Combatting Abortion Stigma

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**Introduction**

A person’s right to decide what happens to her body is one of the most fundamental and essential rights. It encompasses a wide range of decisions, the right to terminate a pregnancy is one of the most controversial. Forty-one years ago, the decision in the Supreme Court case Roe v. Wade made the decision to have a safe abortion a constitutionally protected right for all women in the United States (Blackmun 1973). However, nearly half a century later, the attacks on the legality of abortion are unceasing. ‘Pro-life’ politicians advocate for laws that implement restrictions on abortions and providers that have resulted in an unprecedented number of new restrictions in the last twenty years (Weitz 2010; Boonstra 2014). Some states have restrictions so stringent\(^1\) that accessing abortion is nearly impossible for the majority of women. In the face of such backlash, it is necessary to confront the underlying reasons why a perfectly safe and legal and routine medical procedure incites shame, fear, and anger in varying degrees from both those who support and those who oppose abortion. The stigma associated with abortion is closely connected to anti-abortion legislation. Because it is expected that the law should reflect the ethical views of society, when a law is passed to restrict something, as members of a society it is easy to make the connection that the restricted act is bad or dangerous. As long as restrictions are being passed against abortion, the stigma surrounding it will support more legislation to be passed restricting it. Further, This legislation could potentially initiate a ‘slippery slope’ phenomenon whereby it becomes significantly easier

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\(^1\) Examples of these restrictions are mandated waiting periods that require women to wait anywhere from 24 to 72 hours after seeing a physician to receive the procedure and Targeted Regulation of Abortion Providers laws that are effectively causing clinics that provide abortions to shut down without legitimate reason (Alan Guttmacher Institute 2014).
for legislation to be passed regarding other women’s health issues. When restrictions are raised against a woman’s reproductive rights it undermines those rights making it simpler to raise more restrictions against them. This could make it harder for some of the most vulnerable women – young, minority, LGBTQ, and poor women – to obtain all sorts of reproductive health services including STD testing, mammograms, and contraception counseling. Abortion stigma ultimately threatens the very institutions that provide many forms of reproductive health care to these women, including, but not limited to, abortion services.

I posit from my own experience that the most effective method of combatting abortion stigma is to make it apparent to the general public that abortion is a prevalent medical procedure because, regardless of the statistics that we have that prove this, society still treats women who have had abortions like abnormalities. The most direct method of achieving this is to encourage women who have had abortions to share their experiences. There are numerous organizations that have taken it upon themselves to start this conversation. Exhale, for example has aimed their efforts at creating a dialogue with women about their experiences in hopes of decreasing the feeling women have to stay quiet about them. They hope to create a backing for ‘pro-voice’, a support system for women to voice their feelings and experiences in hopes of creating a cultural change where women can feel supported and respected when reaching out, rather than socially ostracized. In the same vein, the 1 in 3 campaign\(^2\) is using their efforts to end the shame and stigma that women feel about abortion by building a culture of compassion and support around the need for access to basic health care. At the end of this paper, I share

\(^2\) The 1 in 3 Campaign is a grassroots movement that aims to end abortion stigma by encouraging women to tell their abortion experiences and facilitating the spread of the stories through social media.
my own experience as well as capture the experiences of three other women who I interviewed through narrative story writing. I hope to add to the conversations that these organizations have initiated. I attempt to display that while experiences may have similarities and differences, the point is that these abortions happened. The women who had these abortions were not aberrations; they were part of the 35% of women who will have an abortion by the age of 45 (Alan Guttmacher Institute 2014). Aside from making the presence of abortion in the United States visible, it humanizes it. Connecting abortion to actual women, successfully combats the ‘pro-life’ propaganda that uses imagery and rhetoric to remove mothers from the equation.

The form by which I have structured my paper closely follows the steps that I took to understand abortion stigma. First, I took a biological and medical look at abortion by explaining the procedures, numbers of providers, the rates of complications, and their prevalence. From there I moved to a legal perspective where I took a closer look at the restrictions that account for decreasing access to abortion in the United States. I also looked at legality worldwide. By using these two different perspectives, I was able to analyze how abortion stigma is propagated in our society and how it affects the women who experience it.
Chapter 1: A Medical Perspective on Abortion

In this chapter, I explain what abortions are, and why women have them. By describing the procedures, providers, and complications that can arise from safe abortion in juxtaposition to the complications that arise from unsafe abortions, I demonstrate the need for access to safe abortions.

Abortion

Abortion is the intentional process by which a pregnancy is ended. It is a procedure widely practiced in the United States and all over the world. It is a method of family planning that has been traced back as far as 1550 BC (Potts & Campbell 2002). The Alan Guttmacher Institute (2014) reports that twenty one percent of all pregnancies in the U.S. end in abortion, excluding miscarriages. With nearly one in three women having an abortion during her reproductive years, abortion is one of the most common gynecological procedures performed today (Jones and Kooistra 2011).

Many women find themselves face-to-face with an unintended pregnancy. In 2006, 49% of all pregnancies in the U.S. were reported as unintended, and four in ten of these pregnancies resulted in abortions (Finer & Zolna 2006; Alan Guttmacher Institute 2014). Many women report having more than one reason for their abortion. The most frequently reported reasons are financial insecurity, mistiming, and worries about the lack of support from a partner (Torres and Forrest 1987; Broen et al. 2005; and Aneblom et al. 2002).

The decision to end a pregnancy makes a women consider her life from a different vantage point (Jacobs 2006). This decision requires a woman to consider her life’s

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3 While abortion combatants consider family planning only preventative methods against pregnancy, abortion allows a woman to have a family when she wants to which is the meaning of family planning.
structural integrity and to look at every aspect of it that may be affected (Robertis 2006 in Jacobs 2006). The timing of a pregnancy is an incredibly important factor in determining whether a woman feels secure with carrying it to term. An unplanned pregnancy can cause a rift in a woman’s plans regarding education, career, and finances. The disruption that both being pregnant and having a child could bring to any of these areas is one that may lead a woman to terminate a pregnancy and put it off for a more opportune moment in her life.

A woman may feel pressured to have an abortion due to limited financial resources. With the USDA’s estimated cost of having a child at somewhere between $8,990 to $10,230 a year for households with income less than $60,000 a year (Lino 2013), feeling enough financial security to welcome an unplanned pregnancy is extremely tough. This estimate does not even include childcare services, which can be essential to a woman in a low-income household. The cost of child care services varies from state to state, but according to Woods and Kendell (2013) only 12 states out of 50 have legal child care services that cost less than 10% of the median income for a married couple with children.

**Abortion Procedures**

There are two main types of abortion, non-surgical and surgical. Non-surgical abortions are those in which patients end a pregnancy by taking hormonal medications while surgical abortions are those in which the patient’s uterus is emptied using special instruments.
Non-surgical abortions are typically a two-step process that can be used to terminate pregnancies up to the ninth week. One medication is taken to stop the pregnancy by blocking progesterone and causing the uterus lining to break down and the cervix to soften. A second medication that causes the uterus to contract and empty is taken next (World Health Organization 2012). The medication used to complete the first step is mifepristone. After the patient has been administered mifepristone in-clinic, the patient is given misoprostol to be taken at home to initiate contractions. After the misoprostol is ingested by the patient, cramping and bleeding begins a few hours later as the uterus begins to contract and release its lining. This process can take anywhere from a day to a week to finish depending when the misoprostol was taken (National Abortion Federation 2008).

There are two types of surgical abortions that are widely used, vacuum aspiration and dilation and evacuations (D&E) (National Abortion Federation 2008)). Which method is used is determined by how far along the pregnancy is and what the protocols at the specific clinic are. Vacuum aspiration abortions are performed during the first trimester, generally up to 12 or 14 weeks and unlike non-surgical abortions are usually completed in minutes rather than days. The patient may be sedated, if they prefer, before the doctor performs the procedure. First, the provider uses a speculum to hold the vaginal walls apart, at which point they may or may not apply local anesthetic to the cervix depending on if the patient chooses to be sedated or not (World Health Organization 2012). After the speculum is inserted, the cervix is gradually opened using tapered rods. The provider then uses a suction apparatus, either manual or electric, with a cannula attached to the end to

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4 It has been shown by the World Health Organization (2012) that taking misoprostol alone to induce abortion is successful 90% of the time.
5 Sedation may not be included in the price of the abortion.
enter the uterus through the cervix and suction the contents of the uterus. D&Es are performed during the second trimester, after 14 weeks and up until 22 weeks depending on the clinic. This procedure is an extension to the vacuum aspiration abortion that uses additional tools to completely remove all of the pregnancy and pregnancy tissues. Up to 12 hours before the procedure, the patient is administered antibiotics to prevent infection. Because the cervix must be dilated more than is necessary for the vacuum aspiration procedure, either misoprostol is administered a few hours before the procedure or absorbent sterile fiber rods are inserted into the cervix the day before to dilate it as much as is needed. The procedure begins with the provider performing a vacuum aspiration, as explained above, then the provider uses a grasping instrument to grasp larger pieces of tissue. After the larger pieces are removed, a curved instrument called a curette is used to gently scrape away the remaining lining of the uterus.
Abortion Providers

Laws regulating who can perform abortions vary from state to state. For example, while a non-surgical abortion requires only the administration of medication, a procedure that would generally fall under the scope of practice for nurse practitioners (NPs), physician’s assistants (PAs) and certified nurse midwives (CNMs), only 15 states allow mid-level providers to perform medication-only abortions (Weitz et al 2013).

(Weitz et. al. 2013)

As for aspiration abortions, a recent study done by Weitz et al. (2013), has shown that “complication rates from aspiration abortions performed by recently trained NPs, CNMs, and PAs were statistically no worse than those performed by the more experienced
physician group” (458). The implications of this are that, by allowing NPs, CNMs, and PAs to perform both non-surgical and vacuum aspiration abortions, there could be a decrease in cost and increase in providers without a compromise to a woman’s well being. While this would be in the best interest of women’s reproductive health, making abortions available is not in the best interest of the politicians and advocates who are trying to make them inaccessible. With 89% of counties in 2011 lacking abortion providers, laws like these only make abortions harder to get (Alan Guttmacher Institute 2014). As well as effectively keeping the number of providers low, these laws increase the cost of abortions simply because a physician’s time is significantly more expensive than a PA’s, NP’s, or a CMN’s.

**Possible Complications**

While there are possible complications that may arise after safe abortions – abortions performed by trained providers in hygienic conditions – they are extremely rare. About 92% of all abortions performed in the United States are obtained within the first 12-13 weeks after the last menstrual period (Center for Disease Control and Prevention 2013). First-trimester abortions are incredibly safe, with lower mortality and morbidity than pregnancy and childbirth (Hoque 2011). Of the women who have surgical abortions in the first 13 weeks of pregnancy, 97% are reported to have no complication and 2.5% are reported to have only minor complications. Similarly, medical abortions performed within the first 9 weeks of pregnancy result in serious complications only 0.5% of the time (Dudley and Kruse 2006; Henderson et al. 2005). In comparison, the incidence of severe complications during childbirth was reported to be 1.3% (Callaghan et. al. 2012). As for

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6 Considered the first trimester.
those who have abortions 14 weeks after the last menstrual period, it was shown in a retrospective cohort study that only 4% of women who had D&Es reported complications (Alan Guttmacher Institute 2003).

The World Health Organization (2011) defines an unsafe abortion as “characterized by the lack or inadequacy of skills of the provider, hazardous techniques, and unsanitary facilities.” In contrast to safe abortions, which are performed by trained individuals and meet the legal requirements of the country in which they are being performed, unsafe abortions have a considerably higher rate of complications. Singh (2006) estimates that the 2005 annual rate of hospitalization due to complications arising from unsafe abortions in developing countries is 5.7 per 1000 women aged 15 to 44 resulting in more than 5 million hospital admittances that year7. The severe complications that most commonly arise after an unsafe abortion are hemorrhage, infection, and poisoning (Sedgh et al. 2007). Though collection of data regarding unsafe abortions is difficult due to underreporting and misclassification, the data that has been collected shows that the mortality from unsafe abortions is about 60 per 100,000 live births which is more than 60 times that of safe abortions (Grimes 2006; Hendersen et. al 2005). Due to underreporting, it can be assumed that the increased risk is even higher than the one collected.

Unsafe Abortions

In 2008, 21.6 million abortions were unsafe, almost all of which occurred in developing countries (World Health Organization 2011). This accounts for nearly half of all abortions performed that year. While the unsafe abortion rate in developed areas are

7 The availability of misoprostol is changing these statistics.
reported to be a maximum of 0.5 per 1,000 women within the ages of 15 to 44, developing regions have rates more than 14 times that. Africa and Latin America (including the Caribbean) for example, have an average unsafe abortion rate of 28 and 31 per 1000 respectively, though it is as high as 36 per 1000 in Eastern Africa (World Health Organization 2011). These striking differences are correlated to legality. In countries where abortion laws are restrictive with few exceptions, rates of unsafe abortion are the highest. This suggests that even when abortion is not readily available, women will still seek to use it as a family planning method (Ahman and Shah 2004).
Chapter 2: The Legality of Abortion

Legality Around the World

While it is clear that unsafe abortions are linked to a lack of access, 66 countries prohibit abortion either entirely or in any situation in which a woman’s life is not in immediate danger. 25.6% of the world’s population has no access to safe and legal abortion (Center For Reproductive Rights 2013). As for the rest of the world, 40.5% live in areas where abortions are restricted to situations regarding the preservation of health or certain socioeconomic grounds. Only 33.9% of the world’s population lives in locations where abortions are unrestricted.

Legality in the United States

Abortion in the United States was legal before the 1800s but in the early 1800s states began to criminalize it. The largest push to make abortion illegal came from the American Medical Association. The doctors wanted exclusive rights to medical practice in hopes of decreasing the loss of income due to patients going to midwives, apothecaries, and homeopaths to obtain an abortion (Schroedel 2000). While the motives were varied from state to state, the results were the same; abortion was becoming harder to access and in many cases completely impossible to attain legally. While legislation was being passed to make abortions illegal, there were many loopholes. White women with economic resources got the privilege of an abortion performed in a hospital while others depended on their financial resources to find an abortion, turning to illegal practitioners to get
abortions. These procedures could either be safe and done by a provider who was versed in abortion procedures or done by a provider who was not always trained in the procedure, otherwise known as a “back-alley abortion.” This could lead to complications such as those mentioned earlier in regards to unsafe abortion. To make matters worse, these providers also did not have access to the medical advancements to prevent the infections that dominated medical practice. In the event of a complication such as hemorrhage or a perforated uterus without preventative measures against infection, the life of the patient was in grave danger.

**Access in the United States**

While abortion has been legal in the United States for over 40 years, anti-abortion legislators continue to raise wall after wall by restricting abortion procedures and providers to make abortion less accessible to women. For example, as was mentioned earlier, the majority of states require that a physician be the one to perform abortions on patients even though it has been proven that the task can be just as safe and efficient when performed by PAs, NPs, and CMNs.

TRAP laws, Targeted Regulation of Abortion Providers, have been passed. These are laws imposing regulations and rules on abortion providers and clinics that are more cumbersome than those applied to other medical practices. There are three main kinds of TRAP laws (Alan Guttmacher Institute 2014). The first are health facility licensing schemes where the state requires abortion clinics, and not other comparable clinics and health facilities, to adhere to unnecessary and burdensome regulations in order to be licensed with the state. Such regulations include those governing physical characteristics, staffing, or procedures in the clinic. 21 states require the abortion facilities or their
clinicians to have admitting privileges to a local hospital (Alan Guttmacher Institute 2013). If the abortion facility is unable to make the changes necessary to meet regulation when these laws go into effect\(^8\), then it is forced to close down. The second type of TRAP law involves Ambulatory Surgical Center (ASC) regulations, requiring abortion providers to be licensed as an ASC, which is a medical facility that usually performs a variety of outpatient procedures. This requires abortion providers to abide by all the unnecessary regulations that apply to the health facility schemes and then also abide by stringent physical plant regulations that go way beyond the medical guidelines for abortion providers. The third type is hospitalization requirements that require abortions after a certain gestational period to be performed in a hospital.

Texas gives us a perfect example of these laws and their implications. In July of 2013, Texas governor Rick Perry signed into law House Bill 2 which held some of the strictest regulations on abortion in the country. In August, before any of the rules went into effect, there were 42 licensed abortion providers in the state. According to the Texas Department of State Health Services (2014), as of March there were only 28 licensed abortion providers remaining. In September 2014, when the ASC regulations go into effect, there will only be 6 licensed abortion providers left (Figueroa 2014).

Though the majority of these regulations happen at the state level, the Hyde Amendment is an example of a nationwide blow against access. The 1976 amendment, which banned the use of federal funding for abortion, was passed three years after Roe v. Wade and has been attached to the congressional appropriation bill and passed every year since. This means that federal Medicaid funds cannot be used to cover abortion.

\(^8\) For example, in Mississippi, all the clinics have been closed and in 2013 a judge had to rule against a TRAP law that had passed in 2012 to prevent the last clinic from being closed (Dunkley 2013).
may allocate its own funding for it, although most states have not. Hyde leaves the many
poor women living in the 33 states that have not created their own funding for Medicaid
covered abortion in situations where they are financially strained and at times cannot find
the funds to get an abortion (NARAL Pro-Choice America 2013).

In the same vein, state-level restrictions on abortion continue to be passed. In
2011, 92 states enacted provisions that restricted abortions, nearly triple the previous
record of 34 from 2005 (Alan Guttmacher Institute 2014). NARAL reports that in 2012,
25 states implemented 42 anti-choice measures, including abortion-coverage bans,
mandatory waiting periods, and biased counseling laws. All of these laws reduce access to
safe and legal abortion without repealing Roe v. Wade. Prohibiting the coverage of
abortion by state health insurance plans and requiring that women wait anywhere from 24
to 72 hours after seeing a physician for the first time to receive the procedure puts burdens
on many women. During January this year, a bill passed that banned abortion coverage in
federally subsidized health insurance plans making it illegal for individuals to use the
Affordable Care Act’s subsidies to buy plans through the new health exchanges that would
cover abortion services. This effectively discourages insurers on the exchanges from
offering abortion coverage. For some women, specifically those from low-income
households, these laws can create enough of a problem that women are forced to carry
their pregnancy to term. Further, states are passing laws that force providers to use state
developed materials as part of informed consent which include information about the risks
of abortion while excluding the risks of child bearing and pregnancy, fetal development,
and abortion alternatives. Many of the materials that are released by the state include
misleading and inaccurate information. For example, some mention the increased risk of
breast cancer after having an abortion, although recent studies have proved this increased risk to be nonexistent (American College of Obstetricians and Gynecologists 2009; National Cancer Institute 2013). Likewise, some of the materials review the negative psychological effects of having an abortion, disregarding the American Psychological Association’s conclusion that a first trimester abortion poses no greater psychological risk than carrying a pregnancy to term (Center For Reproductive Rights 2010; American Psychological Association 2009). In any medical environment, a situation where a professional gives patients inaccurate information can be detrimental to the health of a patient. In the United States, trust in health care providers has been declining (Robinson & Jackson 2001), with distrust being at its highest in minority communities (Armstrong et al. 2007). This distrust can lead to a health care barrier where patients who don’t trust providers avoid them all together.

A recent strategy to impede abortion access is the effort to pass the Prenatal Nondiscrimination Act. This bill proposes that abortions that are based on the unborn’s sex be banned⁹. This bill operates under the guise of combatting sex discrimination, where in fact, it only undermines abortion access. While son preference is a big problem around the world, there is no evidence to suggest that it exists in the United States (Sneha 2012). Additionally, this problem is rooted in gender stereotypes and social biases and the only way to combat this is to make a change in the underlying societal structures and values that create a preference for sons (Sneha 2012). Because medical providers would be prosecutable under this bill, they would be forced to racially stereotype women who are from places where son preference is widespread, such as China and India. Providers would

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⁹ The original version of the bill also included a ban on race-selection abortion.
also be under pressure to automatically find women with female fetuses suspect to avoid son preference. This will likely drive more doctors away from providing abortions, only making abortions even more difficult to obtain.

**Approval Rates on Abortion in the United States**

Support for abortion fluctuates greatly depending on the reasons cited for having one. In 2012, 83% of the American public approved of abortion when a woman’s life is endangered but only 41.7% of the public approved of abortion regardless of reason (Smith and Son 2013). Even though abortion is as common as a C-section (Cockrill & Nack 2013), the fluctuations in legality and support surrounding it have led to abortion becoming a politically and culturally loaded issue. This cultural and political tension can lead to the stigmatization of women who have had abortions, abortion providers, and abortion allies.

Now that I have looked at the laws and regulations in the United States that restrict abortions and what they mean for access to safe abortion nationally, I will go on to an analysis of abortion stigma. This will, include a more opinion based view on what implications these laws and restriction have for abortion stigma.
Chapter 3: An Analytical Perspective on Abortion Stigma

Stigma

To understand stigma, one must understand the work of Erwin Goffman, one of the most influential sociologists to conceptualize stigma. The majority of the research on stigma relies heavily on his theories. Goffman (2009) defined stigma as an “attribute that is deeply discrediting” (p. 3) to the individual who bears the stigma, and proposes that there are three types: physical, character, and social. Stigma can be either readily apparent or concealable. Different types of stigma manifest in different ways depending on social context. However, all types are the same in that they taint the way society views an individual. They separate an individual from their peers in an undesirable way.

Stigma is produced alongside political and cultural disapproval because it urges others to view an experience as deviant regardless of the prevalence of the experience in question. It stems from shared, socially constructed devaluing effects of particular attributes (Herek 2009). It allows society to justify the mistreatment of certain people by discounting them as tainted and finding them morally culpable for their “discrediting attribute.”

Link and Phelan (2001) explain the four “interrelated components” (p. 367) they believe need to converge for stigma to exist. The first component is that people distinguish between the human differences that will matter socially and those that are irrelevant. The second is that widely held cultural beliefs lead to negative stereotypes for those who are affected by the attributes that were distinguished as socially significant. The third is that the negative stereotypes that have been attached to those who are different become reason enough to place them in a separate group culturally, “accomplish[ing] some degree of
separation of ‘us’ from ‘them.’” (p. 367). The fourth and final component is that this separation causes those with the discrediting attributes to experience “status loss and discrimination that lead to unequal outcomes.” (p. 367) These four components give us a framing by which to easily identify and categorize the proliferation of abortion stigma.

**Abortion Stigma**

Kumar et al. (2009) define abortion stigma as the process by which a woman is marked, internally or externally, inferior to the ideal of womanhood when she chooses to terminate a pregnancy. Abortion stigma is rooted in narrow, gender specific archetypes; by having an abortion a woman signals possible transgression against the widely held essential nature of women. While this essential nature changes from culture to culture, the one role that is always applied to women is that of the mother. The unwillingness to become a mother defies the cultural perspective that a woman’s number one calling is motherhood. Serrin Foster, president of Feminists for Life declares that abortions are simply a failure to support women (Foster 2003). She makes the assumption that all women are choosing abortion because the government and their social support system have failed them and not because they have chosen to not be mothers on their own accord, because “women deserve better than abortion.” She implicitly suggests that no woman ever makes a voluntary decision to abort.

Historically, a woman’s sexuality has been seen as deviant and as something that needs to be controlled. For example, *Marianismo*, a gender standard that is applied to women in many Hispanic cultures, relies on the idea of feminine sexual purity and morality. Much like the normative culture model it suggests that women must be pure and virtuous, reserving all sexual activity for monogamous marriage and procreation (Ellison
The possibility that a woman is having sex for purposes aside from procreation challenges these views completely. Even giving a woman the right to make a life or death decision in and of itself is giving a woman more responsibility than is culturally acceptable in the majority of the world, including the United States. (Cockrill & Nack 2013; Kumar et al. 2009; Luker 1984).

When we apply Link & Phelan’s (2001) four interrelated components directly to abortion stigma, it is possible that the convergence of the cultural and legislative anti-abortion efforts can trigger these components. I propose that due to the sheer number of women who keep their abortions secret, individuals in society come to see having an abortion as socially deviant, accomplishing the first component. With abortion regulations being passed through legislation and anti-abortion groups making claims like, “Every day is 9/11 for the unborn” and comparing Planned Parenthood to drug dealers who get people hooked on sex (American Life League 2013), it would not be a stretch for an individual to attach negative stereotypes such as, promiscuity, irresponsibility, and heartlessness to women who have abortions, thus achieving Link & Phelan’s second component. Fearing social alienation, women keep quiet and avoid speaking out for those who have had abortions. This can in turn sustain the negative stereotypes, thereby fulfilling the third component (Kumar et al. 2009). Finally, Link & Phelan’s fourth component is achieved when women who disclose their abortions experience loss of status, different treatment, judgment, or even discrimination because of the negative stereotypes that individuals may have mentally associated with abortion.
Manifestations of Stigma

There is a sturdy foundation for abortion stigma due to the opposition against abortion, which has been gaining strength over the last 57 years, especially since Dr. Horatio Storer established a national drive in 1957 to end legal abortions (Chicago Tribune Timeline 2014). Even when it was widely believed that life began at ‘quickening,’ the first signs of fetal movement, Storer urged that life began at conception. He blamed the ignorance of the public for the number of abortions and spearheaded the movement to criminalize them. As the chair of the Massachusetts Medical Society and the American Medical Association’s Special Committee on Criminal Abortion, he published papers on the unethical and unjustifiable nature of abortion that were then published in the book *Criminal Abortion in America* (Conrad 2009). To this day the majority of ‘pro-lifers’ still argue that fetal life begins at conception and that abortion is murder. The unwavering support for this point of view throughout anti-abortion organizations creates a solid framework for them to build on. This framing perpetuates abortion stigma because the basis by which abortion can be deemed immoral is universal among those who do not support them. Unlike ‘pro-choice’ advocates who differ in their views of why abortion needs to be legal, from a woman’s right to her body to the lack of fetal life, abortion combatants all agree that abortion is immoral because it is a form of murder.

While abortion stigma varies based on the woman’s immediate social environment it also varies based on its social location. Kumar et al. (2009) describe five different spaces in which abortion stigma can be located: framing discourse and mass culture, government and structural level, organizational and institutional level, community level, and individual level (Kumar et al. 2009). Deconstructing each locale has major
implications for better understanding stigma, its effects, and how it is being spread. Locating the stigma’s origins makes it easier to understand the different ways that abortion stigma can manifest itself in the lives of women.

First, stigma is found in ‘framing discourses’ and in mass culture. Together, they comprise the various modes of communication that shape the way the public thinks about abortion (Kumar et al. 2009). Framing discourses work most effectively through the language presented to the public. Terms like ‘abortionist,’ ‘murderer,’ and ‘baby killer’ have been used to refer to abortion care providers. This language casts them in a negative light, making them seem morally corrupt. It also effectively separates and rejects pregnancy termination as a legitimate reproductive health care option regardless of its prevalence (O’Donnell, Weitz, & Freedman 2011; Harris, Martin, Debbink, & Hassinger 2013; Kumar et al. 2009; Mitchell 2004 as cited by Kumar et al. 2009). When politicians like Texas Representative Bill Zedler, who are supposed to be representing and protecting the moral views of society, compare pro-choice advocates to terrorists and abortion to genocide, people who respect the government may be inclined to listen. The language used in laws such as ‘partial-birth abortion’ bans, a term with no medical validity, also have a way of making their way into the consciousness of the public regardless of legitimacy (Johnson, Harris, Dalton, & Howell, 2005). Anti-abortion groups are using rhetoric to their advantage. These groups claim to be “pro-life” but focus only on fetal life. I believe that an abortion can in many cases, be pro-life; pro the life of the woman who has decided to end her pregnancy as well as pro the life of the unwanted child that would result from carrying the pregnancy to term. As Johnston (2006 in Jacobs 2006) states of her own experience,
“[t]he general public may believe that women who have abortions are turning their backs on “life,” as though the only life involved is that of the potential baby. In my experience as an abortion provider, I know that, really, they are turning toward life in the most responsible way they know how. The decision to end a pregnancy invariably means valuing the living, whether by choosing to care for an existing child or another person in need, or to focus on one’s own future. This decision nearly always considers the quality of life a woman can offer a new life.” (78)

Rhetoric is also used to their advantage when, for example, they use “woman-centered anti-abortion strategies” (Norris et al. 2011) to sway women towards carrying their pregnancy to term. These strategies involve the biased counseling laws stated earlier. The state mandated pamphlets and handouts are worded to make women think that these measures are being taken for their benefit when in fact, the information is based on faulty science.

Another particularly daunting aspect of the anti-abortion movement’s tactics is their way of using images to shape public opinion. Since the passage of Roe v. Wade in 1973, the pro-life movement has been notorious for its use of violent images to further its agenda and shock the public (O’Donnell et al. 2011; Harris 2008; Petchesky 1987). Though they have shifted the focus from fetus-centered strategies to woman-centered strategies in the last decade, this strand of their propaganda continues. As technology has advanced, fetal photography, ultrasounds, and fetal surgery, have allowed for personification of the fetus. Fetal photography specifically, has played a large role in ascribing personhood. Anti-abortion forces have used fetal images to shape the argument that abortion is murder. In some cases, the photos used may not even have been taken in utero or at the gestational age implied in the photo. By using these photos, the anti-abortion groups cut the mother out of the picture and give the fetus a “public presence” (p. 264) of its own. They shift the focus from the social context of the abortion to this false sense of independence and life of the fetus (Norris et. al 2011, Petchesky 1987). Through
popular media, culture, and even sometimes art, characteristics such as feeling, sentience, vulnerability, and desire have been rhetorically applied to fetuses (Kumar et. al 2009; Petchesky 1987). These characteristics allow people to make the jump from fetus to baby and from abortion to murder quite readily, solidifying stigma in framing discourses.

In addition to framing discourses, stigma can be articulated through governmental and structural channels. The most common way that stigma arises from this locale is via formal policies and laws (O’Donnell et al. 2011). Legally restricting abortion is largely involved in perpetuating and solidifying the notion that abortion is morally wrong because laws and morality are intimately related to each other (Norris et al. 2011). The two become inseparable because the law generally reflects the moral principles of society (Preserve Articles 2012). Because of this, people can be influenced when the law attempts to restrict abortion. This raises a considerable problem. As long as the legal restrictions that make it more difficult for a woman to get an abortion create stigma, stigma creates a barrier for legal change. For example, as mentioned earlier, the Hyde Amendment restricts the use of any federal funds for abortion procedures (Dennis, Blanchard, & Córdova, 2011; National Network of Abortion Funds 2013). Much like the use of harsh categorizations for abortion providers, this bill stigmatizes abortion by making it seem fundamentally different from other kinds of health care. At the state level, TRAP laws are relying on stereotypes of abortion clinics and on portraying abortion providers as illegitimate and untrustworthy, thereby, using legal means under the guise of protecting women’s health to perpetuate the stigma placed on these clinics and providers.

Stigma is also perpetuated and reproduced by means of organizational and institutional channels. For example, because abortion clinics operate independently of
other health care facilities, the gap between health care, reproductive health care, and abortion widens even more. It has been shown that this separation makes it harder for women to obtain follow up care and contraception counseling after their abortions (Kumar et al. 2009). The most devastating part of this level of stigma is that the women who feel the repercussions are those who are the most marginalized and who do not have access to the resources necessary to rise above it; women who are in prison, who do not have citizenship, who are underage, who are poor, and in many of these cases who are women of color. These women cannot afford to take time off of work or to find transportation to travel long distances to a clinic for these services. It would close the gap between reproductive health care and abortion if abortion services were offered in facilities where women could get other forms of health care as well.

Private health insurance is another good example of how stigma can be perpetuated through organizational and institutional channels. Many companies selectively exclude abortion care from their policies (Kumar et al. 2009). A particularly telling example of the strength of abortion stigma is illustrated by the fact that two thirds of women who do have private insurance policies that cover abortion care actually elect to pay for it out of pocket, for fear of other people on the insurance policy finding out about their abortion (Norris et al. 2011).

The final locales for stigma are both individual and community. The individual and community spaces have a particularly intimate relationship, working with each other to exacerbate the effects of abortion stigma. Communities reproduce abortion stigma by means of social networks and the stigmatizing attitudes that are often passed along via family, coworkers, friends, and other relational ties. One way that communities manifest
stigma is by oversimplifying the abortion issue. While anti-abortion groups will have the public believe that it is a decision that happens in a vacuum, a woman looking to end a pregnancy has many factors to contemplate. Trying to look at abortion as a right and wrong issue denies the complexity that goes into the decision a woman makes when deciding to terminate a pregnancy.

The stigma that manifests in communities is the kind of stigma that is most closely related to the secrecy that leads to the belief that having an abortion is infrequent. Stigma seems to disproportionately affect women who feel as though they would face social rejection in their community if people were to find out about their abortions. This ties in very closely to abortion stigma that is reproduced at the individual level. Since many women have close personal ties to the community, many women keep their abortions secret to avoid social rejection; this can cause them to internalize the stigma. As Major & Gramzow (1999) and Kumar et. al. (2009), discuss in their papers, keeping an abortion secret from others can provide immediate benefits such as avoiding disapproval and social conflict as well as protecting personal relationships that could be threatened if the abortion was known. It was shown that 66% of women “agree” or “strongly agree” (Shellenburg & Tsui) (p. S153) that if others found out about their abortion they would look down on them. 58% of women reported feeling the need to keep the abortion secret from friends and family and 40% reported that they believed if their friends and family knew of their decision to terminate an abortion, they would think less of them (Shellenburg & Tsui 2012). The potential for secrecy and concealment with abortion can help a women avoid implicating herself or adopting a tainted identity (Kumar et al. 2009), but even stigmas that are concealable can have consequences. It has been shown that cognitive secrecy
promotes intrusive thoughts of the secret (Lane and Wegner 1995). This means that the more that a woman tries to actively keep her abortion secret the more that she will think about it, making it a potential psychological risk. It has also been shown that people become physically burdened, finding that physical tasks take more effort and are more tiring as if they were actually physically carrying an extra weight, when instructed to think about or conceal a meaningful secret (Slepian 2012). This suggests that if a woman is stuck in this cognitive cycle presented by secrecy, she could be significantly psychologically and physically burdened. Shame and guilt are not natural after effects of an abortion procedure, but they are common manifestations of internalized abortion stigma (Kumar et al. 2009; Major & Gramzow 1999; Shellenburg & Tsui 2012).

After their abortions, women may feel as though they have contravened the cultural expectations for motherhood and womanhood, and they may feel as though they have failed their community, friends and family’s expectations (Kumar et al. 2009). These fears are not unfounded. Abortion stigma can often be manifested at an interpersonal level in the form of discrimination. Kumar et al. (2009) states that this can include denial of accurate medical information, excessive fees, verbal or physical abuse, expulsion from school or employment, shaming, ostracism, medical services of poor quality, and the endangerment of marriage prospects. This makes it very apparent that while adverse psychological effects, like “shame, isolation, and loss of self esteem” (Harris 2012) can occur after an abortion, this is largely because of the internalized and community-reproduced social stigma that is attached to abortion.

There is very little research on the effects of abortion stigma on patients and providers, but this field of knowledge is growing as the threats to reproductive rights are
multiplying. As of now, there are gaps in the literature on the effects of abortion stigma potentially because of the controversial nature of the issue leading to a lack of funding.

While current research in this field is lacking, it is important to continue research into this topic. For many women, abortion is a hard and emotion-provoking decision, and many women choose to keep this decision a secret. As mentioned above, this failure to disclose emotions to others has been associated with poor physical health, lower overall wellbeing, and decreased psychological health (Major & Gramzow 1999). Keeping a secret sets into motion cognitive processes that lead to “excessive preoccupation” with the secret, which ultimately is what causes the most psychological distress (Major & Gramzow 1999, Shellenburg & Tsui 2012). It is very apparent that abortion stigma can have numerous negative effects and further research needs to be done to better understand the effects of this stigma.

Repercussions of Stigma

The repercussions of abortion stigma are not just something that will affect the abortion procedure and abortion patients. Fundamentally, abortion stigma is another strategy used to ultimately make abortion illegal, or at least nearly impossible to obtain legally. Criminalizing abortion does not eliminate abortions – it only eliminates safe abortions. This is incredibly detrimental to women who choose to have an abortion because they will have to turn to clandestine and unsafe measures to terminate their pregnancies. It has been shown in the United States and abroad that legal restrictions do not decrease the abortion rate or substantially increase the birth rate. Rather, making abortion illegal significantly increases maternal mortality (Harris & Grossman 2011). Further, these legal abortion restrictions could potentially do away with institutions like
Planned Parenthood that provide many other women’s reproductive health services, such as STD testing, fertility treatments, mammograms, cancer screenings, contraceptive counseling, check-ups, and pap smears. If facilities that provide these services to women are closed down, many low-income, young, and minority women will go without these services, ultimately leading to a public health crisis.

In this chapter, we have defined abortion stigma and located it. By analyzing the social locales that Kumar et. al. (2009) proposed, we found how abortion stigma is being maintained in our society. Though some of these locales can be changed to reduce stigma, I propose that an effective way to do this is to start at framing discourses. As the 1 in 3 campaign explains, by sharing experiences we start to build a culture of compassion, empathy, and support for access to basic health care. By telling abortion experiences we use framing discourses to our advantage to combat the negative rhetoric being used through this channel. By doing this, we humanize abortion and move the focus that the anti-abortion movement places on the fetus towards the women who are making these decisions, effectively placing the mother back into the picture. This is what I hope to achieve in sharing the experiences of these four women.
Chapter 4: Narratives

In this chapter, I will present four narratives that I have written in an attempt to shift towards a social climate where every woman’s unique experience with abortion is supported, respected, and heard; a society where abortion is regarded as the safe, legal, and prevalent medical procedure that it is.

While interviewing these women, it quickly became clear to me that in each experience the magnitude of stigma faced was different. And while each interview had its similarities to the others, it felt like an injustice to generalize them. For example, though in all of the stories I felt that each woman internalized the stigma they were experiencing at one point or another, they all vocalized it differently, one even not vocalizing it at all. The collection of these stories displays that no woman has the same experience as another. Had I had the opportunity to interview more women, I believe that this would be even more apparent.

Each of the women I interviewed was recruited through the Hampshire College Daily Digest. In order not to direct the stories to my own interest, I did not have a set of questions prepared for each interview. I began each one the same, I asked the women to tell me their names and a little about themselves and shortly after prompted them to describe their experience however they felt most comfortable. Not each narrative is written in the same style because in attempting to capture the essence of these stories trial and error was required. Initially, I had anticipated that making the narratives interesting to the public was the most important factor in considering the style I was going to write them in. First, as can be seen in Megan’s narrative, I took the point of view of the interviewee and told the story again being sensitive about not changing or making assumptions about
how she felt in the situation but rather only added detail to the story she had told me
during the interview to make it more of a narrative read. But after writing it, I knew that
adding my own details had made her story less powerful. It was clear that being true to the
women I was interviewing and their experiences was more important than making it
readable to the general public. For the last two narratives, I wrote from my own
perspective and told the story of the interview instead.
My Own Narrative

When I told my boyfriend, we were sitting in his car at a red light only a few blocks from my house. I had been turning the words over in my head for the entire ride, inspecting them carefully as if I could find some way to put them that would be less concerning.

“"I need to go to Walgreens." I muttered.

“What, why?” he questioned nonchalantly as he put his blinker on to get into the other lane.

“You should have told me before I turned the corner,” he sighed.

As I sat quietly, I knew that this was the moment for the words I had been planning. I could feel them at the bottom of my throat, like a pill I had taken without water.

John and I had been together for three years at this point; I knew him inside out. I knew that when he had questioned me about my intentions for the pharmacy visit, he didn’t actually want an answer. He just wanted to have the words suspended in air so that I would know he had thought them but I questioned myself. Did I really have to take a test so soon? My period was only two days late, I had been weeks late before and been in the clear. No, I felt different this time; two days prior when my period didn’t come, my mind had zeroed in. It found no other topic worthy of its time over the last two days. I needed to take a test if only to silence the constant questioning that had been plaguing me.

“I, uh,” I paused.

He turned to me raising an eyebrow, his heterochromatic eyes squinting, my hesitation and tone had intrigued him.
“I, uh, I need to get a pregnancy test. I’m a few days late.” The words surged out of me as if they had broken through a dam in my vocal cords.

At first, I didn’t look in his direction. I stared into my lap at my squirming hands. I focused on my chipped teal nail polish, as if I hadn’t just dropped a line I had been contemplating for thirty minutes. How long had it been since I painted my nails? Where had I even put that polish? It was the only color I liked on my hands. My train of thought was disrupted when I heard him speak.

“Fuck,” he said in a tone I almost didn’t recognize, serious and frightened. “How late?” I could feel his eyes on me. I turned to him; his face was filled with concern. His brow furrowed and his lips were just slightly parted with the corners pointing downwards. It was a look that he seldom wore, even in times of distress.

“Well, only two days,” I said slowly with a wavering smile, trying to dissolve the tension I could feel pouring off of him. It was hard for me to see him like that.

“Oh,” I could see the relief wash over him.

“Why are you trying to freak me out?” He asked with a smile and a chuckle as he put his hand on the back of my neck.

His touch was comforting. He had always been my rock, but my mind did not quiet, the muscles in my back did not relax. I knew that this concern was well placed, I knew that I had failed to mention my own and its severity. I knew that it was not a passing bout of hypochondria.

The bathroom was dirtier than usual. I hadn’t emptied out the trash or bothered to do away with the clutter that always built up on the sink counter in about two weeks. As I
sat with the pregnancy stick in my hand, I watched as the liquid slowly crept in from the left side of the screen. The idea seemed almost funny to me now, I had told John that I felt different this time, that I felt a sense of urgency had taken up residence in my diaphragm as we searched for the cheapest pregnancy test. He had laughed it off, his smile and cool composure so contagious I couldn’t help but be relaxed. Of course I didn’t have a sixth sense. I didn’t believe in things like that.

First, there was the faint appearance of one pink line. That was normal, no reason for concern. Then, as the liquid passed that line there was the faint appearance of a second line.

“What? Wait, no,” I started to panic.

My heart rate instantly doubled and I could feel myself getting nauseous. No. Relax, the ink will travel I told myself. I had only taken two pregnancy tests before and they hadn’t been this brand. The ink will travel to form one line; it would be like the results of my paper chromatography experiment I had done just two weeks earlier in Chem Lab. As each line got darker and more apparent, I could feel my stomach wrestling itself, turning and contracting. I grabbed the pregnancy test box, dropping the second test only inches from the garbage can next to me and nearly ripping the pamphlet inside as I pulled at it. Why would they print this on such thin paper? As I read that the test had to be laid flat for five minutes for a correct reading, my stomach released its wretched grasp on itself and I relaxed. I had jumped the gun in being concerned. Five minutes would show that I wasn’t pregnant. I couldn’t be.

I put the pregnancy test on the sink counter next to me and closed my eyes. The cold tile under my feet was making me wish I hadn’t thrown away my bathroom rug in a
moment of anger a few months ago. It served a purpose, it seems that logic can escape me in moments where my emotions run high. The calm I had convinced myself to feel only half a minute before was deteriorating as fast as I could think, I knew that this was no exception. Logic would lead me to believe that two darkening pink lines would not turn into one, why would I think that? I opened my eyes and looked at the test. Two lines, both dark fuchsia. I was pregnant.

My mind searched for excuses; maybe it was something that I’d eaten that made the test read wrong, maybe it was because I was holding the test instead of laying it flat. But even as I googled on my phone to see if there was any reason that the test could be wrong, I knew that the reading was right. I had known I was pregnant for a few days now.

“You’ll have to take the other one,” John said, not accepting my gut feeling as reassurance.

His voice was emotionless now. He had abandoned being my rock and was completely in his own head. He couldn’t even look at me, his glare glued to the floor. Tears crept down my face. I hadn’t cried in so long it felt unnatural. Surely it was because I was pregnant, because this wasn’t part of the plan, because this was never supposed to happen to me, what other reason could there be?

As I sat next to the second pregnancy test and watched the two lines form a second time, my thoughts consumed me. I thought of what the sac of cells currently growing inside me could eventually be, who it could eventually be born to be and I felt sadness. I would never know. There was no way I could carry this pregnancy to term. And almost simultaneously, it occurred to me that even if I carried this pregnancy to term, the child that would result from it would not have any of the things that I want to give my future
children. With a mother not yet even done with her first year of college and a father just graduating high school, what life could I offer a child? What feelings of resentment would I have towards it? It would be unfair to that child to bear them out of sadness or guilt. And as for the unique egg and sperm that had met to make this unique zygote? They would have never crossed paths if things had gone accordingly, that egg would have never been fertilized. For once, logic occurred to me in my time of desperation. I had a responsibility to this zygote, a responsibility to not carry it to term. I sat for the full five minutes, even though I had known the reading from the second the liquid had coated the screen. Away from John, I felt better.

After the news that second test had come back positive, I sat on the couch across the room from him. Staring at him as he paced from my kitchen to the glass doors in my living room. His steps basically bore holes into the tile, each step had the weight of a million thoughts. He looked like a tiger prowling in his cage from one end to the other, looking for a way out. Every time he glanced at me, I saw that his eyes were absent of the love they were always filled with. His face was filled with the same look of concern that had seemed so alien on his face earlier in the day but now it was accompanied with an underlying tone of disapproval.

As the tears poured down my face, I knew they weren’t about being pregnant; they were about the look of contempt on his face. How could he look at me like that? I searched for some semblance of the John that I knew and loved in his gait just as he stopped in the middle of his route and turned to me.

“Well, you know what has to be done,” his voice cold with a tinge of condescension.
His tone cut through me like a blade. I looked at him with desperation in my eyes, I did know that an abortion was in order and I had come to peace with it, but I had never expected that this would change how he treated me. He hadn’t asked me what I wanted or how I felt once. His glare was burning through me.

“Don’t try to argue with me. We aren’t keeping it.” He said before turning around and sitting at the table facing away from me, his fingers gripping the edge.

It was as if I had lost my right to input through pregnancy. We had both been accountable, why was he treating me so badly?

“What if-“ I started to say between sobs before he interrupted me,

“There is no what ifs. I’m going to go home now, look up a place to do it and we’ll go tomorrow,” he hadn’t even turned to look at me by the time he was through the front door.

I knew that I had to get into my room and into bed before my parents came home. No one could know about this. If someone who loved me so dearly and was partially responsible for the pregnancy could abandon his feelings for me so quickly, I could not even imagine how my conservative parents would feel.

In the following days, there were a few surprises. The abortion that I had imagined would be easy to get was going to cost nearly seven hundred dollars. John apologized and admitted that he had initially thought me irresponsible for getting pregnant but that he had realized that it was both of our faults. Even with his apologetic attitude he was sure to tell me that this revelation didn’t change that the cost of the abortion would be my responsibility. I would have to pay for it, it was my body after all. When I had
successfully scrounged together what was left of my financial aid reward and my book stipend, I had enough.

Walking up to the Planned Parenthood clinic with John, there was no commotion. No yelling from protesters, no plastic babies being thrown at my feet, only a real estate agency with Miami Vice colored blinds and the smell of barbeque lingering in the air from the restaurant next door. My heart raced as I walked up to the counter. I had made an appointment over the phone but I dreaded facing another human being with my unwanted pregnancy. She sat at the desk and looked up with a pleasant smile as I tried to scribble my name on the clipboard as quickly as possible, hoping to avoid any contact.

“May I help you?” She asked with a smile.

I was terrified of telling her I was there for an abortion. I knew that once I told her, she wouldn’t wear the same smile. I didn’t want to be disapproved of. I could feel my hands start to shake. It was if I was doing a presentation in front of a class, the need to please coursing through me so strongly that I was starting to choke.

“I’m here for my appointment at three,” I said in quiet voice.

“And the appointment is for?” She asked.

“Um, an abortion,” I stuttered.

When I looked back at her she was nodding, wearing a smaller but still noticeable smile. She grabbed some pamphlets, handed them to me and directed me to sit down until my name was called. My anxiety started to subside, after all she hadn’t thrown the pamphlets at me or spit in my face. The next nurse I interacted with was not as approving. As I walked behind her, she spoke to me without turning to look at me.
“Have you considered all your options?”

“Yes,” I said confidently. I knew what I wanted to do; the pamphlets hadn’t stopped me even with their mentions of Post Abortion Syndrome and how miserable I was bound to be after my abortion, nothing would.

“All right then, lets check your baby out.” She said raising her eyebrows and turning to catch my eyes while I sat down in the chair.

Baby, the word made my stomach sink. Momentarily, the brief sadness I had experienced a few days earlier was sitting with me again but this time I wasn’t alone. John grasped my hand and gave me a knowing smile, he could see that her statement had affected me. How could he be the same person that talked to me so harshly after we had first found out? Moments later, the nurse informed me that nothing was coming up on the ultrasound and that I would have to come back on a later date. I wasn’t far along enough yet.

“Maybe it’ll give you some time to think things over,” she said as she held the door of the room open for us.

This time, her words inspired anger in me not sadness. Why? Why was this woman trying so hard to make me feel bad about something that I had come to terms with? Who was she to tell me that I hadn’t thought about my decision enough? As we walked out, I was livid. I knew that she was wrong to make me feel bad. I was a grown woman and the choice was my own to make, but somehow I justified her behavior. I realized that this was what I could expect from others when I told them about my abortion, they would judge me for getting pregnant or judge me for getting an abortion. It was just the hand I had been dealt.
After my abortion, I felt no remorse, only relief. I knew that I had done the right thing and the weight that I felt lifted off of my shoulders after I took the mifepristone was proof.

I was sitting in class a few days later, my eyes following my calculus professor as he wrote on the dry erase board. I had woken up that morning feeling sad, but now it was compounding into something else. I could feel guilt trickling into my mind. I focused on it and soon I had tuned out my professor completely. Why didn’t I feel bad? Isn’t regret over something like this protocol? I could feel myself growing closer to crying, but I didn’t even know what I wanted to cry about. I decided it would be best to leave class early and to spend some time with myself, but what I came to find was that I had no answers. I felt bad about not feeling bad but how could that even be logical? The more I thought about it, the more frustrated I became. I couldn’t talk to anyone about it. John was over it already and was acting like it had never happened and as far as I could tell anyone else would most likely change their perception of me if they knew. I wished that I knew someone who had been through the same thing but I didn’t have that luxury. Finally, in a stroke of genius brought about by catching my finger in between two poles on the swing I was sitting on, it occurred to me that one of my close friends had dated someone who had had an abortion. I didn’t know if it was while they were dating or not, but it was worth a try, I needed to talk to someone.

We were sitting in his car in the parking lot of the science building. The seat was warm from the sun when I sat down.
“How was she after?” I asked, really hoping to hear she was fine.

“Well, she was really broken up about it,” he responded.

My mind raced as we sat in silence for a moment. Is that how I’m supposed to feel? At least he doesn’t seem to be judging me over the abortion or the fact that I don’t feel bad. Maybe it’s fine, maybe I’m fine, I’m probably just overreacting.

“I think that you and John did the right thing. I can’t blame you guys. You are both still in school, you don’t have your shit together, and there really isn’t any other option,” he said, interrupting my inner monologue.

“Exactly, it was the right thing to do. Why feel bad?” I said looking up from my hands. I could physically feel the guilt that was eating away at me melt away.

“Yeah, I mean, if you guys were in a different point in your lives or in a better position then I’d say you would have to take responsibility for your actions, but as of now, there was no other way,” he stated while nodding to himself.

Oh my god, I thought, he doesn’t get it. I glanced at him, disappointed and regretful I had told him. He thinks that I’m irresponsible for getting pregnant AND for getting an abortion. I paid over 600 dollars to make sure that I did not bring an unwanted child into the world. I had acted responsibly. I was void of the guilt I had felt earlier that day, but there was something new growing inside me. This was something that I wouldn’t be rid of for three years after that. I developed distrust for the people around me. I found that they were not capable of accepting my abortion as I had. They could sympathize with me and with my situation but they would also feel pity or judge me on account of it. My abortion was my secret and no one could know.
Megan’s Narrative

Megan twisted her hands together in an attempt to create some kind of warmth between them. She wondered about the sub-artic temperature as she tugged on the light blue jacket she was wearing that was proving to be not nearly sufficient. As her eyes surveyed the room, they fell on the plastic orchid on the coffee table in front of her. The thin layer of dust that covered it from top to bottom suppressed the bright green and purple hues it was intended to have and actually made it look more believable. How peculiar, she thought as she narrowed her eyes and leaned in to inspect closer. Almost immediately, the sound of the door next to the counter being opened pulled her attention from the plant and drew her eyes upwards. Leaning against the door, clipboard in hand, was a nurse with her head turned to look backwards as she talked and laughed with the receptionist who was sitting behind the counter.

“Megan Perry” the nurse called out a few seconds later, her big smile lingering after her conversation.

When she heard the first syllable of her name being called Megan hastily grabbed her bag and got up from her chair. She had gone to the clinic to get oral contraceptive and when the nurse informed her she had to take a pregnancy test she’d thought nothing of it, it was just protocol. Get a little blood drawn, get my birth control pills, and be I’ll be on my way, she figured. The nurse directed her to go into room three and take a seat. As Megan hopped onto the vinyl chair, the words pre-natal health in pastel green on the poster in front of her caught her eye, she glanced at the one beside it which had Pregnancy & Birth in bold black letters across the top. As her eyes darted around the room, her heartbeat escalated with every bit of information they gathered. A poster of a baby in a
womb, a list of pre-natal vitamins, a mother holding a child in her arms with a Nature Made logo suspended above her. Megan’s stomach dropped.

“What if someone pretends to be your parent?” Jake asked, as he glanced in Megan’s direction. Her eyes were glued to the wooden dining table they were sitting at, her fingers rhythmically pattering on its surface. She had heard him, but just barely. With her own thoughts loudly thrashing around in her skull, he sounded a mile away. While she had known from the moment that they had decided to stop using condoms that if she got pregnant she would get an abortion, Alabama’s parental consent laws had complicated the situation. Maybe I could lie about my age, she tried to rationalize before quickly shooting herself down. There was no way they would not check her ID and she knew it. As a sixteen year old, from a conservative family, she was looking towards what seemed to be a dead end. It didn’t help that Jake, her boyfriend, was 23 and that he could potentially go to jail if her parents chose to press charges. When she finally looked up at him, her eyes were serious.

“That wouldn’t work”, she said very deliberately, the gears turning in her head were almost audible in the quiet room.

“I mean, there has got to be a way around this,” Jake said with a wavering smile in hopes of raising her spirits while placing a reassuring hand on her shoulder, but the anxiety underlying his tone betrayed the nervousness he had been trying to conceal.

“As of now it doesn’t seem like it,” she said while leaning back in her chair and staring at the ceiling. She covered her face in her hands and dragged them down as if they were dead weight. She had to find a way to get this abortion.
A few days later, Megan was settling into her room to do some homework. Her AP classes had been picking up at a considerable speed, as all classes do before midterms, and she couldn’t afford to fall behind. While setting out her American History textbook on the desk directly in front of her, she heard her cell phone ring from either inside her jacket or her book bag, she had placed both things together on her bed when she had walked in. As she scrambled through her bag, a smile of realization came to her face. She remembered putting it in her backpack’s small front pocket before driving home.

“Oh?” She answered.

“Hi there, this is Susan Miller from the Health Department. Can I speak to Megan Perry?” The voice on the other line responded.

“Ah, you’re speaking to her.” Megan mumbled, the words Health Department reminding her of her currently unsolvable situation.

“Alright then, well, I’m a social worker here at the Health Department and I’m calling in to check up on you because I’m seeing here that you recently tested positive for pregnancy. Have you made any decisions or plans regarding that yet?” her tone friendly as she asked.

“Well, um,” Megan paused, wrestling the idea of telling her she wanted to get an abortion. It was Alabama, after all. “I’m planning on getting an abortion, but the parental consent requirement has put me in a bad position,” she said, deciding that as a social worker Susan must have an open mind.

“Okay, well there is one option, a waiver of consent, but it requires you go to court,” Susan paused.
When Megan heard those words, it was if the weight of a car had been removed from her chest, she breathed for the first real time that whole week. Court or not, now that she knew there was a way, she could do this.

For the next week Megan spent the majority of her free time on the phone with the local courthouse getting transferred from person to person, looking for someone that could help her. The procedure was frustrating and mentally exhausting, each conversation would require her to explain her situation, leaving her exposed and only with another transfer to someone else. Finally, she got in contact with the right person and scheduled the court date.

The courtroom was unusually decorated. The bench where the magistrate sat as well as the podium that Megan was standing at were dark, rich walnut wood. The walls were bare and white, with the exception of a red curtain hanging behind the magistrate that looked completely out of place and clashed with the carpet that was a hideous color between a mint green and olive.

“Why should I believe that you are mature enough to make this decision on your own?” asked the magistrate, her glare falling on Megan.

“I believe that I am mature enough to make this decision for myself because up till now, I have been mature enough to succeed in school. It takes a lot of responsibility and commitment to take high school seriously, a level of responsibility and commitment that comes only with maturity,” she had practiced her response in her head a million times since she had woken up. The words, so familiar to her now, came out clearly and concisely. It helped that she honestly believed that she was mature enough to make the
decision that she knew was right for her. After hearing the sincerity and confidence in her appeal, the magistrate granted her the waiver of consent.

It was about a week after the trial and a few days after Megan had told her two closest friends about the whole thing. They were sitting in a triangle on the multi-colored rug that covered the majority of her room floor. Megan, with her back against her bed, was sitting with her legs crossed and thumbing through the Biology textbook that was open in her lap. Her Biology professor was always so vague about what they could expect on the exam that it always took ages to study for it.

“Oh, Megan, I brought something for you from church,” Samantha said while rummaging through her backpack. She pulled out three pamphlets and handed them to Megan.

From the moment that she had pulled the first one out of her bag, Megan knew from the fetus picture on the front of it, that they were pamphlets regarding her pregnancy.

“Thanks, I appreciate it,” she said as she reached out to grab the pamphlets. Even though she knew that nothing would change her decision, it was clear that Samantha’s intentions were good. It was hard for Megan, she felt so comfortable with her decision, so sure that she was doing the right thing but she couldn’t shrug the feeling that she had a responsibility to portray that this was a super difficult decision to make, as if she had to put on this façade for others. The decision was not one that she made lightly, she had considered all her options and thought a great lot about it, but when all was considered the choice, to her, was obvious.

The night before her abortion, she sat in her bed with her laptop on her lap. She typed ‘abortion risks’ into the search bar only to find a slew of different resources to
choose from. The more she read into it, the more information she found that contradicted something she had previously read. But through all the information she had looked through, something caught her attention more so than everything else. She leaned toward the computer, brow furrowed as became engrossed as she read about the possible connection between abortions and breast cancer. She could feel a brew of anxiety and frustration cooking at the pit of her stomach, before it had enough fuel to bore a hole through her, she closed the computer and put it away.

As she stood in front of her closet with her arms crossed, she considered what she could wear. What does one wear to an abortion, she wondered with a brief chuckle. Well, if I wear pants I’m going to have to take them off, she grimaced and shook her head. A dress would be easier to deal with, she thought as she searched through her closet. Item after item, she gave no more than a shrug or a barely noticeable shake of the head. Finally, she came across a casual stripped dress she knew would fall right over her knees. Not too short, not too fancy, sounds about right. As she stepped into the dress, it became more real for her, it was really happening today.

When she and Jake arrived at the clinic, the clinical assistant that checked Megan in asked her if she had any questions.

“Well, actually,” she started, trying to think of a way to phrase her question, “do you know anything about the connection between breast cancer and abortions?”

The clinical assistant looked up from the paperwork Megan had just filled out and turned it to see Megan, the inquisitiveness pouring off of her. “I’ve, uh, never actually heard of such a connection,” she responded and quickly looked away.

Megan pressed her lips into a hard line as she turned around to sit next to Jake.
“What’s wrong? Did she say something weird to you?” Jake asked while raising an eyebrow, seeing that Megan’s demeanor had changed.

“Not really, she just made me feel a little uncomfortable,” she paused in order to get her thoughts together into the most reasonable manner. “Yesterday I read about a possible connection between breast cancer and abortion and when I asked her about it she said she had never heard of it,” another pause, she crossed her arms and sat back as she attempted to see the situation from all angles. “I mean, I guess I understand why, but at the same time she could have just told me that it was something people said that wasn’t true or that it wasn’t proven. Or maybe she really hadn’t heard about it, I guess. It just seemed like she was lying,” she finished off with a shrug. Jake threw his arm behind her and gave her shoulder a squeeze.

When it was finally time, they got up to leave the waiting room, their hands intertwined.

“Sir, I’m sorry but you can’t come back here,” the nurse said as she held the door open for Megan.

“I want him to be with me during the procedure,” she said, with an iron grip on his hand.

“I’m sorry, it’s not allowed. I’ll be with you during the procedure,” she reassured her with an apologetic smile. Megan sighed, I guess she’s only following the rules, she thought as she loosened her grip on Jake. She looked back at him and gave him a farewell nod before she walked through the door.

Once inside the room, the nurse directed her to take off her bottoms and to get positioned on the stirrups. As the door closed behind her, Megan smiled as she took off
her underwear and shoes, patting herself on the back for not wearing pants. As she hopped up to the stirrups and laid back into a comfortable position, she peered straight up towards the ceiling, what she saw starring back at her caught her off guard. She raised her eyebrows and shook her head as her smile returned, how bizarre, she thought. The poster that was hanging above her was a composite of five butterflies, all in pastel colors flying around a bunch of ribbons and blossoms. But as soon as the nurse walked back inside, the smile was gone. It was strange because, her change in demeanor wasn’t because she was any less pleased about her choice in outfit or because she was any less amused by the poster they thought people would want to look at during their abortions, it was because she still felt this need to play this role of conflicted teenager brooding over her abortion.

When the doctor came in, he walked right past her without even glancing in her direction. He sat down in the empty rolling chair and rolled right on over. The nurse grabbed Megan’s hand and as the vacuum sound started and filled the room, Megan traced the butterflies with her gaze. Why didn’t he say anything to me? I wish he had acknowledged me, she thought to herself as she counted the dots on the butterfly wings. And without a word, as swiftly as he had come in and sat down, he got up, gave the nurse a nod and walked out of the room. Such an invasive procedure and he couldn’t even recognize me as a person who was going through this experience? The second the door closed behind him, Megan felt tears fall down her cheeks. She knew that she didn’t feel sad, but the tears still came. They originated from a feeling that she had become accustomed to, a pressure to perform that she had felt weighing on her ever since she had made the decision to get an abortion.
There were two other women, both sitting quietly in the recovery room when she got there. One was in her early fifties, staring at the television set that was playing the first Transformers movie on mute and bouncing her leg. The other was only a few years older than Megan, simply staring at the floor. When Megan sat down, she glanced at both women, tears still leaking from her eyes and she started to feel guilty. She just slightly shook her head, and frowned. That same pressure she had felt just minutes earlier to perform as she was expected to had transformed from a pressure to cry to a pressure to be stoic too quickly for her body to catch up. The air in the room was thick with the sounds of time passing by, the sound of the blades on the ceiling fan, the sounds from the rolling chair the nurse was sitting on, the sound of papers shuffling while she did her filing, and most notably, the sound of silence.

By the time she had gotten home, her performance was over all together. She stood in the kitchen unloading dishes from the dishwasher as her mother had asked her to. She traced the rim of a plate with her index finger as she thought; no one knows that I’ve gone through this thing today.

“How weird,” she said out loud to herself as she put the plate away and smiled.

Over the next few years, Megan found power and strength in her experience. She had made her abortion happen, even when it had seemed unlikely. When a close friend of hers became pregnant, she was able to impart her knowledge and help her get a waiver of consent to get an abortion as well. It was empowering for her to be able to help someone make the choice they wanted to make. Years later when she looked back on her experience, as a professional in public health, she knew that her decision to have an abortion had allowed her to become the woman she had turned out to be. She looked to
share her story whenever there was an opportunity and to help and empower anyone who
could benefit. Without her abortion, she would not have been able to take advantage of all
her academic opportunities, and she probably wouldn’t have chosen public health even if
she had succeeded academically. Through her experience, she had learned the importance
of accessibility to resources and the difference that one sentence can make. The social
worker that mentioned the waiver of consent in passing had single handedly changed her
life.
**Melanie’s Narrative**

“Well, I am a fourth year here at Hampshire. My name is Melanie Wise,” she started, while following her fingers with her eyes as they grabbed at the hem of her sweater before looking up, “and I took three years off in between and I worked and lived abroad as an Au Pair in the Netherlands and in Portugal.”

As she spoke, it became clear that her interests fit very well with the topic of my own project as she explained that her work as an Au Pair had informed her studies and her identity along with her interest in women issues and the medicalization of the female body. When I prompted her to start with her experience, she leaned back into her chair, her gaze moving around the ceiling and her lips pressing together as she set the scene for the story in her own head. She explained that at the time of the abortion, she was 19 and living in Lisbon, Portugal nannying with a German family for about a year. 

“We were very close and they were very supportive,” she paused, her lips perking up and her eyebrows raised, “they knew about my personal life and they were kind of like a host family in a way,” she nodded as her hands moved in front of her enthusiastically before finding a resting place on her knee.

She had been seeing a Portuguese guy since October, when she had arrived in Portugal, and they had been having sleeping together for a while when in January, they had a condom break.

“It was one time that it broke,” her mouth moved into a frustrated smile, “and we didn’t know until after,” she said through her grin, her eyes opened wide with her gaze glued to the floor. “I had a really bad feeling when he pulled out,” her gaze met mine, her eyebrows raised. “And we were like, fuck! I remember going to the bathroom and trying
to squeeze it out,” she said while laughing, clenching her fists to demonstrate. When her laughter subsided it left only a wincing smile. Because she had always been the type to track her cycle, she could tell that she was in the window of fertility at the time and even though she had exhausted all of the options she had, even resorting to some spermicide that she had from a diaphragm she wasn’t using, she couldn’t shake her bad feeling.

The next month when her period was late that bad feeling persisted but Melanie found herself in denial; she didn’t want to know. It was around week six when she decided that putting it off was no longer an option and she took a pregnancy test.

“It was so surreal cause you never,” she paused and took a deep breath, the corners of her lips creeping upwards, “if you’ve never been pregnant, you never think you can really get pregnant,” her shoulders and eyebrows raised at the same time.”

When she told Serge, he was really conflicted about it. Though they hadn’t known each other for very long, “he said he wished he had been in a better financial situation so that he could be the father and raise the kid,” she squinted her eyes and shrugged, “he was like, very family oriented, I guess,” she paused and sighed. “But he was still living at home, which is common, over there,” she leaned in towards me, I could tell she was trying to get her thoughts together, “and I kind of knew that he wasn’t someone that I wanted to spend the rest of my life with, and I was like, I’m nineteen, I can’t do this,” she paused again, furrowing her brow, “but I, at the time, I wanted to,” she held my gaze and raised an eyebrow. “I was entertaining the idea, like, ‘I wonder what it would be like if I had a kid,’” she looked down and started to fiddle with her sweater. “And I remember talking to my mom on the phone and she was like, ‘Melanie, you can’t, you gotta get rid of it,’” her face donning a smile as she imitated her mom, “she told me that she had had an
abortion too, like when she was the same age even, because she didn’t start having me and my siblings until she was in her 30s and she was just trying to communicate the message like, y’know, this is not the right time, and,” she paused, “don’t even think about it,” she cringed and laughed.

Even after having the conversation with her mother, Melanie found herself reluctant to schedule an appointment. She searched online for a way to induce miscarriage, and decided on trying a method that was based on a regimen of vitamin C, but when she started on it, she found her health declining. After speaking to her mother a second time she decided, it was time to make an appointment.

When she got to the clinic to do the ultrasound, everything was in Portuguese. “They tell you about it and stuff and it was all in Portuguese, and I didn’t understand all of it but I was just pretending to,” she raised her eyebrows and laughed, “I mean I could understand most of it and what was important but that was really weird.”

After leaving the ultrasound, Melanie found it harder to cope with the idea of having an abortion than she had expected. She read online that you should try to be at peace with it and that there should be an opportunity to say goodbye, “So I remember taking a really hot bath and just thinking about it and feeling like, sad because I don’t, I,” she paused and gazed at the floor, “I always thought before, if I got pregnant when I’m young, like too young, I’ll just get an abortion and it’ll be fine. But when it was actually happening it was different,” her eyes narrowed and the corners of her mouth crept upwards as she met my eyes, “and I felt like I had this thing growing inside me,” her hands touching her lower abdomen, “even though it was probably like microscopic or like the size of my pinky or something, I just still had that feeling. And like knowing that if I
don’t medically remove it or interrupt the pregnancy or whatever, that I’m capable of having a baby,” she started to move in her chair and fumble with her boot, “and I also had this feeling that it would be a boy, which is weird,” she shrugged and sighed as she looked up and past me, her eyebrows raised, “but, yeah, so it was just, difficult and emotional.”

When she was at the clinic, she found the mood in the waiting room strange, as she waited to be called on. When it was her turn, the nurse prompted her to strip totally and to lay down with a sheet and shortly after she was put under anesthesia. Unfortunately, when she woke up she found herself in a lot of discomfort, “I woke up in extreme pain, like, my abdomen hurt so much, it was like really intense cramps, and I just felt like, horrible,” she said while shaking her head, “I didn’t think it would be like that,” she shrugged, “and also it didn’t seem like other girls who had had it, who were post op, were in as much pain as I was. I also didn’t know if part of it was emotional,” her brow furrowing at the sound of it.

“And I remember, I was kind of groggy, and the nurse was trying to get me to sit up cause I had woken up, to get my stuff and I had to get dressed. And after you’re supposed to wait in a room they make you wait for half an hour, and get water and stuff and that was really weird too,” a bemused expression on her face. “And I remember like, weeping, and there were other women there and they just seemed like, detached or something, like they didn’t seem that phased,“ her eyes opened wide and her eye brows raised, “And I thought that was weird too because we had all gone through this,” she made a big circular motion with her hands, “intense thing and I was like, really emotional about it, but they weren’t. And I was like, ‘what’s wrong guys?’” She shrugged and chuckled.
Even when she was released, she found that she wasn’t exactly in the best condition; she had to sit and rest outside the facility to feel comfortable walking because there was so much pain.

At this point in the interview, I asked if the nurses had seemed concerned at all about her pain level, which to me, seemed unusually high, “I just don’t really remember them doing anything, or maybe they thought it was normal, or maybe it was normal? For some women to be like that,” she shrugged in response. “But maybe it was just harder for me because I love children, and I do want to have them some day,” she lowered her voice and looked into the camera for the first and only time for the whole interview, “also my boyfriend at the time was also a family kind of person, so just thinking that, maybe if circumstances were different,” she looked back at me with pressed lips and shrugged.

We finished off the interview discussing her own involvement with interviews for a project on homeopathic birth methods and the importance of having a space to share your experiences.
Nicole’s Narrative

She sat in front of me talking about her concentration at Hampshire while Ethan set up the recording. I found myself with my elbows on my knees, leaning in towards her and listening intently. Both her attitude and her smile were incredibly contagious, I was smiling and nodding along before I knew there was anything to smile about. When we began I asked her to tell me a little about herself before we got into her experience.

“My name is Nicole, I’m 32 years old, from the twin cities, Minnesota. I transferred here this year,” she paused, “and this is my first time east,” she raised her hands enthusiastically and laughed.

“Cool!” I said while laughing along. “You can start whenever you’re ready.”

She took a deep breath and her smile lost some width before she began. She explained that she was 17 and had been couch surfing for about year after she had gotten kicked out of the house and that at the time she was involved in a lot of drugs.

“Particularly,” she paused and gave me a small wincing smile and wrinkled her forehead, “crank, a really dirty dirty terrible drug,” she said in a quiet tone while still donning the sheepish smile and shaking her head.

She had been living with a family who was also involved with drugs. The woman of the house got pregnant at the same time that Nicole did, they had gone to their local clinic to get birth control together and started having unprotected sex right away, unaware of the week that it takes for most birth control pills to take effect. Two months later, she ended up in the hospital; she had been vomiting consistently and was so weak she could barely walk. After being settled into a room, she was notified that she was pregnant.
She dropped her voice down to nearly a whisper, “I was like, fuck.” She shook her head, “I had no parents. Nobody. The other person who was pregnant had 3 kids, but, oh my god,” her face suddenly completely downcast, her eyes glued to the floor. “It was the worst. The worst experience,” she peered up and caught my eye before starting to nod. “I think that that actually contributed to me not feeling ready to be a parent because [the other women who was pregnant at the time] had a child [who] wasn’t quite 2 yet, [she] came up to me one time and was like,” Nicole slightly stuck her tongue out twice to demonstrate the motion, “and blood dripped out of her mouth and I was like ‘what?’” her brow furrowed and her eyes wide, “and I pulled a razor blade out of her mouth. And I mean, it was just so,” she let out a big sigh as she shook her head with her eyes closed, wearing a frown.

She went home for two days but her nausea and vomiting only worsened. When she returned to the hospital, one of the nurses pulled her aside and asked her if she had heard about mercy abortions. She hadn’t. At first, hearing the nurse talk about it freaked her out, but her words resonated with Nicole.

“‘Yeah, things aren’t right, y’know? You don’t have any family or insurance, what are you going to do?’” she advised her. Nicole’s eyes were wide as she spoke about this, her eyebrows raised, wrinkling her forehead, “And my boyfriend at the time, of course was like, I mean we’re both 17, we’re a week apart, and we’re like, ‘fuck, I’ve been doing drugs this whole time.’ Like, what have I already done to it? Like,” she sighed, “there was so much guilt, and nobody to talk to. This other lady that was pumped to have her kid, while her other kids are walking around with razor blades in their mouths,” she looked away and pressed her lips together. “And I was just like, I can’t. I can’t do this to a kid. I
had a fucked up my life, and I was like, there’s no way I am going to fuck this kid up. That’s just the worst thing I could do.”

She decided that an abortion was the right option for her, but at the time she couldn’t get one in Wisconsin due to how far along she was so her and her boyfriend went to a Planned Parenthood in Minneapolis. As a minor, she had to go in front of a judge for a waiver of consent.

Nicole laughs, “state my situation in front of them of course, in a public area, and I hadn’t told anyone.”

“Really comfortable.” I stated, shaking my head.

“Yeah, totally, yup, so personal,” she responded with a chuckle and a raise of her eyebrows.

When she arrived at the Planned Parenthood, there were protesters outside, “I was walking through all them, and I was, I was so mad at them, I was like, ‘fuck you, you have no idea.’ And,” she let out an aggravated sigh, her eyebrows were furrowed and her eyes were squinted, the corners of her lips pointing downwards. “Really, you want me to keep it? Are you going to take care of us, or are you just going to take my baby? What are you, what are you saying to me?” She looked up and away from me and tilted her head slightly, ”and I guess that kind of actually kind of made me feel more confident in doing my thing, cause I was like, even the help I was going to get wasn’t even really to help me.”

So she entered the Planned Parenthood and thumbed through the pamphlets they had given her and she watched girls come out of the back crying as she waited for her turn. Finally, she was called.
“So I went in, and I will never forget, cause the tube is clear, like, what the fuck is that?” she shook her head in disbelief while describing the machine they used to perform the vacuum aspiration on her. “I mean, really? Um, I did not, I did not need to see that,” she looked away, still shaking her head.

After the abortion, Nicole was sick the whole way home, and about a week later she found that she had gotten an infection from the procedure. “It just got, it just kept, coming with me,” she said, shaking her head and shrugging with her lips pursed.

She and her boyfriend moved to Tucson, Arizona within the month.” “We were just like, we’re out of here, we can’t watch this with the other kid, and we never really talked about it,” her eyes drew into slits, I could feel her searching through her memories.

“And I lied about it for so long. Like, that I didn’t, because rumors where I grew up, its such a small town,” she rolled her eyes, “and so everyone was like ‘did you’, ‘were you preg-‘, y’know, asking me. I was at a Subway and the girl working there like, asked me about it. I was like, fuck you, fuck no. And so that just like brings down the lock down. Y’know? Like, no. Absolutely not, I did not,” her expression betraying the distaste in her tone.

“Like, why are you even asking me?” I said, equally as annoyed by the thought.

“Yeah, yeah, like where is this coming from? It’s just like,” she paused and shook her head. “Yeah, what do you care? What does that mean? I mean, it’d be one thing if somebody was like, ‘hey look I’m screwed too, help me out.’ But no they’re just,” her eyes narrowed again as she looked past me and a frown appeared on her face. “They just make you feel a lot worse about everything and” she paused, her eyes moving down to the floor, “and we, and we didn’t really talk about it after that. I didn’t talk about it for years,”
she shook her head, “people would talk about it and I’m like, ‘you have no idea, you have no idea the situation that people are in,’” her eyes fluttering as she pulled her gaze upwards meeting my eyes.

“But I think about it every day. I mean, cause I’m like, fuck, I’d have a 15 year old right now,” she said, raising her eyebrows and slowly nodding. “And since then I’ve had cervical cancer, and now they’re like, that may have been my only chance,” a painful smile crept across her face, tears pooling in her eyes, “which is even, worse, like,” she exhaled loudly, “cause you think you’re making like the best decision ever, but now it’s like,” she pushed herself back into her chair and threw her head back, raising her hands from her lap giving a laugh that was laced with sadness before meeting my eyes again, “like, but, I guess that’s kind of selfish, because, I mean, who knows what I did to that fetus, with all the drugs we did,” her expression becoming more subtle, “cause we didn’t know, I wasn’t up on it until it was like really close to the cutoff, where they can’t even do the abortion. And then you just think about like, I paid for that abortion by selling drugs, yknow?” She laughed and patted her knee.

The same way her initial demeanor had spread to me like wildfire, I could feel her inner conflict, her sadness becoming palpable in the room. She continued while looking up towards the window, her expression pensive. “And its just like, the whole,” her hand gesturing a sphere in air before clasping back down to her knee, her expression betraying a frown for a brief moment before returning to a look of melancholy. “But still I can’t help but be like,” she pressed her lips together into a tight line and took a deep breath through her nose, her eyes dislodging from the window and meeting my gaze, “I may never have that chance again.”
“Right.” I said, my own voice sounding and feeling insignificant in the presence of the strength that the vulnerability she had just shown had left suspended in the air. She explained while wiping a tear from her cheek that even now, her family had no idea. After this, there was a pause in the interview; I took the opportunity to reiterate something that she had said earlier that had resonated with me very strongly. “I think it’s important though, you said it earlier, when you said, I had a bad life, and I didn’t want to do that to this kid or my child, so even if, it was your only chance you would have raised a kid in a situation that wouldn’t be good for them.”

A smile crept onto her face as she nodded, “that’s so true, cause like I said, I’m 32 and I’m in college,” her hands raised enthusiastically as she looked straight into the camera for the first time, a laugh bellowed from inside her. “I mean it took me a long time to clean my shit up without having that kid,” she horizontally sliced the air in front of her with her hand. “So, it’s so right, having that on top of it, I wouldn’t be here, for surely not,” she added with a chuckle.

I smiled along with her, nodding enthusiastically. We talked about how, sometimes hard decisions are the best decisions, even when you find yourself conflicted years later. She mentioned how the nurse that had made the comment about mercy abortions had changed her life, “I wonder, yeah. If she wouldn’t have said it, I didn’t know I had an option.”

I asked her if being around the other woman who was keeping her pregnancy made her feel bad, she nodded as I finished my question and explained, “It, kind of both ways, it did make me feel worse because I was like, she can do this, but then I’m like watching her kids, and she’s ended up having all of them taken away from her,” her eyes grew wide,
“she was raising them, the way I was afraid of bringing my kid into the world,” she paused for a moment, “I mean, they were great, they took me in when I had no where to go,” a quick nod before her eyes narrowed and her brow furrowed, “but I just couldn’t see how she, cause she, it’s not like she stopped doing drugs, like really clean up her act. So, a part of me felt like I was stronger,” she leaned back into her chair and looked into my eyes, “because I, I just, I don’t know, I, I don’t know,” she raised her eyebrows, closed her eyes and shook her head.

I started to talk about how, to bring a child into the world and give them the life that you wanted to give them, you need to be in a really specific situation, and sometimes religious beliefs and people can pressure a woman into making a decision against her best judgment. She nodded along, “I feel like that’s kind of the reason why, I didn’t particularly want my family to know, cause I feel like my mother would have totally pressured me, and for her own selfish reasons, like ‘I want a grand kid like, I want, or, yknow to clean up my daughters mess. That kind of thing, like I don’t, I don’t think that she would have ever seen it from my situation.”

As the interview started winding down, we discussed anti-abortion campaigns and how passionate others can become before stepping into a woman’s shoes on the matter.

“It always surprises me like how passionate, or like strongly they believe in those kinds of things, and its like, because there is such a sense of responsibility, like even if my partner would have wanted to have that child and we decided to and something was wrong with it, that would have been my fault, as a mother. Like it wouldn’t have mattered, that the whole time he was doing drugs, or anything. That would have been on my shoulders,” she gestured towards herself with one hand. She explained that if she got pregnant again,
“I would still ask. And be like, okay, you still get somewhat of a say, but, I’m still going to decide what I want to do, you can be in or out,” we both laughed and smiled.

After this, there was a pause in the interview in which I took the opportunity to ask her about times that she had felt stigmatized in her life. She responded as if she had known what I was going to ask before I had asked it, “In conversations where people are debating it. And you want to say like, ‘I’ve had one.’ But then, you know, like, ugh. I don’t want to be attacked,” she pressed her lips together before letting them slip into a smile.

“Is there anything else that you’d like to mention? Anything that stands out to you, pre-procedure or post-procedure, or about abortion in general?” I questioned.

“Just that. I can imagine that a lot of people who decide to have abortions are in that same sense of aloneness, like they can’t turn to people. They feel like they can’t. And I think that that sucks. And I think that that’s because it’s so stigmatized. They feel they can’t tell anyone because they’re afraid, and that’s what sucks the most about the whole abortion thing.”
Conclusion

Abortion stigma is not a natural phenomenon; it is socially and culturally reproduced. Its mechanisms and manifestations are not easily understood and this is partially due to the lack of research and partially due to the intangible essence of stigma. Stigma as a theoretical concept is relatively inaccessible to many people causing them to disregard abortion stigma as an issue in and of itself and sometimes causing them to simply see abortion as a clear-cut, two-sided debate. Divisions between people who consider themselves ‘liberal’ and ‘conservative,’ ‘pro-choice’ and ‘pro-life’ seem to obscure the underlying realities of abortion stigma. It is important to recognize that the decision to have an abortion takes place in the midst of many social variables and each woman’s complex life experiences. Ultimately, women need to be seen as rational human beings who have the capacity to make this choice. However, abortion stigma is supporting efforts to chip away at the availability, accessibility, and legality of the abortion, which has proven to be detrimental to women’s health.

The most practical way to combat abortion stigma is, as Dr. Lisa Harris (2008) states, “to break the silence and change the discourse surrounding abortion” (p. 38). Dr. Harris has made strides towards this end by openly talking about her experience as an abortion provider, and particularly her tactic of making sure to talk about her experience of second-trimester abortion provision. The 1 in 3 campaign is also attempting to break the silence by sharing a diverse range of women’s experiences with abortion, as well as challenging the notion that abortion is rare by repeatedly making it known that as many as one in three women will obtain an abortion in her lifetime. I hope that by following the paths that have been paved by organizations and individuals like these, I may also give
courage to those who have experiences but are afraid to share them. When it becomes part of the dominant discourse that abortion is common, and that abortion is a healthy, safe, and necessary part of a full range of women’s reproductive health care, then we will be making huge strides towards ameliorating abortion stigma and ultimately improving women’s health.
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