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# Women's Experience of Abortion in Aotearoa/New Zealand: Conflicts and Contradictions in Choice

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# Abstract

*No woman wants an abortion like she wants an ice cream cone or a Porsche. She wants an abortion like an animal caught in a trap wants to gnaw off its own leg.* **— Anonymous**

Contemporary constructions of abortion in New Zealand have limited abortion rhetoric to a distinct binary of prochoice or prolife discourse. These binaries restrict the positions available to women when negotiating their experiences of abortion, and position women in a polarising discourse that does not sufficiently encompass the complexity of women's lived experience of abortion. Limiting abortion rhetoric to the dominant binary has consequences for the creation and maintenance of abortion stigma, particularly internalised stigma, which can have negative consequences on women's experience. This research aimed to examine the gap that psychological research has failed to explore by addressing the question of the effects of wider sociocultural factors in women's experience of abortion and the discourses that they engaged with to construct their narratives. Five women who had terminated a pregnancy before 20 weeks gestation were interviewed about their abortion experience in New Zealand using one to one conversational interviews. A feminist poststructuralist discourse analysis was conducted, attending to the binary that enabled and limited positions for women to occupy in regards to the wider sociocultural forces regulating abortion. The analysis showed that the binary both created and exacerbated women's struggle and confusion in their decision-making with the inflexibility of positions on either side of abortion rhetoric. It explored how women position themselves as 'both/and' within the binary rather than 'either/or' and identified some of the conflicts this creates. Further alternative discourses of maternity, individualism and female sexuality textured the prochoice and prolife abortion rhetoric and enabled an examination of how other discourses regulating women's bodies are salient in women's talk about their abortions. This research provides an understanding of the effects of dominant abortion discourses and the power relations implicit in them on women's construction of their experience. Furthermore, how these discourses may be resisted and implications for policy going forward are also examined to reduce stigma and silence surrounding abortion for women in New Zealand and improve the social conditions in which women access this procedure.

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# **Chapter 1 -** Introduction

*"I will choose what enters me, what becomes*
*of my flesh. Without choice, no politics,*
*no ethics lives. I am not your cornfield,*
*not your uranium mine, not your calf*
*for fattening, not your cow for milking.*
*You may not use me as your factory.*
*Priests and legislators do not hold shares*
*in my womb or my mind.*
*This is my body. If I give it to you*
*I want it back. My life*
*is a non-negotiable demand."*
***Right to Life*, from ' The Moon Is Always Female' by Marge Piercy, 1980.**

Abortion is one of the most common health care needs for women of reproductive age and millions of women across the globe access abortion every year, whether or not there are legal or social restrictions to access. The link between unsafe abortions (practiced outside the boundaries of legislated interventions) and maternal mortality is, unfortunately, clear. While the majority of deaths occur in developing countries (up to 250,000 annually), they occur for preventable reasons – from complications of unsafe abortions by unqualified practitioners (Drife, 2010; Williams et al., 2000). The potential risk for women of procuring an unsafe abortion is enormous – as "anything which is likely to kill the foetus, is just as likely to kill the mother" (Williams et al., 2000, p. 498). During the 20$^{th}$ century, as much as 25% of maternal mortality in England and New Zealand alike was attributed to abortion, being carried out by unqualified men, or by women poisoning themselves, to achieve an end to their pregnancies. The risks these women took in order to access an abortion were literally life or death and in many countries today, this is still the case. The contribution that unsafe abortion makes to maternal morbidity and mortality has been widely acknowledged and, as a result, there have been significant advances in policy

and programmes of action aimed at reducing the health burden it creates (Ahman & Shah 2011; WHO, 2012).

The advances in policy to reduce the health burden of abortion on Governmental public health budgets (or statistics) have had significant implications not only for the safety of abortion but for the way it is constructed in society. Many nations have made abortion laws less restrictive in an effort to reduce unsafe abortion practices and protect the lives of women by providing improved access to medical assistance. Throughout the 20th century, women's rights went through unprecedented historical changes. The possibility for independence and control of one's fertility was offered to a new generation of women as cultural changes and medical advances regarding birth control took place. Among a variety of medical events, the introduction of the oral contraceptive pill in the 1960s was of great import (Goldin & Katz, 2002). Alongside the pill was the medical possibility of healthy and 'safe' abortions, one of many catalysts facilitating the legislation of abortion and 'free choice'. The second half of the 20th century saw the development of abortion laws in most western countries. Important landmarks were the Abortion Act 1967 that allowed abortion for limited reasons in the UK (except Northern Ireland) and the Roe v. Wade case in 1973 where the US Supreme Court made it illegal for American states to enforce regional laws that banned abortion.

Similarly in New Zealand, our own abortion legislation was introduced in 1965 through the Abortion and Sterilisation Act. This important legislation authorised the control of abortion by the medical profession under the premise of risk, and gave the state important information about abortion prevalence and incidence, and demographic data about the women who were having them. Globally, abortion legislation in New Zealand could be considered progressive; despite having to meet

certain criteria, women have relatively unimpeded legal and medical access within legislative boundaries. New Zealand currently allows a woman to have an induced medical or surgical abortion before 24 weeks gestation if it is determined by 2 certified medical practitioners that continuing with the pregnancy would pose a significant danger to her life, physical or mental health, that there is substantial physical or mental abnormality of the foetus, that the pregnancy is a result of incest, sexual assault/rape, or that the woman/girl is severely "subnormal" (Crimes Act, 1961).

The legislation only provides guidelines to practice; for example, what is considered to be a serious mental health risk to a woman is at the doctor's discretion, and appears to include emotional and financial stress-related burden (Harvey, 2013). At surface level, it may look as though a taboo has been dispelled - but this is questionable. Greater regulation of and legalised access to abortion on the surface resembles progress, but beyond that surface layer, a considerable level of complexity emerges. By observing changes in the representation of abortion legally, new parameters within which abortion access is socially sanctioned become apparent. With abortion being absorbed under public health policy, it has placed women and women's bodies under surveillance by the state – more specifically, it has normalised abortion in a biomedical discourse, and placed it under the control of medical and governmental macrostructures.

## Biopower and the Surveillance of Women's Bodies

Scheper-Hughes and Lock's (1987) theoretical model of the "Three Bodies" is a useful framework from which to understand disciplinary power over bodies, and women's bodies in particular. Viewing the way public policy has been imposed upon

women's bodies through this lens can open up possibilities to critique the dominant macrostructures through which knowledge and power relations are legitimised. Scheper-Hughes and Lock (1987) suggested that individual bodies have multiple influences to their being – the individual body, the social body and the body politic. The individual body is the relationship of the individual to society, and the lived experience of the self – restricted only by the rights of other autonomous individuals. The social body considers dominant discourses, or cultural constructions of the body that sustain particular social norms and values that are privileged above others. It also suggests that an individual is not truly autonomous – it is influenced (overtly or not) by the actions of others, or others opinions, norms and values. The body politic views the body as an item of social and political control, and refers to the macrostructures e.g. governments that "reproduce and socialise the kinds of bodies they need" through political and legal legislation (Scheper-Hughes & Lock, 1987, p. 25). This model is useful to illustrate how this thesis examines women's talk of abortion; women's experiences are much more diverse than the psychological literature has so far alluded to. Although the individual body is a useful component through which to examine internalised stigma, and this thesis will do that, it is also important to look at the wider sociocultural influences that affect women's talk of abortion and the discourses they use to position themselves through and against. Abortion itself is held to strict social and governmental control; it is impossible to extract women's individual experience from these social norms and legislative restrictions, and so it is theorised that these will have a profound effect on their experience. One way of understanding these effects is through biopower and biopolitics.

As populations expanded and migrated, the ability of dominant institutions (e.g. government) to control its citizens became more difficult. The power of

surveillance of the population was instead shifted from royalty to State, and became subtler, in institutions such as schools, hospitals and prisons, to establish information about the population, but also to monitor them across time and space (Howson, 2004). This indicated a shift from sovereign power to disciplinary power; a shift in the way the human body is regulated to meet the desires of modern capitalist (and patriarchal) societies (Lowe, 1995). One way in which disciplinary power began to manifest, with particular implications for women and women's bodies, was through **biopower** – the Governments increasing interest in the regulation of life (Howson, 2004; Ramazanoglu, 1993). Biopower emerged in the flux of disciplinary normalisation and population management. Attempting to indirectly manage the behaviour of people led to the establishment of disciplinary practices focussing on individual bodies in the guise of being normal life processes (McWhorter, 2010). In this way, biopower, developed from disciplinary power, is founded upon a gathering of knowledge; this knowledge is powerful and maintains power relations in social contexts that influence the legitimate ways people are expected to behave (Feder, 2007). To maintain or measure this power, the biopolitical state collates information on some of the biological processes of the population – namely measures of birth, death and fertility.

An aim and consequence of this shift of power and the rise of biopower and biopolitics was the development of docile bodies – the idea that people would internalise dominant discourses, and engage in activities to meet the standards and ideals of those dominant discourses, believing them to be for their own gain (Howson, 2004). Women's bodies in particular have come under increased surveillance in the past several decades. Bartky (1998) discusses the production of 'docile bodies', created by constant surveillance, whether this is from macrostructures or by individual women conforming to dominant, normalised social practices. More often

than not, individuals surveil themselves, and hold themselves to the standards and stereotypes they have been socialised to accept as natural and true. Bartky argues that women's bodies are socialised to be more docile than men's; that there are additional, gender-specific standards that only apply to the feminine body. She also discusses the "ornamentation" of the female body, the social practices of "learning feminine behaviours" such as walking with arms close to her body, and taking up as little space as possible (and certainly not as much as their male counterparts). Along with several other measures that women access to enhance their "feminine qualities", women's behaviour is also subject to the attributes of social values – for example, what appropriate feminine behaviour is, and what is not. These body-object articulations prescribe to women what it means to be feminine, and therefore a 'real woman' in society as it is currently constructed.

Successful fashioning of the docile body relies ultimately on the internalisation of standards, rules, and norms. In other words, even as women's idealised feminine bodies may be promoted by images in magazines or other media and reinforced by means of rewards and punishments through any number of social institutions (Feder, 2007), the real force of 'disciplinary power' is its distribution by individual subjects who direct this power inward, applying it to their own bodies. If external forces operating to enforce gender norms are identifiable - such as laws regulating abortion - these laws and their effects are secondary, though necessary, to the enforcement that happens in our social world.

Bartky's (1998) theoretical framework mainly addresses women's bodies from a cosmetic angle; in this thesis I wish to add an additional concept to women's docile bodies. I argue that the female body is conceptualised as an incubator, with a reproductive obligation. I also suggest that the additional gender-specific standards

applied to women's bodies (and not to men's) are indicative of wider disciplinary power at work – not only do women govern themselves (e.g. by way of internalised stigma, or adhering to cosmetic practices to enhance their "feminine" characteristics), they are also governed by the state, by way of direct surveillance through gender-specific legislation. Women's bodies have been construed as natural vessels, as reproductive equipment, as unpredictable and often dangerous or deviant, in need of civilised control and as tools to carry out the pronatalist objectives of the state (McWhorter, 2010). How feminism has described patriarchy has differed between groups. Liberal feminism suggests that although the state is not directly patriarchal, it often represents the interests of the dominant group – which is not women; whereas radical feminism suggests that the state is inherently gendered and serves the interests of the dominant group – men (Zajisek & Calasanti, 1998). What is agreed upon is that patriarchy legitimises stereotypes of masculinity and femininity that strengthens the power relations between men and women, based on their biological difference (Rawat, 2014). Hegemonic masculinity has left the male body unquestioned unless that male body displays feminine characteristics. The state has put in place structures to perpetuate masculinist efforts to harness and direct the biological and psychological processes that define and sustain women's reproduction, for example, abortion laws. These issues all amount to women talking about, resisting, and countering masculinist manifestations of biopower in their constructions of abortion experience.

## The Construction of the Binary

The body produced through the biological gaze is constructed on binary opposites, characterised through Cartesian dualism that distinguishes between the mind and the body. Human capacity to be reasonable, logical and 'of free will' is held

as gold standard; conversely the body is seen as wilful, disobedient and mechanical – a system of process (Price & Shildrick, 1999). Feminist constructions of the relationship between women's bodies and women's psychological or emotional functioning have been critical of the representation of women's bodies as pathological, deviant and unpredictable – characteristics that then become gendered and embodied in women in general (Ussher, 1991). Morgan (2005) argues that the split between body and mind also positions women as the opposite of reason and rationality. In other words, these binary opposites are characteristic of relationships of power where one is dominant and the other subordinate. Women become closely associated with irrationality, the body, and emotion, while men are assumed to possess control, logical thinking and level-headedness. Dominant assumptions of the female body as weak and unpredictable, in need of containment and supervision, has led to the dominant view of femininity as deficit.

As women's bodies are constructed in the biomedical discourse of unpredictability or weakness, so too are dominant constructions of reproduction. Associating women's reproductive capacities with the dominant view of women as weak and emotionally volatile, reproduction has become understood as a time of great disturbance in a woman's life – and a process that places them at risk of psychological difficulty if not properly monitored. Considering that the majority of research in the psychological realm has focused on the psychological and emotional aftermath of going through the abortion process, this has perpetuated normalised constructions of abortion. What can be considered 'progressive' legislation in New Zealand has left much to the discretion of doctors who have been given the uncontested authority to make decisions about the mental health of women in regards to keeping or terminating their pregnancy. On the surface, the interpretation of serious mental

health as financial or emotional stress may seem empowering to women, as it enables more women to meet criteria for abortion if they want one. However in effect, it is pathologising normal reactions to a huge life event (a pregnancy). Women's normal reactions and concerns are being categorised as severe mental health issues in order to qualify for abortion, thus constructing women themselves as emotional, irrational and unprepared to cope with the responsibility of motherhood. Having moved, in the 20th Century, for the most part, away from religious doctrine towards an empiricist, scientific discourse privileged in society, the biomedical discourse of pregnancy and scientific discovery has become the "default" way of discussing abortion experiences in Western culture and categorising women's psychology as unstable. Competing knowledges about women, women's bodies, and pregnancies have led to two distinct positions emerging in abortion discourse: prochoice and prolife.

The research and literature so far on abortion, both pre- and post-decision making, has centred on mental health outcomes for large groups of women at a micro level. This in turn has informed "abortion debate" or the "abortion script" and has led to several generalisations and stereotypes. Prolife discourse has normalised the belief that women who undergo abortion are more likely to develop mental health issues in the subsequent short or long-term aftermath. For example, Fergusson, Horwood and Ridder (2006) suggested that in New Zealand, women who had an abortion showed increased rates of depression, anxiety, suicidal behaviours and substance use disorders, even with adjustment for confounding factors – however this research has been critiqued on the grounds of methodological flaws (Cooper, 2009). The majority of good, methodologically sound research has found insignificant or neutral results that negative mental health consequences appear to exist, when controlling for previous mental health, the presence of domestic violence or childhood abuse, and

socioeconomic status/other demographic factors (Charles et al., 2008; Steinberg & Finer, 2010). Other studies even found that having an abortion as a young adult actually increased positive life outcomes, especially education attainment, of women (Fergusson, Boden & Horwood, 2007).

Despite the research to the contrary, the stereotype and myth that abortion can lead to serious mental health consequences continues to be perpetuated in the West through prolife discourse, especially as a rationale for restrictive abortion legislation (Charles et al., 2008), inextricably influenced by the socio-historical context of unsafe abortion and maternal mortality through the ages. However the association between mental health consequences and a woman's experience of abortion does not, based on current research, strongly support either anti-abortion or prochoice claims about the mental health risks associated with the procedure, although it continues to focus on women's deficit (Cooper, 2009). Although there may not be "mental disorders" commonly associated with abortion, there are lingering 'emotional consequences' and regrets that drive some of the women-centred anti-abortion discourse (Appleton, 2011; Cannold, 2002; Trybulski, 2005; Trybulski, 2006).

The long-term phenomena of women's post-abortion experiences has provided the scope for many research studies into abortion that blur the lines between what constitutes a 'negative mental health consequence' such as post abortion grief or depression, and what can be seen as normal understandings and reoccurring thoughts of the experience, similar to other significant life events and not of any particular public health concern (Trybulski, 2006). It adds an additional element to the psychological sequelae research in terms of long-term effects – for example, there have been few studies conducted between 1-11 years post-abortion measuring depression, regret, anxiety, guilt, mental changes and changes in emotional health.

For those that have, the majority of women do not suffer psychological effects long term, but there are women who experience problems afterwards, leading to issues with grief, intimacy or guilt (Trybulski, 2006). These findings can simultaneously provide evidence for and against the argument to legalise abortion, restrictions notwithstanding; abortion can be seen as a significant life event with long-term effects, but also that the most negative of these effects are felt by women who have come from specific circumstances, which don't generalise across women. For example, aborting a pregnancy even against their wishes, aborting a wanted pregnancy, social support issues or late abortions are diverse experiences (Trybulski, 2005). In a similar vein, research that looks at the spectrum of emotional responses to an event that is not taken lightly for women can be vital in removing stigma, decreasing silence and shame, and ensuring that women have their experiences normalised and legitimised through discourses that the available legitimate positions enabled by them (Trybulski, 2006). What this research aims to do is enable an analysis of the gap that the psychological research so far has failed to explore; this thesis will look at the discourses that women use to construct their experiences of abortion within and against the binary, It also broadens the scope to a wider sociocultural context that considers the ways alternative discourses texture these experiences and relate to the maintenance or manifestation of stigma, to remove the construction of women as deficit and their reactions to abortion as pathological.

The debates that prevail in scientific enquiry remain focussed on mental health consequences and alert providers to particularly vulnerable circumstances, such as domestic violence, prior mental health issues and repeat abortions. Kimport, Foster and Weitz (2011) investigated the social sources of women's emotional difficulty after abortion, and discovered that those more likely to suffer emotionally were those

women who felt that the abortion was not primarily her decision or that she did not feel adequate emotional support after the abortion. This has implications for policy and procedure before, during and after the abortion process, for several parties including the women, her perceived or actual social supports, and institutions providing abortion services. Importantly it draws attention to inadequacies in the social realm, rather than individual deficits within women.

The psychological literature so far has relied on dominant constructions of the female body and psyche as weak, vulnerable and often emotionally charged, incapable of rational decision-making, to explain the emotional consequence of abortion procedures. In essence, the focus of abortion research has been on individual women and the aftermath, assessing their emotions and psychological wellbeing. What this literature has not done, and does not enable us to do, is look at the effects of wider social practices upon women's decision making and the influence of wider social practices on their experience – the implications of a female body and mind constituted as defunct and pathological. Social and cultural factors enter into women's coping post-abortion, including her emotional and psychological wellbeing, and enter into the women's decision-making processes about her abortion to begin with.

## Reproductive Technologies, Surveillance and Foetal Personhood

Hospitals are the institutions through which normative medicoscientific knowledge is enacted as true and enforced as authority. Biomedical discourse is one of the most privileged ways of knowing in Western civilization at this present time. Despite the increasing social acceptance women are now experiencing in sexual 'freedom' (for example, access to contraceptives, more autonomy in choosing their husbands, and more equality within their marriages, including legal rights), there are

increasing constraints on their femininity and sexuality elsewhere. With the amplified medicalisation of public health came the inevitable medicalisation of pregnancy and childbirth, resulting in women's bodies being under surveillance of one of the strongest macrostructures in existence and positioned as pathological. Pregnancy was reconstructed from a "natural reproductive experience" in motherhood discourse to one that was problematised in biomedical discourse, and placed under the regulation of medicine (Glen, 2012; Ussher, 1991). As medical intervention into pregnancy was normalised (and midwife intervention/experiential evidence of the mother was problematised or invalidated), biomedical institutions gained access to pregnant women's bodies, both physically and socially, to monitor and regulate them. Biomedical discourse was and is increasingly powerful; women are seen as deviant or wrong if they do not somehow engage with medical technology to express their pregnancies (Glen, 2012). New reproductive technologies, such as the ultrasound/sonogram, reconceptualised more than just pregnancy and women's bodies; the concept of foetal personhood began to gain ground in prolife rhetoric as a discursive strategy to control women's reproduction. A sonogram has become a routine aspect of pregnancy, whether the pregnant woman intends to carry the pregnancy to term or not – even though it has no obvious and immediate medical benefit (Glen, 2012; Petchesky, 1987). Medical doctors were positioned as 'experts' in the woman's pregnancy; she was now an observer, and her experiential knowledge of her body was discounted in favour of biomedical and scientific knowledge of her foetus and her pregnancy. Not only has the discourse of pregnancy changed through advances in technology, but also the social, legal, medical and moral construction of the foetus has been drastically renegotiated (Featherstone, 2008). Women's bodies were already being monitored in the social context of women's sexuality being mostly

consumed by motherhood and the inevitability of wanting to have children. New technologies afforded the foetus with personhood and imposed surveillance on women's bodies from a new angle. The newly anthropomorphised foetus was now seen more as an infant than a foetus, and importantly, separate from the woman who carries it. The foetus, more than the pregnant woman has the moral position of patient, needing care and being vulnerable.

The personification of the foetus and construction of the foetus as an independent, autonomous and functioning being is considered to have had huge implications not only on the rights of the pregnant mother, but on discourses of abortion (Mitchell, 2001). Although foetal imaging may allow stronger maternal and paternal bonding, it can also alienate the mother from her pregnancy by showing the foetus as a solitary floating 'patient' in its own right, detached from the woman's body. Shrage (2002) phrases it as "childlike people floating in disconnected uterine containers" (p. 68). The mother becomes almost irrelevant and the foetus takes centre stage.

By showing the moving foetus and amplifying its 'heartbeat', foetal imaging technology can be a coercive social force regulated by institutions of power (Petchesky, 1987; Zeichmeister, 2001). Lowry (2004) voices concerns that these imaging techniques privilege the foetal rights over women's rights and that society at large (or at least through pronatalism discourse, invested in the interests of the state) appears to see these rights as opposites, similar to the abortion binary. One or the other must dominate. This effectively places pregnant women under surveillance and medical monitoring – and also at the mercy of warring dominant discourses of femininity and motherhood. The pregnant woman is seen as a potentially dangerous and toxic environment, and she is liable to be held legally or morally responsible for

damage to the foetus that is deemed avoidable while in utero (Lowry, 2004; Zeichmeister, 2001). At the same time she is criticised if she wishes to terminate her foetus as this goes against normative constructions of women as being compulsively nurturing, and having a 'maternal instinct'. This is one way in which foetal imaging technology can be understood as a regulating force of disciplinary power in that women's reproductive capacities are socially controlled and monitored by male-dominated institutions such as medicine and science (Drapkin Lyerly, 2006).

The normalisation and easy access of foetal imaging technologies has social and moral implications for abortion discourses as well as motherhood discourse. Much prolife discourse has drawn from the personification of the foetus as a human being with agency, and rights of its own – often to the detriment of the pregnant woman as her rights become sidelined for the foetus to take priority (Petchesky, 1987). Anti-abortion activists have used ultrasound technology to campaign against legal abortion by harnessing the power of the media and exposing the public to distressing images of "live" abortions such as the Silent Scream film, as well as numerous print campaigns to morally position the foetus (Shrage, 2002).

Reproductive technologies are one demonstration of the gender-specific standards women's bodies are held to – both in the expectation that women will become mothers because it is natural, and also that women's experiential knowledge of their pregnancy now comes second to the expert truth that medical professionals hold in and through new technologies that exclude women's participation in that elite discourse. These competing discourses work to produce docile feminine bodies, and have implications for wider discourses of abortion and resultant stigma, enabled and constrained through legal and political movements.

Rather than an individual scope of focus on women's mental health, a wider

sociocultural gaze needs to be employed and the construction of several dominant discourses that position women and women's bodies should be critically examined. This research attends to that wider sociocultural gaze and deconstructs the binary that dominates talk of abortion discourse. Simultaneously this research investigates the texturing discourses that lead to conflict and contradiction in women's talk of abortion and how this relates to the stigma that still accompanies abortion.

# **Chapter 2 –** The Discursive Constructions of Abortion

*"The choice to have an abortion flies in the face of the idea that it is good to sacrifice ourselves. It challenges us to accept our intrinsic power, and to make decisions about pregnancy and motherhood that are grounded in the reality of our everyday lives."*

- **Linda Weber's Life Choices: The Teachings of Abortion**

Aside from the dominant abortion binary of prochoice and prolife political or moral positions, several other discourses texture women's experience of abortion in New Zealand society. These discourses contribute to the prochoice and prolife rhetoric through which women understand their experience of abortion. The first of these texturing discourses is that abortion, through local social phenomenon, challenges widely-held and accepted or upheld assumptions about "the essential nature of women" which includes three main constructs of "femininity" – female sexuality as restricted to procreation, the inevitability of motherhood, and women as being "perpetual life givers" and instinctively nurturing vulnerable beings (Kumar et al., 2009).

## Femininity and Motherhood

Common 'every-day' social practices normalise an idealised 'gold standard' of motherhood; women who are mothers possess inherent characteristics that define them as soft, nurturing and caring. These qualities have come to be seen as natural, or universal in and through a long history of social reinforcement. Dominant discourses of femininity and motherhood essentialise gendered conceptualisations of what women should do and how they should behave; these discourses shape women's social positioning. Ruddick (1985) suggests that it is impossible to discuss women's

positions in the social hierarchy apart from the idea of motherhood, because motherhood is such an integral part to so many women, or is expected to be so at some point in their lives. The factors influencing women's experiences and the way we come to understand them are therefore shaped in and through social power relations. Furthermore, theorists such as Catharine Mackinnon (1987) discuss the subjectivity of women as a direct consequence of traditional gendered norms and values, sustained by institutional and structural orders that privilege the current situation. Femininity, and the construction of women, is often derived from masculinist discourse that defines what it means to be feminine or masculine. The very ideas of what constitutes women are constructed by male standards and values; women are positioned as different from, the same as or complementary to standards of traditional masculinity (Charlebois, 2012).

Femininity, then, has been inextricably linked with motherhood. The female body has been defined and labelled as a 'maternal body', especially since the ascent of pronatalism and the idea that the 'state of the nation' was at stake if (desirable specimens of) women were not reproducing and fulfilling their duties as citizens by birthing future citizens (Beasley & Bacchi, 2000; Khaxas, 1997). Alongside the assumption that a feminine body must be a maternal one, it is suggested that maternal instinct also comes naturally to all women, and as such, pregnancy, childbirth and motherhood is an inevitable evolutionary aspect of a woman's life. Not only do women face social pressure to become a mother in the first place, but they are also criticised if their mothering isn't good enough (Cooey, 1999). This can be seen in the competing discourses of 'good' motherhood or 'competitive mothering'; for example, working mothers are often labelled as uncaring, cold and neglecting their motherly duties, and mothers who stay at home to raise children are often positioned as lazy

and criticised for not making a financial contribution to the household. By making women responsible for the majority of the childcare and child-raising duties (which are 'natural' for women, considering their 'maternal instincts' and 'nurturing, caring dispositions'), social discourse and ideals can reinforce the gendered social order of our culture, as it stands as being normal and true. Abortion is characterised as a deliberate rejection of this – women are effectively using their agency to decide the fate of another life. This illustrates conflict between the multiple expectations projected upon women's bodies.

## Agency, Choice and Autonomy

In abortion debate, discourses of agency, choice and autonomy breach both sides of the moral binary that dominates abortion discourse; mostly in the form of political (and in the United States, legal) clashes between 'pro-abortion' and 'anti-abortion' camps. However, there are also psychosocial issues of autonomy and choice for individual women and women as a larger collective group under current individualist and neoliberal sociocultural contexts.

Feminist literature has devoted much space to establishing women's "capacity for agency" (Madhok, Phillips & Wilson, 2013, p. 1). At its most simple of definitions, agency is the capacity to act (Charrad, 2010). However, the capacity to act cannot be understood without the context of specific social structures. This tension still exists between the disciplinary power of the knowledge that macrostructures normalise and individual agency – a seesaw between the strength that social structures have over individuals, and the ability of individuals 'free will' to overcome the oppression of these structures (Charrad, 2010). Prochoice discourse has challenged the notion that women are less rational, reflective and capable of responsible action as

men – and therefore more suited for submissive domestic roles within the home and requiring protection and guidance. The gendering of agency has changed over the past several decades; in both literature and social understanding, women and men can be agentic human beings and to relegate women simply to "passive victims of circumstance" reinforces the stereotypes of patriarchal ideologies (Madhok, Phillips & Wilson, 2013, p. 2).

Indeed, discourses constructed by neoliberalism and post-industrial individualisation have contributed to a new, pervasive and popular concept of a progressive and modern world for girls and women. New opportunities for unbounded reedom and participation for women in Western democracies is characterised by the removal of constraints and exclusions for women, and a valorisation of the concept of individual choice. Beck (1992) suggests that "people are being removed from the constraints of gender…men and women are released from traditional forms and ascribed roles" (p. 105). Pro-abortion movements in this new free world have become synonymous with 'prochoice' discourse and politics. The 'equality argument' in prochoice rhetoric argues that if men can physiologically avoid the consequences of unplanned pregnancy so too should women. If professional and personal lives of men aren't impacted by an ill-timed pregnancy, then women should be afforded the means to access this too. Neoliberal values and norms validate this position and make it available for women in their talk.

There are several benefits to the emergence of the 'prochoice' and feminist agency discourse. Firstly, it resists the dominant discourse of women and the feminine body as weak, unruly and unpredictable; instead, it can provide women with an alternative dominant discourse through which to position themselves, or be positioned in regards to their maternal and reproductive body. Autonomy is a credible concept

because neo-liberal discourses normalise the idea that individuals can shape or are shaping the conditions of their own lives. Thus, in the context of abortion, discourses of "reproductive freedom", the "right to choose", and the "freedom of choice", "girl power", "independent woman" and "female future" all serve to construct norms of neoliberalist discourse and place responsibility for social inequality on the individual body and their "choices" since the playing field between the genders is now apparently level (Baker, 2008). Citizenship in a neoliberal socio-political climate is an individualised subject that is held to particular social standards of normalised behaviours; these are not overtly enforced by the state, but individuals hold themselves responsible for the perpetuation of these normalised practices (Coombes & Morgan, in press). In some cases, this has been beneficial for women in terms of granting them more control over their reproductive freedom, or at the very least it is legitimising an alternative position to be available in talk. Australian research into discourses of choice and equality have found that the talk of Australian women often reflects the notion that opportunities are open to all in equal measure, and that social or economic hierarchies are the reflections of individual ability and effort. Women are optimistic about the choices that are perceived to be available to them based on the current conditions of their sociopolitical context (Bulbeck, 2005; Mackay, 1997; Summers, 2003). Even in situations of coercion or being controlled in some way, young Australian women position themselves as making active, although unpleasant, 'choices' in order to reflect their resilience and independence – avoiding at all costs, the position of submissive and helpless 'victim' (Baker, 2008).

With that being said, discourses both enable and constrain the subject positions that may be taken up or ascribed to particular people through dominant social practices. Madhok, Phillips and Wilson (2013) argue that the focus on the terms

agency and autonomy can be problematic for feminist theorising if not used carefully. The 'turn to agency' could potentially lead to 'action bias', where women are only considered agentic if they are in directly resisting patriarchal power. Alternatively being perceived as autonomous individualises women, and represents them as being outside of power structures, and capable of removing themselves or resisting them. Fraser (1992, p. 17) articulates the dilemma succinctly: "Either we limit the structural constraints of gender so well that we deny women any agency or we portray women's agency so glowingly that the power of subordination evaporates".

Baker (2008) is critical of the dominant focus on women's choice and agency as it has led to normalised discourse that women are the "lucky ones" and can 'have it all'; inheriting a world of newly forged opportunities. They can both be independent, autonomous participants in the labour market and public sphere, and they can be mothers and raise a family at the same time. This positioning masks the social inequality that still exists. The neoliberal discourse of 'choice' and 'individualisation' has enabled a conservative, masculinist agenda to successfully perpetuate oppression of women under a women's rights discourse. By reducing everything to an individual choice, it is impossible to criticise others or make social change, as every woman has a right to choose for herself. Neoliberalism as an ideology has permeated a socio-political climate, which promotes the 'hyper-responsible self' and dismissal of limitations in order to govern individuals; the normalised understanding is that life is the sum of individual choices, for which women are responsible. To this end, people are governed "through their freedoms and aspirations rather than in spite of them" (Baker, 2008, p. 54).

The notion of choice in feminist discourse has been identified as "structure(ing) both our sense of reality and our notion of our own identity" (Mills,

1997, p. 15) and so can promote women's participation in their own oppression without their knowledge. This was illustrated in Baker's (2008) findings that some individual choices are 'less celebrated' than others, which illustrates the importance of the sociocultural context in which choice discourse is embedded and textured by several other discourses – for example, the 'choice' to stay with an abusive partner, the 'choice' to remain childless - that transgress traditional notions of feminine subjectivities. The 'choices' made available to women are influenced by other norms, and women are expected to 'choose' socially acceptable alternatives (Baker, 2008). When women's preferred choices transgress the norms of femininity, the support for the individual choice wavers, and such choices are considered suspicious (Hughes, 2002). Faced with competing expectations from various norms, women question their choices, and how they are expected to behave through the 'choices' they make. McRobbie (2004) has conceptualised this as women's 're-regulation' through choice and results in women being subordinated even by supposedly liberating discourse.

The discourse of women's choice creates a complex intersection between multiple dominant discourses and produces multiple conflicts. Strongly focusing on the politics of a woman's 'right to choose' can obscure the social responsibility that collective society needs to face in regards to gendered power relations. Discourses of choice may serve to reinforce the binary and have multiple positions that can be used to limit women's agency, especially in the legal realm where feminism has done a lot of work regarding women's bodies and trauma (Suk, 2010). Many of the 'successful' legal gains for women's rights are in the areas of domestic violence, rape and sexual assault – these have been based on the argument that women have been coerced into these situations by others, usually men, and mostly intimate partners (Suk, 2010). They were not able to exert their agency, their choices were not made freely and they

were the victim of abuse or other forms of control. The discourse of choice then has been used to bolster women-centred anti-abortion discourse in prolife rhetoric as well as prochoice. Women most likely to experience emotional issues after abortion are those with a prior mental health history, those experiencing domestic violence, and women who did not feel her decision to abortion was her own (Akyüz et al., 2012; Appleton, 2011; Suk, 2010; Trybulski, 2005). The dominant construction of femininity as weak and vulnerable is reinforced through this discourse, contending that women do not really "choose" abortion, but complete an abortion through the coercive strategies of others, inadequately informed of the realities of the procedure or how they will cope afterwards with any unanticipated emotional effects (Cannold, 2002). Other women-centred anti-abortion discourse has suggested that seeking 'free choice' for abortion is actually hindering women's equality by taking the "womb less male body" as normative, thereby promoting cultural hostility towards pregnancy and motherhood (Bachiochi, 2011). Seeking to imitate the autonomous child-abandoning male is implying that women can only reach their full potential by doing what men do. Even if a woman 'chooses' abortion, she is the one who has to make that choice and go through that procedure; another limitation to prochoice discourse. Again, this is responsibilisation of the feminine body. A focus solely on a 'woman's right to choose' eliminates institutional accountability to change social conditions for women, and the patriarchal structures that continue to oppress women. From this perspective moral agency and autonomy is removed from the woman just as the strongly individualist discourse erases social responsibility entirely and places full burden of action upon the woman accessing an abortion.

As illustrated, women's relationship with structures and discourses of power is complex and conflicted, and leads to complicated strategies that are developed in

order for women to navigate. For instance, in cultures that do not live within Western democratic neoliberalism, women's agency may instead take the form advocating for a better society at the expense of individual autonomy because it provides more individual and communal benefit (Borovay & Ghodsee, 2012). Women's agency in particular can serve to challenge and reproduce norms – for example, having an abortion challenges the norm of a maternal body, and an instinct or destiny to mother, while at the same time resisting the stigmatising position of untimely motherhood, teenaged parenting or other undesirable entrances into maternity. Women's agency is also used within the limits of existing rules and resources (Charrad, 2010), and this can contribute to much of the complexity and confusion that often accompanies decision-making in abortion, and the emotional/psychological abortion aftermath. What must be considered instead is how women can be agentic or autonomous within power structures and dominant discourses; the 'choices' they make as agentic or autonomous beings may in fact position them within the binary in order to achieve the rewards that some of these positions may provide. If feminist research dismisses women's choices to being 'constricted' or 'not real choices' because of gendered social power relations it runs the risk of reinforcing discourse of victimhood. As an alternative to viewing women as the victim of patriarchal power structures, the discourse of women as powerful and resilient and brave could be put forward to take into account the real difficulty of these decisions, and the strength of the women who make them – whilst fully accepting and acknowledging the contradiction and conflicts that are inherent in navigating subject positions within these discourses.

Social structures can simultaneously be constraining and enabling (Foucault, 1980; Giddens, 1979); and Mahmood (2001) suggests that agency needs to instead be conceptualised as a "capacity for action that historically specific relations of

subordination enable and constrain" (p. 203) rather than another way of describing resistance against domination. Structures and institutions have conflicting effects on women's lives depending on our socio-historical context; facilitating empowerment at some levels and increasing marginalisation in others (Charrad, 2010).

## Legal Discourse and Citizenship

Yuvall-Davis (1993) discusses the 'dualistic nature' of citizenship, that even with equality in political rights as citizens; women may still face exclusion or barriers in other political, social and civil areas of life. Commonly, women's domestic and caring 'responsibilities' continue to limit their capacity to enter the labour force, politics or other social structures of power and authority (Beasley & Bacchi, 2000). This creates, especially for abortion, a complicated intersect between legal and moral trajectories.

Legal dispute in regards to abortion has centred on several 'rights' discourses, both in terms of the rights of the pregnant woman, and the rights of the foetus. Smyth (2002) critically examines several ways in which abortion availability has been conceptualised in order to achieve or restrict its provision. For Smyth, the differences between rights and care marked a boundary between the often-complex political agenda of rights discourse and women's capacity to care. The focus on care enabled feminist research to attend to the special relationship between mother and child to fight for the legality and availability of abortion. While this has been criticised as relying on the essentialist assumption of women in their traditional maternal roles and the unequal mother-child relationship, the focus on relationships and responsibilities rather than 'rights' allowed feminists to advocate for abortion access on the level of how substantially women's lives are affected by pregnancy and child-rearing

compared to men's and legitimised this position (Smyth, 2002). This academic and political argument has filtered down to social discourse, and can often be heard in prochoice rhetoric.

In comparison, the subject of 'rights' has been heavily drawn on to support the moral trajectory on either side of the abortion binary. By arguing a right to privacy, autonomy or bodily integrity, prochoice advocates can argue for the rights of pregnant women to decide when and if they will be pregnant, and to terminate a pregnancy as having autonomy over her individual body. Conversely, it has allowed anti-abortion protestors to use moral rights positions to develop the right to life discourse on behalf of the foetus, and constructs the "involuntarily pregnant and implicitly sexually guilty woman" as both "absent and threateningly present" and thus a danger to the innocent life of the unborn foetus (Smyth, 2002, p. 337).

Foetal personhood has become one of the moral arguments associated with the prolife discourse, attributing feelings, desires, pain, autonomy, innocence, purity and vulnerability upon the foetus through popular media and culture. Abortion has been framed in this discourse as murder of a fully anthropomorphised baby, and a violent procedure. This has been exemplified by new ultrasound and other visual technology, which has helped to see the previously unseen, and given form to an otherwise ambiguous entity. The foetus has been drawn into the public forum as a child's life that needs to be protected, exaggerating the independence of the foetus from its mother's womb, and being potentially unsafe inside of her (Norris et al., 2011).

These legal rights arguments reproduce a tension in a binary where the moral trajectories of each 'side' reproduce the dichotomy for or against abortion. Foetal-rights lobbies have argued that the right to choice carries less moral weight than the claim to a right to life, whereas pro-abortion advocates have argued that abortion

decisions for women are inevitably moral. Many women feel that an abortion is the only moral choice they can make in terms of the wellbeing of the unborn child (Saul, 2003). Moral trajectories add further complexity to the dominant conflict already examined, illustrating the need for wider sociocultural analysis.

The language used in these legal arenas have provided the context to dominant social discourses of abortion, illustrated in the common phrases "right to life", "right to choose", "reproductive freedom" and "freedom of choice". This has created several well-known ways of talking about abortion from a legal perspective that incorporates notions of the body, bodily autonomy and subject positions. Petchesky (1986) defines 'choice' as "a woman's right to control her own body", incorporating bodily and decisional autonomy, but also argues for the limitation of this autonomy, as leaving decision making entirely to women "lets men and society neatly off the hook" (p. 7). It connects to the discourse of choice in women's talk of abortion decision-making and the tensions that accompany 'choice'. For example, anti-abortion politics place women's decisional and bodily autonomy at risk, by promoting discourses of abortion synonymous with trauma and regret and needing to protect women from these decisions that are not fully informed or consensual (Appleton, 2011; Suk, 2010). On the other hand, prochoice discourse to some extent facilitate(s) the illusion that a woman can make a private choice free from social, economic and political influences (Charles, 2000). Endorsing the right to privacy can work to remove the obligation of the state to provide abortion services, but constructing this privacy in familial, domestic terms ultimately reinforces essentialist ideas about women as mothers (Smyth, 2002). These tensions texture the pro-choice and pro-life binary that currently dominates abortion discourse in the socio-political conditions of New Zealand.

One argument located in the moral trajectories of the abortion binary which is important for abortion decision making in both a legal and moral sense, is the argument that women have a right to bodily integrity. Cornell (1995) defines personhood as the perception or idea of oneself over time, so the rights-bearing woman's 'indivisibility' is complexly related to her embodied personhood. This argument suggests that it is the imaginary rather than the physical 'bodily integrity' that must be protected in pro-choice argument for abortion access. Cornell (1995) argues:

> *The right to abortion should not be understood as the right to choose an abortion, but as the right to realise the legitimacy of the individual woman's projections of her own bodily integrity, consistent with her imagination of herself at the time that she chooses to terminate her pregnancy.* (p. 53)

Arguments from prolife discourse, which rely on the right to life for the foetus and the legitimacy of fathers to have some decisional authority over a woman's choice to keep or terminate her pregnancy, are therefore strongly resisted in the moral position of arguing bodily integrity. For legal systems to "deny her [the woman's] coherence by separating her womb from herself" (Cornell, 1995, p. 38), it is equated to an assault on a woman's imagined sense of herself and bodily integrity. As 'integrity' is defined as an individual woman's sense of wholeness across time, her decision is paramount and unrivalled in its authority. The concept of bodily integrity may be essential to new positions being available to women in the prochoice and

prolife binary to legitimate their experience. This vision can incorporate sociocultural influences and so does not isolate the woman from her social context.

## The Moral Significance of Abortion Decisions

Both pro- and anti-abortion proponents have argued heavily on moral concepts of care, nurture and choice when putting forth their various arguments for abortion access. Some feminists such as Naomi Wolf have argued that prochoice movement has abandoned the moral significance of abortion decision-making in its academic and political pursuit on the subject (Wolf, 1995). Other anti-abortion writers such as Bachiochi (2011) have agreed, and have taken up the issues with what Wolf suggests are the arguments of the 'burden of motherhood' and the 'burden of pregnancy' discourses that prochoice feminists have used to base their cases on. To problematise that which makes us women and most different from our male counterparts is part of the reason why women's social position remains subordinate to men. In her view, it is immoral to campaign for abortion on the grounds of motherhood and pregnancy as 'burdens' because it normalises the womb less male as 'default' and encourages women to mimic the abandonment men are physically able to do (Bachiochi, 2011).

Other writers, such as Saul (2003) and Porter (1999) hold different views of the moral responsibilities placed upon women's bodies (by social structures and women themselves). Porter (1999) argues that moral decisions are always complex and contain multiple possibilities or options, without which moral agency would be suppressed. She also questions what moral framework should be adhered to if not a religious one, which considers abortion to be a sin, and suggests that moral frameworks of responsibilities and accountabilities are where many would place their support for abortion in alignment with the moral trajectory of neoliberal discourse. In

agreement, Saul (2003) expands on this notion by suggesting that although some women may not attribute any moral significance to their decision to have an abortion, many feel that an abortion is an obligatory moral reality in light of their circumstances.

In direct contrast to Bachiochi's argument, Saul (2003) also suggests that in general, women do not have abortions just to avoid having a pregnancy; the emphasis is much more weighted on whether the woman wants to become a mother or not at that point in time. It is in fact an *appreciation* for motherhood which drives the decision to have an abortion, and wanting to 'do' motherhood in the right way, being very aware of the responsibilities motherhood entails, rather than conceptualising their situation as the 'burden' of pregnancy or motherhood. Morally, the choice may be between 'ending the life' of a foetus rather than providing it with inadequate care when it comes in to the world as an infant. Moral significance then, need not rely on a religious framework, but may instead be individual women's positions about motherhood (informed by discourse), and how they are best able to care for a child once the pregnancy has come to term.

These competing discourses are likely to be central to women's abortion decision making, and could be important in understanding some of the complexity and conflict in narratives regarding the legal and moral availability of abortion for women in a New Zealand context. This has direct implications for this research that questions how the dominant discourses of abortion that create a binary split conceal women's lived experience – that women's experience of abortion is textured by multiple discourses that are not properly explored in the literature surrounding abortion as yet, and relate to the creation and maintenance of abortion stigma.

## Abortion Stigma

Women who have abortions do so in a polarising public discourse that narrows and displaces abortion (Jelen and Wilcox, 2003; Joffe, 2010). Prior to having an abortion, or even considering one, women are likely to be aware of some of the (negative) discourses towards abortion in everyday talk and through media representations. The often-negative public status of abortion (or what it represents) is indicative of prevailing abortion stigma, and can affect how selectively women disclose their abortion history to others and their own sense of self (Major & Gramzow, 1999; Shellenberg & Tsui, 2012). Stigma is a deeply contextual and dynamic social process (Norris et al., 2011) that can be conceptualised as a 'label' that negatively impacts the identity of a person as 'tainted' (Goffman, 1963). Traditionally, stigma has been described as an 'Us' vs 'Them' binary that separates those who have been deigned to possess this negative attribute from the norm, and they experience status loss and discrimination because of this label (Link & Phelan, 2001). Herek's (2009) framework of 3 manifestations of sexual stigma can inform our understanding of women's abortion experiences. Firstly, internalised stigma results from a woman's acceptance of negative cultural valuations of abortion, often manifested in their selective or non-existent disclosure to others. Secondly, felt stigma encompasses her assessments of others' abortion attitudes and her own expectations about how attitudes might result in actions. Finally, enacted abortion stigma is a woman's experience of actions by others. All stigmas stem from shared, socially constructed knowledge of the devaluing effects of particular attributes (Herek, 2009). Abortion stigma here is based in narrow, gender-specific discourses that inform cultural meanings of pregnancy termination (Luker, 1984), including traditional constructs of the "feminine", of procreative sexuality and of women's innate desire to

be mothers (Cockrill & Nack, 2013). While the definitions of womanhood may vary across cultures, there are normative constructs commonly associated with womanhood as a concept – sexuality for procreation, motherhood, biological destiny, protection, sustenance of and deference to others (Gold et al., 2007). Throughout a woman's life, different reproductive/sexual experiences have the potential to signal transgressions of dominant constructions, including unmarried sex, an unwillingness to become a mother and/or a lack of bonding with the foetus. Gendered constructions of deviance may then inform how a woman constructs her abortion experience and decision making process (Cockrill & Nack, 2013). Abortion can also represent a failure to fulfil the stereotype of femininity, a moral transgression – and demotes a woman's social status. Women who have abortions are often relegated to the 'bad girls' social status that has defied social expectations. For women, abortion may be experienced as an individual or social tarnish into the 'bad girls and fallen women' category (Cockrill & Nack, 2013, p. 3). Often, abortion and other sexual 'transgressions' are viewed as choices – therefore these 'bad girls' are positioned as deserving of social retribution because of their own personal failings and the normalisation of responsible docile bodies (Nack, 2002).

Many women still understand abortion as an extremely taboo subject socially, and an event that could produce personal stigma. These perceptions affect many areas of women's abortion experiences including disclosure to others long after the abortion, and their perceptions of others' reactions across a broad range of sociocultural relationships e.g. family, friends and health providers. Therefore, their experiences of abortion are influenced by perceived negative social attitudes and a transgression of dominant discourses surrounding female sexuality, motherhood and the essential nature of women (Astbury-Ward et al., 2012). Simultaneously abortion

stigma can be concealable, rather than overt (Quinn & Chaudoir, 2009). When a stigma is hidden, the amount of distress it can produce depends on how central the stigma is to a woman's identity or how salient the stigma is at a given moment in time, in response to a trigger. While abortion stigma may manifest infrequently, it may also produce more distress for women who have internalised the dominant constructs of femininity and motherhood that having an abortion transgresses. Stigmatisation does not have to result in discrimination from external sources, but it may have a negative impact on the self-concept and constructions of stigmatised women (Deacon, 2006). The prevalence rates of abortion do not do justice to its hidden status in the social world and lead to high rates of secrecy; "self-stigmatisation" and reticence to disclose information even with those whom women have close relationships is common (Astbury-Ward et al., 2012). This consistent underreporting (approximately only 35-60% of what is actually happening) creates a mutually reinforcing 'cycle of silence', further cemented by the ability of women to successfully conceal their abortions without an enduring flag to alert the public that she has undergone one (Kumar et al., 2009; Norris et al., 2011). Previous research indicates that regardless of one's moral or political standpoint, the act of accessing an abortion can be extremely difficult, and one that women do not take lightly let alone talk about post abortion (Kirkman et al., 2011).

Abortion stigma then can envelop several key structures of the social world in which women reside; from mass culture and discourse, to governmental structures, to institutions such as the medical fraternity, to socio-cultural meanings in the community e.g. moral backlash, pro-life demonstrations, and individual circumstances (Kumar et al., 2009). However, the meaning of abortion can also change over time and place. In addition, the power dynamics underlying abortion

stigma relate to the context of the society in which it is constructed, bound by the meaning of family, motherhood and sexuality in a relation with women's life experiences. Despite systematic attempts to control female sexuality, the reality is that millions of women each year access abortion, safely or not, regardless of the barriers (Kumar et al., 2009; Shellenberg et al., 2011). This contested battle of 'agency and resistance' leads to the complicated dynamics in which individual women often resist the systematic processes that exert social disapproval of abortion, and in many cases, govern themselves and hold themselves accountable to social rules.

The argument in this thesis is that the structures perpetuating some negative mental health consequences for women, and ongoing intrusive thoughts about the procedure for others, is stigma or perceived stigma, rather than the procedure itself – which the majority of women concede was the best decision they could have made for themselves at that time in their lives (Shellenberg et al., 2011; Trybulski, 2005). If it is not the abortion itself that is of significant distress to women, then further investigation is necessary to understand the trajectory for the negative experiences. For this reason, the prochoice and prolife binary is not satisfactory in providing knowledge about how women experience abortion and the decision-making process. The abortion itself may not even be the stigmatic act – rather, it is in the representation of deviant sexuality, illegitimate pregnancy, or ill-timed motherhood that is potentially more stigmatising. It is important to investigate the function of stigma and how this impacts on the construction of abortion experiences for women; an abortion is much easier to hide than a baby or a child. As research turns toward understanding abortion stigma, it opens space for the possibility of understanding the wider discourses that texture women's experiences.

Community and individual factors can inhibit women from accessing abortion

without encountering stigma. For communities who are deeply religious, or who frown upon childbirth out of wedlock, there can be a double stigma that increases risk for these women and the associated difficulties with access, mobility and financial resources. Individually, women integrate dominant discourses of abortion stigma into their psyche – often shame and guilt are the two most common indicators of internalised abortion stigma. Women feel selfish, immoral, unnatural for their own decision even if they feel it was the best for them at the time – where "the past reaches into the present" in an ongoing and dynamic process of meaning making (Trybulski, 2006).

Abortion stigma comes in various forms across the differing ways it can be accessed. For example, it may be that individual women, or women who undergo abortions in general, are labelled as "dirty, irresponsible, heartless or murderous" in response to stereotypes of women as instinctive nurturers, inevitable mothers and questionable moral agency (Kumar et al., 2009, p. 629). Simultaneously, abortion has been conceptualised as the easy way out for women who use it as a form of birth control to "compensate for their stupidity" (Kirkman et al., 2010, p. 150). In reality, research privileging women's voices contrasts this argument deeply, framing abortion as a "difficult solution to a problem" in a discursive environment that often identifies motherhood as natural and produces an array of reasons for why women undergo abortion, including their current capacity to mother, and their current financial, educational and partnership situation (Kirkman et al., 2011, p. 126).

While clinical research is abundant on the safety and efficacy of abortion, women's voices of their experiences, and inquiry into abortion stigma (for both women who have them and abortion providers) is lacking. Here, this research

addresses both of these gaps, and provides an insight to a New Zealand specific context for women accessing an abortion, and any potential stigma they face in doing so. This may have implications for policy and practice. While the existing psychological literature has provided valuable information and insights into the emotional sequelae of abortion, it has contributed to abortion discourse being split into a distinct binary, which does not examine the effects of multiple discourses upon women's decision-making and experience of abortion. It has perpetuated the construction of femininity in particular ways and more attention has been devoted to those women who do experience negative psychological consequences – maintaining prolife discursive constructions of women as emotional and irrational, or as naturally maternal. As it currently stands in most literature regarding abortion (psychological, sociological and legal or political), post-abortion discourses currently serve to sustain traditional gendered ideologies of feminine subjectivity. Commonly identified 'feminine characteristics' are reinforced through the literature, which for the most part, has focused on the emotional/psychological effect on women's mental health in post-abortion experience and constructing it as pathological.

There are wider social contributions that are significantly lacking in research and need to be addressed. According to Kumar, Hessini and Mitchell (2009), the scope of enquiry now needs to broaden to a macro level, and focus on the creation and maintenance process of abortion stigma, which until this point has been less widely studied and understood. Abortion stigma is locally created rather than a being a universal certainty; this assumption gives us an opportunity to look at abortion stigma in a uniquely New Zealand context. The creation of abortion stigma relies on socio-historical processes unique to particular geographical and demographic contexts and the existence of power inequalities in order to come into existence (Yang et al., 2007).

In addition, the various institutions such as public health and social sciences have their own dominant discourses, which create differing knowledges of abortion. These normalising discourses change over time and place. By asking questions such as "Why is something as common as abortion…silenced and ignored even by organisations dedicated to women's health?" these researchers have identified a gap in the research which needs to be explored, where state and societal control over abortion can be deconstructed and critiqued (Kumar et al., 2009; Shellenberg et al., 2011).

While international abortion guidelines can be implemented in policy and programmes of action endorsed at bureaucratic levels, social attitudes, beliefs and values remain deeply embedded in local-level social structures and can be a significant factor in a woman's experience of abortion. Abortion stigma, therefore, has become an important aspect of abortion law, legislation, policy and wider abortion-related discourse. As stigma often results from deep social inequalities, the policies and laws of a country or state often reflect social life at the time – for example, the medicalisation of childbirth and decreditation of midwifery has contributed to women's sexuality and maternity becoming increasingly controlled by an institution historically dominated by men and the government. As Kumar et al., (2009) demonstrate these social norms can become enshrined in public policy and law, for example. By criminalising a procedure only needed by women, gender discrimination has become permissible by law. Furthermore, restricting abortion access in many countries and states also prevents many women from being able to acquire this service such as making women travel long distances or wait long periods for services reducing the chances that women with low income or lack of transport have equal access to it, perpetuating social and economic inequalities (Gee, 2011).

These institutional discriminatory practices perpetuate abortion stigma at a far greater level than just community or individual reach and impact women's lived experience.

In New Zealand, the 'moral panic and urgency' that surrounded the very idea of abortion seems to have dispersed slightly, but fear of abortion still resides deep within the psychology of women, ingrained in centuries of carelessness, brutality, pain and death (Wainer, 2008). Despite the law in New Zealand producing legislation for safe pathways to access abortion in 1965, women still experienced access as prescriptive of "deviant behaviour" on their part (Wainer, 2008). The history of abortion is dirty, and carries centuries of illegal, criminal, 'bad women' stigma, tied to their sexuality and role as women. Changes in the law, and the medicalisation of abortion, did not necessarily mean that socially constituted norms of behaviour (stigma) were quite so easily altered.

Thus, despite a paradigm shift in the arena of global public health, which maintains discourses about women's reproductive rights and choices, significant social factors remain that limit women's reproductive freedom. Even in countries with less restrictive abortion laws, estimation of abortion incidence is problematic and often inaccurate (Sedgh & Henshaw, 2010). The incidence and prevalence of abortion is greatly underestimated. At the time of Myers and Seif's (2010) study, abortion rates in New Zealand had increased since 1996 where other countries had declined or stabilised. In particular, the number of European women accessing abortion had decreased, and Asian women were increasingly seeking abortion. However according to Statistics New Zealand (2013), in the year ending December 2012, 14,475 abortions were performed in New Zealand, which was the lowest number since 1995. Additionally, the general population rate was 16.1 abortions per 1000 women, which was a decrease from 17.3 per 1000 in 2011 (Statistics New Zealand, 2011). The

reason for the decline (globally and now, in New Zealand), is unknown; whether it is the access to contraception, a change in social attitudes to motherhood and abortion, or something unrelated – however it hints at other factors being at work other than safe, legal access to abortion in determining abortion rates.

Although the legislation provides the conditions for safe abortion, some women may not be in the position to access and engage in these services. Women still face numerous barriers to the provision of safe abortion services, including financial issues, as well as physical barriers, such as a lack of transportation to a public clinic that may be a considerable distance from the woman's home (WHO 2012). This is particularly a problem for rural women. Moreover, there exist significant social barriers to women accessing safe abortion services. Pronatalist community values, restrictive national legislation and customary norms serve to significantly restrict the practice of abortion in many countries (WHO 2012).

Although the Contraception, Sterilisation and Abortion Act (1971) ensured that abortion in New Zealand was assigned its own legislation, abortion is still represented in the Crimes Act (1961). Categorising abortion as criminal is stigmatising in itself. Abortion in New Zealand, despite having a clear political divide, has not drawn much attention in the past several years. The socio-political conditions in New Zealand almost provide a stark contrast to the USA, where antiabortion protestors and legislation target providers and state laws to limit women's access to this procedure (Gee, 2011; Wyatt & Hughes, 2009). The legislation is rarely discussed locally, and within New Zealand, abortion providers are limited and confined to hospital facilities (which are monitored). There are also referral networks available to women such as Family Planning, a sexual and reproductive health provider who accepts referrals for abortions but does not perform

them. In New Zealand, there are small, unreported protests outside of some facilities (such as Wellington Hospital), but in contrast to the US, these are not effective in lobbying, and rarely target policy or policymakers. However, this may change in the 2014 election with abortion policy introduced for the first time since the 1970s, by the Green Party. The Green Party, a politically left wing, liberal party, has promoted a policy to decriminalise abortion for women in order to update the law to be more in line with actual practice (The Green Party, 2014). While the very creation of this policy is some indication of the sociopolitical conditions of the abortion debate in New Zealand, it is a law that has not been amended since the 1970s and there is inevitable backlash already accumulating.

The unremarkable presence of religious or political protest, however, does not necessarily mean that abortion in this country is not stigmatised, and certainly the presence of isolated protestors may have profound psychological and emotional effects on the women entering those facilities to access abortion services. For instance, when Harvey (2013) suggested that the law should be changed in order to reflect the less stringent criteria that physicians are applying to what constitutes mental health grounds to access an abortion, the head of the Abortion Supervisory Committee denied New Zealand was ready for law change and warned that, "if we start opening the whole thing up… we might end up with something that is worse than what we have got" (Harvey, 2013).

The comment presented in mainstream media suggests that abortion provision in New Zealand has reached a form of agreement between the medical field and the governance of the population through the medical field, in order to maintain the current level of abortion provision without changing the law. However, there are still social barriers to the acceptance of abortion. Even when allowing an open

interpretation of that law in order to avoid social unrest moves to formally legalise the practice have resulted in some form of backlash. While resistance has not reached the level of backlash seen in the United States or resulted in more restrictive laws for New Zealand women needing to access termination services, it does imply that legal pathways to safe abortion are not without social and moral objection. It also suggests that stigmatising discourses of abortion are most certainly riding just below the surface. The conflict between the legal and moral 'right' to have an abortion does not support women who access abortions, implying that they need to be grateful for the 'hush hush' approach New Zealand has to abortions, and in effect increasing their silence and stigma.

The legal pathway to access in New Zealand faces less resistance than in other areas of the world, but calling it a legal right is currently a misnomer. While satisfying the criteria to access an abortion appears to be a widely applied, abortion stigma and stereotypes still persist in dominant discourse around abortion, especially when the criteria most often used is psychological wellbeing. Løkeland (2004) distinguishes between the legal right and the moral right to abortion – in Norway, where abortion is legal "on demand" for women who require one before 12 weeks gestation, regardless of reason, there appears to be no challenge to women's legal access. Socially, however, there is a moral assumption that encourages women to be discreet, sorrowful and ashamed of their decision to have an abortion reflecting an underlying social ambivalence to abortion even if the legal access to it remains undisputed. It is these underlying social processes that are most likely to be reflected in a New Zealand context.

Applying a research focus to these wider sociocultural influences is what motivated me to write this thesis. Abortion has been medicalised and legislated for the

past 5 and a half decades in New Zealand; we understand it on the surface medically, as a public health measure to contain and decrease maternal mortality and provide family planning options to women with ever increasing access to the public sphere. Politically, there is a distinct dominant binary between prochoice and prolife movements, and each movement has its own abortion discourse that impacts the experiences women have of abortion. However, I argue that this binary is ineffective and insufficient to illustrate the complexity of women's experiences, or their decision-making processes when it comes to accessing an abortion. Understanding abortion in a biomedical context that pathologises women is not enough; the scope of enquiry must broaden, and analyse the moral, political and social discourses of abortion that position women in certain ways, which is key to expand the potential positions women can occupy when talking about their abortion experience. The aim is to trouble the current conditions of abortion access and the dominant discourses that normalise how abortion experiences manifest among the discourses of New Zealand women who position themselves or are positioned within (or against) them. It further aims to understand the effects that these conditions have on women's experiences and how their constitution may be politically important for disrupting the binary that permeates abortion discourse.

I argue that there are several texturing discourses that disrupt the binary under which abortion is currently constructed that illustrate that abortion stigma need not come from abortion itself, but rather through the resistance or transgression of other dominant discourses that place restrictions upon the positions women have available to them.

# **Chapter 3** - Methodology

*'Some of us as individuals find abortion offensive to our most basic principles of morality, but that cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code."*

- **Justices O'Connor, Kennedy and Souter, concerning Planned Parenthood vs. Casey**

## Theoretical Framework

In this thesis, I investigate the ways women construct their abortion experiences through discourse, and how social power relations are implicated through the surveillance and monitoring of women's reproductive bodies. I approach the discursive analysis of these experiences from a standpoint of feminist poststructuralism. This approach seemed most appropriate to both examine the dominant binary of abortion discourse and unpack several other discourses that texture those discursive constructions. According to Weedon (1999), feminist poststructuralism is a "mode of knowledge production which uses poststructuralist theories of language, subjectivity, social processes and institutions to understand existing power relations and to identify areas and strategies for change" (pp. 40-41). A central tenet of poststructuralism is that experience is not essentialist, and does not have a discoverable meaning; instead experience is constructed in and through language. Rather than simply subscribing to the political agenda of dismantling patriarchal discourses and giving voice to women's oppression, poststructuralism allows alternative constructions of women's experiences that "move parallel to hegemonic discourse" (Gavey, 1989). This is important to the research question, as I am arguing that the dominant discourses of abortion that create a binary split are not

real – women's experiences of abortion can and do happen within the binary, but are also textured by multiple discourses that are not properly explored in the literature surrounding abortion as yet, and relate to the creation and maintenance of abortion stigma.

### *Discourse as Constructive*

A poststructuralist perspective reminds researchers that language, discourse and power cannot be separated. This perspective views language as playing a constructive part in our multiple and contested realities as opposed to simply reflecting truth. Instead of one fixed reality, there are multiple potential truths and meanings that are possible across time and place at specific locations. Therefore our experiences are without essentialist meanings or interpretations, and are instead constructed and understood through language, norms and values subject to change (Gavey, 1989). Human beings cannot construct reality and make sense of experiences in isolation; knowledge and meaning is an inter-subjective process. Interactions at various points/moments in the process of making sense of our world creates shared meanings, producing 'default' or normalised situations in the form of cultural norms, traditions and discourses (Crawford, Kippax & Waldby, 1994). Views on the moral acceptability of abortion and abortion experiences are therefore, embedded in social power relations. Knowledge is socially, historically, politically and culturally constructed and intimately connected with disciplinary power. Both language and knowledge are always located in discourse and the discourses we draw upon construct our experiences and thus our social realities (Gavey, 1989). Language is used as the transmission of knowledge - power and knowledge, and therefore language, are intimately connected with discourse.

A dominant discourse (or multiple dominant discourses) for a particular subject or phenomena legitimates the talk that can happen in regards to a particular subject, encouraging or marginalising particular positions. Discourse is therefore action-oriented due to the regulative effects on our actions and experiences; discourse can facilitate or limit what can be said, where it can be said, and who can say it (Gavey, 1989; Willig, 2003). Discourse influences ways of interpreting and understanding the world and our experiences within it. In addition, discourses are multiple and open to change - coinciding with a certain time, location, culture and socio-political context (Gavey, 1989). They can also coexist, contradict and reinforce each other. The places in which discourses are formed are often, though not always, institutions, among other processes but can also be collaborative groups sharing similar beliefs or aims such as: popular entertainment media, individual and group socialisation, educational systems, the legal system, science and other institutions (Gavey, 1992). For example, anti-abortion and prochoice lobbyists uphold certain discourses that then inform an abortion discourse, such as ideas of foetal personhood, appropriate female sexuality, and a foetus' right to life, among others.

Discourse makes subject positions both available and accessible for individuals to align themselves to or against (Hollway, 2001). A subject position places an individual in 'a location' from which they can view the world or be a part of a situation and they may be chosen by or assigned to an individual. Subject positions therefore affect personal experiences, or subjectivities.

Power, according to this poststructuralist view of social reality, is neither positive, negative nor oppressive, but instead it is both produced *by* and functions *through* discourse (Sawicki, 1986; Willig, 2003). Power can therefore ultimately inform what is currently conceptualised as 'truth', which is authorised through

dominant discourses, even though this truth is not concrete and is susceptible to socio-historical adaptation. Dominant discourses serve to covertly uphold this power. In other words, discourses both legitimise and reinforce existing dominant social structures, which in turn support the discourses (Willig, 2003). However, in regards to abortion, women have historically been positioned within dominant discourses that are constructed by patriarchal hegemony; that is, the gendered social power relationships that produce heteromormativity characterised by dominant masculinity and subjugated femininity. These discourses have not only maintained and reproduced men's power and women's secondary status but have influenced the construction of ideas around autonomy where 'man' is the marker of bodily autonomy and sexuality, including women's problematic bodies which are labelled deficit. Counter-discourses do exist, as discourse is flexible and multi-layered across space and time, and interruptions in dominant discourses allow for alternative subject positions.

Instead of prescribing one 'feminist discourse', poststructuralism allows for multiple versions of 'reality' to be constituted through competing discourse. This does not deny that, predominantly, conceptions of reality and truth have tended to be patriarchal constructions reinforcing male interests and power relations (Gavey, 1989). A poststructuralist position welcomes a plurality of meanings, of which traditional "science" or "patriarchy" is just one way of knowing. By providing alternative discourses, or plural meanings, it can enable the conditions of possibility to alter oppressive dominant knowledges. Women can have access to more than one "discourse of femininity" or "discourse of motherhood" as potential subject positions, and construct complex, interlocking subjectivities in line with their lived experience.

Comack (1998) contends that there is a difference between "feminist" and "women's" standpoint when it comes to research. She distinguishes that a "feminist"

standpoint relates to research *about* women's lives to question women's political positioning in gendered power relations whereas "women's standpoint" relates to knowledge *for* women. I draw on "feminist standpoint" in my research. There is an undeniable political agenda in that any conclusions of this research will (by necessity) require political activism to challenge legislation, policy, and practice, in order to benefit women – though social change is also required, not just political. Although Fegan (1999) suggests that a feminist standpoint represents a "challenge to dominant understandings about women and the reasons for their unequal/oppressed status in society" (p. 251), I wish to caution that at times, some women may position themselves within dominant constructions of femininity and such a stance has the potential to exclude or marginalise them. I propose that a feminist poststructuralist standpoint can accept the diversity of women's experiential realities, without necessarily rejecting women's own positioning within dominant understandings, although there will be challenges to the dominant gendered binary. It is accepting of the possibility that some women will position themselves within dominant discourses, not challenge them – and it is important to include these women in feminist standpoint research, to reflect the diversity of women's constructions of femininity and womanhood. It is also important to consider the contradictions that are inherent to constructions of knowledge and subject positions; what may challenge dominant understandings in one discourse may conform to traditional understandings in another.

With this considered, conducting research from a feminist standpoint brings forward a number of epistemological and strategic issues that face researchers making explorations into the talk of women's experiences. Specifically, one issue is the acknowledgement that some women *do participate (actively or passively) in*

*dominant discourses* about their social location (as opposed to actively resisting them through resistant or contradictory discourses). *Many women may actually share the ideals of the dominant discourses – and minimising these subject positions because they do not overtly 'reject' or 'resist' dominant constructions of abortion is counterproductive.* This particularly implicates the question of women's *agency and choice*, which has traditionally been suggested as "limited" within dominant Western discourse constructing femininity, motherhood, and the access to abortion (Fegan, 1999). This directly addresses my predominant research question; how women construct their experience of abortion within or against dominant discourses and normalised understanding of abortion, while that experience is textured by multiple discourses that are not properly explored in the literature surrounding abortion as yet, and relate to the creation and maintenance of abortion stigma.

Feminist poststructuralism and postmodernism in psychology in general, have become concerned with the importance of how embedded dominant discourse is in our day-to-day lives even without our awareness. These discourses not only construct women as subjects – they also shape women's understandings and meaning making of experiences (Fegan, 1999). Women's constructions of experience can help to contradict, or reshape the dominant post-abortion discourses, which are currently situated both in psychological literature and in social relations and create a more positive and women-centred construction of abortion using available dominant frameworks.

In New Zealand, where abortion is available under certain circumstances, the option of *choice*, at least superficially, is available to most women. My argument is that for those who do not *want* to choose abortion, and do position themselves subjectively in the "traditional" construction of femininity or traditional beliefs of

motherhood, their talk should be as privileged and protected as those who disagree and provide alternate discursive constructions. Many women who did, or do, consider themselves 'prochoice' in terms of abortion access are often confronted with difficult and contradictory emotions and feelings regarding their own abortions and the decision making around them; indecision, grief, relief, regret, or dismissal. Some women who may have understood themselves as prolife may also shift positions under particular circumstances. In this way, feminist poststructuralism is important as it allows for multiple realities, does not confine women's experiences to the binary and opens space to legitimise these alternative positions.

While our feminist frameworks with feminist agendas aim to bring about alternate discourses, they may not always be positive renegotiations. In this research, it is important that the stories that do not conform to the vision of "feminist progress" are not deconstructed in ways to be used negatively; they are instead used as examples of the complexity, diversity, and agency of women navigating an intricate and often life-changing event. The impact of having an abortion is significant in a woman's life, affecting and being affected by multiple sociohistorical influences.

From a feminist poststructuralist epistemological position, it is my aim to produce this thesis from a perspective that privileges women's experiences; regardless of the ideals and constructions they conform to, so as not to reproduce a "dynamic of oppression vis-à-vis women whose experiences do not conform" to the ideals of feminist progress (Fegan, 1999, p. 248). I am interested in *how* abortion is constructed and what discourses women position themselves (or are positioned in) to navigate abortion decision-making, and the aftermath of that decision. By focusing solely on women's talk, and the discourses they use to make sense of their decision, it may enable an analysis of the complexity of women's experiences and does not relegate

them to prochoice or anti-choice categories. Therefore, the tensions between the binaries of 'prochoice' and 'prolife' may begin to be deconstructed through attention to the complexities of lived experience. It will also enable an opportunity for this research to to find gaps in the process of abortion access, which can potentially be rectified, in legislation and policy, to improve women's access to abortion and influence the level of choice and agency they can exert when accessing termination services.

As noted, a single "truth" is not a concept for which there is any purpose of pursuit. Instead, the experiential reality of women's lives provides the scope for analysis and with that comes the necessary recognition that there are inevitably contradictory and conflicting experiences and needs both *within* and *between* women. For example, Audre Lorde (1984) suggested that difference is key to creating alternative discourses, or alternative constructions of women that subvert the dominant discourse. Rather than a counter-revolutionary ideology of women, an acceptance of the diversity and difference of women's experiences may be key to disrupting the power relations of dominant discourses that have been internalised as normal and true (Lorde, 1984; Sawicki, 1986). Therefore, I do not see women's stories as "proof" of any theoretical position, but rather as indicative of the diversity of experience and the social construction of normalised knowledge. Predominantly, it allows women to construct abortion *publicly* – regardless of how positive or negative that construction is – and this in itself allows an opportunity for engaging strategies of destigmatisation, and an opportunity for the process of access to be improved in a New Zealand context. Without women's talk being accessed, abortion will continue to be constructed in and through discourse that does not fully understand or capture the realities of what women experience. By listening to the talk of women about abortion,

and providing the public space for their stories to be shared, we can appreciate the 'individuality' of experience, and at the same time share the commonalities, to build a multi-textured and women-centred discourse – promoting intersectionality within feminist research without shutting out women's experiences that do not necessarily conform to the political feminist agenda (Fegan, 1999). Silence and secrecy can begin to be dismantled in an attempt to resist the stigma of abortion and how it categorises the women who have undergone this procedure.

## Methodological Framework

The main aim of this thesis is to analyse and deconstruct the current discourses surrounding abortion, both in the prochoice and prolife binary, and the additional texturing discourses that condition abortion access through the dominant discourses that normalise how abortion experiences manifest among New Zealand women who position themselves or are positioned within (or against) them. It aims to understand the effects that these conditions have on women's experiences and how these may be politically important for disrupting the binary that permeates abortion discourse. Foucaultian discourse analysis provides a conceptual framework from which to analyse the dominant abortion binary, additional texturing discourses, and the resultant stigma due to its focus on power relations and acknowledgement of the complex interplay between language, discourse and power. A Foucaultian approach rejects the idea that language is merely neutral and reflective, and instead conceptualises language as constructive and located within discourse (Willig, 2008). Being that language is socially constructed and constructive, we cannot separate it from experience (Gavey, 1989). It is often the case that different, sometimes

contradictory, social realities may be constructed. Because no one truth exists in poststructuralist theorising, complexity and contradiction is accepted as part of a world with multiple and flexible meanings, types of knowledge and truths that are constantly socially, historically, politically and culturally constructed (Gavey, 1989). From a research perspective, this does not affect the validity in a negative way, but instead adds to the richness and diversity of social meaning making. A Foucaultian approach, rather than searching for truth and meaning, analyses the purpose and function of language and discourse at particular sites where gendered power relations are realised e.g. in talk of abortion (Gavey, 1989). This approach was chosen therefore, for its theoretical suitability to application of discourse of this particular topic and alignment to the epistemological standpoint. It allows us to deconstruct the complexities and conflicts that women encounter when negotiating their abortion meaning making in their talk, and examine the power relations that influence the positions they take up or are given in and through dominant discourses.

As well as referring to any form of talk or text, in the Foucaultian sense, discourse refers to a set of rules or knowledge that defines what is encouraged or marginalised in language, and how that reflects and informs normalised/legitimate behaviour. For example, science authorises knowledge claims with established rules and boundaries - it outlines what is possible (or not) from a particular way of knowing about the world. Discourse and meaning are constantly constructed and reproduced and, as multiple discourses always exist, we may call upon multiple discourses at different times and in different situations (Burns & Gavey, 2008). For example, pro-choice rhetoric that constructs abortion in the biomedical discourse as the "removal of a foetus" in and through prolife rhetoric that posits "abortion is the murder of a child" are often present at two conflicting ends of ideology. It is this reliance on multiple

discourses that accounts for the inconsistencies and contradictions present in people's talk and actions. As Gavey (1989) explains, we are caught in a "discursive battle" over the legitimacy of meaning (p. 464).

Dominant discourses are those which are most available, most relied on, and that come across as our common sense, as we view them as unquestionable, natural or right (Gavey, 2011). As those with power define what can be considered (generally), then dominant discourses often function to legitimate and reproduce these power relationships. Power can be understood as productive, and acts *through* individuals as our experiences and realities are constructed through discourse and language rather than being repressive. Power, I argue from a Foucaultian perspective, is a concept that includes both individual and societal levels. It led Foucault to develop a concept of power that used "knowledge", or dominant constructions of it, as a way to exercise that power (Sawicki, 1986).

A woman's decision to access an abortion is never done in solitude. Regardless of who she involves as support she must still access an abortion through the medical system, which is a dominant institution in itself with its own discourses, ideas and norms. The ways, in which the medical institution uses its power as expert in a dominant construction of knowing, can reproduce and inform our subjectivities. Specific to abortion are normative beliefs that the procedure should be done in secret and be kept hidden from public view; that two doctors must evaluate the mental/physical health of the woman seeking abortion; cut-off limits for abortion to be accessed, and so on. Counter-discourses also always exist. Discourses may provide an opportunity for alternative and multiple ways of knowing to be established (Gavey, 1989).

In my research, not only do I identify the discourses that are drawn upon by young women when talking about their abortion experiences, but also I identify any points of resistance or reliance on counter-discourses that may be present and how these inform subject positions. Of specific interest is when these counter-discourses are resistant to the dominant anti-abortion discourse that currently underlies most current social conversation. At the same time, it was important to identify discourses, which are not necessarily *resistant* to dominant constructions of femininity, but which women use to make sense of their experience, as these will be indicative of challenging the binary that does not accurately reflect lived experiences.

Discourses shape conditions of being – that is, they establish positions for subjects to align themselves to and be aligned to (Gavey, 2011). A Foucaultian discourse analysis has a unique focus on the subject positions that are available for individuals to take up or to delegate to others. Subject positions change over time and between situations and are moderated by availability and accessibility - affected by individual characteristics and resistance. Subject positions mark a particular location in a moral order, in and through discourses that inform the boundaries of abortion debates; these moral trajectories are dynamic and fluid. The women who position themselves in particular discourses may be rejecting the positions other discourses would assign them, or reshaping the parameters of particular subject positions according to their own particular moral trajectory.

As discourse and practice are so intricately connected we need to examine both the availability and appropriation of discourses and identify how these have influenced the construction of ideas/practices and formed experience (Willig, 2000). To understand the particular function of language and discourse, language processes as well as the wider socio-political context must be examined in order to identify

common ideas, contradictions and inconsistencies (Gavey, 1989). This is a key influential factor in conducting the study with participants who had undergone abortions in a New Zealand context.

Two important concepts underlie a Foucaultian theory of discourse analysis; truth and power. Truth, according to Foucault, emerges from discursive frameworks, exercising power relations, and building a particular form of knowledge from discourses – which are privileged above alternative constructions of knowledge about the same phenomena e.g. post-abortion narratives as a way of understanding the abortion experience for women. Post-abortion narratives need to be understood as a discursive process, where women identify with certain discourses and construct their positions in this way. Post-abortion discourses are constructed by and through different elements that shape what an abortion experience is "supposed" to represent; it is also constructed by and through the elements that shape what dominant discourses suggest that femininity, woman-hood and motherhood are supposed to 'look' like. Women's bodies often become the location of many of these struggles for dominant knowledge.

Although current dominant constructions of femininity, motherhood and women's social positions uphold masculine values and norms, I would argue that women are active participants in the framing of abortion experiences, whether or not they conform to or resist these discourses. Their participation in discourses of abortion, however recent this may be, demonstrates Foucault's suggestion that power is relational – even if it is gendered. For example, without women contributing their personal stories of abortion (regardless of the lens through which they are interpreted), these particular discourses would not exist. Women's direct and indirect participation in creating these discourses by sharing personal narratives can serve to

perpetuate or challenge specific constructions of abortion experience. Discourses produce objects by limiting the positions that women can occupy when constructing their experiences. The construction of these objects are then used to support the notion of a particular 'truth' – for example, the abortion binary limits women's positions to prochoice and prolife. There is no legitimate middle ground, and other alternative discourses that are influencing women's abortion decision making are left unexamined in other research.

As this research is based in poststructural feminist epistemology, I was aware of the impact it would have in the conduct of the interviews and collection of transcripts. The interview process in itself is a social interaction, and involves the construction of a sociohistorically specific narrative, availing upon socially current discourses of abortion. Drawing on a poststructural feminist epistemology, I assume that the interview relationships are constructive, and that there is no "expert" researcher position. Rather I acknowledged their perspective and their position as experts of their own experience, within their social context broadly, and within the interview context specifically. Choosing discourse analysis as my analytic approach to the data fits comfortably within this poststructural feminist epistemology. My analytic approach draws upon Foucault's ideas of discourse, knowledge and power to explore how women who have undergone abortions in New Zealand construct their understanding of their experience and make use of positioning, including stigma, decision making and post-abortion feelings, at this particular time within a New Zealand social context. Discourses enable (or constrain) representations of how social actors make their world meaningful - discourses are taken up by, or ascribed to, particular individuals (or groups, such as women) and institutions and become normalised. This process of meaning making also serves to construct knowledge that

is disseminated into wider society as 'truth', in that particular sociohistorical context. Truth, thereby regulating docile bodies, and power remain inseparable from knowledge.

As subjects of discourse, we are both constituted by discourse and also can (re)create and (re)negotiate our subjectivity within certain discourses. In other words, discourses provide positions for people to take up, resist or negotiate (Davies & Harré, 1990). Foucaultian discourse analysis enables an exploration of how women constitute particular subject positions through the metaphors, discourses, concepts, stereotypes and norms that certain discourses provide to them. It allows me to investigate how the participants made sense of their social world by navigating multiple (and often contradictory) subject positions made available (or ascribed) to them. Through focusing on positioning, I was aware that the interview process was part of an ongoing, dynamic and meaning-making procedure where, in and through talk, we all engaged in the positioning process (Davies & Harré, 1990). Discourse analysis, my choice of method, is described more fully in the next chapter.

# Chapter 4 - Method

*"A "right to life" is, at the end of the day, a right to not have somebody else's will imposed upon your body. Do women not have this right as well?"*

- **Seth Millstein**

## Design

Given that the focus of this research was on the lived experience of women who had undertaken a surgical abortion in New Zealand before 20 weeks gestation, and subsequently, the telling of these experiences, the design of the study was qualitative. It was my aim to elicit rich, detailed data from a smaller number of participants, inherent to qualitative research design. However, the main aim is more political and focused on whether the stigma of having an abortion is actually related to the abortion itself – or whether there are more intricate relationships involved. Analysing dominant discourses to inform policy and politics is of more importance to this thesis than making generalisations and broad assumptions about an entire group or population. It will cast a spotlight on the current conditions of abortion access and the dominant discourses that normalise how abortion experiences manifest among the talk of New Zealand women who position themselves or are positioned within (or against) them. It aims to understand the effects that these conditions have on women's experiences and constructions and how these may be politically important for disrupting the binary that permeates abortion discourse.

## Ethical Considerations

This conduct of this Master's thesis project was reviewed by Massey University's Human Ethics Committee Southern B (HEC: Southern B Application 13/69) and received ethical approval. There were a number of key ethical issues that were important to consider in designing and conducting this research, and ethical considerations were made throughout. As an overview, some of these consisted of confidentiality, dealing with unexpected disclosure or unexpected emotion and negative feelings after the study (reducing the harm to participants), and privacy and safety during disclosure.

Emotional and psychological safety for both the participant and myself as a researcher was paramount to the ethical conduct of this study. Before commencing interviews, I established continuing consultation if required for participant safety from an experienced psychotherapist and specialist pregnancy counsellor (Appendix A). In addition, I negotiated and obtained external supervision for my own safety from an external psychotherapist, for the length of my research (Appendix B). This was to ensure that I could provide support to my participants in the event of an unexpected disclosure or particularly negative feelings brought up by telling their stories post interview. It also ensured that I was able to access support and supervision for myself to debrief if my supervisor was unavailable, due to my location in Auckland and she being in Palmerston North.

Physical safety was also an ethical concern, and one that was raised by the Ethics Committee, who suggested that interviews should not take place in a public setting due to the sensitive nature of the subject, and the often-unpredictable responses one might face with a selection of the public unknown to both the participant and myself. This placed limitations also on my method of recruitment, as

there was an expressed concern for safety if I placed an advertisement on a website or in a paper; we did not want to invite negative or aggressive backlash against the participants or myself from prolife advocates.

With regards to confidentiality, both prior to and during the interviews, I reminded the participants that the interview was a conversation for them to tell the parts of their stories that they wanted to share, and that they felt were most important for them to tell me. This included allowing them space to express emotions such as sorrow, frustration or regret in a non-judgmental area; and participants were advised that they could request to stop the recording at any time if they felt overwhelmed or needed some time to regroup. Even though the participants had read the Information Sheet (Appendix C) prior to volunteering to participate, I provided each woman with a hard copy of the information sheet at the time of the interview, and provided another verbal overview of the research and what it entailed, offering the opportunity to ask questions before we began the recording. As a bit of fun, I told the participants also that they were able to pick their own pseudonyms if they wanted, and reassured them that any identifying information would be masked or not used in the transcripts. Each participant signed a Consent Form (Appendix D) either at the commencement of the interview, or sent it back to me in the mail or by email, if we were conducting the interview on Skype (in which case verbal consent to proceed was attained before recording began). With abortion being a sensitive and deeply personal issue, I made all efforts to ensure that the interviews could be conducted face to face, in a private and comfortable space for the participants, using only audio recording to protect confidentiality.

The audio files and transcription files were kept on my personal computer and password protected. The Consent Forms, once signed and received, were passed to

my Research Supervisor and kept on campus at Palmerston North to ensure that consent forms and transcripts were separate to protect potential for identification. Hard copies of the transcripts were kept in a locked drawer in my personal residence.

From what we know of stigma and the underreporting of abortion, there was a possibility that some of the women I was interviewing may not have spoken about this experience before, and if they had, perhaps not at the level of detail at which I was eliciting. Due to the sensitive nature of the subject, it was possible that talking about it might produce negative or strong emotions or responses they had not anticipated. While participation was voluntary, the conversational style of interviewing enabled participants to talk about what was relevant to them, and to disclose only that which they felt comfortable with.

It was important to me that this potential risk was mediated as much as possible to avoid psychological harm or distress to the participants. I have been trained in client-centred and strengths-based counselling through Youthline and other external organisations, and judged myself to be able to navigate any unexpected reactions during the interview to a point where the participants left the interview feeling as though they were in a safe psychological space. At the end of the interview, I checked whether they needed additional support. My supervisor and I are both connected to local and national networks providing counselling – Youthline Auckland in particular provides specialist pregnancy counselling which includes terminations, and operates nationally. I ensured that I had referral sources on hand to provide to the participants if they felt the need to seek further support after sharing their story. I provided some warning of these potential reactions on the Information Sheet and on the Consent Form before the women participated in the interviews to ensure they were as informed as possible, and so that they were aware of the potential harm that

disclosure may have. They were also provided a list of possible questions so that they had an understanding of what might be asked.

Although two participants did begin to cry during the interview, all participants were confident to talk about their experiences. For those who did cry, their emotions were acknowledged, affirmed and validated and they were able to continue without pausing or leaving the interview. None declined to talk about a particular aspect of their experience. After my first participant requested counselling resources, I incorporated a follow up text or Facebook message/email into my procedure to ensure that there were no lingering negative or distressing feelings from the day before.

Participants were given the transcribed copy of their interview via the medium through which we had initially made contact (email, Facebook), and were asked to read over it before coming to me with any concerns or changes; at that point, if there were changes I offered another meeting to work through the changes together. One participant requested changes but was comfortable making them via email.

## Recruitment

My method of participant recruitment was through snowball sampling, a technique widely used among the social sciences in qualitative research, as it allows safe and discreet access to many vulnerable populations, including those who have undergone induced abortion (Fossey, Harvey, McDermott & Davidson, 2002). It allows the researcher to reach an increasing number of participants through contact with an initial participant, or from family, friends and colleagues who could access potential participants on the researcher's behalf. One of the limitations of this

sampling method is that it strongly relies on the quality of the researcher's social networks, and often tends to result in a homogenous sample.

My initial mode of recruitment was to post a message on social media to my friends and family, informing them of my research, what was expected of participants, it's purpose, and my contact details, with requests to notify me directly and privately if they were interested, and to pass on the details to any of their own networks who may be interested. Several of the members of my social networks 'shared' this request to their own networking sites, or to websites of support groups e.g. new mothers groups, that they were members of. The participants in this study therefore, were only those who contacted me because they voluntarily wished to be a part of the study, and not all of them were known to me. There was some homogeneity, especially in relation to ethnicity, in this process of participant selection however, the common factor among all participants was having undergone an abortion and being willing to participate in university research on a very intimate topic.

Once initial contact had been established with the women (generally through a private Facebook message, or email), and I had provided them with an overview of the research, it's intentions, what the participants would be required to do, as well as confidentiality limitations, I gave each woman an information sheet outlining these points and a confidentiality agreement. Potential participants did not need to be of any particular sexual orientation, class or race, however there was a limitation placed on age. I had placed limitations on age so that no woman currently under the age of 18 may participate, as this could result in more complicated legal and political issues, and compromise the level of confidentiality the participant could expect if I had to contact parents or guardians. Additionally the women participating

must have had a surgical abortion in New Zealand prior to 20 weeks gestation; beyond this timeframe, extra considerations (legal, political, emotional and otherwise) would be involved in late-term or second-trimester abortions that would be difficult to adequately cover in this thesis.

The time frame between the initial expression of interest and the email confirming they would like to participate was quite small – 1-2 days was a general rule for the communications. Several women who showed an initial interest in participating did not commit to a particular time for an interview, and one potential participant did not keep the scheduled time, nor did she respond to further communication. Due to the voluntary participation requirement, I did not make an attempt to further engage those women who did not continue with the process.

## Participants

Following the recruitment process, 5 women agreed to participate in this study. Age, ethnicity, and pregnancy/abortion information of the participants is shown in Table 1 (see following page). All of the participants were aged 37 or younger, with the youngest being 23 years of age.

**Table 1: Participant Demographics**

| Name | Current Age | Ethnicity | Number of Abortions | Age at time of abortion(s) | Current number of children |
|---|---|---|---|---|---|
| Natasha | 23 | NZ European/Pakeha | 1 | 22 | 2 |
| Kelly | 27 | NZ European/Welsh | 1 | 20 | 1 |
| Maggie | 34 | Eastern European | 2 | 19 & 33 | 0 |
| Ashley | 25 | NZ European/Pakeha | 1 | 21 | 1 |
| Rose | 37 | NZ European/Pakeha | 1 | 19 | 2 |

One of the limitations of this research was that there were no participants of Māori/Pacifica, Asian or Middle-Eastern descent. It is difficult to know whether this is a limitation of snowball sampling in terms of the homogeneity of my particular networks, or whether this is a cultural reticence to discuss the abortion topic. Research has indicated that Māori are less likely to engage with calls for participation in research, perhaps due to a long history of research being focussed on Māori deficit rather than for Māori (Smith, 1999). Scientific research is viewed by many Māori with suspicion and scepticism due to the role it has played in the past with colonisation and imperialism. There has been a history of minor impact for positive change and the tendency to represent Māori through a Eurocentric lens (Teariki, Spoonley & Tomoana, 1992). This may be one of several contributing factors to the lack of Māori interest in this study; additionally Māori tend to be under-represented in abortion statistics. Although the abortion rate was slightly higher amongst Māori than

European/Pākeha teenagers, Māori who became pregnant were much less likely to have an abortion (Dickson et al., 2000).

## Procedure

Interviews were conducted individually; their duration ranged from 29 to 79 minutes and produced between 10 and 24 pages of transcript per interview. I conducted all interviews, in a place where the participant felt comfortable. Although it was suggested by the Ethics Committee that public places such as a café could be inappropriate to have the discussion about a sensitive subject such as abortion, one participant suggested she would be more comfortable in an "anonymous" situation such as a café, or in a place that was unfamiliar. In this case, the café chosen was large and quite busy, where traffic noise or other members of the public could mask conversation. I was able to discuss with this participant the potential difficulties of speaking about a sensitive subject like this in public; she still requested that it was conducted in a café.

My supervisor was informed of when and where each interview was taking place and I was contactable by cell phone at all times. In the event that my supervisor was not directly contactable (e.g. during weekends), one of my flat-mates or my partner was informed of the interview time and location, and notified when I left. The interviews were intended to be conversational in nature for flexibility in the topics and experiences that women could talk about, ensuring they were natural, comfortable, trusting and open. However, I did have a list of prompts that were there to help if the participant didn't know what to talk about, wanted more direction, or if it was needed to bring the interview back from a tangent. These potential topics were

provided to participants before gaining informed consent so that they were well versed as to what may be asked in the course of the conversation. Some of the women chose to go through each topic in order, expanding on each, and others chose to talk about their experience in a freestyle fashion, only consulting the prompts near the end of their narrative account, in case it could jog conversation in an area they hadn't thought to touch upon.

Upon arrival at the interview, I first went over the information sheet the participants had already received and discussed any questions or concerns they still had. Each woman then signed an individual Consent Form, apart from those who were conducting the interview via Skype. For those women, I obtained verbal consent (although this was before beginning the recording in one case; this process was then amended to include verbal consent in the recording process until the Consent Form via email or in the post was received).

I intended the interviews to mimic general everyday conversation around abortion and abortion experiences that these women had encountered, to provide them with the space and opportunity to speak freely about their experience. Mindful that stigma often affects the ability to have a voice about an experience that is extremely important to a particular group of people, and that abortion is not usually considered "general everyday conversation", the interviews became more structured than I had originally expected, and the interviews followed the prompts more closely than I had anticipated. A common theme I encountered was that the participants had never been asked about their abortion experiences in this manner before; when initially expressing interest in participating, many of them asked what I wanted to know, and the type of information I was interested in. I therefore played an active part in these conversations, not only to build rapport and make sharing conducive, but because I

acknowledged my own role in negotiating these issues and experiences with these women. The day after the interview I followed up with a text or Facebook/email message thanking the women for their participation, checking on their emotional wellbeing, and reiterating my access to counselling or support networks if they felt they needed to. This process was not in my original plan; however, it was added as a precaution after the first woman I interviewed requested information for counselling, and it became apparent across the interviews that there was a lack of post abortion counselling services.

The interviews were digitally recorded and transcribed verbatim by myself with the inclusion of repetitions and pauses in the majority of cases. Confidentiality was ensured through the use of pseudonyms and by removing any identifying material in all transcribed documents and digital recordings were deleted once transcription was complete. Once I had transcribed all the interviews, the transcripts were sent to each participant by email or via Facebook (a method agreed upon with each participant at their interview) for their personal review. Each participant had the opportunity to read the transcript, make any deletions, changes or additions and to discuss any issues with me. Only one participant requested changes. A Release of Transcript Form (Appendix E) was sent to each participant, along with a stamped addressed envelope in which they could return it, or they were given the opportunity to print and scan it back to me via email.

## Bicultural Considerations

Although this research is a small study and the likelihood of including many Māori participants was slim, it was important to position the research within the bicultural context of New Zealand, and prepare accordingly to be culturally sensitive.

I invested in significant consultation with Māori leadership and training within the field.

While no Māori participants volunteered for this study, I was aware of the cultural importance of understanding manaakitanga and incorporating this principle into any research conducted in New Zealand, with Māori and non-Māori. Manaakitanga is understood to be a form of compassionate, down to earth caring for another and their experiences during a process of discussion – for example, providing tea or coffee, showing basic compassion and allowing for a recess if the person is feeling distressed (Durie & Hermansson, 1990). This was particularly important to me considering the subject I was investigating and the strong emotional attachments that may accompany constructions of these experiences. I was also aware of the importance of understanding whakawhanaungatanga as the "process of establishing relationships, literally by means of identifying through culturally appropriate means, your body linkage, your engagements, your connectedness and therefore (unspoken) commitment to other people" (Bishop, 1996, p. 219). This became an important principle guiding my research, ensuring that I provided my participants with all available comforts in the interview preparation, e.g. allowing the participant to set the time, date, location and seating arrangements once we were in the interview context.

As a researcher, I went into the interviews willing to openly communicate my own background and/or whakapapa and motivation to pursue this subject of study. A potential avenue to achieve this openness was through the method of conversational interviews, which privileges kanohi ki te kanohi as it enables "the seen face" and implies "being prepared to show one's face and share of oneself" (Jones, Crengle, & McCreanor, 2006, p. 68). This was important in the interview process, so every effort was made with the participants to ensure that we could meet face-to-face or with

video capability on Skype (even though only the audio was recorded) to provide as much openness and transparency between researcher and participant as possible.

It also employed aspects of kaupapa Māori/mana wahine research in that the participant and researcher negotiated space and the researcher did not assume the role of expert, but rather of learner or listener. There was no aim to generalise the inferences made from this research to Māori, or women overall as I expected diversity both within and between different groups of women.

## Analysis

I used a discourse analytic approach to interpret and analyse the data generated through my interviews. I attempted to 'deconstruct' the textual accounts and explored how the women were constructed by and constructive of specific discourses around abortion, such as choice, morality, motherhood, and decision-making and many others. In essence, the interest of this research lay within how women are positioned in/through dominant discourses of abortion. The debate is that the binary that currently constrains our knowledge of abortion is actually textured by other discourses, and research to date has not adequately taken the complexities of multiple positions into account. Interviews, in particular, allow us to access specific sociocultural versions of realities and enable us to see change over time, moral and ethical systems/practice and different ways the self and others can be constructed having made the 'choice' to undergo an abortion (Arribas-Ayllon & Walkerdine, 2008). As discourse and practice are so tightly bound, we need to examine both the availability and appropriation of discourses and identify how these have influenced the construction of ideas/practices and formed our understanding of our experience (Willig, 2000). It is also important to investigate the role of discourse in wider social

processes of legitimation and power; they are strongly implicated in the exercise of power as they privilege versions of social reality that perpetuate existing power relations and social structures (Willig, 2008). To analyse the function of language and discourse, language processes as well as the wider socio-political context must be examined in order to identify common ideas, contradictions and inconsistencies (Gavey, 1989) so that we can open possibilities for new forms of knowledge.

Willig (2008) sets out six stages that make up what she proposes as a Foucaultian discourse analysis: (1) discursive constructions, (2) discourses, (3) action orientation, (4) positionings, (5) practice and (6) subjectivity. Firstly, examining the shared meanings present in the participants talk must identify discursive constructions. This means identifying the different ways in which the discursive object (abortion) is constructed in the text; for example, pro-choice, anti-abortion, biomedical, moral and so on. Secondly, differences in constructions must be identified and each construction placed within wider discourses. This step identifies the multiple discourses that are drawn upon. For example, a woman may draw on a motherhood discourse when she talks about the process of deciding whether to have an abortion, a biomedical discourse when she talks about the process of accessing one through medical institutions, and a psychological discourse when she talks about the aftermath of that decision. Thirdly, the influence of these discourses must be examined on her initial decision making, the way she experiences that decision and the way she constructs this experience in talk, amongst other things. This involves questioning what the particular construction achieves, how it functions and how it interlinks with other constructions. For example, by using a neoliberal individualism discourse, it may allow a woman to position herself in the moral trajectory of that discourse, as taking her decision seriously and with a lot of thought, a biomedical

discourse may emphasise the extent to which her bodily experience is removed from her control, and a psychological discourse may be drawn on to express her feelings in a way that positions her in the least stigmatising position possible. Therefore women can position themselves within or against several discourses simultaneously, and position herself morally to justify her experience (for herself or for society, depending on which is sanctioned and without repercussion). Fourthly, the subject positions that are available and accessible are identified. This involves looking not only at the subject positions taken up by the women in the study but also at the subject positions that they are placed in (for example other women or other parties included in the abortion decision-making or stigma) and the exploration of this particular way of viewing oneself, others and the world. Women are positioned through particular discourses/knowledge and institutions (such as, the biomedical discourse) and this constructs abortion in particular ways. It also incorporates power relations, and how the dominant knowledge of abortion is both conformed to and resisted. Fifthly, the implications of these constructions and subject positions are examined. This step looks at the actions, talk and understandings/interpretations that are both enabled and restricted; it defines the conditions of possibility that reflect, reproduce and reinforce these discourses. For women who position themselves as prochoice, for example, it enables them to inhabit a privileged position in a discourse that vilifies teenage motherhood or solo motherhood, as well as a privileged position within discourses of individualism and freedom. Lastly, individual experience that results from the taking up of certain subject positions are examined – for example the implications for their wellbeing. This takes into account the positive or negative feelings the women express by positioning themselves in certain ways or within (or against) certain discourses; for example, positioning oneself as pro-choice may give women a strong

sense of independence, freedom and choice, but it may inspire feelings of guilt and shame, or selfishness as they transgress maternal expectations.

## Reflexivity

Because I, as the researcher, would play an active role in the construction of the telling of their experiences, through the generation of talk and as I began the process of reading/interpreting transcripts, it was important to locate myself in the social relationship that framed this research. I am a 24-year-old woman, a university student and youth development worker for a Not-For-Profit charitable trust, and I am of New Zealand European/Pākehā ethnicity. I have also undergone a termination in New Zealand under the same criteria applied to participation in this research. This is an important aspect to be aware of, both for implicitly projecting my own views upon their transcripts, but also through making explicit the shared social experience that may have increased the participants level of comfort in talking to me about their experience.

Both personally and professionally, I tend to take on a therapeutic role, whether working with clients or friends and colleagues. I had to maintain a level of awareness about how my position necessarily influenced the interview relationship. It was not intended that I would be "objective', as my interest in the research was also that of an insider, a position that was useful to facilitate meaningful conversation in a safe manner. My insider positioning required careful negotiation of the struggles between having a therapeutic relationship with each participant that was respectful of their individual experiences and the analysis of their talk as discourse in a big picture sense. I remained conscious of my own feelings about my own experiences both before and after the interviews with the women. Although at times there were

inevitable re-memberings of my own abortion, overall there was a sense of solidarity that lingered. I felt a strong sense of responsibility to the women who had come forward with their stories – many of them expressed a desire to help people as their reason for volunteering for the study. Together we were 'breaking down the taboo' and bonding together in direct defiance of the silence we endured previously.

# Chapter 5 – Analysis

*"I have met thousands and thousands of pro-choice men and women. I have never met anyone who is pro-abortion. Being pro-choice is not being pro-abortion. Being pro-choice is trusting the individual to make the right decision for herself and her family, and not entrusting that decision to anyone wearing the authority of government in any regard."*

**– Hilary Clinton**

Basing my analysis strongly in Foucaultian theories of discourse, concerned with social power relations, dominant discourses, and normative constructions of "truth", this research questioned how women construct their experience of abortion in and through (or resisting) dominant discourses and normalised understandings of abortion, and how that experience is textured by multiple other discourses that relate to the creation and maintenance of abortion stigma.

My analysis of the text showed an incredible complexity to the discourses that the women relied on to negotiate their positioning in constructions of femininity and motherhood. Additionally, the level of contradiction, conflict, and often seemingly counterintuitive messages that were realised through the discourses were evidence of the complexity of abortion decision-making in and of itself, and for the implications for women's understanding of their experience. The analysis showed that the women discursively constructed their experience in five main ways. These were 1) within, between or against the prochoice/prolife binary, 2) moral implications and positions of abortion decision making, 3) complex socio-political/cultural relationships that texture discourses of abortion, 4) the manifestation and maintenance of abortion stigma and 5) the abortion experience (including navigation of the medical system and accessing an abortion) in a uniquely New Zealand context. While these discursive

constructions organise the analysis, they are also embedded within a complex relationship with the pro-life/pro-choice binary.

The action orientation of these discourses is analysed through their function and what it allows the women to achieve. Implicated in this is the positioning available and accessible to women – that is, how women are positioned in dominant discourse, or position themselves in alignment with or against these discourses. Finally, the implications of these constructions and subject positions are examined throughout the analysis including some of the ways in which alternate or resistant constructions of abortion may inform policy or legislation.

## Prochoice and Prolife: Navigating the Binary

Abortion talk is generally organised in to two main discourses: prochoice and prolife. Those who lobby for women's rights to abortion are often positioned as 'pro-choice' and those who lobby for the restriction or criminalisation of abortion are often positioned as 'pro-life'. Given that dominant discourse is contested on the binary of "pro-life" or "pro-choice", these two positions are key in several legal, political and social arenas of a woman's life – it is likely that she is aware in some form, before having an abortion, that there are these two main prevailing ways of talking about abortion socially.

There are powerful legitimising forces behind each of these dominant discourses. Giving authority to the 'pro-choice' position is a neoliberal discourse of individual choice, free will and rational thought. It assumes that women are rational, decision-making human beings who have the right to decide when or if they become a mother. The gendering of agency has changed over the past several decades; in both literature and social understandings, women and men can be agentic human beings

and to relegate women simply to "passive victims of circumstance" reinforces the stereotypes of patriarchal ideologies in and of itself (Madhok, Phillips & Wilson, 2013, p. 2). Indeed, theories of neoliberalism and post-industrial individualisation have contributed to a new, pervasive and popular concept of a progressive and modern world for girls and women. To be pro-choice now is assumed to be synonymous with feminism, liberal political thought, and individualism (Echevarria, 2013). Growing social acceptance of these normative constructions of what it means to be a contemporary neoliberal woman (subject) can be seen in the increase in age of women delaying marriage or childbearing (or not doing either at all), the increase of 'alternative' family arrangements, and the increase of women's participation in the public sphere of the labour market.

A prolife position, in contrast, is legitimated by patriarchal values of what traditional femininity, motherhood and women should look like, do, and be. Abortion challenges widely-held and accepted or upheld assumptions about "the essential nature of women", transgressing dominant understandings of female sexuality, motherhood and femininity (Kumar et al., 2009). These assumptions are not merely attached to the subjective 'female' – they inscribe meaning upon the bodies of women and the things that their bodies do - discourses are embodied.

Both of these dominant discourses are drawn on heavily in women's talk of their abortion decision making, but what emerges from the analysis is the insufficiency of the binary to provide positions to women that match their actual lived experience. The prochoice and prolife binary presents many women with a conflict: prochoice does not necessarily mean pro-abortion, contrary to the normalised discourse constructing the moral trajectories of abortion. Simultaneously, prolife does not necessarily mean anti-abortion. Although women may position themselves within

neoliberal discourses of individual choice more than traditional discourses of femininity and motherhood, or vice versa, this did not dictate their talk about abortion positions. There was movement within accounts that did not neatly fit the binary of neoliberal discourse, or traditional discourses of motherhood and femininity. The women took up various positions within the discourses available; even in a contradictory relationship within the debate, especially when the implication of what it meant to be 'pro-choice' clashed with their position within 'traditional femininity/maternity'.

**Natasha:** *I'm not against abortions, at all, obviously there are certain situations where it has to be done...I can be pretty understanding with it, but I wouldn't say that I'm pro-abortion, at all.*

In this account the conflict, either for or against abortion, is realised. Natasha does not take up a fixed position on either side of the binary. Natasha went ahead with her abortion taking up the position that is 'not against abortions' and within a contradictory position that is also not 'pro-abortion'. As her talk oscillates between the two dominant discourses, there is no legitimate position in the middle to stand in. Crucially, she directly resists the implication that prochoice means pro-abortion – and this was a running trend through the women's narratives.

**Kelly**: *I've never had a problem with abortion, I've always been pro-choice, so you know, the decision behind getting one wasn't a hard one for me. Would it stop me from having another one (abortion)? Probably not. It would just be more discussion, based around it, the people that are involved. Saying that, I don't know if I*

*would have another one (abortion). Actually. I wouldn't want to get pregnant, and I wouldn't want to have another baby, but saying that, I don't know if I would actually terminate one now.*

Again, even though Kelly and Natasha position themselves more strongly in different rhetoric – with Natasha in prolife discourse, and Kelly in prochoice – both of them are neither positioned completely in one or the other. Even though she is prochoice, Kelly suggests she might not choose abortion if she found herself pregnant again, which rejects the assumption that to be prochoice is to be pro-abortion. In this case the binary is insufficient in describing women's lived experiences; although women may be prochoice, that does not mean they will choose abortion with every pregnancy and there are mediating circumstances in line with positions made available (or placed upon women) from other salient discourses.

An extract from Ashley's transcript illustrates some of the conflict between being prochoice, and at the same time, identifying closely with motherhood:

**Ashley:** *I wasn't against abortion, I was very pro-choice, but at the same time I'd wanted kids my entire life*

**Interviewer:** *Yeah…so was it like abortion wasn't for you per se?*

**Ashley:** *Well I mean it was and it wasn't. I have no problem with that, I'm very open to it if that's what you wanna do then that's what you wanna do, that's fine. For me at that time… I wanted to have a baby but at the same time I knew I couldn't.*

Although Ashley positions herself within prochoice rhetoric generally, she qualifies that by saying "at the same time" her desire for children had been lifelong, indicating that she has simultaneously positioned herself in both prochoice and prolife rhetoric. The moral trajectory of the motherhood discourse generates stigma for women who position themselves outside of normative constructions of motherhood. According to the binary, positioning oneself in the prolife rhetoric should exclude them from the prochoice position of choosing abortion. The binary dictating talk of abortion does not make this conflict a legitimate position for women to occupy, but the conflict is real in women's lived experiences. In this way, the binary constructing abortion discourse is insufficient to capture the complexities and conflicts associated with abortion decision-making. The next section will take up the moral positions that texture abortion decision-making within the prolife and prochoice binary, and how this impacts the overall abortion experience, and how women construct it within wider abortion discourse.

## Women's Moral Positioning in Abortion Rhetoric

Each of the dominant discourses of abortion, legitimated through various social power relations are imbued with a moral trajectory that women embody when they position themselves within, through or against the dominant discourses. It is these moral positions that appear to generate the most conflict and contradiction for women deciding whether or not to have an abortion. Characteristic of pro-life discourse is a moral trajectory centred on foetal personhood; that a foetus should have a right to life and be accorded rights that are given to born infants. In addition to (and perhaps overarching) the foetal rights moral position is that of the 'Good Mother', a discursive construction of how women should be in regards to their maternity.

Abortion in prolife discourse has often been constructed as a moral (and indeed evolutionary) transgression that 'bad' women will choose if they have been deviant (for example, become pregnant after a one night stand) and unnatural in that women are going against their life's purpose by terminating the life of a child and not embracing motherhood.

More characteristic to pro-choice discourse is the moral trajectory of human rights, and the bodily integrity of women, in alignment with the social norms and values of free will, individual choice and rational thought. A direct implication from this position is that women are more than the reproductive capacities of their bodies and that it is their right to a quality life to plan their own family and manage their fertility. It also attempts to provide an alternative position for women in regards to foetal rights by appealing to a biomedical construction of the foetus and the age at which it becomes viable, rather than a psychosocial construction of its innocence and need for protection. Whether women explicitly expressed themselves as prochoice or prolife in their talk or not, these moral positions were exceptionally important to their decision-making and experience of abortion. They presented some crucial conflicts in how women negotiated these discourses.

Ashley repeatedly reiterated this conflict between positions, of being pro-choice but still valuing motherhood and traditional femininity. The binary is working to produce a moral tension by polarising the two positions and being unable to reconcile them somewhere centrally:

***Ashley**: I was very pro-choice but at the same time I'd wanted kids my entire life…I'm still pro-choice but if I had to go again, I definitely wouldn't do it again. It*

*screws with you really badly, for a long time. It never leaves, (but) it's not like it's changed my decision. I'm still pro-choice.*

Although she positions herself multiple times in a 'pro-choice' discourse, morally, her own choice to have an abortion is one of great distress and personal anguish to her. These conflicts contradict the morality of the abortion binary that is dominant in social discourse – that to be 'pro-choice' means to be 'pro-abortion' and in some ways immune (or not allowed to express) to any negative feelings towards it. Although Ashley is strongly and negatively affected by her own decision to have an abortion, this does not indicate that she disagrees with abortions being available for other women. It indicates the experience of moral conflict in having to position herself as either prochoice or prolife as evidenced by her explicit positioning as prochoice, but also her resistance to the assumption that this means she is pro-abortion, or that abortion is an easy choice. A discourse of autonomy and choice is being expressed here – her desire for children and motherhood makes it a morally difficult decision, but simultaneously she does not wish to prevent other women from being able to make it – another moral conflict.

Drawing on a discourse of choice, the women were able to validate their decision at that time but it did not mean that they fully accepted the position that prochoice discourse placed them in.

**Rose**: *I think it is a decision you live with for the rest of your life. I think people who say "Oh well this girl is just taking the easy way out" – well it's not particularly easy. And I really strongly believe that a silly decision that I made at 19 shouldn't, I shouldn't have to – it shouldn't define me for the rest of my life... So you*

*do kind of have to say well everything happens for a reason and I never think I made a wrong choice. Um, I think I made a sad choice, but I don't ever think it was a wrong choice, if that makes sense.*

**Natasha**: *Ultimately, it's your decision and people just have to suck it up…it's not their choice…because it's you that has to go through this horrible experience. It should be yours, so you know whether or not you're going to be okay with it. I made the decision for me…it's up to you because it's your body, and you're the one who has to go through this.*

Although they position themselves within prochoice rhetoric, their talk is resisting the position that prolife discourse would assign to them for having an abortion – Natasha refers to her abortion as a 'horrible experience', and Rose references the stereotype that she, as a pregnant teenager 'took the easy way out' by having an abortion and how this was not the case. Her 'sad choice' and Natasha's 'horrible experience' are just two examples of how they justified their abortion in the dominant discourse; abortion was constructed as a psychological punishment – that they were choosing a procedure that did not align with their personal values, but in order to justify an abortion they had to express their decision within a pro-choice political discourse. By accepting responsibility of their actions (legitimised in discourse of choice and autonomy) and resisting the position of 'bad girl' or 'fallen women' in prolife discourse, they are able to morally justify their choice to have an abortion. Ashley and Rose further illustrate the conflict in the moral trajectory of prolife and prochoice discourse:

**Ashley**: *For some people it's going to be like I had a random one-night stand and got pregnant, definitely can't keep it you know – so for some people it's an easy throwaway decision. For others it's not so easy, you know we were in a position where it wasn't so easy for us, it took a lot, like a month worth of talking about it and decision making to even come to that point.*

**Rose***: Choices that are available to us because we live in this free Western world, it doesn't necessarily mean that it's going to be the right choice to everybody but it is a choice that's available to you.*

In addition to using the moral position of free will, autonomy and choice to justify their decision to have an abortion, the women used other positions. These moral trajectories within discourses often took the shape of talk firmly embedded in pro-life rhetoric, mainly foetal-rights and the morality of abortion from the perspective of the foetus, which was indicated in several women's accounts, and enabled both a political and a moral standpoint from which to position oneself (or be positioned):

***Natasha****: It's hard to say whether you're against like, killing someone or not, like it's like condoning murder. People who haven't had kids, it's more just a mentality, like can they mentally cope with it [abortion], because of what you're actually doing. Because it's not just like "Let's go and pull a tooth out" it's actually like, a person…As gross as it is to say, like you are killing someone - that is just what it is, and it's just how it happens.*

Natasha's understanding of an abortion has been constructed firmly within prolife discourse, which holds the life of a foetus in high regard and often compares abortion to murder. She has drawn on prolife discourse to understand the kind of choice she is making, which has made it an extremely difficult one. To hold this position morally is usually associated with the belief that a woman's rights and wishes are subordinate to that of her foetus, or that the right to life of the foetus should take precedence - which is a very difficult position to take up for women who are accessing an abortion service and choosing to terminate. Instead of positioning herself in prochoice discourse, her talk remains embedded in prolife rhetoric, but she avails herself of the moral position of the 'Good Mother', therefore justifying her decision as one of self-sacrifice and for the good of her existing children and family. This is sanctioned in traditional constructions of motherhood, maternity and femininity:

**Natasha**: *It wasn't just an "Uh, can't be bothered" like it was a thought out, like we couldn't afford it! It wasn't just a spontaneous "Nah I don't want it, I can't be bothered dealing with another one". I think she would support that rather than supporting the abortion, like it's supporting the decision as to why or why you didn't.*

From this perspective, being quite explicit in her traditionally 'prollife' view that abortion is murder, justifying her own abortion was reliant on discourses of maternal sacrifice rather than prochoice ideals. Positioning herself in this way enabled her to resist the moral transgression of having an abortion, and instead align herself to the position of 'Good Mother' to describe her decision.

Considering these conflicts, it was not uncommon for both prochoice and prolife rhetoric to inform the talk of women justifying their decision-making. Ashley,

for example, positioned herself within the prochoice discourse of choice and autonomy, as her moral right, and also within the prolife discourse of the 'Good Mother' and nurturing her existing family:

***Ashley:*** *You make the choice for your child. Even now, [Jamie] couldn't make a choice, his choice is between whether he wants juice or milk. He can't make a decision to save himself (laughing). It's my decision you know, well mine and [Rob's], and what we choose for him. So it's exactly the same, it can't make decisions, it can't be like "Hey I want to have this" you know…we make the choices for our children every single day. And obviously you don't want to bring – if you don't want to bring a child where you can't afford it.*

The morality of motherhood, and the justification of abortion in maternal terms both allow and constrain women from occupying certain positions within that discourse, and also in others. The constructions of the discourses often pit women against themselves in their positioning; they tend to construct their experience as a 'both/and' experience in multiple discourses, rather than an 'either/or' in the prochoice or prolife binary that is commonly understood.

Maggie also described her decision to have an abortion within the prolife context that she associated her religious upbringing with:

**Maggie:** *We come from a Catholic background, so um, abortion is frowned upon. And I think it's still illegal…where I'm from, but I mean both my mum and my sister were very supportive of me, because they said look, it's for the better, and good for you and good for baby. If you go ahead and something happens, then everything*

*will fall apart. Everyone out there has the right to make the choice that's best for them. And I mean, I'm just another person, I made a choice that was right for me, and I wouldn't want someone going round saying that you've made the wrong decision.*

Although Maggie faced social pressure from her religious and cultural upbringing and may not have personally agreed with abortion, she chose to have one regardless, and legitimated that decision by positioning herself within a pro-choice framework. *Pro-choice and pro-life then do not necessarily become synonymous with pro-abortion and anti-abortion* – it is a very subjective and fluid movement between these discourses and positions, and women are navigating these conflicts in the binary with positions made available by other texturing discourses. What this is showing, is the women's constant positioning within both discourses and within the binary itself simultaneously – both accepting and resisting positions from both discourses. The choice is also a deeply moral one, constituting some of the biggest conflicts behind a woman's abortion decision making.

## Texturing Discourses of Abortion: Exploring the Complexities

As women navigated their abortion decision making through the binary it became apparent that this two-fold position was not sufficient to capture the complexity of the women's positioning. While the prolife and prochoice debate was constantly weaving throughout the women's talk, there were discourses associated with their decision making that are not adequately addressed in the binary. Three main areas emerged as texturing discourses in women's talk of abortion decision-making: biomedical discourse, the merging of the 'autonomous' and the 'maternal' subject and female sexuality.

### *Biomedical Discourse*

As medical intervention to pregnancy was normalised (and midwife intervention/experiential evidence of the mother was problematised), biomedical institutions gained access to pregnant women to monitor and regulate their 'pathological bodies' Reproductive technologies, such as the ultrasound, reconceptualised more than just pregnancy; the concept of foetal personhood began to gain political ground. Medical doctors were seen as 'experts' in the woman's pregnancy; she was now an observer, and her experiential knowledge of her body was discounted in favour of biomedical and scientific knowledge of her foetus and her pregnancy. Not only was the discourse of pregnancy changed, but also the social, legal and medical status of the foetus was drastically renegotiated (Featherstone, 2008). Women's experience with these warring ideals of experiential versus medical knowledge of their experience was borne out in their talk.

**Natasha**: *I had pregnancy tests from the doctor already that I just had from like months ago or whatever. And I did them just to see because I was like well, I'm pretty sure I'm pregnant, like I know when I'm pregnant.*

Natasha illustrated the power of the biomedical discourse related to pregnancy and the strength of this knowledge as legitimising her pregnancy; without confirmation from the doctor and pregnancy tests, her own body's knowledge of her pregnancy was not taken seriously. However, her talk illustrates a resistance to the omnipotent knowledge of the biomedical gaze on her bodily experience – "I know when I'm pregnant".

Similarly, Maggie discusses the navigation of the biomedical discourse in her experience of her body being 'inconvenient', and the experience of the pregnant woman being subordinate to those accessing it.

**Maggie**: *When I went for one of my scans, they were trying to measure the neck of the baby and they couldn't get the baby to turn, so I was turned every which way possible and they finally said no we'll do a vaginal scan, so when they did that, the lady was bumping my cervix, saying "Oh it's just a little uncomfortable". And I just looked at her and said "Would you like me to do that to you? We'll see how uncomfortable it is".*

Despite the dominance of the biomedical hold on pregnancy and decision-making, some of the women were both extremely scared but strongly resistant to the hold it had over the abortion experience for them. The position of the rational, autonomous (genderless) body in neoliberal discourse allowed them to resist the prevailing stereotype of women's bodies in biomedical discourse, disrupting the dominant construction of unpredictable, volatile bodies in need of surveillance.

**Rose***: I remember at the time there being this huge urgency about you know, getting it done as quickly as possible because there was – if you go after this amount of time, then you can't have it done. I remember thinking oh my god, a sense of panic, because I was so terrified that I would be one day over and that they wouldn't do it or something really stupid. And I do remember that absolute fear of not being able to get it, oh my God. What would happen all of a sudden if someone said no you can't have it?! Certainly when you're having that "interview" or whatever they call it –*

*consultation – I felt like I had to give the right answers to get this done. I felt like if I didn't tell him what he wanted to hear, then he'd say no and it would be like well what the hell…it would be like failing an exam. Yeah, I felt like I had to pass a test to get permission to do something to MY body, which at the time I didn't think anything of it but now it's like, no, if I want to get my hair cut I'll get my hair cut, if I want to do this I'm going to do it.*

Rose explains the struggle between trying to express her experiential knowledge (not wanting to be pregnant, and knowing why this would be awful for her future), and having to meet the standards of the biomedical discourse – and acknowledging the power that the medical institution had to deny her access to this procedure based on her answers. Rose felt she had to comply with the biomedical discourse in order to have her abortion. Similarly, she expressed anger at this, and resisted strongly to having to access permission to do this from someone who had no knowledge of her circumstances – the counter-discourse of experiential knowledge was strongly accessed to resist biomedical dominance of her experience.

Biomedical discourse and individual rights of the women (from a neoliberal discourse of individualism) are often implicated as the moral trajectory in the 'pro-choice' binary (both with positive and negative consequences). To legitimise their position as prochoice, and their decision to have an abortion, they justify it through the powerful discourse of the biomedical structure. This indicates an extremely important discrepancy in how the binary has constructed abortion experience, and how women actually experience it.

What is interesting, however, is that although women construct their experience of having a maternal body as highly personal and emotional, resisting the

biomedical construction – they are actually more likely to construct their foetus in the biomedical discourse instead.

***Kelly**: I think I'm just really scientific about it, like it's a foetus, it's not a baby yet. It's just a foetus. It's no different to a sperm apart from the fact that it has a heartbeat, you know, it's no different to me.*

***Rose**: I think it's also an education thing about, when a baby's heart starts beating, when is it a baby and not a foetus, when is it an embryo and not a foetus, and you know, that kind of...that whole, um, deeply controversial thing about when life begins, which I always have a really good giggle about because I think well, every time a boy wanks off into a sock, you know, [laughing], how is that any different.*

***Ashley:** I don't see it as being murder, obviously a lot of people see it as being murder, but not that I've ever spoken to anyone that thinks it's murder...but you know, I mean, it's a foetus, it's not – it will obviously grow into a child, but at that point in time when they do it, it's not a child. And I just don't think it should be illegal – it's not, it doesn't have feelings, it can't know what's going on.*

Ashley, Rose and Kelly positioned themselves within prochoice rhetoric, although in Ashley's case she also expressed talk aligned with traditional beliefs about motherhood and rejected the prolife moral position that to be prochoice is to reject ones maternity. Although the biomedical discourse is often associated with 'prochoice' rhetoric, the women in this study did not draw upon it when constructing their pregnancy and decision making; instead, these aspects of the abortion experience

been constructed in discourses of maternity and neoliberal autonomy. When the women discuss their abortion *decision-making*, they strongly resist the biomedical construction of that decision; instead, to them, their bodily and experiential knowledge of their bodies and pregnancy takes precedence, and is highly imbued with emotion. Rather it was the foetus being constructed in the biomedical discourse, not the women's experience of pregnancy or decision-making. The way women construct their pregnancies and their foetuses is almost directly opposite to how typical social talk constructs the two. Essentially this is problematic, as their abortions and the decision making surrounding them are often constructed very clinically in the biomedical discourse, which does not legitimate the emotional and difficult part of their decision making.

### *The Conflict of the 'Autonomous' and the 'Maternal' Subject*

The act of undertaking an abortion does not necessarily mean that the women are resisting dominant discourses of femininity – to the contrary, many of them are actively participating in the dominant discourses and very much position themselves within them. Availing oneself of an abortion is not a blanket rejection of motherhood overall, but a conscious act to delay motherhood (in my participants cases). There is something more intricate behind accessing an abortion service than rejecting the traditional notion of femininity. This particularly implicates the question of women's *agency and choice*, which has traditionally been suggested as "limited" within dominant Western discourse constructing femininity, motherhood, and the access to abortion (Fegan, 1999) as explored in the previous section. Critics such as Gill (2006, 2007) have suggested that the illusion of newfound freedom for women is actually the work of the power relations of neoliberal discourse on the female subject, expressing

normative power upon individual bodies that facilitates the illusion of agency and choice. Although neoliberalism lauds the rational, individual and responsible consumer, it does not mean that this consumer is not gendered. Instead, Gill explores the idea that instead the female sexual subject is being reconstructed, as assertive and confident, and autonomous (Gill & Scharff, 2011) – and this creates a conflict in itself between two dominating constructions of women's sexuality, femininity and what it means to be a woman.

The women who participated in this research explored the conflict between being an autonomous, 'genderless' neoliberal subject as well as the embodied gender-specific social practices associated with women's bodies, and the standards to which women are held accountable in their behaviour. Through their talk about decision-making, women are actively positioned in the dominant discourses of femininity, but there is something else acting as a barrier for them to do this well. Alongside the assumption that a feminine body must be a maternal one, it is suggested that maternal instinct also comes naturally to all women, and as such, pregnancy, childbirth and motherhood is an inevitable evolutionary aspect of a woman's life. Not only do women face social pressure to become a mother in the first place, but they are also criticised if they don't do this well (Cooey, 1999). In society where the autonomous, individual subject is revered, each choice they make comes with the responsibility associated with that choice. Women now have to weigh up the positions of both discourses – between fulfilling the social expectation to become a mother (regardless of whether they are already, or plan to in the future) and the social disapproval or rejection that would face them if they were to admit they were unable to cope with the consequences of the choice to have that child. Motherhood and the subjectivity of

women's bodies, is a public and social practice now, which opens up potential for stigma or at least disproval.

The women in this study illustrated being actively positioned in both the prochoice and the prolife discourse – justifying their decision morally in both prolife and prochoice terms. The act of accessing an abortion for some women who previously had children involved women positioning themselves within the "Good Mother" discourse as a moral justification - sacrificing this child for the sake of her family. Even if she did not want to access an abortion, she had to do so for her existing children – within the context of an individualistic society. Essentially she combined the two:

**Natasha**: *The thing was more of having to consider I already had two kids, so I was like okay, at least I've got some, whereas some people can't have any.*

**Maggie:** *The pregnancy was very high risk…at that point I kind of sat there thinking, well they've told me I'm never going to have children, now I'm pregnant. I thought okay well yes I can go ahead with this pregnancy, take this high risk for something that's going to be wrong with the baby, and at the same time, there's also a very high risk for me. And even though I said, this might be my one and only chance, I just wasn't prepared – not so much for myself – but I wasn't prepared to do that to an innocent child.*

Natasha actively positions herself within the dominant discourse of femininity as the sacrificial mother, but her positioning within abortion discourse resists the implication that abortion is contrary to what it means to be a woman and a mother.

Instead, abortion is constructed as something devastating, but necessary, and she considers it the best choice she could have made in order to maintain her position and construction of herself as the good mother. Abortion is articulated as being essential to Maggie's ability to become a good mother. Abortion is being constructed as a sacrificial decision, and although her moral justification involves positioning in prolife rhetoric, her pregnancy itself is very much embedded in prochoice discourse of medicalised maternity and autonomy to make that decision.

This discursive positioning was similar even for women who did not have children in their life plan. Kelly described the importance of maternity and motherhood as a key reason behind her decision to get an abortion, which was nested in prolife rhetoric. The dominant abortion discourse of being an 'easy way out' for women is strongly resisted, and reframed as an informed, and rational decision about the responsibility of traditional maternity:

**Kelly**: *I would have been completely useless as a mum. I got the abortion because at the time I didn't think I was capable of looking after a baby, I still don't think I would have been capable. When I got pregnant the second time…I was more in a position to be able to, you know, look after a baby, and even though the baby still wasn't in the life plan, I was more in a position to be able to actually look after one.*

Kelly resists the dominant discourse that abortion is a tool to reject traditional femininity, but rather constructs it as an essential aspect of family planning - to ensure that maternity and motherhood is 'done properly' and that she can resist stigma from a poor choice of entering unwed motherhood, single motherhood, or teenaged motherhood. Even though Kelly did not specifically want or plan for children, her

second pregnancy, in much more stable circumstances, resulted in her carrying it to term.

Some women, like Kelly, attributed much of the abortion decision making to external factors such as financial constrictions, and did not experience much distress in her decision-making – but the same was not true for women who strongly identified through dominant discourses of maternal femininity. Prolife rhetoric was drawn upon to express some of the emotional difficulty of the decision, even though eventually the decision was made to terminate the pregnancy. Their decision is also legitimised through prochoice rhetoric that approves of "responsibilisation" of the individual subject in choice. However this may indicate more serious difficulties for women in positioning themselves within both rhetorical spaces; they are being held accountable for their choices, and at the same time told that these choices, which are so devastating to them, go against their natural 'duty' as women of reproductive age. This conflict and contradiction can lead to the creation and maintenance of stigma through a cycle of shame and silence.

**Ashley**: *I sat on it for ages and ages tossing and turning like – there were days where I was crying, because it was all I wanted, like I wanted to have a baby but at the same time I knew I couldn't. And it was one of the hardest decisions that I've ever, ever had to make.*

**Maggie***: I really didn't want this. But at the same time… I think for at least a couple months thereafter I just wasn't myself; I had a lot of regret. But it's just like at the same time, telling myself, you know, it was the right decision, you know, you can't gamble with someone's life, all that kind of stuff. But it didn't make me feel any better*

*if you know what I mean? Because still I thought, well this was my one and only chance. You know, it's like someone gives you the candy and then takes it away all at the same time.*

**Natasha**: *I pretty much talked myself up in my head that I had to do it um, which was really difficult, cause I had [Luke] when I was 17, and I had the option then to go and do it but I knew I couldn't, so I was surprised I could actually go through it this time. Um, cause I always had the fear that if I aborted, I'd never be able to have kids again.*

**Natasha**: *I'm very much a kid person but it was kind of more "What if that was my only chance to have a girl" because I've got two boys, and I want a girl, so um, yeah there was just heaps of drama going through my head. That's pretty much the hardest thing I've ever had to do…I wouldn't ever be able to do it again, I was...I'm probably still depressed about it, but it was really bad.*

These women had strong emotional reactions to their abortions, which may have influenced their rejection of the common perception that abortion is something that women will do when they want the easy way out, or if they are single and having a one-night-stand. In addition, they are positioning themselves within the discourse of neoliberal individualism, and taking responsibility for their 'choice' regardless of the emotional difficulty; therefore resisting a discourse of pathological maternal bodies. This counter-discourse was widely accessed in all of the interviews by the women. Their strong position in the dominant discourses of femininity and maternity give them cause to strongly reject positioning from prolife discourse of abortion as it

currently stands, and are reframing it as a devastating choice they had to make, which felt to them as though they were going against what they actually wanted as women and mothers. The limitations of women's choice within these binary positions are evident here.

### *Female Sexuality*

Women's maternity and reproductive capacity has been a source of both shame and secrecy, as well as the source of new generations, lauded and upheld as a woman's greatest contribution to her own life, and to society. However, the circumstances in which these children come in to the world are perhaps the most telling of how women's reproductive capacities are viewed, creating a continuous push-and-pull scenario for women to navigate in gendered social power relations. Questions of sexual legitimacy still deeply penetrate social discourse on reproduction and maternity despite a social migration to 'alternative' families that are slowly gaining acceptance, such as single mothers, older mothers and same sex parents. Despite this, there is a prevailing social mistrust for some of these alternative family arrangements, and the construct of heterosexual marriage remains the default legitimate situation in which a woman should find herself to be expecting a child. Conservative constructions of female sexuality are commonly aligned with prolife discourse and the positions it offers for women.

As women have made gains from the 1970s onwards in terms of participation in the labour market, independence from their male spouses, and other rights, abortion legislation appeared to follow in that general pattern, providing women with an alternative (legislated) option to avoid an illegitimate or unwanted pregnancy.

All of the women who spoke in the interviews constructed their pregnancies in

varying levels of legitimacy, whether in relation to their partner arrangement, or their material ability to raise a child. Women's sexuality has been defined by patriarchal and paternalistic values where gender appropriate sexuality is managed within marriage or heterosexual normativity. For those women whose situations deviated from the 'heterosexual marriage' blueprint, the engagement with the discourse of sexuality was diverse within itself. Rose viewed her illegitimate pregnancy (and subsequent need for an abortion) as a punishment for her 'deviant sexuality':

***Rose**: It was a one night stand but it was a one night stand with somebody that I had a really, a quite deep connection with. So I went home with him and found out however long later that I was pregnant. And didn't really know whether it was my boyfriend's or my one night's stand, which was horrific, it's a horrific feeling.*

***Rose***: *I was like "I've made a mistake, this is my punishment". I really sort of felt like I'd got myself into the poo and therefore I had my cross to bear, to use the phrase my mother uses. You make your bed, you lie in it, however you want to put it.*

Rose's talk of making a mistake and having an abortion as punishment is reflective of the pervasive prolife discourse that the unintended pregnancy is shameful and unacceptable outside of the socially sanctioned discourse of heterosexual marriage, and especially shameful in the context of a one-night stand. Her 'punishment' is to go through an abortion; constructing abortion itself in a negative light, as something she has to suffer through to right her sexual deviance. Similarly, Natasha framed her abortion as shameful:

**Natasha:** *I think the people that I did tell, I probably trust the most. Because I've probably talked to them about other dirty little secrets like, yeah. I think it just made it easier, because I knew I could probably trust them and that they weren't going anywhere, and I knew they wouldn't just air my dirty laundry.*

Describing her abortion as 'dirty laundry' and a 'dirty little secret' expresses shame for an unplanned or illegitimate pregnancy in particular contexts that transgress the norms of female sexuality, and perpetuates cycles of shame and silence. However, the abortion itself did not appear to be the stigmatic act; it was the transgression of moral norms that appeared to be the difficulty for women. The idea that abortion itself is not stigmatising was realised in the talk of some women who did not construct their abortion as shameful, even in the context of 'illegitimate' sexuality. Kelly did not construct her pregnancy and need for abortion as shameful, or as a negative act on her part:

**Kelly**: *The intention of getting pregnant was never there because I was actually on birth control. At the time, obviously I don't think I ever planned to have kids. It was never a part of my life plan… the decision behind getting one (an abortion) wasn't a hard one for me.*

Despite being in similar situations, Kelly had been actively trying to avoid getting pregnant. In this way she was able to attribute her unplanned pregnancy to the failure of birth control, rather than deviant actions on her part, even though she was not in a 'legitimate' heterosexual marriage in which one would be expected to get pregnant. Externalising the blame to faulty biomedical technology allowed her to

position herself outside of the moral trajectory of shame and secrecy, and abortion was not sought in the context of 'punishment', as it was in Rose's narrative. Specifically, Kelly was able to use the privileges associated with the dominant biomedical discourse to justify her need for abortion. Socially, she may be viewed sympathetically as her abortion was a result of the failure of contraception rendering her not individually responsible for having to make her choice, and therefore the blame rhetoric could be drawn on to justify her decision to abort.

This reveals multiple potential positions that women can hold or be held to in regards to female sexuality as a texturing discourse of abortion decision making. How abortion is constructed and approached by women through their narratives is therefore often extremely reflective of the circumstances in which they found themselves to have gotten pregnant, rather than their view of abortion itself on a grander scale – much more embedded in discourses of sexual legitimacy and sexual deviance.

Being in a heterosexual marriage legitimises pregnancy socially; associated with heterosexual marriage is financial stability and the ability to provide a secure home for a baby. The circumstances in which the women found themselves were extremely important for their decision-making, and it has enabled a position vaguely associated with neoliberal discourse of individual choice to emerge from what used to be traditional family arrangements. It is becoming more socially acceptable (with the increasing pervasiveness of neoliberal discourse) to get pregnant in alternate arrangements that are not heterosexual marriage as long as the parenting that child receives is of the same calibre. In particular, with the decline in social traditions of marriage, a newer 'shame' has been placed upon women who enter single motherhood, especially as teenagers. The deviance of female sexuality has lessened in some respects and increased in others. The discourses of motherhood have shifted and

changed as they become enmeshed in those of neoliberal individualism. Whilst navigating the positive and negative constructions of motherhood (e.g. the 'Good Mother' or the 'Welfare Queen' popular in social talk), they also are pressured with having to conform to both constructions of motherhood and neoliberalism (Gill, 2008). One way in which this has manifested is the lauded and privileged 'Superwoman' – the woman who does it all, and does it while being glamorous and perfect (Jacques & Radtke, 2012). An increase in alternative family arrangements has instead placed more emphasis upon financial and practical considerations for young women who are contemplating their options with an unplanned pregnancy, despite being in a monogamous heterosexual relationship, more emphasis is placed on the financial considerations of potential single (or teenaged) motherhood. This could be reflective of an emerging change in the manifestation of what can be considered legitimate in discourses of choice or maternity. While it is becoming more socially acceptable for women to have children outside of the traditional heterosexual marriage, there is now an expectation that if they do so, they are taking responsibility for the same quality of upbringing that children born into the traditional arrangement would receive. These arrangements are still considered 'deficit' within dominant discourses of heterosexual marriage, and still hold these alternate families to the same standards. Single mothers and teenaged mothers do not usually receive legitimate social endorsement due to a wide belief that they are unprepared to maintain this standard.

Complex interactions with changing conceptions of femininity (the independent woman, participatory in the labour market) means women contemplating abortion now have to consider not just that they are in a heterosexual relationship with a partner that can support them, but whether they could support themselves in the

event that this partner were to leave. Although there is more freedom in family arrangements, there is also more risk that a woman may be left to carry that family alone.

Rather than a focus on the actual circumstances of becoming pregnant, their decision-making was connected to the legitimacy of their social situation to carry that pregnancy to term and parent the resultant child. Women positioned themselves in relation to their pregnancy as 'not being the right time' or 'not [being] in the position' to have a baby – their pregnancies did not fulfil the criteria of 'legitimate' in their social contexts.

**Ashley**: *We started discussing…what we were going to do, because we weren't in the right position to have a child. [Rob] was in a crap job that he hated, and I'd only just started and I was a temp, I didn't even know if I'd be full time, and um, we were living with [Rob's] mum…We weren't in the right position… she was like, you can't have it, and you're just not in the position to keep it.*

These questions of legitimacy were expressed in the talk of the women in regards to their male partners, which indicates that the discursive binary of prolife and prochoice is further textured by a discourse of sexual deviance in solo parenthood. The legitimacy of their pregnancy not only relied on their own ability to be mothers, but on the ability of their partners to be fathers. To avoid stigma of single motherhood, several women cited their partner's suitability on level playing ground with their own to be parents:

***Kelly**: I discussed it with my partner at the time; he was as young as what I was, so he wasn't in a position to be able to look after a baby either so he fully supported my decision.*

***Rose**: And look, my boyfriend wasn't gonna marry me. You know – he wasn't gonna be a dad, he wasn't – you know, I had no illusions that that was gonna happen!*

Abortion decision-making was entwined with deeper concerns of legitimacy, both from socioeconomic and with potential partner support for those women who were not in long-term (or stable) heterosexual partnerships. Although this was the case for some women, illustrating the diversity of abortion experience was the talk of women who were seeking an abortion despite being part of a socially sanctioned partnership. Maggie positioned herself within the discourse of legitimate female sexuality for her first pregnancy, which ended in an abortion:

Maggie: *When I was 19, it was an accident. I was already married at the time, so it wasn't like it was out of wedlock or anything.*

Although her pregnancy was unplanned (and she was a teenager), her initial reaction appears to be one of less shame than Rose, justified with her positioning inside the legitimised discourse of heterosexual marriage. Positioning herself within the discourse of socially sanctioned sexual behaviour provided Maggie with a justification for her unplanned pregnancy that allowed her to construct her experience outside of the stereotypes surrounding women who access an abortion. However, being in a position of 'power' in the legitimising discourse (i.e. being in a

heterosexual marriage) also created its own difficulties, as those women who found themselves in this position struggled with the idea of an abortion – it was not considered something a woman in that position should have (or want) to access. This position justified her pregnancy but proved difficult when justifying her abortion.

Natasha discussed her concerns with managing motherhood, as she already knew of the responsibilities it involved, and expressed this as being of more consideration to her than the financial aspects or 'being in the right position' as several other women did. The legitimacy of her pregnancy involved her ability to be a mother to another potential child, considering the 'position' she was in with her current two children. Although her pregnancy was 'legitimate' by standards of dominant discourse normalising women's sexual behaviour, she had to position herself in another discourse to justify her choice of abortion. In this case, she utilised discourses of maternity and motherhood, "The Good Mother", in order to justify her abortion. To be a good mother to her existing children, and conform to the ideal of a mother as nurturing, sacrificial and caring, an abortion was the only option for her to be able to continue to do this with the constraints of family. In Natasha's narrative, her psychological wellbeing and its effects on her children enabled her decision-making. Therefore, abortion is produced here as a legitimate course of action but remains difficult to negotiate when dominant constructions of abortion lie within the pro- and anti- binary.

**Natasha:** *I think it wasn't even the money, it was just the fact that [Jason] was so young, and I couldn't like mentally handle him, because I went through quite a bad patch of post-natal depression with [Luke], my oldest one, um pretty much up until I met Ben, I was still depressed and mentally retarded um. I actually couldn't cope with*

*anything, I was drinking every night and using that as an excuse to go through that, so that was another big thing. I was scared that it would be worse this time, and I regret what I put [Luke] through so I didn't want to do that to [Jason] or possibly the other one.*

Similarly, Maggie found herself going against the expectations of her age and social situation by choosing to terminate a pregnancy based on health reasons. The binary forces women to reject one position in one discourse for one in another when the reality of their situation may stem from multiple conflicting avenues that are reduced and dismissed to simplistic and stigmatic binaries.

The women articulated their discomfort with the dominant discourses of motherhood and expected femininity, and resisted the expectation that being in a certain position socially (i.e. in a heterosexual marriage) meant that abortion was not a consideration for them. Rather, resistance to expectations was enabled through an understanding of abortion as 'birth control', morally justifiable through previous decisions that the family was complete.

**Rose:** *My husband and I were talking, because we don't want any more children, and we were talking about abortion as a "contraceptive" choice you know…if a mistake happens when you're this age, and you really, really, really don't want another baby, the choice is available to you. But it's a hell of a lot harder to make that choice, because you've got children, you know you can do it, your children are not sick or ill you know, they're perfectly healthy happy children, you haven't screwed it up so far*.

For these women, the legitimacy of their pregnancy was an extremely important aspect of their decision making in order to access an abortion. Illustrating the diversity of women's reproductive needs, the women in this study showed the difficulty that women face when navigating an unplanned pregnancy; whether they are in a 'legitimate' position or not. The positions that the dominant discourse make legitimate do not adequately cover women's actual reproductive needs; it restricts the positions that women are sanctioned to occupy without stigma being ascribed to their experience.

## The Manifestation and Maintenance of Abortion Stigma

Abortion in public discourse is polarised between the dominant binary, which narrows how abortion can be talked about and legitimately experienced in social contexts (Jelen and Wilcox, 2003; Joffe, 2010). Abortion stigma then can widely impact several key structures of the social contexts in which women reside such as government policy, community support and individual reactions to disclosure (Kumar et al., 2009). Herek's (2009) framework of 3 manifestations of sexual stigma informs our understanding of women's abortion experiences; internalised stigma was the main one felt by women in this research, although felt stigma and enacted stigma was alluded to in some of their talk.

The power dynamics underlying the creation and maintenance of abortion stigma relate to the context of the society in which it is produced and reproduced, bound by the meaning of family, motherhood and sexuality in a relation to women's life experiences. For women whose choice to have an abortion transgresses these socially acceptable meanings, the concealable nature of abortion means that their experience is often silenced in an attempt to avoid the enacted stigma that disclosure

might result in, One form of silence functions through internalised stigma, which may prevent women from reaching out for fear of being judged, and perpetuates self-surveillance. In prochoice discourse of individual autonomy, abortion and other sexual 'transgressions' are constructed as choices and women are held as individually responsible for the consequences of their actions, removed from the social context in which the decision to abort occurs. In order to avoid the potential felt or enacted stigma associated with these failings, women tend to internalise the stigma instead, and only selectively disclose their abortions to a trusted few; it produces silence.

Internalised stigma came through the women's talk in terms of justifying their abortions – they were acutely aware of dominant discourses that produced the 'kinds of women' that had abortions, and this rhetoric was drawn on to position themselves and others both positively and negatively in their narratives. One way in which stigma was talked about was embedded in the prolife discourse of the 'types' of women who have an abortion, and how these women are bad, or fallen. A strong moral position that emerged in the women's talk was that some women are more deserving of abortions than others, mostly in relation to rape or incest, or if there was great medical risk, legitimate positions within dominant discourse. Interestingly this is portrayed even in "pro-choice" abortion discourse, particularly in popular media and political representations of the movement – further indicative of the tensions between the binary positions. Pro-choice does not necessarily mean pro-abortion – but this leaves women who *are* pro-abortion in a state of silence or bearing stigma. Even the movement that is closely aligned to abortion rights rarely discusses or supports the woman who has multiple abortions, who considers abortion a contraceptive, or late term abortions.

**Rose:** *I always felt like I had to justify it…Like oh you know, no it's not my first pregnancy, I had a termination when I was 18. I can't just say oh I had a termination. I have to say I had a termination when I was 18. Like that somehow makes it acceptable or better or…it's like you feel like you had to justify to people why.*

Rose constructed the stigma of the 'kind of woman' (young, stupid) who access abortions in order to avoid judgment – by justifying her abortion with the disclaimer that "I was 18". She is positioning herself in the prolife rhetoric of the kind of women who gets an abortion – as well as stereotypes of teenaged girls – as being naïve, impulsive and sexually deviant – something that she is suggesting she is not now. Although she positions herself in this rhetoric to justify her abortion decision, its purpose is to resist the stigma of having an abortion by implying that if she had not been able to have one, she would not be the successful mature woman she has become. In this way, Rose has used the stigma associated with prolife rhetoric and positioning of teenaged girls who have abortions after one night stands to distance herself from that in her current life.

Other women's talk also drew upon prolife rhetoric of the 'type' of women who get abortions to position themselves within or outside of that, in an attempt to avoid the stigma of abortion and the assumptions about their own experiences that would go alongside identifying themselves with those women:

**Ashley**: *For some people it's going to be like I had a random one-night stand and got pregnant, definitely can't keep it you know – so for some people it's an easy*

*throwaway decision. For others it's not so easy, you know we were in a position where it wasn't so easy for us.*

For Ashley, although her circumstances made her vulnerable to social disapproval, she positioned herself outside of prolife rhetoric and embedded her talk more firmly in prochoice rhetoric, and in a discourse of choice to avoid being positioned alongside the 'loose' women whose abortions are 'easy throwaway decisions'. At the same time, she remains in prolife rhetoric to reinforce her position of not being against motherhood; it is instead that she is unable to enter motherhood well at this time. Even when navigating stigma, these women are still positioning themselves within both dominant discourses of the binary, and simultaneously rejecting positions associated with the stigma of abortion.

Women's talk of stigma also drew upon prochoice rhetoric in a discourse of reproductive autonomy, associated with the individualism and choice associated with the neoliberal discourse. Most strongly it was used in women's talk of internalised stigma – within their positions, their talk became indicative of 'self-government' and the concept of permanent visibility which leads to the automatic functioning of power – or in this case, the internalisation of dominant discourses of femininity and motherhood. The dominant binary of abortion talk produces a conflict for these women; although they are drawing on a prochoice discourse of choice and autonomy, it does not adequately represent their lived experience, and they also struggle with breaching the norms of female sexuality and motherhood. Women are in a state of perpetual self-surveillance. In this case, it is the internalised stigma of what abortion symbolises or represents (deviant female sexuality) than the actual abortion – and in many cases it is this that is more damaging than external stigma:

**Ashley**: *I think it was more disappointment in myself rather than other people at the situation more than anything. It's not a situation that anybody wants to be in…I didn't really get any judgment from anyone. I think it was more just myself, kicking myself over and over and over again for it, rather than anybody else. A lot of people sympathised and were like "Yeah that's sucky" but no one sort of told me I'd made the wrong choice. Whereas I was mentally kicking myself for putting myself in that situation, and being like "I'm one of those people"…"I'm that guy".*

The legitimising discourse of individualism, agency and free choice valorises individual choice only to a point; as long as it is within the parameters of what is deemed acceptable behaviour for women. Pro-choice abortion discourse (and subsequently, the binary) still holds women who undergo abortion to a set of standards that stigmatises and silences a large number of women whose abortion experiences do not fall within those parameters. This may be where much of the internalised stigma is rooted. Even prochoice discourse rarely supports women who are pregnant in circumstances that transgress traditional norms of femininity and female sexuality. Ashley's extract illustrates a huge conflict; prochoice discourse allows her to justify her choice, as individual choice is sanctioned, but this particular choice is not considered a socially acceptable or desirable one. What emerges is self-surveillance in regards to disclosure, and the maintenance of secrecy and shame – leading to stigma. This internalised stigma may stem from discourses of individualism inherent to neoliberalism – that women who had their pregnancy forced upon them, or with unforeseen complications, are more deserving of unrestricted access to abortion than those women who had simply made 'stupid mistakes'. Discourses of choice and

autonomy in this case can work both ways - to both advocate for the opportunity to have an abortion, and also perpetuate blame on women who got pregnant in unacceptable circumstances.

**Rose:** *You never, ever, ever know whether that 15 year old girl walking in there to have an abortion has been raped, you don't know whether she's been sexually abused, you don't know whether she's been gang raped at a party because they got her drunk, you don't KNOW, you never know anyone's story. And yeah, I have no doubt that a lot of girls make really silly mistakes and make really silly decisions you know – but we all do, that's human nature.*

Rose acknowledges the conflict in the binary that some girls may have been raped (legitimate), and some may have simply made a silly mistake (deficit) but argues that both are valid reasons for abortion. Her justification for both of these positions is that people should not assume or judge based on the action and that the action does not define the woman. This position may provide an alternative in the current binary for women to occupy and for social change to occur.

The discourses that provide legitimate positions for women to access (or resist) also place limits on those positions, and restrict the parameters by which women can align themselves to these positions without experiencing social backlash. In turn, this creates stigma for women who are accessing abortion – and perpetuates a cycle of silence. Although the choice to have an abortion in New Zealand is made legitimate by discourse of choice and rational thought, the social approval of these choices is limited by prolife discourse, or the transgression of dominant constructions of femininity and motherhood. Limitations of the prochoice discourse mean that

women are individually responsible for the decision and other social circumstances are ignored. In this way, prochoice rhetoric can be extremely limiting and stigmatising. Navigating these conflicts means that for women whose abortion 'choices' do not fit into the socially approved circumstances, the experience is felt as intensely private, shameful and often hidden or disguised as something else in order for the woman to keep it a secret from her significant other, family, work colleagues and friends. The silence and the expectation of privacy around abortion can lead to conflict in a neoliberal society where the dominant discourse is changing – women are 'empowered', it is a new dawn and a new day for women everywhere. However, these 'empowered' women are still experiencing conflict among other dominant discourses and institutions that are powerful enough to normalise that knowledge.

Although felt and enacted stigma was much less common in the women's talk than internalised stigma, it still played a part in women's construction of their abortions. Women talked of felt stigma or enacted stigma as secondary to the internalised stigma and the guilt that they felt for their own circumstances, illustrating the way in which the feminine body is reponsibilised, and women perpetuate self-surveillance even in the context of non-stigmatising lived experience:

**Ashley:** *I didn't really get any judgment from anyone; I don't actually know anyone who's like "prolife" like super prolife that they would be like no, that's the wrong choice. So everyone I hang out with, that were close enough to me to know what was going on didn't make a snap call at all. Yeah it was good, I think it was more just myself, kicking myself over and over and over again for it, rather than anybody else.*

**Rose:** *I don't tell people because that's – because I don't know how they're going to react and I don't want them to change their opinion of me based on their…narrow-mindedness, or whatever, their personal opinions. But I, I'm also, I'm not ashamed, I'm not embarrassed about it*

In Ashley's situation, her friends and family when she disclosed were supportive of her decision, and did not stigmatise her with prolife rhetoric; she acknowledged that it was mainly her own position in abortion discourse that stigmatised the experience based on her own transgression ofher own moral position. In contrast, Rose asserts that she is open and unashamed of her decision to have an abortion (currently)- but this does not prevent her from being selective with her disclosure based on the potential for felt or enacted stigma from others. The potential for stigma – and women are well aware of this potential – is enough to perpetuate the cycle of silence and contribute to the difficulties women face in publicly disclosing their abortions. In effect they are continuing to self-surveil even in the face of unlikely enacted or felt stigma. This has implications for the way abortion is constructed and contradicts the assertion in prolife discourse that it is the individual pathology of women that results in negative emotional consequences of abortion. The wider sociocultural presence or threat of stigmatising responses increases women's anxiety about disclosing their abortions, and results in internalised stigma and negative self-concept.

## Conflicts with Abortion in New Zealand

In earlier socio-historical periods, women were sequestered away with illegitimate pregnancies to give birth in secret, giving their babies up for adoption,

and returning to their families as though their pregnancy had never happened. Midwives were employed to help women with their pregnancies and births, which happened mostly at home in the woman's private residence without hospital input. With the medicalisation of maternity and a move from sovereign power to disciplinary power, the way in which women's reproductive and maternal bodies were managed changed. Some of the dominant discourses that legitimised certain ways of knowing about women and pregnancies were both produced and altered after the First World War and Second World War - post-war pronatalism became a strong influence on the discourses of women's maternity, where the state held invested interest in the population. Women were encouraged to reproduce, as was their duty of citizenship, to replenish nations of their men lost at war. As women have entered the public sphere in the last 4 decades, increasingly engaged in the public sphere, this has had implications for female citizenship, and therefore female sexuality. In order for women to engage in public participation some of their private issues, such as illegitimate or unwanted pregnancies, have entered public spaces and the tensions were explored in the women's talk. Women's bodies have become more public as women themselves have entered this sphere.

In Auckland, New Zealand, Epsom Day Unit is the publicly funded organisation that performs most of the abortions in Auckland. Despite existing as a specialist unit, it is embedded within a larger hospital setting. However Epsom Day Unit and its purpose is well known to citizens, and the women who enter there are assumed to be accessing a termination. This provokes tensions between what can be considered private and public – although they are accessing an abortion through public District Health Board funding, women still construct abortion in their talk as an

intensely individually private issue, and their talk hints at the tension between positions of having a right to privacy, and the public/private maternal body.

**Rose**: *I think it is something that women, we shouldn't be ashamed of it. It shouldn't still have the background stigma like it did in…1855. Women are very, very judgmental of each other and I think that's why so many people don't talk about it. But I think that…on the flip side of that, it is a very private thing and for some people it's a very, very emotional and a very difficult decision to make. And you should be able to keep it really private. And that's…I think…privacy is really hard you know.*

Rose's conflict stems from contradictory constructions of women's bodies and dominant discourses that frame abortion; women's maternal bodies are now under public surveillance (for example, through biopower) and at the same time, they are pathologised and labelled as deviant if they engage in their reproductive function outside of socially approved circumstances. Prochoice discourse does not sanction those individual choices – leaving women to navigate the conflict between public and private. Women also expressed difficulty with the lack of privacy they felt when accessing abortion through the medical system, reflecting some of the tensions between private-and-public discourses of abortion and of female sexuality.

**Rose***: It felt like a real violation of people's medical privacy, the fact that Epsom Day Unit existed as Epsom Day Unit and that it was called Epsom Day Unit…everybody knew why you were going there, there was absolutely no anonymity.*

**Rose**: *Things like being on a shared ward, this very old fashioned ward full of beds, with curtains around them, with people going through things that is a hugely emotional and very private moment in people's lives. That's really so incredibly invasive to have to sit on a bed, waiting to go and have this procedure done, knowing that there's 6 women in the beds that side of you and 6 women in the beds that side of you and you're all going through the same thing and there's absolutely no privacy and no respect for that.*

The medical context for undergoing an abortion in this case did not promote solidarity and comfort; instead it was viewed as invasive and offensive, to be in a public hospital in a shared ward for something that is constructed as intensely private and emotional for individual women. Rose talks specifically about the tension between the medical, public discourse of abortion, and the difficulties of not being given a private position within this discourse:

**Rose***: It is very clinical and it has to be, it's a medical procedure. But it all being very much like okay this is what you're going to experience, this is what you do, you know, take some panadol, off you go, see you later. Any problems talk to your doctor. And it's like well no, I'm not going to talk to my doctor because I didn't talk to my doctor in the first place about this, my doctor is my family doctor, who everyone in my family sees.*

**Natasha**: *I actually had to go to a different doctor, because my doctor's against abortions, he isn't - and this doctor I've been with like since I was out of my*

*mum's tummy, like he actually birthed me. There's actually quite a close relationship there, so it would have been really weird anyway.*

This is a common situation in New Zealand, which has a small population comparative to other countries across the world. Often families will all see the same doctor, and especially in rural areas, these doctors are known to generations, for many decades. This clash between the public and the private is something quite specific to the New Zealand context of abortion access – in one woman's case, the specialist who performed a gynecological procedure on her 20 years later was the same man who performed her abortion. There is conflict here for the women who struggle to maintain their medical privacy in a social context where they often have very public relationships with health professionals. In a socio-political climate where the discourses of neoliberalism are dominant, this inability to maintain that autonomous and private personal space implies fear of felt or enacted stigma, as it does not allow women to anonymously conceal their abortions.

Also in New Zealand, abortion is only available with the consent of 2 doctors who agree that continuing the pregnancy poses a serious risk to the physical or mental health of the woman, or if there are serious foetal abnormalities. This legislation allows for abortion under certain circumstances, and medical obligations are clearly outlined. Here there appears to be another strong discrepancy: pregnancy is medicalised in dominant discourses at a macro level but it is internalised and emotional at a micro level. Talk from the women highlights some of the difficulties between the legal and the moral 'right' to have an abortion, or the prochoice/prolife construction of abortion. Many felt that the quality of initial information provided to them about the abortion, and the care by the hospital and medical staff themselves

was acceptable, and objective. It also rejects the assumption from prolife discourse that abortion is harmful to women because they are not adequately informed of what the procedure involves and how they would feel afterwards. Abortion in medical institutions constructed it almost exclusively in biomedical discourse, which had positive implications for the women's experience of their decision-making process as unbiased and feeling as though they were not judged. It also enabled them to feel less risk or fear in regards to the safety of the actual procedure:

**Ashley**: *They were very good actually – they were very unbiased about the whole situation and I found that, 'cause I went there with my second pregnancy as well. And there was no sort of "This is what you have to do" type of thing. Yeah they were actually really, really good, they were awesome…The doctor himself was actually really good about it, and he seemed quite unbiased, he was like "This is what I do".*

**Natasha**: *Everyone like the doctors and nurses and stuff they were all really lovely, they gave you all the information that you needed, and they gave me um information on getting contraception afterwards. I think having the information did really calm my fears, because I could read it all, I was prepared for it. Whereas if I had just gone in and not read anything, I would probably, I would definitely not have been mentally prepared at all. Because I wouldn't have known what was happening. And actually up until that day, that I read the information, I had no idea what went on, I had no idea.*

**Maggie**: *I was under hospital care already, accessing an abortion was quite easy for me. They made it my choice, but they obviously just wanted to double check to make sure I really wanted to do it and I was doing it for the right reasons…Every time I saw them, saying "Are you still okay to keep going?", you know, saying that it's dangerous, you realise this is dangerous, so are you sure you want to keep going? They also wanted to see from that point of view you know, I was aware of what was happening, that there were risks.*

Generally the experience of medical personnel themselves was positive, and constructed as informative and non-judgmental, non-biased and non-pressuring, which the women felt both comforted and surprised by. From this perspective, their expectations of medical care, for the medical aspect of their abortion enabled a positive experience, and their comfort of being positioned as patient in this discourse was shown in their talk.

However, aspects of the clinical medical care conflicted with the women's construction of their pregnancy and abortion decision-making as a moral situation. Herein lay the dominant conflict - as the care of the pregnant woman having an abortion lies entirely within the biomedical realm, their inflexible construction of abortion as a medical procedure limited their ability to care for women's diverse emotional needs. Despite being a pregnancy that resulted in abortion, it was still a pregnancy – an experience in a woman's life that can match great joy with great sorrow just as quickly:

**Rose**: *It was such a clinical conversation, and I remember walking out of the appointment, that first appointment and thinking "Have I done – am I making the*

*right decision?" because it was so cut and dry, it was so clinical, it was so cold, it was so unemotional.*

**Natasha**: *The waiting room it just, it just makes it worse, because you're sitting there quiet, and they needed it more friendly. It's too like, down to business. It was just that room, was horrible…even like the sitting, waiting to get it done, they need something to like take your mind off it.*

**Kelly***: It was really weird, it was the weirdest thing ever, just being a room full of chicks who are getting terminations, it was kind of a little bit weird, it was kind of like a cattle call.*

**Ashley**: *It feels kind of judgey, you know, because you're all just sitting there waiting, it's like you're waiting for your death sentence.*

The comparison of the waiting room as a 'cattle call' and 'waiting for your death sentence' starkly illustrates the tensions between the two discourses of abortion that the women are engaged with – the first, that abortion is a clinical, medical procedure, and the second, that abortion is an emotional, personal and morally stressful decision for the majority of women. There is nothing quite like it to compare to – no medical procedure (with the possible exception of euthanasia) can elicit such polarising medical and moral views. Women's talk of their lived experiences attributed emotional meaning to their abortion, rooted in maternal discourses of abortion rather than the biomedical discourse of pathological bodies, and this was shown by their confusion, uneasiness and disappointment with the 'clinical' treatment

they perceived was given to them. The medical institution positioned them as patients in a clinical setting – the women resisted this with a counter-discourse of individual humanity and emotional importance. However, in resisting the discourse of clinical medical sterility, Kelly constructed her clinical experience alternatively and positions herself within the biomedical discourse, but in a way that promotes an emotional connection:

***Kelly**: I think with that many people, and the different age groups, that were in that room as well. You just realise you know, that you're not the only one in that situation. So it's kind of calming as well, you know that you're not alone in it, even though it was still weird.*

Kelly's experience was constructed in a discourse of femininity or traditional motherhood to be more communal and supportive. Women are traditionally positioned as communal, caring and family-oriented. By harnessing the support of women in similar situations, there may be opportunities to increase the comfort of women undergoing abortion even within the clinical setting of biomedical institutions.

These tensions did not exist only in the pre-abortion decision-making and administrative phase. After the abortion, the women also discussed their difficulty with the lack of follow up they received from their medical provider in terms of their mental health, illustrating the texturing discourses of abortion and the difficulties in adequately expressing their experiences:

**Ashley**: *I wish it was a little bit more support, in terms of possibly even counselling afterwards, something like that, something small that would help, even if*

*it was just a few sessions of like subsidised counselling afterwards, that would help hugely. Because you kind of get – it kind of goes, you get pregnant, you have an abortion, that's it. That's the end of it, they don't really care after that point, there's nothing else.*

**Natasha**: *I think they should make it like, you HAVE to go for a follow up appointment. Maybe make it like 6 months after to see how the person's coping. Because sometimes that can be the most painful time in their life, like they could just really need help, right then and there. Like you don't really think about it straight after, it's sort of like a LOT in the future.*

**Maggie**: *The nurses post-procedure were nice, but it was still more like okay we're here just to look after you, you know as long as you're comfortable we're happy. Anything other than that was just kind of like…it um, they didn't really necessarily worry too much about that.*

The clinical medical care that affected the pre-abortion experience for women also impacted their feelings post-abortion, and highlighted the importance of emotional decision-making. It points to the inadequacy of current abortion talk and current practice that reinforces that binary; it creates stigma, and keeps women's guilt silenced. Additionally, for one woman whose abortion was performed in private facilities, there were other difficulties associated with the ward she was on:

**Maggie**: *There is support there, I just didn't feel comfortable going back to the hospital because again it's all within that maternity area, so I was like no I don't*

*want to be around pregnant women. I didn't want to be associated with the maternity people all at the same time. Just going for the check-up was hard enough let alone sitting there waiting for a counsellor to become available.*

Emotionally, Maggie did not feel as though she (or her experience) belonged or felt comfortable in the maternity ward; once her abortion had been performed, Maggie no longer considered her body to be a maternal one. She may even have internalised some of the talk of pathological female bodies, and felt shame and guilt that hers was 'dysfunctional'. However, this is not the same for the medical field, where she is being positioned as a maternal body in need of surveillance, and the facilities do not cater for varying experiences of the maternal body. Maggie expresses a feeling of exclusion and conflict between the two discourses – medically, she is regarded as maternal, in need of supervision, but emotionally and personally, she now feels excluded from maternity discourse. Her position does not match that of the biomedical discourse; she is resisting the discourse of the medicalised (and pathologised) maternal body and asserting the conflicting layers of expectations inflicted upon her maternal body.

These practices reinforce and are indicative of the structural stigma that exists about abortion as it currently stands in legislation; the medical field is obliged to provide the information and the procedure within the criteria, but there is considerable conflict between the discourses of abortion, and difficulties in positioning within the construct. To argue that it is a medical procedure that is safe for women and should be legal and available to them often implies that it is psychologically emotionless, painless, and easy for women to access. To argue that it is a personal, emotional and difficult decision and journey for the woman can leave the pro-abortion movement

vulnerable to arguments from the opposition that abortion is dangerous for women's mental health. That it is traumatising, and is not conducive to informed consent, as it is rare that a woman will know how she feels (or if she has any regret) about her decision until after it is too late. Women have negotiated these conflicts and contradictions – many agree that it is a medical procedure, and necessary, but resist being positioned entirely in the clinical, sterile discourse of abortion. They very much view their abortion as a difficult decision, and one that is not to be drained of emotion.

## Analysis Conclusion

Abortion decision-making and women's experiences of having an abortion in New Zealand are considerably more complex than the well-known binary of prochoice and prolife rhetoric would suggest. The abortion binary continually reproduces more tensions between positions, which in turn create more binaries. The binary in existence that generates the dominant discourse of abortion rhetoric, in legitimising only a prochoice or a prolife position, does not sufficiently comprehend women's lived experiences of abortion. It is because of the binary that texturing discourses around abortion (such as biomedical discourse, female sexuality, and the discourse of motherhood) cannot become anything other than binaries. Regardless of how women attempt to position themselves against either of the binaries, they must instead live within them, and attempt to reject certain positions ascribed to them by positioning themselves simultaneously between the two. Instead of producing clear positions that legitimate women's lived experiences, their actual lived experience is obscured, as positioning oneself within one discourse refuses them a position within the other, and produces more tensions.

Rather than an either/or position between the prochoice or prolife binary of abortion discourse, the women positioned themselves (often) within both at the same time, rejecting the implications of one while aligning themselves to other aspects of that discourse in others. What this did was create a complex and contradictory experience for women, who could not legitimise their abortion decision making, it seemed, without feeling some level of stigma, shame or discomfort. What emerged was women's reluctance to talk about their abortions with others, and a lingering internalised stigma that made them feel that their decision was going against some moral position, regardless of whether or not they believed that decision was still the best one that they could have made. By admitting that, they were then stigmatised as seeing abortion as a choice led to assumptions that they should bear the responsibility of that choice. In this way, they were denied an emotional position within the prochoice rhetoric, but struggled to justify their position within prolife rhetoric. The way in which abortion is constructed in society, and in the macrostructures that manage it, have implications for women's lived experiences of abortion and their decision-making about the procedure.

# Chapter 6 - Discussion

*The reality is that so-called pro-life movement is not about saving babies. It's about regulating sex. That's why they oppose birth control. That's why they want to ban abortion even though doing so will simply drive women to have dangerous back alley abortions. That's why they want to penalize women who take public assistance and then dare to have sex, leaving an exemption for those who become pregnant from rape. It's not about babies. If it were about babies, they would be making access to birth control widespread and free and creating a comprehensive social safety net so that no woman finds herself with a pregnancy she can't afford. They would be raising money for research on why half of all zygotes fail to implant and working to prevent miscarriages. It's not about babies. It's about controlling women. It's about making sure they have consequences for having unapproved sex.*

**- Libby Anne, "How I Lost Faith in the 'Pro-Life' Movement"**

My initial interest in this research was piqued in my undergraduate years, when I found myself in the position of having to navigate my own decision-making process about an abortion. What I believed would be an unquestionable decision became one that left me confused, emotionally fragile and incredibly disappointed, both in my situation and myself. I was firmly prochoice and children were definitely not in the plan for my near future, if at all – how could I suddenly be so conflicted when faced with the choice to terminate an unplanned pregnancy? The hypothetical "What would I do if I got pregnant?" question I'd been asking myself since my teenaged years suddenly became much harder to answer. I became interested in the "other" factors – the social, the financial, the psychological, and the wider political contexts in which women of diverse backgrounds make these decisions. There was no adequate language for me to express myself within the binary of prochoice or prolife discourse to make sense of how I *felt.* How could I be pro-choice and then claim to feel grief or regret for the choice I had made? To be pro-choice, even in pro-choice discourse, has become normalised as synonymous with pro-abortion, and as I found myself lurching between the two I experienced conflict with my inability to reconcile

the different positions with my own feelings. I knew it was bigger than me, so why was I the one feeling all the shame, the guilt and the sadness? I could not explain my experience. I was silenced.

As a student of psychology, I first looked to the psychological research to seek a meaningful understanding of my conflicting or unresolved positioning, having had an abortion *and* feeling grief - and found it immediately lacking. Furthermore, psychology's engagement with abortion glaringly illustrated that the social factors contributing to individual women's negative emotional or psychological reactions remained conveniently uncriticised, unexplored, and unchallenged. What I began to see as important were the macro level structures that enabled a framework to legitimise or constrain aspects of women's lives and behaviour; this exceeded the binary presented to women, which did not and does not show the effects of these wider socio-political influences on their decision-making, and consequently, their lived experience of having an abortion in New Zealand. The insufficient binary resulted in women constructing their abortion amongst other discourses, which textured the prochoice and prolife rhetoric that dominates abortion talk. The stigma of abortion, transgressing traditional values of femininity and maternity was perpetuated through cycles of silence.

I began this research with the aim of hearing from women themselves. I wondered if it was possible that other women had also experienced the tensions between positions as they came to terms with their unplanned pregnancies and what action they would take towards it. If so, could other voices begin to dismantle the cycle of silence? Could we start the process of enabling women to have access to a new position that legitimised their tensions between the gendered understandings of the pathological maternal body, the 'individualised' and responsible self, the political

standpoints available in abortion discourse, and multiple moral positions surrounding abortion?

As shown in the analysis, the binary of prochoice and prolife is clearly defined, and women struggle with the conflict between their political and personal understanding of abortion when they find themselves in the situation of needing to access one. My analysis showed that there were 5 main areas through which women positioned themselves and were salient in women's talk of their abortion experience, 1) within, between or against the prochoice/prolife binary, 2) moral implications and positions of abortion decision making, 3) complex socio-political/cultural relationships that texture discourses of abortion, 4) the manifestation and maintenance of abortion stigma and 5) the abortion experience (including navigation of the medical system and accessing an abortion) in a uniquely New Zealand context.

The analysis demonstrated that the women did position themselves within the binary of pro-choice and pro-life, but constructed the meanings of this binary very differently to traditional dominant understandings. For example, to position oneself as pro-choice politically was not to position oneself as pro-abortion morally. However, positioning themselves in prochoice rhetoric did not mean that their choices to have an abortion did not produce a moral tension. To justify an abortion on moral grounds, women often constructed themselves within traditional positions of femininity and maternity. Their abortion was constructed as a decision that involved much self-sacrifice, and often was done in the context of difficult familial or financial situations that positioned women within the dominant discourse of women as self-sacrificing and nurturing. This resisted the pro-life binary stereotype of the kinds of women who access abortion as 'looking for the easy way out', and as immoral and sexually deviant but reinforced constructions of women as self-sacrificing. In contrast to

dominant social constructions of abortion in biomedical and neoliberal discourse, women tended to construct their experience to the opposite and produced a moral tension that was not necessarily synonymous with the prochoice or prolife discourse. Their lived experience of pregnancy and having a maternal body was embedded in a moral trajectory, which was in direct opposition to the dominant biomedical gaze upon the maternal body. In contrast, their abortion decision within the biomedical realm was instead to apply a biomedical gaze to the foetus instead of their body or pregnancy. The foetus was constructed scientifically and objectively in women's talk, whereas in dominant discourse the pro-life rhetoric constructs the foetus as a separate individual imbued with moral meaning. Aside from creating a moral tension as women navigated these discourses, it illustrated the complexity of women's decision-making and lived experience of abortion within these dominant discourses and the constructions of their own bodies, and their foetuses.

These struggles bear resemblance to research that has been done across the world, but through this research there was a specific sociocultural context of being in New Zealand that added an extra layer of complexity to the experiences of the women. For example, the women in this study struggled with the difficulty of public vs private knowledge of their abortion. While this may resemble difficulties in other parts of the world, New Zealand women specifically mentioned the often long-term and close relationships with their doctors. This made it very difficult for them to approach their GP for healthcare related to their abortion, often for fear that the abortion would become known to family members, or that the doctors close relationship to them would be stigmatising.

By focussing on the binary, this research disturbs the boundary between the two positions by addressing the conflicts and contradictions, the resistances and

alignments to particular subject positions within various discourses, and to all the other texturing that is not adequately addressed in the binary. This directly relates to the creation, maintenance and perpetuation of abortion stigma and silence.

Despite feminist criticisms aimed at hegemonic biomedical constructions of the female body, the biomedical knowledge that inscribes the maternal body and abortion with meaning remains dominant. New Zealand itself has a dominant neoliberal political structure where notions of individual choice and agency are also incredibly powerful, and women are responsible for their maternal choices. It is the legitimacy of the medical gaze and maternal risk that dominates these narratives. Women who undergo abortion must wrestle with several competing dominant discourses, in order to position themselves in meaningful ways, while navigating their subject positions within the social norms that having an abortion can transgress. With that being said, the women were able to draw upon other discourses that challenged the dominant biomedical normalisation of abortion – by positioning themselves instead within both neoliberal, political discourses, and traditional maternal discourses of sacrifice, self-denial and nurturing, their abortions could resist the biomedical 'clinical' gaze, and could also resist several stigmatising assumptions about women who have abortions.

The ways in which women construct their abortion in and through often conflicting and at times contradictory discourses offers a challenge to psychological research and practice, as well as to the potential policy and law that governs abortion. Women's navigation and alignment to, or resistance of, dominant constructions of both women and embodied experience gives us an insight into the gendered social power relationships that bring meaning to the maternal process. The production of the maternal body and reference to maternal instinct are made meaningful through subject

positions made possible (or not) by discourse. Butler (1990) argues that in place of an objective female body we should attend to "those specific power relations by which the trope of the maternal body is produced" (p. 92). The understanding women have of the morality of their abortion has implications for the understanding of the morality and politics of psychology's gendering stories (Coombes & Morgan, 2004). By examining the discourses of abortion that disrupt the normalised binary of understanding, it uncovers the tension between biomedical and women's lived experiences as they make meaning of maternity and motherhood, so that abortion does not conform to the boundaries on either side of the binary. By taking up an epistemological framework that enables us to question the limits of the binaries, this research and the experiences of the women who participated in it, can pave the way for new discourses of abortion to be legitimised and understood. For abortion decision-making to become less stigmatised, less silenced, and the binary to be shifted to include the multiple, converging influences involved in women's decision-making, means opening spaces for these conversations to be heard. This research brings the subject of abortion back to the forefront of political discussion, joining the left-wing political parties of New Zealand in their 2014 campaign to legalise what is already being practiced and begin to reduce the stigma that still surrounds abortion.

The aim of the study was to examine how women construct their experience of abortion within or against dominant discourses and normalised understandings of abortion. In doing so, the women's narratives showed that this experience is textured by multiple discourses that are not explored in the current literature surrounding abortion, such as the complexities of motherhood, and differing constructions of femininity between 'traditional' discourses of female sexuality, and new neoliberal discourses of individualism and choice. As research to date has not properly explored

these conflicts and complexities, even prochoice discourse limits how women can legitimately talk about their abortion experience, which perpetuates stigma and maintains abortions secretive and shameful construction in society. Implicit in that aim is to provide outcomes from the analysis that can affect policy, especially in the light of recent campaign work by the Green Party in New Zealand, who wish to decriminalise abortion and remove the criminal or illegal stigma from abortion. What this thesis has shown through the analysis is that the current understanding and conceptualisation of abortion in New Zealand by the macrostructures does not match the lived experience of women. There is direct conflict between the biomedical construction of the maternal body, and women's maternal experience of pregnancy.

There is also a particular contradiction in how women construct the foetus (using the biomedical discourse) and how the foetus has become privileged through technologies that 'see' it, as an autonomous and rights-bearing being, separate from the mother. Within this context, a particular conflict is apparent in the post-abortion area – for women, this is where policy and procedure fails them, and where the biomedical discourse of abortion removes the moral and emotional tensions from women's experience of their maternal bodies. Women in this study felt as though the biomedical construction of their pregnancy was not enough; the biomedical gaze on the maternal body removed the emotional and psychological aspects, except to pathologise them as needing surveillance and expert guidance. The medical arena, through which abortion is managed, does not adequately support women in the aftermath of their abortions and leaves women often feeling silenced and illegitimate in their feelings of sorrow, grief or confusion. To examine these wider constructions of the biomedical, moral and psychological maternal body could lead to the implementation of measures (such as compulsory post-abortion counselling, or

support groups) that accommodate women's needs, and respond to their actual lived experience of abortion. Psychological literature has focussed on the psychological 'damage' that abortion does to women, identifying that many of them express grief, sorrow, disappointment or regret after their abortions, if not actual mental health issues. Rather than pathologising women's reactions and maintaining and individual lens from which to view these women's psychological reactions to a potentially life-changing event, focussing on the social contextual features of women's abortion experience, and how the community around her including macrostructures can influence this experience could lead to the psychological aftermath of abortion being less disruptive for women. Combined with the decriminalisation of abortion that is being proposed by some of New Zealand's left-wing political parties, implementing post-abortion counselling, and listening to the difficulties women have within the socially constructed meanings of abortion, it is possible that future research could examine the effect of social interventions on women's individual psychological responses to abortion. Rather than focussing on the psychological consequences of abortion on women's emotional wellbeing, I suggest that future research should examine the social conditions that surround women having an abortion, and aim to reduce the stigma and complex contradictions that surround it in macrostructures and discourse.

The limitations of this research are bound within the epistemological assumptions that guide the ethical and methodological conduct of this research. I brought my own experience, the context of tensions between the current abortion binary, and the contradictory meaning of the maternal body to the analysis. The analysis then is consistent with the components of feminist poststructural epistemology. The structured approach to discourse analysis was not to represent all

women who have had an abortion in New Zealand. It was to listen for the potential beyond the individual level and speak to a wider discursive construction of abortion, abortion decision-making and abortion stigma. The analysis therefore suggests a set of experiences that *could* be experienced by any woman in New Zealand who had a surgical abortion before 20 weeks gestation. These conditions are also limits as the sample was extremely small. However, to generalise from this sample across the population was never the aim. Instead, it provided a snapshot of how a group of women navigated the dominant discourses surrounding their abortion experience and how they positioned themselves or were positioned.

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# **Appendix A** – Letter of Support (Specialist Consultation)

Youthline
Changing lives.

10th August 2013

Dear Massey University Board of Ethics,

My name is Juliette Baertschi and I am a Counsellor at at Youthline Auckland Charitable Trust. Part of my practice involves specialty pregnancy counselling with Youthline's Pregnancy Centre, where I have been working with women who are making complex pregnancy decisions, generally related to an unplanned pregnancy.

Part of this work involves informing, supporting and counselling women who have undergone voluntary terminations. I have been involved in this area for approximately 10 years now and would like to advocate for Dayna Cooper's Master of Arts in Psychology thesis research topic into women's experiences of abortion in New Zealand.

Based on my experience in working with women who have had abortions, it is my belief that Dayna's research has identified an area that not only requires more research investigation and support but also has wider benefits for the women involved. Speaking about their experiences of abortion and being allowed to reframe it in a discourse that doesn't trivialize their reasons for abortion can foster closure, catharsis or insight and allow them to fully come to terms with their own reasons for undertaking an abortion, whether they are socially sanctioned or not.

The majority of women who have had a termination do not seek counselling for it, and speak of it rarely, if at all to their closest family and friends. Being able to express their stories in a safe and positive environment can have positive psychological outcomes. It is also an important focus of research for the forward-movement of abortion talk in wider society that will increasingly destigmatise abortion as a procedure, and relieve some of the shame and silence that many of these women feel as a result of undergoing voluntary terminations.

I would be happy to advocate for the importance of this thesis topic and hope that the Ethics board grants approval for this research to commence.

Kind regards,

Juliette Baertschi

Juliette Baertschi
(M.A. Psychology, Dip Counsellling, NZAC)

Mailing Address: PO Box 8670 Symonds Street, Auckland 1021
Help Line: 0800 37 66 33, Free Text: 234
Office Tel: (09) 376 4179, Fax: (09) 376 6650, Email: changlinglives@youthline.co.nz

## **Appendix B –** External Supervision Agreement

Youthline
Changing lives.

12 August 2013

Dear Massey University Board of Ethics,

Please take this letter to confirm that Dayna Cooper has approached me to negotiate external supervision for the duration of her Master of Arts thesis in Psychology (including data collection and analysis). I have agreed to be available for Dayna in a professional capacity to act as a source of supervision in the event that she requires extra assistance to reduce any harm to her as a researcher that may arise in the course of conducting her Master of Arts thesis.

This support is additional and provided on an as-needed basis to mediate potential difficulties that may be caused by the distance between Dayna in Auckland and her academic supervisor in Palmerston North. It is not intended to replace the full-time academic supervision of Dr Leigh Coombes of the Massey University School of Psychology.

Kind regards,

Amber Davies
Acting Clinical Services Manager
Psychotherapist (PBANZ)
Youthline

amber@youthline.co.nz
**DDI:** 09 361 4161

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## **Appendix C –** Information Sheet

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA

### Information Sheet

Women's Experiences of Abortion in New Zealand

You are invited to participate in a research study conducted by Dayna Cooper, from the School of Psychology at Massey University as part of a Master of Arts thesis. Your participation in this study is entirely voluntary. Please read the information below and ask questions about anything you do not understand, before deciding whether or not to participate.

**OPTIONAL:** You have been asked to participate in this study because you have undergone a voluntary surgical termination/abortion in New Zealand, before 20 weeks gestation.

- **PURPOSE OF THE STUDY**

The purpose of the study is to allow women who have had a surgical abortion to speak about their experience fully and in a non-judgmental space. Despite legal gains, in social life the topic often remains taboo, stigmatised, and many women feel pressured to stay silent about what may have been a life changing experience. Furthermore, the "ordinary" majority of women do not often have the reasons for their decisions legitimised even in pro-choice talk about abortion. The study aims to bring women's stories of abortion to the forefront, regardless of the reasons behind them, and to critique the existing structures in society which frame abortion in its moral, emotional and psychological current state. It is hoped that by sharing these experiences, more women will be empowered to share their stories and the stigma and silence surrounding abortion can begin to shift.

- **PROCEDURES**

If you volunteer to participate in this study, you will be asked to do the following things:

You will be asked to participate in a conversational interview, which will last between 1-2 hours. I, the researcher, may ask some open-ended questions but the main focus is on your experience and story. Some of the topics I am interested in hearing about are how you negotiated the process of termination, the usefulness of information given to you pre and post termination, your feelings pre and post termination, whether you have experienced stigma following disclosure and whether your views on termination have changed over time.

This interview will be audio recorded either by tape recorder if the interview is conducted face to face, or via audio recording if the interview is conducted via Skype.

The researcher will then transcribe your interview and it will be brought back to you as the participant to ensure that what has been transcribed is correct. You will have the opportunity to

make any changes to your statements if you feel necessary. This review of the transcripts should take between 1-2 hours.

- **POTENTIAL RISKS AND DISCOMFORTS**

Talking about your abortion might be an emotional, distressing or uncomfortable experience for you and for this reason it is important that your participation is entirely voluntary. It is possible that this interview may bring up emotional responses, and these may be unexpected, especially if your experience is recent or unresolved. You have the right to pause or stop the recording at any point during the interview for any reason. The researcher is trained in client-centered counseling and has several years of experience in theories of grief and psychological distress. Both the researcher and her supervisor at the Massey University School of Psychology are well connected to national networks of support services and will provide you with referral resources on site if you find yourself continuing to experience a negative reaction once the interview has concluded. You are welcomed and encouraged to discuss any concerns or questions with the researcher prior to signing this consent form and prior to the interview itself.

- **CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. However, if you should disclose potentially harmful behaviour, directed at yourself or others, I would need to inform my supervisor and report it to the relevant services for safety reasons. Confidentiality will be maintained by means of storing interview data separately from signed consent forms, securing consent forms in a locked office only accessible by the research supervisor and destroying the audio recording of the interview once you have signed off on your transcription. Consent forms will be securely destroyed after 5 years. All identifying information will be removed from the transcripts and any excerpts from the transcriptions included in the research will be incorporated in a way so as to avoid identification with any one participant. All names will be changed and participants provided with a pseudonym.

- **PARTICIPATION AND WITHDRAWAL**

If you decide to participate, you have the right to

- decline to answer any particular questions,
- withdraw from the study at any given point prior to the sign off of transcript,
- ask any questions about the study at any time during participation,
- provide information on the understanding that your name will not be used and be given access to a summary of the research findings when it is complete.

- **IDENTIFICATION OF RESEARCHERS**

If you have any questions or concerns about this research, please contact:

Dayna Cooper (researcher)
School of Psychology
Massey University
Palmerston North
Phone: 021 155 3464
Email: dayna.cooper18@gmail.com

Dr Leigh Coombes (Research Supervisor)
School of Psychology
Massey University

Palmerston North
Phone: (06) 350 5799, ext 2058
Email: L.Coombes@massey.ac.nz

- **RIGHTS OF RESEARCH SUBJECTS**

*This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application 13/69. If you have any concerns about the conduct of the research, please contact Dr Nathan Matthews, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 350 5799 x 80877, email humanethicsouthb@massey.ac.nz."*

# **Appendix D -** Participant Consent Form

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

## *Women's Experiences of Abortion in New Zealand*

**PARTICIPANT CONSENT FORM - INDIVIDUAL**

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the Information Sheet. I have been given a copy of this form.

**Signature:** ..... **Date:** .....

**Full Name - printed** .....



Te Kunenga ki Pūrehuroa
School of Psychology - Te Kura Hinengaro Tangata
Private Bag 11222, Palmerston North 4442, New Zealand T 06 356 9099 extn 2040 F 06 350 5673 http://psychology.massey.ac.nz

## **Appendix E -** Authority for the Release of Transcripts

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA

# *Women's Experiences of Abortion in New Zealand*

## AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

**Signature:** ..... **Date:** .....

**Full Name - printed** .....