Speaking Abortion:
Understanding Stigma, Support Networks, and Faith Within the Lives of Abortion Care Providers
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There’s story after story, and it’s not really the stories themselves, except for the continued affirmation of real life people living real lives, and exercising what control they have in order to be the people that they believe they are, and want to be.

--Charles, clergy member, chaplain in abortion clinic, and participant in this thesis

The purpose of the method of selecting interviewees was to discover the elements of the universe, not simulate it. --Rob Rosenthal
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Abstract

Abortion has been a constant of human reproductive life throughout recorded history. Its more recent history in the United States, however, has been extremely contentious. Abortion has turned into a polarizing issue for many in the United States, and this polarization and politicization have had significant impacts on the lives of those who provide abortion care. In this thesis, I use oral histories of abortion care providers in a city on the East Coast in order to explore how stigma, support networks, and faith all play a role in their communities and their work in abortion care. I take an activist scholar approach to this work, in the hopes that sharing the stories and lives of providers will increase public understanding of the importance of their roles in reproductive healthcare and the need to support their work.
Introduction

On March 2\textsuperscript{nd} of this year, I found myself at a rally calling for continued abortion access outside the United States Supreme Court in Washington, D.C., on the first day of the oral arguments for \textit{Whole Woman’s Health v. Hellerstedt}. I was one of a crowd of three thousand people who had come from all over the United States in order to demand protection of abortion access. Despite the chilly weather, the rally lasted for the length of the morning’s oral arguments, with speakers such as Willie Parker, an abortion provider in Mississippi and Alabama, and Cecile Richards, President of Planned Parenthood Federation of America, addressing the crowd. The event brought together providers, people who had had abortions, and allies to stand in solidarity for the right to the healthcare that we find necessary. The crowd stayed enthusiastic throughout the rally, alternately cheering, chanting, and lifting cleverly worded signs high above the crowd. Casual conversations between individuals in the crowd about where we had come from and why we were there started and stopped, and then started again. The rally was a high point for me in this year of studying abortion providers, as I joined the thousands of people willing to publicly defend and celebrate the right to abortion, and witnessed once again the strength of these people and the abortion access movement.

In \textit{Whole Woman’s Health v. Hellerstedt}, a Texas-based abortion clinic is contesting the constitutionality of restrictive legislation designed to shut down abortion clinics in Texas.\textsuperscript{i} People are already facing the consequences of this legislation. A study done in 2015 estimated that between 100,000 and 240,000 women of reproductive age have attempted to end their pregnancies without professional medical help in Texas (Grossman et al., 2015, 2). This research followed the passage of Texan state law HB2 in 2013 (part of which Whole Woman’s Health is challenging), which closed over half of the abortion clinics in Texas, dropping the number of
clinics in the state to only 18 (Grossman et al., 2015, 4). If Whole Woman’s Health loses the Supreme Court Case, only 10 clinics in the state will be able to continue offering services (Grossman et al., 2015, 4).

I am one of many who feel a personal connection to this court case. In 1939 my great-grandmother, Kahma T Long, lived in Texas. She was in the process of divorcing her alcoholic husband when she found out she was pregnant. Divorce was already scandalous at that time, and Kahma T had both a young daughter (my grandmother) and her mother to financially support. She couldn’t afford to have another child. So, although it was illegal then, she left her small town and went to Dallas to have an abortion. Kahma T survived the experience, and shared the story with my mother. However, many other women in that time were harmed in illegal abortions. In 1930, nearly one fifth of all recorded maternal deaths in the United States were officially caused by abortion (Gold 2003, 8). In 1940, just under 1,700 women died from illegal abortions (Gold 2003, 8). The thought that others might have to resort to measures such as these again, and that some women are already attempting to self-abort in Texas, is abhorrent to me.

*Whole Woman’s Health v. Hellerstedt* takes place in an environment of increasingly restrictive regulations of abortion clinics and violent rhetoric targeting clinics and providers. In the past four years, there have been over 200 laws across passed in states across the country that restrict abortion access (Robles 2015). These restrictions have enormous impacts for the people seeking abortions and the people providing them. In Mississippi, Missouri, South Dakota, North Dakota, and Wyoming, only one clinic in each state has been able to stay open (Deprez 2015). Legislative attempts to close abortion clinics have been augmented by anti-abortion activists’ efforts. The so-called Center for Medical Progress released a series of videos in the summer of 2015 accusing Planned Parenthood of selling fetal tissue, which had a range of harmful effects
on reproductive healthcare (Fernandez 2016). The claims made by the Center for Medical Progress sparked conservative pushes in different levels of government to defund Planned Parenthood (Fernandez 2016). These videos have also dramatically increased the violence and threats of violence around abortion care—in 2015 alone, there were 3 murders, 9 attempted murders, and 94 threats of harm or death (National Abortion Foundation 2016, 2). In November of 2015, a gunman killed three individuals in a Planned Parenthood in Colorado, and cited the videos in his defense of the protection of the unborn (National Abortion Foundation 2016, 2, and Turkewitz 2016). Including these most recent deaths, 11 people have been murdered for their involvement with abortion care in the United States (National Abortion Federation 2016, 2). I focus on the narratives of individual providers in this thesis, but this background of increasing regulation and consistent harassment of providers is important to keep in mind. The aggressive targeting of clinics through both activism and legislation has affected most abortion providers through the creation of an environment of fear and heightened job insecurity for abortion providers, including those who shared their stories for this thesis.

Despite these regressive cultural trends, spaces for hope continue to exist within abortion care in the United States. Abortion providers and their allies have faced these attacks together, and a diverse coalition has come together to advocate for reproductive freedom and bodily autonomy. This was visible at the rally at the Supreme Court, as speaker after speaker named their different communities. Black, Asian, Latina, and queer communities all had a presence on stage that day, as did many different geographic locations. The resilience and strength of the community is also apparent when speaking to providers, as they share the motives that drive them and their desires to continue working in the field, regardless of threats to their safety or community standing.
The deeper one gets into an issue like abortion, the more sides of the issue appear. I went into this project knowing that I wanted to listen to the stories of abortion care providers, in order to better understand why there are so few abortion providers, and why abortion in the United States is so embattled. After months of talking to these extraordinary people, and listening to the stories of not only the individuals who get abortions but also those who provide them, I have realized that I cannot write here about all the facets of abortion that I think we should be discussing as a society. Therefore, I have chosen to focus on three aspects of abortion providers’ lives that I believe have a significant impact on their practice: stigma, support networks, and faith. Experience as a provider largely depends upon one’s community, and how willing it is to protect access to abortion. By studying stigma, support networks, and faith, we can better understand the ways in which abortion care providers are regularly impacted by the communities in which they live and work.

This paper begins with a brief examination of the history of abortion in the United States. The background I offer focuses on the providers of abortions, and their role throughout the history of the country. The history will then situate the experience of providers currently working in the United States in a context of those who offered abortion services in the past. Following this condensed history, I will examine the stigma that the providers I spoke with experience because of their work. Most of the providers who shared their narratives for this thesis mentioned at least one type of stigma and its impact on their lives, and this section will focus on those experiences. I will next delve into the support networks that abortion care providers use, and the ways in which they manifest both personally and professionally. Support networks shape an abortion provider’s experience of her work through the actions and beliefs of colleagues, family and friends, and therefore significantly impact the providers. The next part of the paper will
explore the role that faith plays in some of the participants’ understandings of their work. These beliefs can play a prominent role in providers’ lives, in how they handle stigma, the sources of motivation they have for the work, and the systems of support that they rely upon.

Before I begin this paper in earnest, then, I find it important to make my own investments known to the reader. I strongly believe in reproductive justice and abortion access, and my work will demonstrate this leaning. This position comes partly from a knowledge that I would not be here today if some of the women in my family had not been able to have abortions. It also comes from my involvement with organizations working towards reproductive justice and gender equality. I want people in the United States to continue to have access to abortion services, regardless of income, race, or location. While my thesis focuses on aspects of providers’ lives, that examination is grounded in my desire to de-stigmatize abortion and understand how to make it more accessible within our society.

This positionality has certainly shaped the conversations that I have had with providers and the thesis that I have written. The responses I got from participants were at least partially shaped by my openly stated belief in their work. I have also grown in my understanding of the social challenges that abortion providers face while writing. Even as a researcher, I have experienced a kind of stigma in my decision to write on abortion access and providers. Although I am very open about the focus of my thesis on abortion, I notice an internal conversation weighing the pros and cons of disclosing every time that I tell someone about the work that I am doing. If someone quickly changes the topic after I tell them my thesis topic, I wonder if they do so because they do not believe that abortion should be available. These repeated experiences have increased my sensitivity to some of the different challenges that providers face when deciding whether or not to disclose their work.
I find the current inaccessibility of abortion in this country to be unacceptable. Abortion should be a legal, easily accessible procedure for reasons of public health, the right to bodily autonomy, and human rights. My hope is that, after learning about the experiences of the providers who so generously shared their stories for this thesis, my readers will agree with me. It is time for a societal change in how we view abortion care and the people who provide it, and I hope this thesis can contribute to that shift.

**Methods of Research**

My research centers on the oral histories of abortion care providers that I gathered in a city on the East Coast. All of the providers currently work in this city’s network of abortion services, with the exception of one participant who is completing her doctoral residency in the Midwest. I used the snowball approach in order to find participants, and was connected to willing individuals by others in the reproductive justice field. I found this indirect approach to be especially important considering that many abortion providers are not fully public about their work, largely for reasons of stigma and fear for personal safety, and may not be comfortable being approached by a stranger. Six of the interviews took place in person, and two occurred over the phone. The transcripts of these interviews, approved by the participants, are the main source of my research. The conversations lasted between one and two hours, and were preceded and followed by conversations over email in order to try to ensure comfort with the presence of the participants’ narratives in my thesis. This continuing presence of the participants’ perspectives was important to the process of the thesis, and to an effort to adhere to oral history practice (Borland 1991, 73). The edits that participants suggested were not dramatic, yet still helped to ensure that my analysis of providers’ experiences respected their own understandings.
of their stories. A few of my participants offered clarification on moral or ethical positions, which strengthened their voice in the document.

I chose to use oral histories as my main source of research for a number of reasons. In-depth interviews allowed me more time to speak with providers, and to hear their opinions on the different aspects of abortion care that they deal with on a regular basis. Oral histories require a significant amount of time spent with not only the participant or narrator, but also with the conversation itself (through transcribing and listening over the recording, and then reading over the transcripts multiple times) (Mayotte 2013, 107).iii This, of course, is the case in most anthropology and ethnographic work. However, inside the constraints that accompany a one-year undergraduate thesis, I thought that having a smaller number of in-depth interviews would allow more space for analysis and understanding than would a large quantity of shorter conversations.

The most significant factor in my decision to use oral histories was the level of interaction between myself and the participating individuals. Oral histories give a large amount of control back to the narrator or participant, in order to confirm that participants are comfortable with the text the research is using and the way in which they are portrayed. The agency over the narrative given to the participant helps put the interviewer and the participant on the same level, which leads to a more open and honest conversation (Rosenthal 1991, 118). This continued dialogue with the participants throughout the process of writing and interviewing felt like a respectful way to conduct anthropological research. Oral history also plays an important role within traditionally stigmatized communities. Through the longer interviews and interactions between interviewer and narrator, oral history roots itself in an attempt to “value the lives that contemporary ideology renders deficient, trivial—or invisible” (Di Leonardo 1987, 3). The method offers the researcher a chance to explore an issue through the different perspectives of
the individuals intimately involved with that issue, and to understand its impact on those same individuals (Cave and Sloan 2014, 272). Oral history thus counters the single narrative that is perpetuated by the larger community (Clark 2014, 258). The increased opportunity for participants who are usually ignored to share their story is what most drew me to oral history as the primary method of fieldwork for my thesis.

Although oral histories were my principal source of primary research, I also employed a number of other methods. I have volunteered irregularly at an abortion clinic over the past year, which has increased my understanding of both how independent clinics function, and how the staff interact with each other and with the patients. I had the opportunity to sit in on a couple of information sessions for patients that happen on the day of the abortion before the actual procedure. This observer participation gave me a better sense of how information sessions work, and of some of the mandatory schedules and forms that government regulations impose on clinics. I have attended events celebrating Roe v. Wade and abortion access. Finally, since September I have worked at a hotline that helps low-income women pay for their abortions. In this role, I have interacted much more with the people receiving abortions than with providers. However, it has reinforced and strengthened my belief that safe, accessible abortion for all who need it is crucial. I have not done any fieldwork in anti-abortion settings because my thesis focuses only on providers, and does not cover perspectives of those who oppose abortion care. This thesis offers one aspect of abortion in the United States, and so I did not expand research beyond that one group.

These primary sites of study have been supplemented by my extensive secondary research both around the issue of abortion in the United States and the theories that examine why politics around abortion have been shaped in such a controversial way. The reading has been a
mix of academic theory, history, and news about current events around reproductive healthcare. The work of scholars Erving Goffman, Carole Joffe, Lori Freedman, David Cohen and Krysten Connon have all shaped my understanding of abortion care in the United States. Their thoughts influence much of this thesis.

Following these notes on methodology, I would like to say a few words about the language I will be using in this paper. As I wrote in the introduction, I do not claim to be a unbiased observer. I strongly believe that abortion should be accessible for reasons including public health and the right to bodily autonomy. Over the course of this past year, I have spent a significant amount of time with abortion providers, and I admire the ones that I have met enormously. With these positions stated, I want to identify language I use that is overtly opinionated. I will be using “anti-abortion” in order to describe individuals and groups working to limit or erase abortion access in the United States because I am only discussing their work that is specifically against abortion. I call my participants “abortion care providers” because I have spoken to people who occupy different roles in abortion access, not solely doctors.

My thesis includes excerpts of oral histories with Andrea, an administrator at a hospital-based clinic; Caroline, a member of an abortion access fund; Judith, an administrator at an independent abortion clinic; Kristin, in residency to become a doctor; Breanna, an access counselor at an abortion access fund; Charles, a Baptist chaplain at a clinic; Ryan, director of nursing at two independent clinics; and Elle, a medical assistant who also works in pathology.

I have chosen to use pseudonyms for the participants in this thesis and a broad geographic location for reasons of confidentiality and security. Providers regularly face consequences for the work that they do, such as social isolation, professional marginalization, or threats to their personal safety (Cohen and Connon 2015, 6; Joffe 1995, 160). Because some of
the participants that I spoke with are not publicly open about their work in abortion care, I have refrained from using their real names. I identify their geographic location simply as a city on the East Coast for similar reasons. Because restrictive regulations around abortion in the past few years have closed a significant number of clinics, using a more specific location would make it easier to identify my participants. The location of the East Coast therefore gives a general sense of the political climate while simultaneously preserving the participants’ privacy.

**An Abbreviated History of Abortion Care in the United States**

Abortion is the longest lasting and most consistent method of regulating fertility (Petchesky 1990, 28), and for as long as there have been abortions, there have been abortion providers. Within the United States, abortion was not regulated until the mid-nineteenth century (Hull and Hoffer 2001, 27). Up until that point, informal networks of family, friends, neighbors and midwives performed procedures or helped women to find abortifacients (Hull and Hoffer 2001, 15). During this time, abortions were only illegal if they took place after “quickening,” or the first felt movement of the fetus, which was understood to be the first true confirmation of pregnancy (Petchesky 1990, 30). An entire industry existed around abortion, with abortion providers and sellers of abortifacients advertising openly, and it became increasingly public in the latter half of the nineteenth century (Ginsburg 1998, 25; Hull and Hoffer 2001, 27).

Abortion care was thus not exclusively controlled by doctors. Physicians in the United States sought to consolidate their authority, however, and so began a campaign to restrict and criminalize abortion in this same time period (Joffe 1995, 28). These campaigns were successful, and led to a condemnation of abortion by lawmakers, religious leaders, and the general public (Hull and Hoffer 2001, 32). By 1880, at least 40 anti-abortion laws making abortion a crime at
any point had passed (Ginsburg 1998, 25). However, this widespread criminalization did not stop women from having abortions (Ginsburg 1998, 33).

There are many providers’ accounts of the period between criminalization in the mid-nineteenth century and decriminalization in the 1970s. Because women did not stop seeking out abortions, people continued to provide the procedures. The practice simply moved underground (Joffe 1995, 29). Abortions continued to occur at a significant rate—some estimates put the rates of illegal abortion in the years between criminalization and *Roe v. Wade* as high as 1.2 million procedures every year (Joffe 1995, 29). However, since these procedures were illegal, both providers and patients faced negative consequences for their involvement. Patients underwent possibly dangerous, unregulated procedures that could lead to their deaths. If patients were hospitalized after an illegal abortion, they often faced judgment and questioning by medical staff and police (Joffe 1995, 61). If people decided to offer abortion services, they risked jail, and if they were doctors, loss of their medical license (Ronan 2015). Doctors especially saw the consequences of illegal abortion every day, in hospital emergency rooms where women came with complications from abortions (Joffe 1995, 56). Despite the frequency of this procedure, and the harm arising from it, abortion was not often discussed publicly (Ginsburg 1998, 33). Because of its identification as a women’s issue, abortion did not garner a significant amount of public interest (Hull and Hoffer 2001, 49).

In the 1960s, the issue gained traction once more, and the United States started to experience more pushes for reforming or repealing abortion laws (Hull and Hoffer 2001, 101). State legislatures began to address abortion, and in 1970 New York became one of the first states to repeal its abortion laws, and put in their place some of the most liberal abortion laws in the country (Hull and Hoffer 2001, 111). While states were dealing with abortion in their national
legislatures, *Roe v. Wade* and *Doe v. Bolton* were brought to the Supreme Court in an attempt to challenge both the anti-abortion laws still in place and the selective exceptions to those laws (Ginsburg 1998, 41). On January 22, 1973, the Supreme Court ruled on the cases in favor of essentially legalizing a woman’s right to choose an elective abortion (Ginsburg 1998, 41). While subsequent court cases have shifted the ways in which abortion can be regulated, this right to an elective abortion has continued within the United States (Hull and Hoffer 2001, 258).

While abortion was legalized in 1973, and doctors could then offer the procedures openly, the procedure still did not enter normalized medical practice. Instead, providers experienced stigma because of their work, and were marginalized in the medical community (Joffe 1995, 152). Harassment and violence against providers increased after the ruling and throughout the end of the 20th century (Ginsburg 1998, x). In response to the extreme targeting of abortion patients and providers, the Freedom of Access to Clinic Entrances Act, or FACE, was passed in May of 1994, making it a federal crime to block clinics or access to them (Ginsburg 1998, xiii). Despite this federal action, violence has continued. Indeed, recent studies of individualized targeting of abortion providers have found an increase of these types of incidents over the past few years (Cohen and Connon 2015, 6). Increasing targeted regulation of abortion providers, known as TRAP laws, have continued to close clinics and put providers out of work, as I detailed in the introduction. This history continues to impact the current situation of abortion providers, and is important to keep in mind as I move to analysis of the experiences of my participants.

### Lived Impacts of Abortion Stigma on Providers

Stigma appears throughout providers’ lives in various ways. Kristin, a resident who is currently located in the Midwest, spoke of a case where a woman with a desired pregnancy
developed health complications and desperately needed an abortion. Despite the severity of the situation, Kristin and the other providers had an incredibly hard time finding nurses or anesthesiologists to help with this patient’s procedure in the operating room. Kristin said that in the end, “There was a third year resident, myself as a second year resident, and the attending, and we scrubbed the case ourselves without any nursing assistance. We had a circulator nurse, but that was it. And the anesthesia attending [anesthesiologist] gave us a very hard time about what plan he would allow for her anesthesia. It was a very difficult case to get done.” Kristin is next heading to a family planning fellowship, and she said that nearly all of the hospitals that she interviewed at mentioned similar issues with operating room staff and nurses. This is simply one of the many experiences surrounding abortion and stigma that the participants I spoke to mentioned, and ways in which they are affected by the negative perception of abortion within the United States.

Though stigma also affects the experiences of patients who receive abortions, as shown in Kristin’s narrative above, my focus remains on providers. These groups’ experiences differ, but are rooted in the same cause—the negative societal judgment around the procedure of abortion. Stigma appears in the conversations that I had with providers and in the literature that exists around abortion care provision. This stigma ties into a broader framework of violence, fear and silence that all work to reinforce each other and further marginalize the medical procedure of abortion and the people who perform it.

In his foundational text *Stigma: Notes on the Management of Spoiled Identity*, Erving Goffman defines stigma as occurring when “an individual who might have been received easily in ordinary social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on
us” (Goffman 1963, 5). Stigma need not be visible in order to exist; although the decision to provide abortion care is not apparent on the physical bodies of providers, the societal judgment attached to that decision still adversely impacts their day-to-day lives (Kumar, Hessini, Mitchell 2009, 2; Joffe 2009, 18). Providers face isolation and judgment for deciding to perform abortions, and also for belonging to the group of individuals who work in abortion care (Goffman 1963 4). This can be seen as a stigma resulting from membership, which “can be transmitted through lineages and equally contaminate all members of a family” (Goffman 1963 4). Due to these two forms of stigma, multiple abortion providers have experienced public scorn and harassment. In fact, it is such a common experience that “abortion stigma” itself has become a term. Abortion stigma appears both in interpersonal relationships and in the local community’s cultural understanding of abortion care (Kumar, Hessini, Mitchell 2009, 2).

Scholars offer different definitions of abortion stigma, depending on the groups of people they study. In their book discussing anti-abortion terrorism, David Cohen and Krysten Connon describe it as “the commonly shared idea that abortion is morally wrong and/or socially unacceptable, even though abortion is a common, safe, and legal medical procedure” (Cohen and Connon 2015, 276). Their explanation includes effects for both providers and patients. Kumar, Hessini, and Mitchell offer another definition: “a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood” (Kumar, Hessini, Mitchell 2009, 4). These authors then go on to explain the types of womanhood that are challenged by abortion: “female sexuality solely for procreation, the inevitability of motherhood and instinctual nurturance of the vulnerable” (Kumar, Hessini, Mitchell 2009, 4). Their definition focuses on patients, but the implications of it extend to providers. I use the combination of these definitions, focused on both patients and providers, to
understand how abortion stigma impacts providers. By hearing about the experiences of abortion stigma among providers, we better understand the marginalization of the procedure in our society, and how that marginalization can shape the lives of providers.

Though expected gender roles impact abortion patients more than abortion providers, providers are often understood to facilitate this rejection of the traditional womanhood that is rooted in maternity, and thus receive stigma as well. While society paints women who receive abortions as traitors to their gender, providers are more typically cast as criminals and murderers (Kumar, Hessini, Mitchell 2009, 7). Alongside this condemnation of character, the occupation of abortion care itself is subject to many different types of stigma: “Abortion work is dirty work, associated with all three taints: physical (blood, fetal parts); social (contact with stigmatized patients); and moral (ambiguous fetal moral status)” (Harris et. al 2011, 1062). The largely unfavorable perception and understanding of their work impacts providers’ lives in many ways. Their experiences range from social isolation and professional loss of face (Joffe 1995, 152; Freedman 2010, 21) to harassment, threats of violence, and actual violence (Cohen and Connon 2015, 5). In the interviews I conducted with current providers in a city on the East Coast, a number of the participants echo these realities.

Some participants mention a reticence around disclosing their involvement in abortion care work to personal acquaintances or strangers, due to anxiety about damaging relations or entering potentially controversial and/or dangerous situations. In my own research, those who are more cautious about sharing their work explain their reasons behind this decision, while also discussing the different emotions they feel surrounding it.

Breanna works part-time as an access counselor at an abortion fund. Although she does not physically provide abortions, she and other access counselors at abortion funds play an
integral role in helping low-income women access abortion care by arranging funding for the procedures. In this role, Breanna says that “I found more and more that I’m more aware of telling people where I work. And it’s something I caught in myself just at the beginning of the semester, and I was like, I don’t know why I’m hesitant… I think that there’s a time and a place to sort of say this stuff, but at the same time, you know, I don’t really think that the word abortion should be a dirty word, or something that you feel like you can’t say… I don’t feel ashamed of it, so why do I treat it like something I’m ashamed of?” Breanna was not the only participant who mentioned silence because of fear of stigma, or retribution stemming from this stigma (such as anti-abortion violence). Ryan, director of nursing at a couple of independent clinics, tries to keep his work private because of stigma and the possibility of violence. Caroline is a member of an abortion access fund, and she also typically is very careful about who she discloses this work to, in order to avoid negative and/or dangerous reactions. Writers and researchers such as Carole Joffe, Lisa Harris, David Cohen and Krysten Connon have all noted similar reluctance among providers to speak or silence about their work with abortion as one of the ways that abortion providers handle abortion stigma.

If the reason one experiences stigma is not physically visible, the challenges facing that individual shift. When should one self-identify with the stigmatized group? When should one be silent? Goffman describes this decision: “The issue is not that of managing tension generated during social contacts, but rather that of managing information about his failing. To display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when, and where” (Goffman 1963, 42). It becomes a decision that the individual can largely control, unless outed by one with knowledge of the stigmatizing characteristic (or in the case of providers, profession). These decisions to disclose, while sometimes positive, can
also have serious consequences for abortion providers: as noted previously, revealing one’s abortion provider status may isolate them, incite harassment against them, and can potentially result in violence.

Providers deal with these threats in different ways. Some of them react by publicizing their work in an attempt to minimize the stigma and teach others the benefits of having abortion accessible. Others struggle much more with being public about their role in abortion care. As most providers understand, both of these reactions (silence versus public acknowledgment of working in abortion care) bear consequences when working in such a marginalized field. As Harris et al. write in their study of abortion care providers’ handling of stigma, “Silence reduces risk of rejection, harassment, and threat from others, but also leads to compartmentalization and internal contradictions, missed opportunities for connection, and inability to see or access available support” (Harris et al., 2011, 1066). The same study found that, when using the other approach of disclosure, one benefits from an increased sense of self and knowledge about others’ opinions about oneself, while risking unfavorable judgment from others, damage to relationships, and emotional exhaustion (Harris et al., 2011, 1066).

Abortion stigma therefore has the potential to adversely affect providers whether or not they are public about their work. In common conversation such as Breanna describes, then, “it is not that he [the abortion provider] must face prejudice against himself, but rather that he must face unwitting acceptance of himself by individuals who are prejudiced against persons of the kind he can be revealed to be” (Goffman 1963, 42). The stigmatized individual has some agency over how they are perceived, but this control over perception is accompanied by denial of part of one’s self. In some ways, then, the politicized nature of abortion care in the United States makes it so that the very decision to share or not share work in the field becomes a political decision
itself (Cohen and Connon 2015, 160). In this way, abortion care providers have to claim a political identity that in a way that many jobs do not require (Cohen and Connon 2015, 158).

Judgment of one as an individual providing pregnancy terminations is simply one of the ways in which abortion stigma presents itself. Another is a larger, societal condemnation of the field of abortion care. The judgment appears both on the individual level, with doctors and nurses in associated hospitals, and on the institutional level, with hospital policies silencing abortion advocacy or denying abortion care altogether.

Ryan speaks of the judgment present in other medical professionals towards abortion providers. His clinic rarely needs to send a patient to the local hospital because of a complication. However, when a patient does need to be transferred to a hospital setting, he says that there is typically a fair amount of discomfort and judgment on the part of hospital staff. He has stopped using the word abortion when asked about the original procedure and cause of complications, because of the silence that statement causes. Instead he uses the medical term D&E (Dilation and Evacuation) or D&C (Dilation and Curettage), to avoid that silence. Ryan’s decision to use medical language to describe abortions demonstrates an attempt to negotiate the stigma placed on providers by other medical practitioners. Even with this change, he remarks on how judgment from the hospital staff is visible: “When you’re bringing the patient who has had an abortion related complication, it’s always ‘Well what did you do?’ Like, that’s the unspoken but perceived sense from the other healthcare providers. It’s always like, you know, well you shouldn’t have been doing this [providing abortions].” Even within the medical field, as soon as one leaves the sphere of abortion care, discomfort and moral judgment around abortion become apparent. This has been true for a number of years—in her book examining the lives of doctors providing abortions immediately before and after Roe v. Wade, Carole Joffe notes that stigma
around abortion in the United States continued even after it became legal. As she writes, “The dilemma facing contemporary abortion providers, therefore, might be summed up as follows: these providers are strongly opposed by a highly energized minority within medicine; rather passively tolerated by the majority; and actively supported only by a relative few” (Joffe 1995, 160). This summary, though written a number of years ago, continues to be the case. Abortions are still primarily offered in outpatient clinics, and mainstream medicine continues to maintain only a lukewarm support (if any) of the procedure (Freedman 2010, 25; Joffe 2009, 19).

While judgment and disapproval towards abortion providers and patients occur when transferring clients to a hospital, the detrimental reactions only intensify when providers are working within a hospital to provide abortions. When arranging for terminations in the operating room, providers struggle to assemble a supportive team. Participants note the challenges in finding helpful nurses, anesthesiologists and scrub techs. Andrea works as an abortion clinic administrator within a hospital, and she says that over the years her clinic has been able to get together a strong support team on their regularly scheduled days in the operating room. If there are any emergent cases that need immediate attention on days that are not on their normal schedule, however, it is much harder to get helpful medical staff. She says that, even with medically necessary pregnancy terminations, “it’s a lot of kind of constant education about, like, no this abortion is good, this abortion is gonna save her life. So that she can continue to be a parent to the children that are already here, her spouse who is with her, her family…a fetus has value, but dude, this is an adult woman who has living breathing children!... So we do still bump up against discomfort within the health system. And folks who are not comfortable with the work that we do.” Andrea and Kristin are the only two participants who work directly within a hospital healthcare system, and they both highlight the difficulties caused by a lack of staff willing to
help with terminations, and the consequences of this issue. The staffing issues and other institutionalized forms of stigma within hospitals thus constrain Kristin and Andrea’s agency to control how they offer abortion services.

The majority of abortions happen in clinics instead of hospitals—one source published in 2009 found that 94 percent of the abortions that take place in the United States occur in freestanding abortion clinics (Jones, Kooistra, 2011, 42). This separation of abortion care from mainstream medicine occurs largely because of the stigma and unfriendly treatment of providers and patients that I have described, and because outpatient clinics procedures cost less for patients (Joffe 2009, 48; Freedman 2010, 3). Outside of the operating room itself, hospitals also have policies that demonstrate the presence of abortion stigma within the medical field. Catholic hospitals, for instance, refuse to provide abortion care (Joffe 2009, 87). Their adherence to the “Ethical and Religious Directives for Catholic Health Care Services” prohibits these types of hospitals from offering abortion care, sterilization, birth control, assisted reproduction, or emergency contraception (Joffe 2009, 87; Chavkin 1996, 1205). As mergers between secular hospitals and Catholic hospitals have increased in the United States, the refusal of these services has become a larger issue (Joffe 2009, 86). Catholic teaching hospitals also do not share or teach information on various forms of reproductive medical care—Ryan went to a Catholic university, and he says that many of the elements of miscarriage management were left out of the curriculum, as were contraception and sterilization. Restrictive or silencing policies are not limited to religious hospitals. Although Andrea’s secular hospital and its leadership support the work of her clinic, they do not want publicity about the abortion care that the center provides. She says that

If I ever get a media request or one of our physicians gets a media request, we’re typically asked by the health system that we not mention that we provide abortion care at
the hospital. That we talk in the context of miscarriage management or pregnancy loss, or contraception for women with multiple health issues, but that we don’t talk about the fact that we provide elective abortion care…So it’s a really interesting place for us who want to be able to shout very loudly, like, this hospital provides amazing abortion care.

This silencing within the medical community may arise out of others’ fear that the stigma will be reflected on them. As Goffman writes, “In general, the tendency for a stigma to spread from the stigmatized individual to his close connections provides a reason why such relations tend either to be avoided or to be terminated, where existing” (Goffman 1963, 30). Andrea’s experience with her hospital leadership supports Goffman’s point. Although the hospital quietly sustains the abortion clinic, the leadership does not want the clinic’s abortion services to become well-known, for fear of loss in prestige or funding.

Finally, alongside individuals’ judgment and institutions’ lack of assistance, providers also are undermined by the protesters and threats of anti-abortion violence that tie into and arise out of abortion stigma. In 2008, 88% of abortion clinics reported some sort of harassment (Jones, Kooistra, 2011, 48). This harassment can seriously impact providers’ lives (Cohen and Connon 2015, 15). The providers I spoke with shared some of their experiences of harassment and threats of violence with me. One day, soon after Judith had begun working at her current clinic, a group of protesters blockaded the center’s entrance. By the time of the protest, the Freedom of Access to Clinic Entrances Act had passed and been enacted, and so this type of blockade was illegal. Civil Affairs officers were present, but they did not enforce the federal protections for the clinic. Judith describes the balance that providers had to maintain while this blockade was happening:

this is the beauty of clinic, is that you still need to run clinic while you’re in it. You can’t stop everything, and you want to make sure people feel as safe as possible. So those folks who have the most amount of experience are talking, negotiating, with the Civil Affairs [officers] and the protesters, and documenting everything, and then we’re on the inside, like ‘no, of course everything’s fine. We’ll let you know if it’s not fine, but as of right now let’s focus on you.’
The protests around abortion, and the ensuing high-stress environment for both patients and providers, can be tied to abortion stigma, and the understanding of abortion as a morally wrong procedure. Those protesting find the procedure to be so completely abhorrent that those receiving the procedure or providing it are othered. The dehumanizing impact of stigma (Goffman 1963, 5) can lead to violence, which then is irregularly dealt with by police and civil affairs offices.

These protests and threats of violence undermine feelings of safety for providers and patients, and disrupt care for those who are seeking abortions. Elle recounted more experiences of anti-abortion violence than the other participants. In her thirty-some years of abortion care, she has experienced two bomb scares and two anthrax scares. In the case of the first bomb threat, Elle says that: “We had to evacuate the building, they had to evacuate the whole area downtown. The bomb squad came, and there was nothing there. They had to go in the building and search the building, so everybody had to come out of the stores and stuff in that area, until they went and searched, and everybody went back to work.” Elle’s matter-of-fact recounting of the story demonstrates many providers’ acceptance of this sort of disruption as a hazard of their work (Cohen and Connon 2015, 15). When we examine these examples of violence more closely, however, we can see connections to the societal marginalization of abortion care. The impacts of abortion stigma elsewhere facilitate this violence against providers and clinics. Because abortion care has been marginalized within medicine, and is primarily offered in freestanding outpatient clinics dedicated to reproductive health, it becomes easier to target providers and their patients (Joffe 1995, 161). Abortion stigma’s effects enhance each other: the othering of abortion care by mainstream medicine distances providers from societally accepted medical positions and facilitates violence against providers, patients and clinics. The violence then makes mainstream medicine and providers less likely to publicly offer or defend abortion care.
In the interviews, providers speak of experiencing the effects of the societal turning away from those who provide and receive abortions. All of the participants I spoke to are proud of their work, and strongly believe that abortion should be an available, affordable service for women. However, despite this belief in the cause, they still experience the impacts of stigma in their work and their personal lives. The three aspects that I have focused on here—individual marginalization, challenges arranging healthcare support for patients, and policies excluding or silencing abortion care—explain how stigma impacts abortion care providers in both their work and their personal lives. I have gone more in depth in how it affects their professional spaces because the next section, support networks, explores more of the personal lives of providers, and stigma’s role there.

**Support Networks, Self-Disclosure and Movement Building**

In my conversations with providers, one topic of conversation that kept appearing were the support networks that providers utilize. All the participants mentioned someone who knows about their work and encourages them, whether they spoke of those people briefly or at length. They discussed different forms of emotional and practical assistance, coming from both friends and family, and from the local and national abortion care provider communities. The connections within the abortion care community help to ensure that providers have the resources to offer the best care possible to patients seeking abortion, and that the providers themselves have backing and encouragement. Personal support networks can offer similar emotional assistance, and often help to determine a provider’s comfort in disclosing their work, or in pursuing activism.

Support networks are not a new phenomenon in abortion care. Even when abortion care was illegal, informal and discreet communication connected abortion providers to one another, and to sympathetic doctors who did not perform the procedure but offered referrals and
advocated on the behalf of providers and patients. Sometimes these networks existed inside a hospital (Joffe 1995, 75). Other times, the network and support was as minimal as simply knowing that respected doctors in one’s community were providing abortions as well (Joffe 1995, 127). Alongside connections between doctors, there were also feminist groups that counseled women, and helped them find safe abortion services (Kaplan 1995, 61). Another crucial section of abortion networks during this period was the Clergy Consultation Service, begun in 1967 (Joffe 1995, 88). These different groups helped to disseminate information regarding abortion techniques, while also working to assist the provider and patient, and pushing for legal reform of abortion (Joffe 1995, 88). The structures that facilitated abortion have altered since the procedure was legalized in the United States, but systems of support continue to be present in the national organizations and more local abortion care provider communities.

Support networks help providers deal with the daily stresses that come from working in abortion care in the United States. This assistance appears from various sources for most providers, including the ones I spoke with, as it typically does for people facing stressful situations (Edgell, Mather, and Tranby 2013, 295). The multiple sources of help result in different people or organizations offering instrumental support, informational support, and emotional support to the providers (Cohen 2004, 676). Assistance typically appears in the course of a relationship based in mutuality (Gottlieb and Bergen 2010, 512). It becomes useful, then, to look at the different sorts of mutual relationships that providers rely upon. Examining these relationships gives a better sense of the communities that the providers work in, and how their communities offer support (or lack thereof). The providers I spoke with receive help from both personal and professional networks, in which they fully participate. While providers actively rely on these support networks, research demonstrates that individuals with strong
networks that can offer assistance sometimes do not need to utilize their systems of support in order to feel its benefits; the perceived support can, in some cases, be enough (Gottlieb and Bergen 2010, 512). The different forms of assistance, actual as well as perceived, are visible in the accounts of the providers who spoke with me.

“We’re all connected to the same mission and striving for the same thing”:

*Professional Support Networks for Providers*

The providers that I interviewed spoke positively of the abortion care provider community, and identified it as one of their means of support. Organizations such as the National Abortion Federation (NAF) and the Abortion Care Network facilitate these provider connections. NAF provides education and medical training around abortion, presents providers’ experiences at conferences, and offers patient and provider perspectives in policy debates around abortion (“About NAF,” NAF website). The Abortion Care Network focuses on independent abortion clinic providers and their patients in order to assist the providers, ensure excellent care for their patients, and “challenge these social norms that bully, shame and marginalize people seeking and providing care” (“End Harassment,” Abortion Care Network website). Both organizations offer a nation-wide space for those working in the field of abortion to come together and share their stories, challenges, and ways of offering ethical and compassionate care to their patients. Some of the participants I interviewed are associated with these networks. Judith is a member of the Abortion Care Network, and she describes it as “a collective of independent providers who support each other, and meet annually at a conference to talk about their various experiences. And it’s just a way of not having to remake the wheel every time…they focus a lot, too, on feelings. Making sure that providers are supported, and heard, and have a place to not feel
isolated or alone.” Judith thus identifies this organization as both a source of instrumental and informational assistance, and a place to seek out emotional encouragement.

There are also nation-wide communities for certain roles within abortion care. For instance, Kristin is completing her residency as an OB/GYN in the Midwest, and will enter a family planning fellowship this summer. The fellowship has locations across the country and connects its members to one another. She says that the fellows “have sort of a built-in network… you sort of form a professional relationship with all of these people that are in your same year across the country, see each other at meetings and conferences, and you make that network of like, here’s somebody I could reach out and talk to if I’m having an issue.” This network specifically creates connections for doctors who are beginning to provide abortion care, and those contacts will then continue to be resources for the doctors after they complete their fellowships.

The professional connections that span the field of abortion care in the United States not only offer assistance in terms of the provider and the patient, but also help to push the movement for affordable, accessible abortion forward. They give providers a chance to both help women access abortion on the immediate, direct service level, while also ensuring that this service will continue to be present in the United States. Caroline notes this type of assistance and connection as one of the highlights of her involvement with an abortion fund:

One thing that differs between this work and the work that I was doing before is just the movement building that’s going on. We operate as individual funds, but it’s also cool to be part of a larger movement of abortion funds and feeling like we’re all connected to the same mission and striving for the same thing…And I love that collaboration, I love being able to tap into people who have expertise that we lack at our individual fund.

Therefore, organizations like NAF, the Abortion Care Network, the family planning fellowship, and others help abortion care providers’ work both in a direct way, and also through policy and
legal matters. They operate on different levels of engagement in order to offer aid to the individual providers and to the field of abortion care as a whole. These engagements in various forms of social structures strengthen the ways in which providers can rely on their professional ties and organizations.

Professional support is present both in these wide-reaching professional networks, and also on a more local level. The providers and others who are involved in abortion access work in this city on the East Coast know each other by name. They refer patients from one clinic to another, if the patient is too far along or has medical complications that need to be seen in a hospital setting. Sources of support thus arise in the city’s abortion provider community as well as on the national level. Ryan works as the director of nursing and clinical services at a couple of clinics located in the region, and he spoke about how this connection has appeared when he feels burnt out: “Not too long ago I posted something on Facebook, of like, ‘Sometimes you just really need a change.’ And one of my friends who’s a care coordinator at a [local hospital-based abortion clinic] said, ‘I don’t care what change it is, but you better be there on the other end of that phone when I call.’” Providers rely on each other, and offer this type of encouragement when the work becomes overwhelming. There have also been efforts to create support groups for both abortion providers and residents who may enter abortion care. The model groups work to give providers a space to discuss the challenges that they experience with abortion care and the controversy and stigma surrounding the procedure (Singer et al., 2015, 57; Harris et al., 2011, 1063). These types of workshops and support groups help to counter the effects of abortion stigma and to create connections with other local providers (Harris et al., 2011, 1067). They offer a more formalized means by which providers work to help one another in their local communities.
Overall, many note the community of providers as one of the aspects that sustain them in their work. Judith speaks about the connection with other providers as one of the main reasons why she cannot see herself leaving the field of abortion care:

I don’t see leaving; this is too good of a family. It’s too supportive of a family…It’s pretty fantastic to be surrounded by a passionate, articulate, go-get-em, ragtag bunch of individuals who are scrappy. That’s the best part about it. They are scrappy, and they are foul-mouthed, and they have a great sense of humor, and they know how to have a good party. And they don’t play misery poker…Because if anyone could win at misery poker, it’s abortion providers. And they don’t play it, because it’s futile. And that’s really nice.

In her description of the community as a family, Judith points to how close-knit the community is, and indicates a deeper level of camaraderie than she would expect to experience between casual workplace acquaintances. These deep connections can be, in part, linked back to stigma. Goffman notes that members of marginalized groups often rely on each other for moral support and for advice on shared problems (Goffman 1963, 20). These groups also supply “the comfort of feeling at home, at ease, accepted as a person who really is like any other normal person” (Goffman 1963, 20). Increased reliance on others doing the same work then leads to deeper bonds. The professional networks that providers seek out and participate in, then, offer emotional and practical support to those working in the field, while also working on a larger scale to advance policies and legislation that protect accessible abortion across the states. Professional connections with other providers thus facilitate providers’ participation in activism, while also reinforcing their daily work providing pregnancy terminations.

The Role of Personal Support Networks in Providers’ Lives

The personal support that abortion care providers do or do not have for their work plays another significant part in the ease of their roles providing abortion care. Among the individuals I spoke to, encouragement and backing from personal networks appeared to be significantly less automatic than that offered by professional abortion care structures. Providers had a wide range
of experience in regards to the assistance they did or did not experience from their personal relationships, which has impacted their openness around their roles in abortion care and other aspects of their work.

Caroline currently lives in the city that I studied, and has found the environment to be generally in favor of the right to abortion. However, she grew up in a state in the Midwest where abortion is highly stigmatized and silenced. She says that when she got involved with the fund, “I called my father, and I was like, I got this…and I’m really excited! And he said, ‘Great, I’m so happy you got [it], but I just want you to know, I really don’t agree with you when it comes to abortion.’ So we really just don’t talk about it.” Her parents’ opinions on abortion contrast those of her community in the city where she currently lives, where she has “never, in [this city], even in my own church community, had a negative reaction to the work that I do.” The difference in support for her work at home versus in her current city affects her conversations around abortion care. Caroline discloses her work in multiple different circumstances (though not all) while in her city of current residence, but in her home state she says that she does not tell people about her involvement with the fund. She does not discuss the abortion fund with her parents, as they do not believe in abortion, and she says that “I certainly wouldn’t bring it up in company. Both for safety reasons, cause you know I get to leave but then my family is still in [the state], and also because it would just really end a lot of conversations prematurely.” Without a certain level of personal backing, then, it becomes more costly for Caroline to announce her membership in an abortion fund. In this way, her personal support does not match the level of assistance that she finds within the professional sphere.

In contrast to Caroline, Judith has friends and family who nearly all believe in the importance of abortion access. She recognizes this as a gift—“I’m insanely fortunate on that one,
where I wear my heart on my sleeve and my friends support that. … And my family fully supports me, including my 86-year old, exceptionally Catholic grandmother. She thinks that it’s the person’s decision, and that everyone should be treated with respect and afforded dignity.” Judith thus experiences emotional encouragement from both family and friends. She has also experienced instrumental assistance from her friendships and family through their presence at the clinic where she works: “they’ve done stuff at the clinic, when I need maintenance work done, when I need locks installed because the DoH [Department of Health] asks us to and they’re coming back the next day, when I need volunteers for various things…they’ve all shown up there.” Judith has only one individual in her life who disagrees with the idea that safe abortion access is a fundamental human right, her partner’s mother. However, they have agreed to what Judith calls “a mutual level of respect,” and simply do not speak about abortion or politics. Because this person is relatively peripheral to Judith’s life and work, Judith is not significantly affected by the other woman’s beliefs. Instead, the strong senses of both perceived and actual support from the majority of her personal relationships alongside assistance in more professional networks increase her ability to deal with the stresses of running a clinic, and her comfort disclosing her work.

Ryan’s personal group of friends and family are generally less positive about his work than Judith’s friends or family, or Caroline’s current community. He says that “I grew up in a very strict Catholic household… and it was always, abortion is wrong, abortion is murder, you know every child deserves a life, that kind of thing.” Once he decided to begin working as a nurse at an independent abortion clinic, he had a hard time disclosing to members of his family. Two of his four brothers know of his work, and his mother knows while his father does not. Ryan felt the most nervous about telling his mother, because “I figured [she] would be the
hardest person to tell. And I actually didn’t tell her when I was sober, I went out after work, and I was like, I’m gonna call my mom. And I did, and she was like, ‘Okay, so let me tell you about my abortion.’” His mother is worried about his safety more than anything else, and has been relatively supportive otherwise. On the other hand, after Ryan told one of his siblings about his position at the clinic, “we were having a conversation around [the] Thanksgiving dinner table, and my younger brother called me a baby killer.”

Positive backing in Ryan’s family for the work that he does is therefore uneven. Most of Ryan’s close friends know about his job, and while they do not necessarily agree with him, they understand his reasons for working in abortion care. They have also begun discussing reproductive healthcare and abortion with him. These conversations around reproductive health have had an impact—Ryan says that “one of my good friends actually brought her 14 year old daughter here [to the clinic], and was like, you need to talk to her…because she thought that her daughter was pregnant. So that was kind of an eye-opener. And every now and then I’ll get a text message randomly that’s just, like, thank you for what you’re doing right now, or thank you for being brave enough to do what you do.” While he does receive emotional encouragement from some of his friends and family, Ryan’s networks offer less consistent forms of support around his job. This unevenness means that he cannot rely on his family and friends’ encouragement as a way to deal with the stress and potential danger of being an abortion provider (Gottlieb and Bergen 2010, 512). Keeping his work private can then act as an alternative way to lower Ryan’s stress around the job.

There are many factors that go into the assistance that one experiences from personal relationships. As Caroline and Ryan’s experiences point out, this type of emotional backing for the provider may be related to the geographic space one is in, or to the other person’s religious or
political background, or to a well-founded fear of violence. Personal support networks can act as one of the factors that affect the decision whether to disclose one’s work as an abortion provider. Having the encouragement of one’s family and friends may make it easier to deal with attacks from strangers or acquaintances. It may also feel riskier to be public about working in abortion care if one has not disclosed to all of one’s family members or friends for fear of their reactions. The community of personal relationships constitutes an important aspect of the networks that providers rely on for assistance and as ways to deal with the stress that comes from a marginalized profession such as abortion care.

“God Showed Up”: Faith’s Positioning within Providers’ Lives

Not all of my participants mentioned religion or faith in our conversations; however, some did speak about their understandings of religion in regards to abortion care. Various religions have played a significant role in the conflict over abortion in the United States, and the experience of providers thus offers a way to understand the impact of religions and faith on the field. Faith’s position on abortion and involvement with the issue changes between religious branches, and different groups of people. Some use their faith to strengthen an active position advocating for abortion rights, while others use it in order to attack the procedure. Religion therefore has a similarly variable role in the lives of the providers I interviewed. Depending on their religious traditions, providers find religion to offer different levels of moral motivation, social support, and alternately, stigma.

Both Breanna and Kristin spoke about faith in our conversations, but did not talk in depth about its presence in their practice providing abortion care. Breanna does not speak about faith’s role in her own life, but rather about how she shapes her conversations on abortion when she
knows that she is speaking with a person of faith. This does not necessarily have to be a stifling consideration. For instance, Breanna says that

I have another friend who I’ve been friends with since freshman year, and she’s very connected to her faith, she’s Catholic, and we talk a lot about sex before marriage, sex within marriage, birth control, and abortion. Our relationship survived that, even though we disagree, and I think that those conversations can be very powerful as long as there’s a mutual respect and mutual understanding that, you know, I understand that you’re not gonna be where I’m at. And that’s okay.

On the other hand, sometimes others’ religion can stop Breanna from sharing her work in abortion care. In particular, she has a newer friend who is active in her faith community and attends church every week. Breanna has hesitated to tell this woman about her own work as an access counselor at an abortion fund. This returns to Goffman’s understanding of invisible stigma—Breanna has to decide whether or not to disclose her work, while knowing that it may make her new friend uncomfortable and could have consequences for their friendship. In this way, religious beliefs can act as one of the factors that reinforce stigma for abortion care providers. The feeling of stigma stemming from religion can occur even when the provider is not religious in their own life, and demonstrates another way in which abortion stigma pervades providers’ lives in both friendships and contexts of faith.

Like Breanna, Kristin does not say a great deal about faith, and notes that religion does not have a significant presence in her life or in her practice as an abortion care provider. She identifies as Jewish and agnostic, and says that “religion doesn’t personally play a very big role in my life from a religious standpoint. It does from a philosophical standpoint, of sort of how I interact with and question the world… Judaism does teach you to fight for civil rights, to advocate for people…And it teaches you to question what you’re taught, and question the way things are laid out in a way I don’t think all religions do.” Though Kristin does not identify faith as a part of her personal and professional practice, she notes that the teachings of Judaism may
influence her thoughts (and the thoughts of other Jewish providers) on her work as a provider. In this way, her past experiences with religion could be said to have a continuing, indirectly positive effect on her thoughts on abortion care. However, Kristin does not think that this is the case for all providers. She sees faith’s effect on abortion provision as a very individual matter that varies person to person.

In comparison with Kristin and Breanna’s more secular positions, Caroline is an elder in her Presbyterian church, Charles is a retired Baptist clergy member who volunteers as a chaplain at an abortion clinic, and Ryan is Catholic and a godparent to three children. They spend more time in their narratives discussing the influence of religion on their own practice, and on the issue of abortion in the United States overall. The commonalities in these three narratives are noteworthy, especially those between the experiences of Charles and Caroline, who speak about similar ideas and scripture as ways to discuss the position of faith in abortion care.

Both Charles and Caroline identify their work in abortion care as in line with their faith. They mention the same Bible passage when speaking about religious perspectives on abortion. In this passage, located in Exodus 21:22-5, a man accidentally hits a pregnant woman, and she loses her pregnancy as a result (Meacham 2009). When this happens, the man is not charged with homicide, as he would be if the woman had died (Meacham 2009). Many, including Caroline and Charles, read this passage to mean that fetuses are not considered, in Biblical terms, to be equal to persons who have been born, and Charles also understands it to indicate that life begins with one’s first breath and ends with one’s last. Caroline identifies as Presbyterian, and she says that this branch of Christianity does not see abortion as a moral sin. She does not think there is a necessary conflict between faith and abortion, and finds it encouraging when religious voices appear in support of abortion care.
Charles is a Baptist clergy member, and a resolution approved by his particular denomination does not condemn abortion outright. While many Baptists oppose using abortion as a form of birth control, many still believe that the decision is up to the woman, and they encourage her to seek out spiritual counsel in the process of deciding (Pew Research 2013, conversation with Charles). Charles identifies a lot of freedom within the Baptist faith to follow one’s own moral path: “Baptist principles hold that every individual has the right and responsibility to work out their belief system and understanding of Scripture according to their own conscience, according to their own intellect, according to their own experience.” Charles therefore uses his faith as the main tool for his work in abortion care. When he was an active minister with a congregation, he included issues such as abortion in his sermons. He says that “I’ve always been inclined to organize my ministry around real life…there are certain things that are very basic. Money, sex, all the things that come out of money and sex, family, ability to get an apartment, you know.” In his continuing work as a chaplain at an abortion clinic, he offers spiritual counsel for patients who want it. He describes the position as a relatively unstructured role: “It’s free-flowing, there’s no prescribed thing other than having access to the patients, checking in with them. I do not make any effort to transplant my belief system on theirs. I will on occasion, when they’re stumbling around, and obviously very uncomfortable, say, ‘Would it help you if I tell you what I think about this, for you to relate to?’ And then sometimes that opens up conversation, that may be the first time they’ve heard a clergy person say that.”

Charles has found that, even if he has not had a conversation with someone, his presence as a chaplain can offer a sense of comfort or encouragement. Charles offers emotional assistance from a religious background, which may be especially helpful for patients who are seeking abortions. Studies have found speaking with clergy to increase coping ability (Fiala, Bjork, and
Gorsuch 2002, 766). This could be especially helpful in the case of those having abortions, which have been so highly stigmatized. People are more likely to ask advice from a religious leader in times of stress than from any other type of professional (Fiala et al., 2002, 765), and Charles makes this type of advice accessible within the clinic. He locates his form of support in Christian theology as well. As he says,

90 percent of the job is done by showing up, by being a clergy person inside the clinic instead of somebody out on the sidewalk. The fact that I’m in there, I’ve had women literally thank me for everything that I did for them when I never even had an opportunity to talk with them. And that has to do with having identified myself as clergy, that I mean to be supportive, and I’m not being judgmental, and I’m there. So I really think that’s the biggest thing that I do, which is nothing to be proud of or feel productive about. But it’s also consistent with Christian theology, it’s an incarnational kind of theology of, God showed up. That was the message. God showed up.

In his presence as a clergy member in an abortion clinic, Charles further disrupts the idea that people of faith are necessarily against abortion, or as he puts it, “somebody out on the sidewalk.” He acts as a sort of perceived support by informing patients that if they need spiritual counsel, they can come to him (Edgell, Mather, and Tranby 2013, 295). This holds value especially when considering the important role that religious communities play in terms of social support for many people in the United States (Edgell et al., 2013, 295; Fiala et al., 2002, 763). Even when patients don’t use him as a resource, this perceived support is still present for them.

Both Caroline and Charles emphasize the importance of religious perspectives being included on the pro-access side of the abortion debate as well as the anti-abortion side. Caroline notes that religious voices have been most vocal against abortion: “I think that there’s also the religious component, which is huge, right, because it’s really shaped the way that we talk about abortion in the United States. So there’s this idea that it’s a huge and grave moral sin to have an abortion, and that cannot be, I think, understated. Because if we forget about the impact of anti-choice religious voices, then we will forget about the importance of including faith perspectives
and voices in our movement to promote abortion access.” Evangelicals’ positions have moved towards condemning all forms of abortion, regardless of the circumstance; however, other religions have grown more accepting of abortions, especially in traumatic circumstances (Hoffmann and Johnson 2005, 180). There is space for those more accommodating voices to step forward. Caroline identifies a need to balance the religious voices opposing abortion with religious voices who understand its importance. By saying this, she highlights the variety of opinions within religious communities around this issue, as Charles does when he talks about his chaplaincy at the clinic.

Charles also speaks on the importance of including religious voices in abortion advocacy. As a retired clergy member involved with the abortion access movement, he has been acting in this role for many years. Although chaplaincy at abortion clinics is not a new phenomenon, Charles says that it is not altogether prevalent. He notes a few challenges in place that prevent religious leaders from getting more involved in the movement for abortion access. The first is a hesitance on the part of reproductive rights organizations and abortion clinics to include religious voices: “Groups that provide clinic services, whether it’s Planned Parenthood or other groups, rightfully have their own allergy to religious groups. I mean they’ve been battered. And so, there is a tendency at times to just sort of say no, no, no, we can’t go there, we can’t, we don’t want to deal with religious issues.” Although he understands their reasoning, he agrees with Caroline that this exclusion comes at a cost to the organizations and their mission to protect reproductive freedom. The reassurance that some patients feel from having him in the clinic as a chaplain demonstrates the value and authority religious voices can have when supporting abortion rights in this debate, and the abortion access movement would benefit by including those religious leaders.
Openly advocating for abortion care can also put strain on the clergy person within the congregation:

To be a pastor is to be a politician. You got a mixed group in every congregation, and it doesn’t matter whether it’s a liberal denomination or a conservative one, you got a mixed political dynamic within your congregation. And number one, you don’t want to be fired, number two, you don’t want to have to have more fires to put out than you have to…so it’s hard to mobilize clergy these days in the same way that they were in the ’60s and ’70s, when they knew people who were getting butchered.

As Charles points out here, there is a tradition of clergy being involved with abortion advocacy, counter to what popular opinion might believe today. In 1967, religious leaders began the Clergy Consultation Service on Abortion, or the CCS, in New York in order to refer women to safe abortion providers (Joffe 1995, 88). The service eventually had fourteen hundred clergy in two dozen states, and referred about one hundred thousand women to providers between 1967 and 1973 (Joffe 1995, 88-89). In 1968, two of the founders of clergy referral services—Howard Moody and Harris Wilson—successfully brought a resolution to the American Baptist Convention in 1968 urging ministers to help women with family planning and abortion (Kaplan 1995, 62). Many clergy thus took active, public roles in calling for the legalization of abortion (Kaplan 1995, 62).

By speaking to this past connection between clergy and abortion advocacy, Charles aligns himself with that history. However, he also indicates that this type of clergy activism around abortion is not present in the same way now. He, like Caroline, connects religious leaders’ reticence to the power of the anti-choice position: “the loud voice is the negative voice. I don’t know that that represents the whole truth of it. And that’s the reason I was saying that the number of clergy I know who are very pleased that I do this and are pro-Planned Parenthood, but they’re not gonna say it out loud from a pulpit.” We can tie the reluctance among clergy to push for abortion access back to the stigma surrounding the procedure. When one becomes associated
with a stigmatized issue, as Goffman points out, one is “obliged to share some of the discredit of the stigmatized person to whom they are related” (Goffman 1963, 30). If women are not dying from illegal abortion, then, it becomes easier for clergy to publicly avoid the issue and avoid the attached stigma. Although they are unwilling to take a public stance in favor of abortion access, other religious leaders have still expressed private encouragement for Charles’ work in abortion access.

Despite the hesitancy to advocate for abortion on the part of other leaders and people of faith, both Charles and Caroline largely frame the interaction between religion and abortion care work in their lives as beneficial. They mention the negative opinions towards their work that are present in other branches of Christianity or religion, but in general they reflect positively on their experience of the connections between religion and abortion care. Charles says that “I’ve never been so pleased to be clergy as I am when I’m in the clinic.” Caroline has never had a unfavorable reaction to her work in her current church community. Overall, then, their strong religious beliefs do not conflict with their passion for ensuring access to reproductive healthcare and abortion. Indeed, their faith motivates them to offer this assistance to individuals seeking abortion.

Ryan, on the other hand, has had a different experience when trying to balance his faith and his work as a abortion care provider. He grew up in a strict Catholic household, where abortion was always framed as a sin. Ryan also attended a Catholic university, where curricula excluded information on abortion, miscarriage management, contraception or sterilization, the issues on which he now focuses his career. He continues to be a practicing Catholic. However, he has changed his participation in Catholicism because of his work in abortion care:

I go to church whenever I can, I am a godparent to three wonderful children. The one thing that I don’t do is I don’t receive Holy Communion, because I’m not sure where I
stand with the Catholic faith. So, in order for anybody in the Catholic faith to receive communion, you’re supposed to not have sin on your soul, you’re supposed to go to confession first. In knowing that my confession would probably get me excommunication, I have made the conscious decision not to take the Eucharist.

The Catholic Church’s stance against abortion is well known. The official position of the United States Conference of Catholic Bishops states that “God loves each human life from the instant of his or her conception and entrusts this gift to the protection of a mother and father. Abortion ends the life of a child and offends God. It also deeply wounds the men and women involved” (2016). Many Catholics disagree with the official position against abortion, and Catholic women in the United States have abortions at the same rate as women within the general population (O’Brien and Morello 2008, 3). However, despite the plurality of opinions present within Catholicism on abortion (the organization Catholics for Choice is another example of dissension from this opinion), its position as an institution is more black and white than many other faiths. The Vatican’s stance at this point continues to be explicitly against all abortions.

The challenges that Ryan faces in regards to his religious practice parallel and overlap with the uneven levels of support within his personal life. He feels connected to both family and religion, though he does not experience consistent backing or encouragement for his chosen work from either. By looking at the role of faith within Ryan’s community, then, we begin to see connections between faith, stigma, and support networks. Religious participation—in Ryan’s case, participation in Catholicism—can come into conflict with abortion provision, and result in isolation and judgment of the provider (Joffe 1995, 169). Even if a provider has balanced individual religious beliefs with a belief in the necessity for safe legal abortion, it can continue to be challenging to find a church community that backs one’s work (Joffe 1995, 170). Ryan experiences this discrepancy between his religious practice, his community and family, and his job, even though he notes that his commitment to God and family is one of the reasons why he
began working in abortion care: “I stood up in front of God and my family in 2004, and took an oath to promote health and heal the hurting, and I figured that the best way to actually do that would be to actually work in abortion care.” Ryan shares with Caroline and Charles a religious motivation to become involved in abortion care. Unlike the others, though, Ryan’s religious community condemns his work with abortion. Through the conflict he experiences around faith, Ryan portrays a different way in which religious motivation conflicts with religious community support, and the ways that contradiction appears in the provider’s life.

By hearing the perspectives of these five providers on faith, we begin to see a broader view of how religion and abortion care interact in providers’ lives. Religions do not hold monolithic stances on abortion, even in branches such as Catholicism where authorities have strongly stated positions. This range of beliefs and opinions around abortion will most likely only expand when other religions are included beyond the Judeo-Christian faith practices I discuss here. Providers’ religious beliefs can thus act either as a form of encouragement or as a source of stress when they come in contact with abortion care. The interaction between faith and abortion can be based on one’s internal beliefs, but is also largely shaped by one’s religious communities. This reflects religion’s position in the national debate on abortion overall.

**The Shape of My Research**

There are a few different elements of research for this thesis that should be noted. Seven of the eight providers did not mention children of their own, and six of the eight were women. While abortion care is generally female-dominated, many providers have children, and so I am missing that perspective. This may be because those with children are less likely to disclose their professions, and thus are less interested in interview projects of this sort. I tried to get a range of different occupations within the field, but was unable to speak to people in all the different roles
of abortion care. I also only spoke with one individual who works at a Planned Parenthood. Due
to the size of the organization and its multiple affiliates, Planned Parenthood has a more
bureaucratic structure. Planned Parenthood also offers a range of reproductive health services,
while independent clinics and funds only offer abortion care (“Get Care,” Planned Parenthood;
“Ensure Access,” Abortion Care Network). Because I only spoke with one individual working at
a Planned Parenthood, my work mainly focused on the impact of community on providers who
work in independent clinics and smaller funds.

The limitation of participants to those who work at independent clinics and abortion
funds helps me to better understand the impact of stigma, support networks, and faith on this
specific group of providers, who in many senses have a more isolated path. As Judith puts it,
“indies [independent clinics] can often feel, well, like they’re out on the prairie all by
themselves. And it’s hard, when you’re trying to keep your doors open, and you’re seeing
patients, you’re doing everything.” Exploring the impact of community on this specific group of
providers, then, narrows my focus to a group who may feel an increased intensity around faith,
stigma, and support due to their individual structures and singular focus on abortion care. In
future work, a comparison of providers from both independent clinics and Planned Parenthood
could explore whether these social experiences are indeed more intense for independent
providers.

The oral histories that I gathered centered specifically on abortion providers’ experiences
in and around their work. I did not gather a life history for the participants, but instead focused
on only their experiences in abortion care. This narrow focus meant that I did not speak to
providers about their race, ethnicity or age in our conversations (unless it came up naturally in
the course of the conversation). However, this does not mean that these elements of identity do
not impact the participants’ work. All of these aspects affect community, and how abortion is viewed in those communities. In a larger work, I would expand on race, ethnicity and age, and how they impact community understandings of abortion and abortion care.

One notable constraint of my research was time. I have had eight months to research and write this thesis, while taking other classes. The limited amount of time mainly presented a challenge to the type of oral history work that I wanted to do. I would have loved to do multiple interviews with providers, and to have an even more collaborative process with them in order to determine what this paper should focus on. However, that method was not feasible for the scope of this project. With those difficulties in mind, I have attempted to maintain as high a standard of interaction between participant and researcher as possible.

**Conclusion**

Abortion care holds meaning far beyond my thesis. This simple medical procedure gives me and countless others control over when and how to have children. It means that women and female-bodied individuals are more than simply reproductive machines, and indeed reaffirms our societal worth as human beings. The providers who ensure this right to abortion should be celebrated, not demonized.

I have used the space of this thesis to discuss three aspects of community (stigma, support networks, and faith) that significantly impact providers’ lives. By applying Goffman’s theories around stigma to these themes, we better understand how abortion stigma is created, and how it works to marginalize abortion and its providers in multiple levels of society. The ways in which abortion stigma appears has consequences not only for providers’ daily lives, but also for the security of their jobs, and the presence of legal, accessible abortion in this country at all.
This research holds value from both a scholarly approach and from an activist’s point of view. If we can better understand abortion stigma and its impacts within support networks and religion, then perhaps we better understand how to dismantle it. A deeper knowledge of support networks can point us towards supportive groups and positive environments. Broadening our view of religion’s perspectives on abortion also opens the door to strengthening that ally-ship between people of faith and clinics. Beyond these points, simply knowing more about abortion providers creates space to consider them as individuals with both a shared goal of ensuring abortion access, and with unique experiences. When we look at the broader trends of violence and restrictive policy around abortion care in the United States, this understanding becomes even more important.

Engaging in this work as both a researcher and an activist has allowed me to truly explore the human aspect of abortion. I claim no distance from the issue of abortion, nor do I want it. In seeing my own proximity to abortion, I understand how close to this issue we all are. I feel incredibly grateful to the individuals who spoke with me about their work in abortion care for this thesis, and made this project possible. While I understand the potential pitfalls of researching and participating in activism around the same subject, I believe that the resulting depth of knowledge and empathetic understanding of abortion I have gained after pursuing this activist scholarship overcomes the negative elements of the partiality that accompanies it.

I have focused on the individual narratives of providers in this thesis in order to ground the current situation of abortion care at a human level. We may not all agree on abortion access, but we all recognize the fear that would accompany a bomb threat, or the hurt that comes from a family member’s condemnation. People experience abortion, and provide abortion, every day at a personal level. When an issue becomes as polarized and demonized as abortion has become in
the United States, one loses sight of this human impact. Oral histories allow us to better see the
individuals involved with abortion care, and the experiences that they bring to their work. If we
better understand providers’ experiences with abortion care, and their communities’ reactions to
their work, we may be able to learn how to ensure abortion access in a lasting way within the
United States.
In *Whole Women’s Health v. Hellerstedt*, plaintiffs are challenging the elements of Texas House Bill No. 2, or H.B. 2, which require physician admitting privileges to a local hospital for all physicians performing abortions, and require all clinics performing abortions to meet standards set for ambulatory surgical centers (Opinion for the United States Court of Appeals for the Fifth Circuit 2015, 2). Both of these requirements are widely denounced by medical authorities and associations, who say that these two requirements are medically unnecessary and, indeed, harm women’s health (Brief for Amici Curiae American College of Obstetricians and Gynecologists, et. al, 2015, 5).


My original understanding of oral history comes from an summer internship I did in 2014 with the oral history nonprofit organization Voice of Witness, whose book I cite here. While I have expanded my understanding of oral history since that time, that organization’s commitment to the story of the narrator/participant and the tremendous amount of work that they put into each narrative has stayed with me.

Research has connected emotional support to positive outcomes and increased ability to deal with stress (Edgell, et al. 2013, 293; Cohen 2004, 677). Forms of aid other than emotional support help by offering important information about the stressor, or material assistance (Cohen 2004, 677).
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