtalen?
- Är det något annat du skulle vilja berätta?
- Är det något du skulle vilja fråga mig?
- Skulle du vilja läsa igenom innan inskickning?