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The a-word: destigmatizing abortion in American culture.

Kathryn Lafferty Danner
University of Louisville

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By

Kathryn Lafferty Danner
B.A., Rutgers University-Camden, 2010
M.A., Rutgers University-Camden, 2012
M.A., University of Louisville, 2018

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A Dissertation Approved on

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by the following Dissertation Committee

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Dr. Ranen Omer-Sherman

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Dr. Stephen Hanson

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Dr. Nancy Theriot

_____
Dr. Ann Allen

DEDICATION

This dissertation is dedicated to my amazing and supportive husband,

Patrick Danner.

Without you, this dissertation (and so many other things) would not have been possible.

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ABSTRACT

THE A-WORD: DESTIGMATIZING ABORTION IN AMERICAN CULTURE

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This dissertation uses an interdisciplinary perspective and explores the topic of abortion through legal, medical, philosophical, and cultural perspectives, providing alternative ways to talk about abortion. In some states, especially since the overturning of *Roe,* abortion has become almost impossible to access, particularly in the South and Midwest. Abortion as a medical procedure is highly stigmatized and although it is a common procedure, it is taboo to discuss in American culture. Exploring how different media work to destigmatize abortion in the United States can lead to a deeper, more nuanced understanding of an overly politicized topic.

The introduction is a brief overview of my activism within reproductive justice and the importance that activism has on this project. The first chapter of this dissertation highlights a number of legal rulings and explores how the language within those rulings allows for negative interpretations of abortion. It also discusses practical aspects to obtaining an abortion in America, demonstrating how legal rulings impact real-world access to abortion.

The remaining three chapters focus on how different media incorporate and address the topic of abortion. In chapter two, I discuss abortion stigma and the

importance of destigmatizing abortion in American culture. I then explore how social media is being used to destigmatize abortion, specifically through hashtag campaigns and Twitter activism such as #ShoutYourAbortion. Chapter three concentrates on a newer branch of medical humanities, graphic medicine, that uses comics and graphic novels as a way to discuss medical experiences. I focus on *Abortion Eve* (1973), *Not Funny Haha* (2015), and *Comics for Choice* (2018) as well as one public-facing comic to demonstrate how comics and graphic novels both provide information on abortion and also aid in destigmatizing the procedure by providing a more nuanced perspective. In chapter four, I explore how television, even fictionalized, can impact how individuals view abortion procedures and the importance of portraying more accurate representations of abortion. I use episodes from *Jane the Virgin*, *Dear White People*, *Shrill*, and *Friday Night Lights* to discuss how these episodes accurately portray abortion and ways that those fictionalized portrayals can be improved to better address abortion stigma.

TABLE OF CONTENTS

LIST OF FIGURES

FIGURE PAGE

INTRODUCTION

This project started off not just with my interest in abortion, but with the activism that surrounds abortion. In January 2017, I reached out to Every Saturday Morning, a group of volunteers who served as clinic escorts for EMW Women's Surgical Center, the only abortion clinic that was operational in Kentucky at that time. I remember my second day out on the sidewalk, a chilly Saturday at 7am, where dozens of anti-abortion protesters (antis, as they are referred to by clinic escorts) lined the sidewalk. It was not just preachers and old women praying quietly, but big, burly grown men, their wives, and their children, who were all yelling at patients walking into the clinic and holding up 4'x3' signs of "aborted" fetuses. I stood right next to a seven-foot-high speaker system while middle-aged men took turns yelling bible quotes into the microphone or telling people entering the clinic that they "don't have to be the mother of a dead baby." It was a surreal scene and something that has stuck with me ever since. As clinic escorts in Kentucky, we practice non-engagement with protesters and focus solely on getting patients and their companions into the clinic with as little issues as possible. But this experience, being out on the sidewalk a few times a week (and always on Saturdays), made me realize just how little people know about what abortion access looks like in the

Midwest and southern states and how, after all the struggle of getting to the clinic, you are then faced with a public shaming.

Clinic escorting quickly turned into me getting more involved with abortion access, and in the spring of 2017, I started volunteering as an abortion access hotliner for Kentucky Health Justice Network. As a hotliner for over six years now, I assist people who want an abortion by helping them get funding, organize transportation, help with lodging, and act as a general resource for them. For some callers, I am the only one they talk to about their abortion for fear of negative repercussions. For others, they have the emotional support of friends or family but not the practical support such as funding and transportation to the clinic. As I continue to do this work, I have found that my activism is inextricably linked to my scholarship and my scholarship is largely influenced by my activism; I cannot divide what I write or research about and what I have experienced as a reproductive justice advocate. Reproductive justice is not just a theoretical framework for scholarship, but a framework for activism as well, relying on a human rights foundation that seeks to end reproductive oppression.

Before being a clinic escort and an abortion access hotliner, most of what I knew about abortion came from discussions in classes, with friends, or what I saw in our broader culture–movies, TV, books, etc. I always considered myself pro-choice, but I never grasped just how important abortion access was in America, and just how quickly it can begin to fade. I honestly thought that abortion was an outdated issue, something I no longer had to worry about because *Roe* was the "law of the land" and was not going anywhere. The more I read and wrote about abortion, along with what I saw with my own

experiences volunteering, the more I realized how important it was to continue these discussions.

Throughout this dissertation, I use both fiction and non-fiction narratives to make my arguments. I want to make one thing clear: relying on true, personal narratives to keep or argue for the legality and accessibility of abortion within healthcare settings is an abomination. No one should have to tell their personal stories of their abortions on national television, through social media, or in court hearings in order to have legal and safe abortions in America. It can be used for some as a way to heal, or to find community, or to better understand their identity, but it should not be needed as a way to defend abortions. I attempt to use these stories that people have willingly and bravely shared as a way to demonstrate the power of personal narratives and am grateful to those who have shared their stories.

Many people who have abortions are afraid to discuss their abortions with others, particularly in public spheres, out of fear of being judged or shamed which results in testimonial smothering. Carol Sanger argues that talking about abortion "puts women at *reputational* risk" (Sanger 2016, 653; emphasis original). She describes that even in abortion support circles, there is a need to distinguish between the termination of a *wanted* pregnancy and a "seemingly more casual abortion" (653). A person's reputation is at risk when they discuss their abortion and the fear of discussing their abortion often leads individuals to keep silent about their experience. This silence only adds to the stigma that is associated with abortion in American culture.

Because of the stigma and shame associated with abortion in public discourse, people do not often discuss their abortions, especially in cases where the termination is of

an unwanted pregnancy. People who attempt to speak openly about their abortion are putting themselves at risk in many ways, leading to testimonial smothering. As Kristie Dotson (2011) states, "In testimonial smothering, testimony is omitted that is both unsafe and carries the risk of causing negative effects by virtue of being unsafe" (244). Discussing an abortion experience can put individuals at risk physically, mentally, emotionally, and spiritually. Since abortion is such a complex topic and there are people that feel very strongly about it, whether for or against the procedure, when someone opens up about their abortion experience, there can be repercussions such as violence against the person, a religious community shunning a person for openly discussing their experience, or being denied emotional support from their partner or family members because of their decision. Since talking about abortion can open the door for negative repercussions, people often "smother" their own testimony and do not talk about their experiences. This coercive silencing prevents individuals who have had abortions from changing the cultural narrative of abortion and influencing the ways in which abortion is discussed.

Medical Humanities Framework

Throughout this dissertation, I rely on a medical humanities framework to better understand how we can use the arts, specifically narratives, to increase compassionate and empathic care as well as policies in the United States. As a field, medical humanities seeks to "humanize" medicine through humanities-based education. Our cultural understandings of "illness" or "disease" shape how the patient makes meaning of their medical experiences, and while abortion is not necessarily an "illness," it is medicalized and pathologized in current medical, legal, and public institutions. The field of medical

humanities often relies on terms such as illness and disease but I argue we can see abortion as a type of medical experience in similar ways that Rita Charon (2001, 2002, 2006, 2017), Arthur Kleinman (1988), and Arthur Frank (1995) talk about illness or disease in their seminal works. Within the context of American culture and its perceptions on sexual purity as well as traditional gender roles, we can see the effects of abortion stigma in social, political, cultural, and ethical ways. I propose that medical humanities, including text narratives shared on social media, graphic novels and comics, and television, can be used as a tool to effectively ameliorate some of the negative notions of abortion and assist people who have had abortions to make sense of their own medical experiences while informing others about this particular, lived experience in both public and private settings.

Rita Charon's seminal work, *Narrative Medicine* (2006), highlights the need for the medical field to put the patient first, through listening to their narrative or their story, combining the fields of humanities and medicine. She argues that this can lead to creating more empathy towards the patient and that it humanizes the patient in a way that the medical field broadly dehumanizes the patient. This field focuses on the importance of narratives and places an emphasis on understanding patients in their own contexts. In *Narrative Medicine*, Charon argues that "Narrative knowledge enables one individual to understand particular events befalling another individual and not as an instance of something that is universally true but as a singular and meaningful situation" (9). Her theory repositions the individual as the center of the discussion and attempts to create empathy for the individual through the use of narrative.

While much of Charon's work centers around the physician and the ways in which physicians can use narrative to better their own practice and provide more effective care, the narrative features of medicine she discusses can be used as a tool for self-knowledge as well. Charon outlines five features of medicine--temporality, singularity, causality/contingency, intersubjectivity, and ethicality--that are not only used in clinical practice, but are also features of narrative practice. She argues that medical practice already incorporates narrative features, stating, "Our intimacy with patients is based predominantly on *listening to what they tell us*, and our trustworthiness toward them is demonstrated in the seriousness and duty with which we listen to what they entrust to us" (53). The five narrative features she outlines are "not isolated one from the other" (59) but instead intertwine to form a complete narrative. Narrative skills will encourage "serious communication" (235) not just between a doctor and their patient, but Charon sees the idea of narrative medicine expanding beyond this, incorporating social work, nurses, and the community as well. Narrative helps to organize and comprehend experiences, not only for the doctor but also for the patient as well. Her narrative features have laid the groundwork for narrative medicine and she provides useful tools to assist with communication that will ameliorate some aspects of health care disparities and lead to better care.

Charon builds on the work set out in Arthur Kleinman's *The Illness Narratives* (1988), where he stresses on the importance of empathic listening within the clinical experience and argues that the illness experience takes on meaning through stories. Discussing the difference between illness and disease, Kleinman sees illness as being socially and culturally shaped, whereas disease is what practitioners have been trained to

see in the medical encounter. Kleinman argues, "Illness takes on meaning as suffering because of the way this relationship between body and self is mediated by cultural symbols of a religious, moral, or spiritual kind" (27). The patient creates the meanings within illness as they construct their own personal narrative and order their experience of illness around stories. While Kleinman mostly focuses on chronic illness, he implores the reader to "inquire into the structure of illness meanings: the manner in which illness is made meaningful, the processes of creating meaning, and the social situations and psychological reactions that determine and are determined by the meanings" (185). Empathic listening becomes key for the doctor, while the patient is able to organize and make meaning of their illness experience through the use of stories created within a specific cultural context.

Arthur Frank also argues that stories of illness do not just help the patient make sense of their illness, but can also help to repair damaged identities. Stories make up much of our regular communication in our daily lives, and Frank argues that stories "*repair* the damage that illness has done to the ill person's sense of where she is in life and where she may be going" (53). Often in the illness experience, the ill person suffers a "loss of self" (Charmaz) and in order to repair that self, Frank argues that stories help the patient to "reclaim" or "find one's voice" in the telling. For Frank, patients become "witnesses" through their illness experience, assuming "a responsibility for telling what happened" and offering "testimony to a truth that is generally unrecognized or suppressed" (137). Similar to Charon, Frank proposes that narrative ethics can act as a moral guide, not for just patients or doctors, but also for lay individuals.

Howard Brody expands on the idea of narrative ethics and argues further for the incorporation of narrative in medical practice. He notes the limits of medical ethics and philosophy in making ethical decisions and claims that narrative ethics provides more compassionate and empathetic care in the medical experience. Brody attempts to make a case for shifting from a more analytical and traditional form of medical ethics into a more patient-centered narrative ethics. Once again, the notion of sickness as a social and cultural experience is highlighted, building on Kleinman's view of how culture imbues meaning into the illness experience.

Abortion testimonies carry a similar purpose to those of illness narratives and can be viewed as a specific type of "illness" narrative in a broad sense. While abortion is not a chronic illness or an illness that is visible, like the examples set forth in Kleinman and Brody, it becomes a medical concern with potentially life-altering decisions to be made. As Kleinman and Brody argue, our culture shapes our understanding of illness and abortion is an often-discussed topic in the American socio-political sphere. Therefore, our culture alters how we see and view not just abortion procedures, but also those who have abortions as well as contribute to their own understanding of their "illness." There is a stigma and shame attached to the procedure in a similar way to that of illness, perhaps even more, since there are very strong opinions on the morality of abortion.

Abortion testimony can also help to repair damaged identities and organize their understanding of the "ill" experience the same way patients use illness narratives to make sense of their experiences and assist in repairing damaged identities through stories. Furthermore, as Arthur Frank suggests, illness narratives "offer testimony to a truth that is generally unrecognized or suppressed" (137) and within the abortion debate, a person's

voice about their abortion experience is often silenced or suppressed in public discourse. Illness narratives and abortion testimonies work towards similar ends, crafting a story of the patient's experience that pushes against dominant cultural narratives, repositioning the patient at the center of the ethical or moral discussions within health care settings, and leading us to employ narrative ethics within both medical and social spheres.

Narrative medicine aids in training medical students towards competencies such as communication, collaboration, and professionalism. In a recent study by Arntfield et al., narrative medicine had positive responses from medical students who participated in a narrative medicine course. Artnfield et al. found that narrative medicine not only helped to fulfill the goals set by the Accreditation Council for Graduate Medical Education, but the students found that the goals and methods of teaching narrative medicine were warranted. The students involved also noted that the opinion of narrative medicine is misunderstood and misconstrued in medical education, often being referred to as non-essential and "fluffy" (284). By working in small groups, reflecting on the practice of medicine and their clinical experiences in a non-judgmental environment, and writing, the students worked towards the competencies of communication, collaboration, and professionalism, responding positively to the experience.

A follow up to Arntfield's study also reveals a longitudinal effect of narrative medicine education, citing positive benefits 1.5 years after the completion of the narrative medicine course. One student remarked that the course "allowed for culturally sensitive understanding of patients," while another noted that they "used narrative training to improve the capacity to understand patients, extend empathic care, and communicate well with patients and families and other medical providers" (284). Narrative medicine, and

medical humanities education broadly, better trains residents in communicating effectively to their patients. It can also help to improve cultural competencies within the clinical setting by attempting to understand different perspectives and a more holistic view of patients. Although this study is on a small scale and only considered a one-month narrative medicine course, it provides evidence to suggest further courses are needed and speaks to the potential benefits of medical humanities courses being implemented throughout medical education. And while medical humanities as a discipline specifically focuses on medical education, I see the principles of medical humanities extending out into the community and being used as a way to increase empathy as well as communication.

Narrative medicine, while traditionally used as a tool only in medical encounters, would be a useful instrument in political, ethical, legal, and social discussions of abortion, since abortion has such an interwoven relationship with these other aspects of American culture. Abortion is no longer just a "medical procedure" or a private matter, but has been turned into a very public and politicized discussion, one in which the pregnant person is often disregarded or silenced. Narrative medicine uses a multiplicity of features to convey complex information and generate conversations about the more nuanced aspects of medical decision-making. Abortion testimonies provide a subjective experience and convey complex emotions, humanizing the experience of abortion and re-centering the individual within the larger cultural conversation on abortion, acknowledging their role as a moral agent while also relaying the lived experience of the individual.

There is a large mountain of texts that could have been included in this dissertation, from legal rulings to artistic endeavors. For example, a number of novels that have received praise for their portrayal of abortion and the abortion debate could have been included. Novels such as *Mercy Street* (2022), *Absolute Convictions* (2006), *A Book of American Martyrs* (2016), *The Handmaid's Tale* (1985), *Red Clocks* (2018), *The Cider House Rules* (1983), and others have also influenced the cultural understanding of abortion in the United States. Some of these novels, like *The Handmaid's Tale*, have even expanded their "readership" through turning the novel into a television series that had record-breaking viewership (Porter). The newest novel, *Mercy Street*, received rave reviews, despite abortion being a polarized and politicized topic, perhaps now more than ever (Russo). While novels are out of the scope of this current project, it is important to acknowledge the importance of and contribution to abortion portrayals in various types of media.

Outline of Chapters

In this dissertation, I focus my argument on how media representations can aid in ameliorating abortion stigma in American culture. In chapter one, I situate the abortion debate in the United States by using legal rulings as primary texts. I focus on a number of different rulings, including *Casey* and *Hellersteadt*, to demonstrate how the language used within those rulings contributes to abortion stigma and influences abortion access in the United States. This chapter acts as an introduction to the abortion landscape and incorporates a wide variety of disciplines, such as feminist bioethics, law, philosophy, and women's studies in order to ground the main arguments and discussions that follow in the remaining chapters.

Chapter two turns attention to a newer form of media and knowledge-sharing: social media. I start the chapter off by discussing how personal abortion testimonies, such as the Redstockings Speak-Out, have influenced our current moment. Now, we use Twitter, Facebook, and Instagram—along with other social media platforms—to openly share information with followers. In this chapter, I analyze tweets by individuals who have openly shared their abortion story on social media. In sharing these stories, the users have continued the tradition of sharing their abortion stories in public settings in order to create change and push for better access to abortion. Specifically, I focus on the #ShoutYourAbortion campaign that started in 2015 as a reaction to the effort by some politicians to defund Planned Parenthood. I argue that sharing these more personal stories of abortion in this very public way influences how others perceive abortions and those who have them. Abortion storytelling is one way that abortion stigma can be reduced, leading to a more nuanced understanding of the procedure.

Chapter three builds on chapter two's argument about reducing abortion stigma but focuses on graphic medicine, a more complex and nuanced genre. Graphic medicine has formed as a subgenre of medical humanities, a newer exploration of how graphic novels and comics can be used within medical and public health settings to address certain disparities. I use four primary texts, *Abortion Eve, Comics for Choice, Not Funny Haha,* and "I Went to Kentucky's Last Abortion Clinic" to demonstrate how, from the 1970s up to today, we have used comics not only as a way to talk about abortion, but as a way to share valuable information about abortion. I also discuss the importance of addressing abortion in medical schools, one topic that is often left out of medical curriculum. One way to incorporate learning about abortion in medical school or public

health settings is through using graphic medicine, a genre that provides more nuanced discussions since it combines both textual and visual elements.

The final chapter addresses another medium, television, that adds even more nuance to the abortion discussion through the visual as well as dialogue. Television is an easily-accessible form of media and the viewer would not necessarily need to seek out an abortion plotline to see one, widening the impacted audience. I focus on four television shows that include an abortion plotline: *Jane the Virgin*, *Dear White People*, *Shrill,* and *Friday Night Lights.* In all of these shows, a main character has an abortion. Using a number of recent studies about the impact even fictionalized plotlines can have on current debates, I argue that better television representations of people who have abortions leads to less abortion stigma. I also discuss how race and class play a large role in abortion access, yet television plotlines ignore the demographics of those who get abortions in reality.

By analyzing social media posts, graphic novels and comics, as well as television representations of abortion, I argue that we must create more accurate portrayals of abortion experiences in order to destigmatize the procedure, leading to better care and a deeper understanding of the procedure. In addition, using these mediums to discuss abortion can lead to an increase of empathy for those who choose to have an abortion. Destigmatizing abortion in American culture can improve how we talk about abortion legally, ethically, socially, politically, and personally. As abortion access continues to decline in America, it is essential that we as a society find ways to have more nuanced and informative conversations about abortion before it is too late.

The overall goal of this dissertation is to add to those voices who are working to preserve abortion access in the United States and show the importance of how humanities disciplines can be used in more practical ways to preserve that access. In addition, there has not been a lot of research on abortion stigma since it is a fairly new concept, and an important part of my dissertation focuses on how abortion stigma can greatly impact the way we discuss abortion—legally, culturally, socially, politically. Continuing to discuss abortion in ways that normalize and destigmatize it is essential for furthering this discussion. Often, abortion is discussed in more philosophical or abstract ways. The primary texts that I use in this dissertation demonstrate that abortions do not happen in a vacuum, or in abstract and philosophical ways; they happen to individuals moving through the world, and whether those individuals are fictional or real, their stories are important to tell.

CHAPTER I

AN INTRODUCTION TO ABORTION IN AMERICA

Abortion has been a contested issue in political, religious, legal, ethical, philosophical, and cultural contexts in the United States starting in the mid-nineteenth century. From the presidential debate stage to representations in media, abortion has been portrayed in countless outlets and contextualized in a variety of ways, resulting in conflicting cultural narratives and connotations about abortion. The cultural narrative of abortion in the United States is primarily new, only having garnered large public discussions since the 1960s. Yet since that time, abortion has been at the forefront of our larger cultural narrative. Every day in America, abortion is discussed (and debated) in the public sphere. In order to understand the current cultural discussions of abortion, it is necessary that we look back and trace how abortion has been framed over the last approximately 150 years.

Up until the 1850s, before abortion became more of a public discussion, it was often not discussed at all in the public sphere except between women and their mothers or grandmothers, with herbs and tonics being used to "bring on" menstruation. Medicine and healing were largely confined to the realm of women and midwives who were considered healers within their communities. Abortion before "quickening," or when a

woman began to feel the fetus move, was predominantly accepted as morally faultless within American culture. However, with the professionalization of the medical field and an increase in physicians, abortion took on a negative connotation and starting in the 1850s physicians began the first "right-to-life" movement in America.

Physicians began advocating against abortion publicly and lobbying to outlaw abortion in the latter half of the nineteenth century. The American Medical Association, founded in 1847, began to pass resolutions condemning abortions in 1859, except when recommended by a physician, and continued to publicly advocate for anti-abortion[1] legislation as well as publishing books on the medical and moral wrongs of abortion. As Kristin Luker points out in *Abortion and the Politics of Motherhood*, physicians became invested in abortion for two reasons: to show American women that abortion was a moral crime based on ignorance, and because they felt obligated to "save women from their own ignorance" regarding the development of the fetus (21). Portraying women as ignorant and medically ill-informed presented an opportunity for medical professionals to become the experts on the topic of abortion and gatekeepers to obtaining an abortion. Luker argues, "By taking an anti-abortion stand, regular physicians could lay claim to superior scientific knowledge, based on the latest research developments and theories

[1] I use the term "anti-abortion" instead of "pro-life" because it better reflects the views of these groups that are opposed to abortion. While "pro-life" is often used to talk about politicians and groups like the National Right to Life Committee, these politicians and groups are often only advocating for an end to safe and legal abortion. The National Right to Life Committee was founded in 1968 and the main goal of that organization is to end abortion. The group has publicly denounced and criticized anti-abortion "rescues" or direct action strategies designed to shut down abortion clinics, but does not condemn the use of inflammatory rhetoric purported by the more radical groups. In 1979, the National Right to Life Committee created the National Right to Life Political Action Committee, becoming active in every federal election since and continuing to push through pro-life/anti-abortion legislation (Baird-Windle and Bader 5-6).

(usually from abroad) to buttress their claim that pregnancy was continuous and that any intervention in it was immoral" (27). In other words, physicians claimed their superior scientific and technical knowledge as well as their moral standing as being more rigorous than women or the general public when it comes to abortion and therefore, better at making medical decisions. The AMA was also attempting to diminish the profession of midwifery, claiming superior knowledge over women's health than midwives. Taking an anti-abortion stance gave the ability for physicians to make the claim that they are saving human lives by not performing abortions and saving the life of the fetus. It resulted in women being excluded from the decision-making process and physicians being regarded as the only knowledgeable agent in abortion discussions.

Most laws regulating abortion that were passed before the twentieth century had therapeutic exceptions "to save the woman's life" but that could often be interpreted in a variety of ways, depending on the physician. Given the ambiguity of the phrase "to save the life of the woman," these laws effectively made physicians the gatekeepers of abortion, having nearly unlimited discretion whether to provide an abortion to a patient or deny the request. Abortion decisions were thus reallocated, from women making those decisions to physicians deciding whether to perform an abortion, starting in the latter half of the nineteenth century and continuing through the *Roe v. Wade* decision in 1973, which secured the right to legal abortion. As Luker points out, "the contradiction between the two efforts by physicians--to convince the public that abortion was murder and to make this newly created moral issue one in which medical judgment was necessary--had consequences that were to shape the abortion debate for the next one hundred years" (39). By exerting their technical and professional knowledge, physicians were able to remove

women from the decision-making process through laws and policies that restricted others from performing abortions. However, this did not stop women from having abortions before it became legal and underground abortions were commonplace.[2] For some women, getting an abortion before *Roe* was a matter of having money and the resources to find a doctor willing to perform it. In other instances, women had to rely on "back-alley" abortions or home remedies that were dangerous.

It was not until the Sherri Finkbine case in 1962 the door was opened for a more public ethical and moral discussion of abortion (Greenhouse and Siegel). Sherri Finkbine was a public figure and hosted a children's morning show in Arizona. She was a 30 year old mother of four children when she became pregnant with her fifth child. She had been taking Thalidomide, a sleep aid known to cause fetal deformities. After realizing there was a high chance her child would be born with severe deformities due to the high dose of Thalidomide, her obstetrician scheduled her for an abortion. The day before her procedure, she spoke with a local news reporter about her situation in order to warn other pregnant people that this drug can cause fetal deformities. Finkbine did not want other women to continue taking the drug, knowing it has such harmful consequences. Word spread about her story and even though she simply wanted to warn other women about taking the drug, she was publicly reprimanded. Her appointment for an abortion was canceled due to the high profile case and the fact that abortion was still technically illegal. Finkbine's life was not necessarily at risk, so therefore the procedure was not absolutely necessary. This forced her to fly to Sweden, where the laws on abortion were

[2] It is estimated that between 200,000 to 1.3 million illegal abortions were performed each year from the 1940s to the early 1950s (*Abortion Wars*).

less severe, to get the abortion. It also, for one of the first times in US history, caused a large public discussion about when abortions should be allowed, from a medical, ethical, and legal standpoint. Because of Finkbine's high-profile case, medical and legal professionals began looking deeper into the ways in which the law defined "the life and health of the mother" and the medical field began to split even further in how they interpreted that law.

While Finkbine's case was not the first instance of medical, ethical, and legal discussions of the morality of abortion, it did open the doors for a larger cultural discussion of abortion that centered on the ethical disagreement of whether the embryo could be considered a full human being. Before the 1960s, abortion was less of a publicly debated issue but was primarily an issue for elite professionals and rarely discussed in the general public. Since the 1850s, ethical discussions of whether an embryo should be considered a full person divided the medical professionals into "strict" and "broad" constructionists. Strict constructionists argued an embryo was a full human while broad constructionists thought of an embryo as a continuing pregnancy and would make medical decisions whether to perform an abortion or not on the contextual elements of the situation, such as if a woman had a previously bad pregnancy and does not want to risk having another (Luker). With the Finkbine case, this ethical and moral conundrum pushed its way into public discussion, taking with it the morality claims that had previously been left up to the physicians.

Starting in the 1960s, grassroots organizations began to push against the paternalistic structure for procuring an abortion, arguing for bodily autonomy for women and a legal right to abortion (Greenhouse and Siegel). Before *Roe,* a woman had to write

letters to a governing board at a hospital in order to have a safe and legal abortion; otherwise, they were left to the previously mentioned "back-alley" abortions which presented a host of concerns, primarily the risk of death that was associated with unsafe abortion practices. Grassroots organizations and individuals pushing for abortion reform wanted the decision to solely be left up to the woman herself, not a physician or other authorities who had been the abortion gatekeepers for the past century. One group, the Society for Humane Abortions, began to use the language of rights when talking about abortion and attempted to sway the public by holding abortion teach-ins to make the "unspeakable" a speakable topic. This shifted the discussion of abortion from the professional elites to one in which ordinary people, primarily women, were arguing to be seen as experts about their own medical decision-making, shifting the framework from one of morality into one of rights.

Since the passage of *Roe*, grassroots organizations have shifted the conversation in legal and cultural contexts. While abortion is still often talked about through the lens of morality, shifting to the language of rights gave women agency; they were no longer passive, docile bodies at the whims of governing boards. In this chapter, I will look at abortion through a legal and bioethical lens, reflecting on how the larger cultural conversation is both shaped by and informs these two disciplines. I look at two of the more recent rulings that have influenced the abortion debate in the first section, discussing how these laws created barriers to abortion access and influenced how abortion is addressed in a larger cultural dialogue. I then move into how women's bodies have, both historically and medically, been politicized and thus, heavily regulated in the medical encounter. This section incorporates feminist bioethics as a way to understand

this medical regulatory practice and seeks to show how both political and medical discussions of abortion play a role within the abortion debate. The last section of this chapter outlines some of the broader, cultural understandings of abortion and how our restrictive discussions on abortion lead to stigmatization. This stigmatization and shaming of abortion care results in broad generalizations and misinformation about abortion that then influence the policies, laws, and medical practices related to abortion services.

Casey and *Hellerstedt*

Laws and policies that regulate abortion services reflect and reinforce some of the negative cultural notions about abortion in our current society and have resulted in a fetal-centric view of abortion, eliminating the pregnant person from the equation, and often portraying abortion as an inherently immoral and harmful medical procedure. *Roe v. Wade* was the first abortion ruling that set the tone for the abortion debate in American culture, giving those who seek abortions legal protections to do so without criminalizing the patient or abortion provider. Since the implementation of *Roe,* the right to have a safe and legal abortion has been challenged. The ruling in *Planned Parenthood v. Casey* in 1992 and *Whole Women's Health v. Hellerstedt* in 2016 paved the way for even more restrictions on abortion, such as TRAP laws that have been implemented in many states. TRAP laws ("Targeted Regulation of Abortion Providers (TRAP) Laws") are one example of how misinformation and stigma surrounding abortion plays into legal decisions. Mandatory waiting periods, parental consent, and even regulating the width of hallways are just a few TRAP laws currently in place across the US. The primary purpose of TRAP laws is to limit or eliminate access to abortion ("Targeted Regulation of

Abortion Providers (TRAP) Laws"). According to a 2018 study comparing abortion provider regulations to other medical facility regulations, "states had frequently singled out abortion provisions for targeted regulation" (Jones et al. 2018). These laws specifically target abortion providers not because abortion is medically unsafe--abortions are safer than a colonoscopy and are generally simple, in-patient procedures (Doyle)--but because of how we conceptually think about the fetus in relation to the pregnant person and the cultural associations with abortion.

Privacy has been a large concern in public discussions of abortion since before *Roe v. Wade* and has continued to be a key factor since then. Anita Allen, writing on both law and women's issues in society, highlights four tiers of privacy-related concerns in abortion: "(a) privacy at home, (b) bodily integrity and self-determination, (c) decisional privacy, and (d) informational privacy" (92). Allen further states, "Secrecy and confidentiality assure that women can elect abortions without fearing that family members or others in possession of the knowledge will cause them harm" (92). These different aspects of privacy show that abortion should be a private matter, especially since keeping an abortion a secret may be important to the woman or knowledge of an abortion could cause her harm should a family member find out.

Carol Sanger offers similar sentiments about *Roe v. Wade*, arguably the most influential law when it comes to abortion. *Roe* uses privacy as a means for the justification of abortion being legalized in the United States. Sanger writes,

> In 1973 the Supreme Court in *Roe v. Wade* held that a woman's right to choose an abortion was encompassed within an existing 'right to privacy' […]. Privacy was the umbrella concept under which various expressions

> of personal liberty and choice--marrying, raising children, using contraception--had been lodged constitutionally throughout the twentieth century. (50)

This 'right to privacy' respects a woman's personal autonomy along with her capacity to make decisions of her reproductive care in consultation with her physician. Privacy has been used as a means to protect autonomous decisions regarding personal matters, especially medical care. However, even though the concept of privacy is explicit in *Roe* and other abortion laws, there are still aspects of abortion that are incredibly invasive of that privacy.

From the implementation of *Roe v. Wade* in 1973, the anti-abortion movement has cast abortion providers and the pregnant people who get abortions as immoral and murderous individuals. As the movement gained traction in public through the 1980s and 1990s, creating groups like the National Right to Life Committee that crafts stock anti-abortion legislation, proposals for anti-abortion legislation increased. In 1992, the *Planned Parenthood v. Casey* ruling allowed states to have an "interest in fetal life from the moment of conception,"[3] mandating that a pregnant person's body, which the fetus is biologically a part of, is no longer fully theirs but is policed by the state in which they reside. It also allows for the state to "prefer childbirth over abortion" and pass laws that attempt to persuade pregnant people to give birth instead of terminating the pregnancy. While *Casey* upheld the right to abortion as established through *Roe*, this ruling, and following cases using it as precedent, led to a decline in clinics across the country and it

[3] *Planned Parenthood of Southeast Pennsylvania et al. v. Robert P. Casey et al.* 1992

also culturally shaped the abortion conversation, reflecting negative views of abortion. Furthermore, it granted personhood to the embryo and imbues the fetus with rights over the pregnant person's body. This harmful legal, rhetorical, and political shift of attributing personhood to a fetus makes possible the dehumanization of those who have abortions and gives rise to an "abortion is murder" mentality in the legislative body. Ruling that a state can prefer childbirth to abortion, or that a state should be able to coerce patients into medical decision-making, assigns abortion as the inferior choice and ignores the medical necessity of safe abortion procedures.

The *Planned Parenthood v. Casey* ruling led to many restrictions and policies on abortions and encouraged such policies to provide state-mandated "informed consent." The court ruling stated,

> In attempting to ensure that a woman apprehend the *full consequences of her decision*, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that *her decision was not fully informed*. (Casey, 505 U.S. at 883 qtd. in Daniels et al. 185, emphasis mine)

This section of the ruling undermines a woman's knowledge about her own body and implies that she does not understand the concept of pregnancy. It further assumes that she will regret her decision of having an abortion. Most importantly, it implies that she is at fault for her decision and that she is solely to "blame" in her medical choice. To claim that the goal is for "a woman [to] apprehend the full consequences of her decision" negates her role as an autonomous decision maker who is aware of her situation and

places unnecessary and unwarranted blame on her. It also results in disciplining her for making that decision, leading to an unjustified coercion that results in emotional or psychological harm. Maya Manian responds to this ruling, stating, "*Casey* marks a turning point where abortion law explicitly began treating women as decision-makers less capable than other competent adults. It permitted the State to impose biased information when women are choosing to reject the traditional role of motherhood" (Manian 252). Not only does this ruling permit the state to impose unnecessarily and scientifically unsound information on women, but it calls into question her competence, one of the main defining features in informed consent. From a feminist bioethical perspective, this is a direct affront to the principle of bodily autonomy and it is viewed as a way to question whether the woman is knowledgeable about her own body as well as the choices she makes. It is further used as a disciplining tool to promote and reinforce norms of femininity with the subtext being that if you have sexual intercourse and it results in an unplanned pregnancy, the pregnant person must understand the "consequences" of that sexual encounter through being forced to abide by unnecessary medical regulations that interfere with the doctor-patient relationship.

From the *Casey* ruling, states began passing legislation that further restricted abortion services and interfered with the doctor/patient relationship while promoting false and misleading information about abortion services. Laws and policies that restrict abortions are also used as ways to further discipline women and question their decision-making capacities. These laws, often deemed "Women's Right to Know" laws, are a direct result of the *Casey* ruling, which affirmed three elements that are central to informed consent laws in abortion procedures: "That the state has an interest in fetal life

from the moment of conception, that the state could prefer childbirth over abortion, and that the state could enact regulations to ensure that a woman's choice was 'thoughtful and informed'" (Daniels et al. 182-3). This ruling paved the way for some of the most restrictive reproductive policies since *Roe* and began to chip away at reproductive rights across the country. Although it upheld a constitutional right to abortion, the language and influence of *Casey* can be seen in the slew of TRAP laws that followed. Laws such as mandatory state-generated informed consent, waiting periods, and parental consent policies began placing unnecessary burdens on abortion clinics, sometimes forcing these clinics to close, leaving some states with only a few–or less–abortion clinics for the entire state population.

Casey also allowed states to generate mandated literature provided to patients who want an abortion that include a wide variety of medically inaccurate information. In one study that analyzed the medical accuracy of state-mandated and state-generated materials given to women prior to abortions, researchers found misleading and inaccurate statements. Daniels et al. reviewed the state-generated material and analyzed the statements of twenty-three states, focusing on potential medical inaccuracies. They discovered that approximately one-third of all statements made were "medically inaccurate," citing examples of those medical inaccuracies such as the size of the fetus during the first trimester, when the development of the spinal cord starts, and when other organs begin to develop (191). Furthermore, Daniels et al. note that, "A total of 45 percent of statements about the first trimester were rated as medically inaccurate" (193). This false or misleading information about the development of the fetus leads to an infringement on the rights of the woman to obtain a medically accurate version of

informed consent about her pregnancy. Considering over ninety-one percent of abortions are performed before 13 weeks (Jatlaoui et al.), the lack of medically-accurate information given to patients is unethical and interferes with the doctor-patient relationship. This also leads to a creation of new knowledge that is specifically formulated to coerce a woman into a decision. With the lack of medically accurate information, the state does not provide the woman with medically accurate or unbiased informed consent and violates basic principles of medical practice as well as diminishes the purpose of informed consent.

Informed consent is a cornerstone of good medical practice and while it is beneficial in most cases, state-mandated informed consent specifically targets women's bodies and regulates them beyond medical necessity. Ian Vandewalker notes the differential treatment of specific medical interventions and their informed consent policies, stating, "Some states have informed consent statutes specific to sterilization. Some states have laws specific to breast cancer treatment, and some show special concern for psychological treatments like electroconvulsive therapy and psychotropic drugs" (7). Vandewalker continues, "unique application to women or reproduction is a feature of most of these areas of special regulation of consent" (8). In other words, Vandewalker comments on the "special regulation of consent" in areas that are primarily concerned with women's bodies or women's reproductive decision-making, echoing the view of feminist bioethics broadly and the oppressive powers that come into play when medical decisions are made. This distinction between women's and men's health care as viewed by the law is a direct affront to a woman's autonomous choices and negates her

knowledge, relying on others to "tell" her what the risks and benefits are, even if that information is medically inaccurate.

Similarly, in *Whole Women's Health v. Hellerstedt*, abortion providers in Texas sought to challenge two provisions that directly affected abortion services in the state. Known as HB 2, these provisions impacted the number of clinics in the state of Texas. The first provision would require abortion providers to have admitting privileges to a hospital within 30 miles of the clinic. The second provision would require any abortion clinic to be licensed as "ambulatory surgical centers." In this case, the abortion providers argued that if both of these provisions passed, it would put many clinics out of business. With the implementation of the admitting privileges portion of HB2 beginning in 2014, twenty-two of the forty-one clinics in Texas closed, leaving pregnant people driving upwards of 300 miles to the nearest abortion clinic (Soffen). This was the purpose of TRAP laws: to shut down clinics and diminish or eliminate access to abortion across the US. The Court ruled that HB2 would cause an "undue burden" on the patient and therefore, was not fully implemented. However, as of 2017, Texas has only 21 clinics that perform abortion services, a 25% decline since 2014 (Jones 2019). Along with other regulations, such as a mandatory 24-hour waiting period, patients have to be at the clinic twice to receive care, often putting other logistical burdens on the patient. Carol Sanger notes that *Whole Women's Health* "gave a textured account of how women in Texas experience the consequences of abortion regulation" (*About Abortion* 36) and solidified that "there are constitutional limits to abortion regulation" (*About Abortion* 35). *Hellerstedt* forced the Court to balance the nearly non-existent medical benefits of this

decision with the very significant burdens it would place on people trying to access abortion services.

While *Casey* and *Hellerstedt* both upheld the constitutional right to an abortion as set in *Roe*, the effects of constantly defending abortion through legal means became embedded within our culture and had serious repercussions on the practical aspects of obtaining an abortion. In *Scarlet A,* Katie Watson writes, "By 2016, 26 states had enough restrictions that the Guttmacher Institute classified four of them as 'hostile to abortion rights' and 22 as 'extremely hostile.' Collectively, these hundreds of state laws make it difficult for women to exercise their constitutional rights, and they demean and degrade women who do so" (Watson 180-181). With half of the states in the US being deemed "hostile" or "extremely hostile" to abortion, it is no surprise that our culture and public discussion of abortion has been influenced by these legal rulings. Furthermore, the legal rulings are also influenced by our culture. As Watson notes, these Supreme Court rulings can "draw our attention to masterplots" or "a culture's recurring stor[y]" (40). Legal rulings can influence our cultural understanding of something as complex as abortion and our culture can impact the legal decisions that are made.

The Historical Politicizing of Women's Bodies

Along with former legislative rulings, we also need to acknowledge how women's bodies have historically been portrayed and regulated within the medical profession in order to better understand the cultural notions about abortion. The health care system broadly categorizes bodies into abnormal or normal and influences the way interactions with those bodies occur. Biddy Martin explains, "Woman, as a category of meaning, and women have been subject to the gaze, the interventions, and the control of medical,

psychoanalytic, and aesthetic experts who do the work of limiting and regulating what it means to be a woman in line with the exigencies of their own discursive fields and legitimate truths" (14). In other words, particularly in medicine but also socially, women have been the object of this "gaze," whereby the individual is separated from the physical body through visual, discursive, linguistic, and knowledge-creating means. Through the medical encounter, women are pathologized simply for being in the category of woman and always as the site of potential child-bearers.

The category of "woman" is in itself its own knowledge-source within this medical mechanism. Kathryn Pauly Morgan offers a similar sentiment in her discussion of women's bodies, stating that many fields, such as gynecology, "'demonstrated' that women's bodies are generally inferior, deformed, imperfect, and/or infantile. Medical practitioners have often treated women accordingly" (40). Morgan further argues that, until the rise of new reproductive technologies, "women's reproductive capacities and processes were regarded as definitional of normal womanhood" (40). Not only are women subjected to a medical gaze not experienced by the opposite sex, but women are in a particular position to be defined solely based on their reproductive capacities and viewed as "inferior" in the medical encounter. It is this medically and socially constructed "knowledge of the inferior" that circulates and compounds to inform the abortion debate.

Beginning in the mid-twentieth century, particularly with the ruling of *Roe*, the questions surrounding the ethics and morality of abortion started to become serious discussions within philosophy, with a central question being when, if ever, abortion is morally justifiable. Traditionally, this debate has taken two different routes: attempting to

determine the moral status of the fetus and weighing the rights of the pregnant woman with the "right of life" for the fetus. The abortion debate within traditional bioethics spans a wide variety of conceptual approaches to the issue. However, with feminist bioethics gaining popularity in the 1980s, the debate expanded to include even more complexities, such as the conflicting understanding of autonomy, that are often not considered within traditional bioethics. Feminist bioethics reinterprets the abortion debate by situating individuals within their socio-political contexts and demonstrates how the rights-based as well as moral-based arguments that are put forth by traditional bioethics are inadequate in reaching any real conclusions on either the moral or rights-based aspects of abortion.

While arguments about rights and fetal personhood have generated much of the discussion starting in the 1970s, feminist bioethics began to take up the discussion in the 1980s with an acknowledgement that traditional bioethics had not paid enough attention to the power dynamics and gender disparities in healthcare. Feminist bioethics as a discipline gained more traction in the 1990s and was a direct response to mainstream, traditional bioethics as laid out in Beauchamp and Childress' *Principles of Biomedical Ethics* (1979). While traditional bioethics provides useful theoretical approaches to medical decision-making and highlights the four core principles laid out by Beauchamp and Childress (i.e., autonomy, beneficence, non-maleficence, and justice), feminist bioethics recognizes the intricate relationship between philosophical theorizing and the practical realities within which medical decisions are made. Furthermore, feminist bioethics attempts to represent marginalized groups in ways that traditional bioethics had not, placing an individual within their socio-political position and recognizing the need to

address discriminatory practices as well as power relations in health care with regard to gender, race, and class.

Feminist bioethics sees the body as inherently political and a site of control as well as discipline by paternalistic and patriarchal powers. Feminist bioethics approaches ethical decisions by opposing oppression and recognizing the need for a more relational framework of bioethics (Sherwin 1992, Tong 1997, *Feminism and Bioethics: Beyond Reproduction*). Critiquing the oppression of women, Susan Sherwin argues that feminist bioethics speaks "from the explicitly political perspective of feminism, wherein the oppression of women is seen to be morally and politically unacceptable" (*No Longer Patient* 49). This feminist, relational approach generates a better understanding of relationships with others and appealing to a "more realistic and politically accurate notion of a self as socially constructed and complex" (53). Feminist bioethics argues that the oppression of any group is morally wrong; therefore, we have to "uncover and examine the moral injustice of actual oppression in its many guises" (54). Looking closely at political decisions and policies through the lens of feminist bioethics, it is apparent that abortion decisions are not contextualized within mainstream abortion discussions.

To counter the systemic oppression of women, feminist bioethical theory strives to understand such oppression and reframe the way in which society and medicine think about women's bodies. Feminist bioethicist Susan Sherwin notes how women's reproductive abilities are sites of domination and oppression, stating, "In the West male-dominated institutions restrict women's abilities to prevent or terminate pregnancies unless the women are members of a minority race or are poor or mentally disabled, in which cases they are vulnerable to being coerced into sterilization" (*No Longer Patient*

17). Sherwin continues, "Either way, women are denied the chance to make their own decisions about reproduction" (*No Longer Patient* 17). Autonomy is not only an important concept within bioethics but it is an essential component of the "American way." Independence and individualism, along with bodily autonomy, are pervasive throughout American culture. However, when it comes to women's reproductive choices, bodily autonomy does not play a prominent role. In fact, in some instances, bodily autonomy is diminished in a way that is similar to how children are treated. The process of getting an abortion portrays women as unknowledgeable about their own bodies and further questions their autonomous decision-making abilities. Elizabeth Boetzkes, in "Equality, Autonomy, and Feminist Bioethics," describes a woman's role in making autonomous decisions in a public context, stating, "The moral responsibility of the pregnant woman is unavoidable and profound, and it engages her actively in a dialogue between the world of public meaning and her own self-understanding" (Boetzkes 123). A pregnant woman seeking an abortion needs to navigate the "public meaning" of what her decision implies regarding her moral responsibilities in a way unlike almost any other aspect of adult life.

One concept generated by feminist bioethics that provides a more nuanced idea of how the decision-making process occurs has been the concept of relational autonomy, rejecting the narrow concept of autonomy put forth by traditional bioethics. As argued by Susan Dodds, autonomy from the traditional bioethical lens is too narrowly defined and "assumes something like an atomistic individual, making a choice wholly for herself" (216). She also argues that this traditional concept of autonomy ignores the "social circumstances and power relations that affect choice contexts" (216). Susan Sherwin

explains the idea of a relational approach to autonomy in order to understand "the full range of influential human relations, personal and public" ("A Relational Approach to Autonomy in Health Care" 19). Sherwin politicizes the term in order to place an emphasis on the socio-political dimensions of relationships that "structure an individual's selfhood" (19) instead of the narrowly-defined, atomistic autonomy of traditional bioethics. Abortion decisions do not happen autonomously, but involve nuanced discussions about the individual's situation, family life, finances, and future plans. As Molly Stanton argues, "Realizing that women seeking abortions are not always single and young, and have other financial responsibilities, may perhaps dispel myths and help others to understand, at least in part, reasons for seeking an abortion" (Stanton 31). Abortion decisions are influenced not only by the laws and public discussions on abortion, but also by the individual's context within which the decision to have an abortion is made, adding complexity. By expanding the notion of autonomy out to encompass a more comprehensive and nuanced understanding of it, this newer approach better suits the ways actual decisions about health care are made: not in a vacuum, but relationally.

Feminist bioethics also employ the use of morality claims in different ways than traditional bioethics, crafting the woman as an active moral agent instead of a passive moral agent, as is implicit within fetal-centric arguments as seen in *Casey* and other legal rulings. Boetzkes argues that we need not see the pregnant woman as a "passive" moral agent, but as an "active moral agent" (124). Instead of thinking about pregnancy as a "natural," default mode for women, we should recognize that they are active moral agents in the decision-making process. Susan Sherwin also echoes this sentiment, stating,

"physicians have tended to treat women as passive bodies to be subjected to medical manipulations," and further, "the fetus-child is often viewed as the dominant subject of obstetric care; women may be assigned a merely passive role" (128). Within health care settings, particularly before feminist bioethics, women were often given a "passive" role in their decision-making processes through paternalistic practices. However, feminist bioethics notes how women should be perceived as being not just a moral agent, capable of making decisions with morality in mind, but also that they have an active role within their health care. Much of the discussions surrounding abortion, particularly from traditional bioethics but also within anti-abortion arguments, view the fetus as the "moral subject" and the pregnant person as a mere fetal carrier or host, removing the pregnant person's moral agency from the discussion or purposefully excluding their active moral agency.

This erasure of the pregnant person and pure focus on fetal personhood runs counter to practices and policies that seek to eliminate discrimination and oppression within medical encounters. However, it is reflective of anti-abortion legislation such as TRAP laws. Sherwin remarks, "The constraints imposed by feminist ethics mean that, for instance, we cannot discuss abortion purely in terms of the rights of fetuses, without noticing that fetuses are universally housed in women's bodies" (*No Longer Patient* 55). Acknowledging that a woman has to "bear the burden" of a pregnancy gets glossed over by public and political discussions, attempting to display this argument in a non-gendered, apolitical way. However, feminist bioethicists note the inherent gendering of pregnancy and therefore, the implicit potential for discriminatory or oppressive practices

and policies in health care settings that could potentially eliminate the rights of women to have an abortion.

Feminist bioethics provides a more nuanced understanding of abortion, one that I carry forward throughout this project. It has greatly influenced how I see the abortion debate unfolding throughout the United States and while it is not always explicitly talked about, the core tenets of feminist bioethics seep into our current cultural discussions, providing useful perspectives on abortion, ones that can lead to a more empathetic, complex, and compassionate conversation. Abortion is unnecessarily medicalized in American culture, requiring pregnant people to seek out a licensed doctor to perform their abortion. In that way, I see feminist bioethics as playing a central role in crafting better legislative decisions in the future based on the core principles this branch of bioethics has to offer. Feminist bioethics informs how I conceptualize not only the legal rulings on abortion, but also how abortion is culturally, politically, ethically, socially, and personally constructed.

Abortion and the Culture of Silence and Shame

The abortion debate is a complex one, as seen in the many legal restrictions that have passed, that is not removed from our larger cultural context but is deeply woven into the fabric of American ideals and values. Laws and restrictions placed on abortion not only influence our culture, but our culture also influences the laws that are generated. The anti-abortion vs. pro-choice dichotomy is not simply about abortion (though that is how it tends to be portrayed), but about larger cultural understandings of motherhood and a different understanding of how both groups perceive the world. Kristin Luker acknowledges the different social worlds that anti-abortion and pro-choice activists

operate within, claiming that the abortion debate is not only about the fetus, but about "the meaning of *women's* lives" (194). Division of labor within a larger cultural context allows for abortion to become a "symbolic marker between those who wish to maintain" (201) the traditional gendered roles of work and those who "wish to challenge it" (201). Pro-choice activists inherently challenge the traditional views of women being primarily homemakers and mothers because they believe that pregnant people should be able to *not* be mothers if that is their decision. Abortion as a medical procedure needs to be destigmatized in the United States in order for us to move beyond the cyclical pro-choice/anti-abortion arguments historically and currently made about abortion. Richer discussions and conversations about the nuances of abortion are possible when we can look at the nuances surrounding the procedure.

The public discussions around abortion can increase negative stigma surrounding abortion procedures, causing unnecessary shame and silence about it. Abortion stigma is defined as a "negative attribute assigned to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood" (Kumar et al. 628) and challenges "widely-held assumptions about the 'essential nature' of women" (628). Abortion stigma impacts the many different ways abortions are discussed in a legal, medical, ethical, and cultural context that can lead to negative associations, not just about the procedure itself but about individuals who have abortions. Stigmatization can isolate women who have had abortions or those contemplating abortion and can hinder their self-worth, particularly as a moral agent. The current public discourse about abortion, mainly relying on misinformation or not thinking about a pregnant person's moral agency and lived experience, can lead to feelings of isolation or that an individual

is doing something "wrong." Male and female gender roles are normalized and naturalized in American culture, with males often doing the stereotypically masculine work, such as providing an income, while women are often left to do more feminine work, such as raising children and taking care of the household chores. These gender roles have become "naturalized" in American culture and, until recently, have often gone unquestioned in public discussions. The body subscribes itself to follow this hidden "natural" order and conditions, or otherwise be further objectified and disciplined by those specified powers. Yet the "natural" itself is otherwise foreign to the woman's body, and not until it enters this disciplinary scene does it become subject to a range of technological, social, scientific, religious, and political 'knowledges' that it was once foreign to.

The anti-abortion movement and those who support their efforts, including politicians and physicians, couch abortion in a morality framework, one that relies heavily on primarily Christian religious ideas about what it means to be a "woman" and is reminiscent of the "traditional family values" of women being mothers first and foremost. It also reflects the view that all girls and women are always potential mothers. In order to be a "good" wife or a "good" woman, you also have to bear children and care for the household. In this context, those who reject being a mother through abortion are seen as evil, contrary to nature, and/or morally corrupted. Anti-abortion activists and politicians have painted pregnant people who choose to have abortions as selfish, immoral, irresponsible, and even murderous individuals and therefore, have been able to argue that these individuals should not be given full bodily autonomy or provided moral agency.

As a result of this culture of shame, many women who have abortions are afraid to discuss their abortions with others, particularly in public spheres. Carol Sanger argues that talking about abortion "puts women at *reputational* risk" ("Talking About Abortion" 653; emphasis original). She describes that even in abortion support circles, there is a need to distinguish between the termination of a *wanted* pregnancy and a "seemingly more casual abortion" (653). A woman's reputation is at risk when she discusses her abortion and the fear of discussing their abortion often leads women to keep silent about their experience. Because of the stigma and shame associated with abortion in public discourse, women do not often discuss their abortions, particularly in cases where the termination is of an unwanted pregnancy. Women who attempt to speak openly about their abortion are putting themselves at risk in many ways.

Discussing an abortion experience can put women at risk physically, mentally, emotionally, and spiritually. Since abortion is such a complex topic and there are people that feel very strongly about it, whether for or against, when a woman opens up about her abortion experience, there can be repercussions such as violence against the woman, a religious community shunning a woman for openly discussing her experience or being denied emotional support from her partner or family members because of her decision. Since talking about abortion can open the door for negative repercussions, women often "smother"[4] their own testimony and do not talk about their experiences. This coercive silencing prevents women from changing the cultural narrative of abortion and influencing how abortion is discussed. As a society, Americans are often unwilling to talk

[4] This "smothering" comes from Kristie Dotson's "Tracking Epistemic Violence, Tracking Practices of Silencing" (2011). Dotson argues that some people choose to "smother" their own testimony out of fear of being misunderstood. The speaker views their audience as unable to or unwilling to understand their testimony, and therefore, the speaker decides to self-silence.

about the complexities of abortion and many times, the anti-abortion contingent in America is the loudest voice in this debate because it is more socially acceptable to be against abortion for moral or religious reasons. For example, doctors can opt-out of telling their patients about abortion services or options as well as deny prescription birth control through the conscience clause, even in cases of the mother's life. The conscience clause allows for doctors to deny care based on their personal or religious beliefs, but this clause almost always comes into play in cases of female reproduction. Even when the woman explicitly asks about abortion services to her doctor, the doctor does not have to listen to her or give her recommendations on finding a doctor who will provide abortion services. This, while only a small example, reflects how Americans view abortions and if doctors can deny a patient's testimony, then society can also refuse this testimony as well. Religious communities can also carry strong anti-abortion sentiments as well and women can be reluctant to share their experiences in these contexts due to the audience's perceived unwillingness to understand her testimony. Because of the negative associations of abortion in American culture, women often feel as though their testimony will go unheard or misunderstood and therefore, do not choose to provide testimony, resulting in testimonial smothering and self-silencing.

Abortion stigma impacts women in a variety of ways within public discourse, government regulations, and medical encounters. Unsubstantiated claims about the link

between abortion and breast cancer,[5] or the emotional trauma[6] that women feel after receiving an abortion, only adds to this stigma, particularly when it is mandated by the state to provide this information to the patient. Norris et al. discuss how this abortion stigma "may cause women to feel less empowered to ask questions about the procedure and its health consequences" (552) as well as diminishing their self-esteem by painting abortion as "dirty" and only happening to women who are sexually promiscuous. Katie Watson notes, "Anti-abortion laws quietly justify and generate private policies and social norms that also decrease respect, autonomy, and access to quality health care for women" (198). Relying on the conception of "normal" and the ideal version of womanhood, abortion stigma delegitimizes women and acts as a disciplinary mechanism not just in institutional settings but also in public discourse. Molly Stanton, in her article "Abortion: Silencing of Women's Experiences," notes that, "Policies and laws tend to imply that a woman should not make a decision about her body while simply thinking about her own self" (29). In political discourse, abortions are rarely discussed as being acceptable simply because the woman no longer wants to be pregnant. There must always be a "good" or more acceptable reason for wanting an abortion in American culture, such as in cases of rape, incest, or fetal abnormalities that threaten the life of the mother, and that

[5] This is a common anti-abortion talking point that links the number of abortions with an increased risk of breast cancer. There are currently no conclusive scientific studies that support this talking point, yet it is often used in debates about abortion in American culture. In fact, this talking point has been proven to be untrue and numerous studies have found no evidence between abortion and breast cancer (*American College of Obstetricians and Gynecologists,* 2003).
[6] This is another common talking point of anti-abortion activists and politicians. In addition, legal rulings like those in *Casey* imply an emotional trauma after having an abortion. While some pregnant people may experience emotional trauma after an abortion, there is no conclusive evidence that abortions cause that emotional trauma. In *The Turnaway Study* (2020), the largest study of its kind, there was no evidence to suggest that women suffered emotional trauma after having an abortion. In fact, women were either the same, or better off, after having an abortion.

embeds the idea that abortion in most cases should be socially unacceptable (Watson). The three main reasons cited for getting an abortion revolve around the understanding of responsibility, with the main reasons being: "concern for or responsibility to other individuals; the inability to afford raising a child; and the belief that having a baby would interfere with work, school, or the ability to care for dependents" ("U.S. Abortion Patients") The socially acceptable reasons for having an abortion are hierarchical and there is little solidarity, even among people who have had abortions, as to what abortions are morally/socially permissible (Sanger "Talking About Abortion").

Another way abortion stigma negatively impacts women can be seen in the laws being passed as well as societal discourse. Paula Abrams, in discussing women's stigmatization in abortion and surrogacy, argues, "The state should not be a participant in the process of shaming women for their reproductive decisions; such actions deny women moral agency" (Abrams 188). Laws that restrict abortion services only reinforce negative stereotypes of women who get abortions and lead to a decrease in women's agency. For instance, laws like *Casey* that infer a woman is incapable of making a reasonable medical decision paint women broadly as needing to understand the "consequences of their decision" if they want to have an abortion. All medical decisions have some consequences or risks, but it is abortion that is the most regulated medical procedure and most often discussed in political spheres. Political pressure and social stigmatization of abortion increases a person's sense of shame and guilt for making their decision as well, potentially leading to harmful psychological consequences.

Furthermore, the ultrasound abortion law and other laws that jeopardize a woman's reproductive rights produce feelings of shame and stigmatize the abortion

process. Paula Abrams discusses the role of stigmatization within abortion procedures, arguing that reproductive decisions such as abortion are often stigmatized and cause emotional harms to women. She argues, "When reproductive decisions are stigmatized, both the women who make these decisions and the procedures become marginalized. Marginalization leads to further stigma and isolation that may encourage legal restrictions; stigma thus becomes normalized" (181). Normalizing the stigmatization of abortion further shames women and marginalizes those who have abortions as engaging in "morally wrong" behavior, resulting in the woman questioning her own self-image. With the *Casey* rulings, "public opposition to abortion in the absence of rape or medical risk has increased" (Abrams 184). This ruling, as well as the ones that have followed in its wake, stigmatizes the abortion process and the women who partake in it, leading to marginalization in the public realm, even though it is a private decision. Physical and psychological stresses are a result of the stigmatization of abortion and perpetuate a false notion that women who choose to terminate a pregnancy are immoral and can result in a negative self-image.

Finally, reducing the stigma surrounding abortion in medical schools is one of the most pressing issues facing the abortion debate. There is a long history of abortion providers being harassed on a regular basis as they enter their place of work and anti-abortion activists have even murdered some abortion providers. The stigma of abortion providers leads many to not follow that career path, along with the constant threats and harassment some abortion providers endure. In a recent study of medical schools, over half of study participants who recently graduated from medical school used the term "elective" when referring to abortion services (Smith et al. 28). This use of the term

elective, a term typically used to designate a medical procedure that can be delayed, was used to make a value judgment on whether the medical professional would be willing to perform an abortion on the patient. Smith et al. reflects on how abortion stigma has seeped into the curriculum at medical schools and is reinforced through the use of the term "elective" when talking about abortion. They note, "Our participants' use of 'elective' repeatedly demonstrated their acceptance of or participation in normative, gendered judgments about women seeking abortions" (32) and that their findings "reveal an opportunity to clarify professional communication surrounding abortion, which may reduce stigma and remove barriers to care for patients" (33). Reducing the stigma in medical schools could lead to an influx of students wanting to become abortion providers to service areas in need. Furthermore, it could begin to chip away at some of the negative associations of abortion that can be found in the medical field and influence how laws and policies are created.

There are numerous ways that the state and society rely on new knowledges that construct a disciplinary mechanism and exert societal control of women's bodies, but additionally, these laws and policies break key bioethical principles and further marginalize abortion procedures. Especially with informed consent, the protectionist and paternalist language employed attempts to justify control over a woman's choice. Utilizing protectionist language, such as within the informed consent procedure, negates a woman's sense of autonomy in making her own decisions and assumes she needs protection in the first place, a paternalistic concept. More recently, laws and policies such as specially regulated informed consent have moved from a fetal-protective framework to a woman-protective framework, relying on the idea that a woman who is scheduled to

receive an abortion needs protection, potentially from society or herself. Jesudason et al. comments on this emergence of protectionist language that surrounds abortion access and informed consent:

> More recently, protection of women's health has been the core argument behind state-based laws to mandate that abortion care be provided only in ambulatory surgical centers and that doctors have admitting privileges at local hospitals. These laws have been enacted despite long-standing evidence that abortion care is already extremely safe and recent evidence that such restrictions reduce access to abortion care. (Jesudason 261)

The laws passed that are purported to protect women are causing serious harm to society. Requiring an abortion provider to have admitting privileges to a hospital is not only a medically unnecessary proposal, but it further stigmatizes the procedure and demeans women in the process. It also employs paternalistic language, much like we see in the *Casey* rulings, where a woman must understand the "consequences" of her actions. Putting special regulations on abortion providers as well as the patient receiving the abortion marginalizes and stigmatizes the procedure, making abortion seem as though it is riskier than it actually is in practice. In fact, the risk of death is fourteen times higher in childbirth than it is in abortion (Raymond and Grimes 218) and the risk of death during childbirth is even higher for women of color. While it is a noble feat to attempt to protect women through utilizing the law, special regulation informed consent procedures attempt to control situations and strip the woman of her autonomous decision-making capacities.

It is of high importance that the recognition of the legal, sociocultural, and medical contexts of abortion are discussed in the framing of the abortion debate. Abortion

does not exist in a vacuum, but is part of a larger, interwoven structure of legal, cultural, and health-related fields. While this may seem like an obvious point, the abortion debate is not a simplistic account of the moral obligations to the zygote or fetus. Arguments that are this simplistic in nature fail to recognize the many ways in which it is harmful to talk about abortion strictly in regard to only the fetus. Not only does it negate the pregnant person's role in the process, but it further leaves out fundamental components that can, and often do, have dire consequences. Abortion must be contextualized and analyzed from a variety of different perspectives and disciplines in order to understand the full scope and reach of this topic. Furthermore, acknowledging the realities that exist in American society--lack of paid parental leave, limited support for people who have children, lack of access to proper sex education and birth control--is necessary in the abortion discussion.

In the following chapters, I take this feminist bioethical framework and use it to inform my analysis of cultural artifacts that work to destigmatize abortion in America. The second chapter discusses how social media, particularly the #ShoutYourAbortion movement, seeks to make people feel comfortable talking about their abortions with others. The #ShoutYourAbortion movement places an emphasis on not being ashamed about your abortions, thus, "shouting" about them through social media, particularly Twitter. Twitter is a public-facing platform and therefore, anyone can view or come across this hashtag.

The third chapter focuses on graphic novels and comics being used to destigmatize abortion through graphic medicine. I focus heavily on the issues in medical schools in educating medical students about abortion and argue that comics and graphic

novels can be used to assist in this outcome. This medium is more limiting in its audience and relies on either an educational setting to provide, or a conscious effort to seek out texts that address this topic. In the final chapter, I analyze a number of more recent television shows that have incorporated an abortion storyline. Television shows have been a core cultural influence in American society and I argue that portrayals of abortion in television shows should reflect a more accurate and realistic version of what it is like to have an abortion in America today, especially for low-income or people of color who are already marginalized.

CHAPTER II

ABORTION STIGMA AND ABORTION TESTIMONIES

On March 21st, 1969, the first abortion speak-out took place in New York at the Washington Square Methodist Church in Greenwich Village. This event, organized by the radical feminist organization Redstockings, attracted around 300 attendees to listen to women speak about their abortion experiences in public. This was the first documented abortion speak-out in the United States, a reaction to hearings about the legality of abortion where 12 men and one woman–a nun–were deciding whether abortion should be legalized. One of the organizers, commenting on this use of power to continue restricting abortion access, spoke, stating:

> And this is why we are here tonight: to make things come home, not to discuss the philosophical aspects of it, not to talk about the religious aspects of it. These things do not exist. We exist. Each one of us exists. We are the ones that have had the abortions. We are the only experts. (Redstockings Women's Liberation 24:45-25:03)

The Redstockings speak-out highlighted the voices of people who have had abortions, arguing that those who have had abortions are the only experts to speak about the realities of abortion. This speaker also addresses the philosophical and religious aspects of abortion, claiming their insignificance in the discussion of legal abortion. This humanizes the abortion discussion and asserts that individuals who are impacted by abortion laws

should be considered the experts. Their statement also creates a sense of autonomy and first-hand knowledge of abortion experiences instead of generalizing or philosophizing about what abortion is, how it is performed, and how it impacts individuals.

While the first abortion speak-out was in 1969, when abortion was illegal in the United States, abortion storytelling is still used today to try and combat restrictive abortion legislation, continuing to echo similar themes over 50 years later. Narratives can be especially useful in social movements to raise awareness about certain causes and are often used by activists (Allen "Narrative Diversity"). Storytelling acts as a powerful tool to shape cultural understandings of people or things. There were previous examples of people telling their abortion stories in other public outlets before the Redstockings Speak-Out (Gillette), stories from people like Sherri Finkbine, public figure and mother of four who had to fly to Sweden after being denied an abortion in the United States because she was taking Thalidomide, a sleep aid known to cause fetal deformities.[1] Abortion storytelling is still used in the United States to fight harmful abortion legislation, with more campaigns relying on social media to generate interest and talk more openly about their abortions in a public way.

However, mainstream narratives of abortion often paint abortion in negative ways, politicizing the discussion and giving rise to laws that directly impact abortion access in the United States. Older beliefs about abortion, such as those who have abortions are selfish because they do not want to have children, are counteracted by the reality and lived experiences of those who have abortions. In the United States, 60% of people who have abortions are already a parent ("U.S. Abortion Patients"), but the

[1] In chapter 1, I talk in more depth about this case that resulted in legal and ethical discussions about how we define "the life and health of the mother" in abortion cases.

assertion that those who have abortions are selfish because they do not want a child is still prevalent in current discussions. Anti-abortion advocates paint people who have abortions as only thinking about themselves, relying on outdated expectations of women as always selfless and wanting to be a mother. In order to change these negative cultural narratives and reduce the stigma that surrounds the procedure, abortion activists have continued the tradition of abortion storytelling through mediums like social media.

Hilde Lindemann Nelson (2001) argues that counterstories, such as abortion testimonies, can act as a freeing experience and counteract some of the more harmful narratives that circulate from oppressors. Abortion is consistently discussed and debated in terms of a "failure" of some sort and is mostly seen as a shameful act in American culture (Kumar et al.). However, Nelson claims "counterstories allow oppressed people to refuse the identities imposed on them by their oppressors and to reidentify themselves in more respectworthy terms…this reidentification permits oppressed people to exercise their moral agency more freely" (22). Abortion testimonies are one of the clearest examples of how a narrative can resist the identities imposed on individuals by their oppressors. By crafting their own stories, individuals who have had abortions can "reidentify" themselves in ways that are respectful and counteract more negative associations with abortion (Woodruff et al.). In a recent edition of *The Lancet*, Katie Watson argues that abortion is often thought about or talked about in terms of morality, especially among anti-abortion advocates, and creating counterstories that acknowledge abortion can be a moral good could lead to more moral agency among those who have had abortions (Watson).

American culture and society shape how we see and view not just abortion procedures, but also those who have abortions, and these associations contribute to an individual's own understanding of their abortion experience. There is a stigma and shame attached to abortion and within the abortion debate, a person's voice about their abortion experience is often silenced or suppressed in public discourse. Abortion stigma impacts individuals and communities, acting as a vicious cycle that results in greater abortion restrictions in the United States. Abortion storytelling pushes against dominant cultural narratives, most of which increase abortion stigma, by repositioning the marginalized individual at the center of the discussion. Social media campaigns that portray abortion in a positive way can influence the cultural narratives of abortion and assist in reducing abortion stigma, leading to better access to abortion and a deeper understanding of those who have abortions. From the Redstockings speak-out to our current social media campaigns, abortion storytelling has been used to create counterstories to more mainstream narratives of abortion and highlight certain themes that continue from 1969 to the present.

Abortion Stigma

Despite abortion being a common gynecological procedure, with more than one in four people able to get pregnant choosing to have an abortion in the United States, there are still negative associations with abortion. Some of the reasons abortion is stigmatized include: violating 'feminine ideals' of womanhood, granting personhood to the fetus, legal restrictions, and abortion being perceived as dirty or unhealthy (Norris et al.). Abortion is often stigmatized because of traditional gender norms that are still apparent in the United States, where sex out of procreation for women is seen as a threat (Kumar et

al.). Also, with an increase in imaging technology, such as ultrasounds, the fetus can be personified, both in cultural and legal ways. Legal restrictions on abortion reinforce the idea that abortion is morally wrong and put barriers in place to make it harder to obtain an abortion. The idea that abortion is "dirty" or "unhealthy" stems from a historical perspective of the "back alley" illegal abortions that were prevalent and that abortions hurt women[2]. The anti-abortion movement uses stigma as a powerful tool in order to advance their cultural and legal agenda.

Abortion stigma has been discussed at length as a "social phenomena that is constructed and reproduced locally through various pathways" (Kumar et al. 628). They define abortion stigma as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood" (628). Although they note that different cultures have differing definitions of what womanhood entails, they note three main archetypal features typically ascribed to women: "female sexuality solely for procreation, the inevitability of motherhood, and instinctual nurturance of the vulnerable" (628). Kumar et al.'s definition of abortion stigma and their description of the ideals of womanhood apply to American culture and how women are perceived, not just historically but also in our current culture.[3]

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[2] The idea that abortions hurt women can be seen in some legislation as well, such as the "Women's Right to Know" laws. Many laws have been proposed across the US that dictate to medical professionals what should be included in informed consent for abortion procedures. Medical providers already discuss informed consent with their patients and abortions are the only procedure where informed consent can be dictated by the state. These laws have resulted in mandatory waiting periods, inaccurate information, and forced ultrasounds.

[3]For example, many people with uteruses still have issues with doctors refusing to give them a tubal ligation, even when the patient asks repeatedly, because of sexism and these "idealized" notions of motherhood. Most recently, with the overturning of *Roe*, many people are seeking tubal ligation as a permanent solution to not get pregnant. Doctors have been refusing to perform these surgeries on younger patients (30 and under) or patients without children, with the doctor claiming the patient may find a spouse who wants children or they might regret their decision later in life (McGowan).

In addition to these archetypal features, researchers have begun to describe a framework for how abortion stigma is experienced by those who have an abortion. The first part of the framework discusses perceived stigma, or "a woman's awareness of the devaluing attitudes of others concerning her abortion and her own expectations that these attitudes may result in discriminatory actions" (Hanschmidt et al. 169). A majority of patients do not tell anyone about their abortion experience due to fear of being discriminated against and harassed because of that decision. Those who have shared their abortion experiences in a public way have experienced harassment about their abortions, even when sharing their stories anonymously through online campaigns (Woodruff et al. 6). While some people are very comfortable with sharing their abortion stories, others are, rightfully, reluctant to share because of the potential stigma and harassment they could face as well as the discriminatory actions that could come out of their testimony. This risk factor is so severe that two out of every three abortion patients anticipate experiencing some degree of discrimination or harassment as a result of getting an abortion (Kissling 10).[4] Expecting a negative reaction to their abortion testimonies, many people end up not sharing their stories due to this perceived stigma.

The second domain focuses on internalized stigma which results when "a woman incorporates devaluing social norms, beliefs, and attitudes related to abortion into her self-image, creating a sense of shame, guilt or other negative feelings" (Hanschmidt et al.

[4] The overturning of *Roe* in June of 2022 could add to this list of risk factors, including criminalization by fines and jail time in certain states if you get an abortion. This could also criminalize even those who are tangentially related to someone getting an abortion, for instance, someone driving across state lines to help their family member or friend get an abortion. In states like Texas, citizens can sue doctors and nurses who perform abortions after 6 weeks since their 6-week abortion ban passed in September 2021. There is currently not reliable information on how these acts would be prosecuted.

169-170). In other words, people who have abortions internalize negative cultural notions of abortion and then project those negative feelings onto their own self-image. Particularly among anti-abortion advocates, abortion is seen as something most women end up regretting. However, *The Turnaway Study* (Foster) found most women do not end up regretting their abortion and in fact, the most common emotion people who have abortions feel afterwards is "relief." In this study, women who received an abortion when they wanted one were better off physically, financially, and emotionally than those who were denied an abortion.[5] Even though most people do not experience regret after their abortions, this causes individuals to silence themselves and reinforces the idea that abortion is taboo or is shameful in some way. If the person does not experience regret, they could be viewed in society as being callous or heartless. If the person does regret their abortion, that would further give justification to anti-abortion advocates to push for more abortion restrictions. Abortion stigma can negatively impact an individual's sense of self-worth and reinforce the notion that abortion is shameful.

The last domain, enacted stigma, "describes actual experiences of discrimination or negative treatment by others that are directly related to a women's abortion experience" (Hanschmidt et al. 170). This enacted stigma does not just impact those who've had abortions, but also extends out to abortion providers, companions of patients, and anyone else who might be involved. In 2015, a man murdered three people at a

[5] *The Turnaway Study: Ten Years, A Thousand Women, and the Consequences of Having–or Being Denied–an Abortion* is a longitudinal case study of 1,000 women over a five year period, studying the effects of unwanted pregnancy on their lives, the largest of its kind. They found that denying women abortions and forcing an unwanted pregnancy on women is more harmful than having an abortion, resulting in worse financial, physical, and family outcomes. They also found that being denied an abortion results in lower self-esteem, a higher chance they will stay with abusive partners, higher rates of health complications, and has serious implications for the child (and possibly other children) of those being denied abortion access.

Colorado Springs Planned Parenthood because he was "upset with them performing abortions and the selling of baby parts" and was "happy" with his attack (Hughes). This demonstrates how harmful rhetoric espoused by current discussions of abortion have negative, real-world implications and can get people killed. Anti-abortion organizations, such as Operation Save America[6], also target abortion providers' neighborhoods and have held large-scale flyer campaigns that "out" abortion providers. Regional extremist groups, such as Indiana's P82, have picked up on this tactic and use it to harass other clinics throughout Kentucky and Indiana. While people who have abortions are affected by abortion stigma, those who provide abortions are also at risk of discrimination, stigma, and harassment from others.

The three domains of an abortion stigma framework provide a more nuanced and complex view of abortion, showing how stigma impacts not just the individual but extends out to others. Stigma acts as a vicious cycle that continually reinforces itself. Due to abortion being seen as an "irresponsible" act, many do not disclose that they had an abortion. This self-silencing that occurs then reinforces the "shaming" of those who have an abortion and perpetuates the idea that abortion is not a common medical procedure simply because people do not discuss it openly. People who have abortions are then viewed as being a "deviation" of the norm, and therefore situated within a marginalized community. When the norm of a society is "motherhood," a denial of that motherhood through abortion is seen as deviant behavior (Luker). While the source of abortion stigma

[6] Operation Save America, previously known as Operation Rescue, is a fundamentalist Christian organization that seeks to abolish abortion in America. This group is known to protest at abortion clinics across the country and some members have been convicted of violence against abortion clinics (Risen, James and Judy L. Thomas. *Wrath of Angels: The American Abortion War*. Basic Books, 1998.)

varies, it can be found in nearly every aspect of American culture. The most frequent source that is reported is society (Sorhaindo et al.) the community (Shellenberg et al., Sorhaindo et al.), and significant others (partners, family, and friends) (Shellenberg et al., Sorhaindo et al.). Abortion stigma can be seen in religious groups as well (Shellenberg et al., Sorhaindo et al.). In addition, research also suggests that abortion stigma can be influenced by political and legislative powers (Shellenberg et al., Sorhaindo et al.). Stigma is not just an individualized event but operates in the social world (Millar). Even though abortion stigma is most often thought about in terms of the individual, it can have a large impact on our cultural understanding of abortion and influence how decisions are made in political and legal contexts.

Abortion stigma impacts, and is impacted by, the ways abortion is represented in American culture through the use of narratives. In legislation, for instance, the emphasis is mostly placed on the fetus and not the pregnant person, de-centering the pregnant person from the narrative. With laws such as ultrasound abortion laws[7] that de-emphasize the pregnant person's role in abortion narratives, the emphasis is then placed on the abstract notion of the fetus, personifying it. The fetus is a perfect 'main character' in these narratives; they are 'innocent' and become an easy way to shame and stigmatize abortion procedures and those who have them. De-centering the pregnant person in these narratives and emphasizing the fetus also decreases the autonomy of the pregnant person.

[7] These laws vary from state to state, but in most instances, it requires the pregnant person to view the ultrasound and listen to the doctor discuss the gestational age of the fetus. In some states, patients are allowed to look away and cover their ears. One ultrasound abortion law was halted in North Carolina in 2014 with a unanimous three-judge ruling, arguing, "The state freely admits that the purpose and anticipated effect…is to convince women seeking abortions to change their minds and reassess their decisions" (Judge Harvie Wilkinson III qtd. in Tracy & Fox)

Abortion stigma operates within society in three ways: perceived, internalized, and enacted stigma. In these ways, abortion stigma marks individuals as "inferior" to "normal" or idealized versions of womanhood (Kumar et al.). This stigma extends beyond the individual level and into the community, creating a vicious cycle that is constantly reinforcing negative associations with abortion. This stigma can impact a person's self esteem, the amount of shame they feel about their abortion, and could even result in facing harassment or other violence. Abortion stigma also promotes negative stereotypes and reinforces harmful narratives of the procedure.

In order to decrease the harmful stigma related to abortion, personal abortion narratives can offer a potential solution. Some suggest that abortion storytelling can counteract some of the negative stigma (e.g. Shellenberg et al. 2011 and Millar 2019). Abortion testimonies are shown to foster public empathy for people faced with making an abortion decision (Hanschmidt 176). By demonstrating how someone might come to the conclusion to have an abortion, abortion testimonies can shape how others--and society--might understand where an individual is coming from. In addition, sharing a variety of stories about those who have abortions gives agency to the individuals and they can be seen as having agency. Abortion storytelling can also act as a counternarrative to mainstream narratives about abortion. Abortion speak-outs, popularized starting in the 1970s with the women's liberation movement, are also another potential source to counter abortion stigma (Millar).

During the first abortion speak-out, numerous women talked about the stigma associated with abortion. Getting an abortion before *Roe* proved difficult and extremely risky in most cases, unless the woman was granted an abortion by a doctor. If a woman

wanted an abortion before *Roe*, deemed an illegal abortion, she would be told to go to a certain location and at that location, would be blindfolded. She would then be transferred to an unknown building with suspect medical equipment–not always sterilized or sanitary. She would also pay at least $700 to have the procedure and, because it was not always a sanitary procedure, many women would then have infections and complications or even die from the procedure. However, hundreds of thousands of women had illegal abortions every year in the United States. One of the speakers at the Redstocking abortion speak-out commented that she felt as though she did not know anyone who had ever had an abortion, stating:

> It wasn't till after my abortion I found out that it happened to other people. When I had it, I thought I was the lowest of the low, that I couldn't get any lower and that I was the worst human being in the world. To find out that my mother, that my cousins, that people I was close to, had abortions, helped me more than most of the therapy that I had to go through. And that I'm sure there are women sitting out here right now who are feeling the same thing that I'm feeling. (Redstockings Women's Liberation 8:49-9:18)

This comment highlights how abortion stigma works in a number of ways. First, this woman thought she was the only person who had an abortion and she was so afraid to talk about it because of the perceived stigma she thought she would receive. Second, she had internalized this stigma by thinking she was "the lowest of the low" and "the worst human being in the world." She also acknowledges that there are others there who probably felt exactly as she had, who might be fearful of talking about their own experiences because of perceived or internalized stigma.

Not sharing abortion stories was extremely common, especially since abortion was illegal. However, even today, people are reluctant to share their abortion stories with others, whether it is out of fear of how others will react, fear of their reputation being tarnished, fear of their partner finding out, and so many other reasons. Abortion stigma acts in various ways not only to silence people who have abortions and make them fearful to share their stories, but that stigma is also internalized, as the sentiment of the quote above states. People are made to feel as though they are doing something morally wrong, and even though we are no longer requiring people to be blindfolded and taken to another location, that same sentiment exists in our broader culture that shames and stigmatizes abortion and those who have one.

However, individualized levels of outreach, or the kind of localized, one-on-one, analog storytelling popularized by the Redstockings, fall short of creating larger, more influential change in ameliorating abortion stigma. Millar argues, "one's beliefs about abortion are attached to systems that sustain relationships of privilege and disadvantage and, as such, individuals are deeply invested in them, not least because of the material and psychological benefits they can bestow" (5). Millar uses a reproductive justice framework to conceptualize how abortion stigma is related to a larger, social and political, context that plays a role in both material and psychological benefits. We especially see this within the religious discussions of abortion, primarily from Christians and Catholics who view abortion as murder, where these ideas are deeply ingrained within their culture and belief system. Reproductive justice scholars include abortion stigma in a larger conversation about reproductive oppression and show how, by taking an intersectional view of reproduction, stigma relies on inequality and exclusion.

Reproductive justice encompasses the experience of reproduction in its entirety, taking an intersectional and historical view of reproduction in order to provide a framework for activism and thinking more deeply about differing experiences of reproduction. Reproductive justice, as outlined by Ross and Solinger (2017), can be defined as "the right *not* to have a child; the right to *have* a child; and the right to *parent* children in safe and healthy environments" (9). Their framework is intended for both scholars and activists as a way to better understand or fight against reproductive oppression faced in the United States. Abortion storytelling is one part of their discussion, and they argue that "storytelling is an act of subversion and resistance. Stories help us understand how others think and make decisions" (59). Storytelling is essential to a reproductive justice lens and offers a unique way to understand a particular viewpoint or situation. No singular story can provide enough to describe everyone's experiences. Storytelling, or using abortion testimonies, is essential within a reproductive justice framework.

Storytelling, or using abortion testimonies, can offer one way to ameliorate abortion stigma, whether that stigma is perceived, internalized, or enacted. Abortion stigma is used at the state or federal level to create harmful laws and policies but is also used on an individual level to shame those who have had abortions or those who are affiliated with providing abortions. The reasons for stigmatizing abortion can vary, from sexism to religious beliefs, and there can be negative health outcomes due to stigmatization. One way to push against this harmful stigma is through the use of abortion storytelling. This provides an opportunity for individuals to resist the harmful

stigma associated with abortions, find community, and offers a unique perspective on abortion.

Hashtag Activism and Abortion Narratives

Personal abortion narratives have been used to push against and respond to some of the more harmful aspects of abortion stigma that abound in American culture. The Redstockings speak-out, a direct response to the question of legal abortion in the United States, provides one of the first iterations of sharing abortion stories to a large crowd. However, with the internet, it is much easier to share that same message with people all across the world. Social media campaigns that seek to continue the narrative tradition of abortion storytelling address abortion stigma in similar, but also unique, ways. Similar themes emerge between abortion speak-outs of the 1970s and those that are in existence today through Twitter and other social media sites. These newer campaigns, like campaigns past, still challenge anti-abortion legislation and create counterstories that push against harmful discrimination of abortion. They also continue to highlight how those who are impacted by laws and discriminatory practices are often the ones whose voices are not considered. Newer campaigns in the 21st century have become bolder in their approach, with individuals not just sharing their abortion stories with a few hundred people but instead, broadcasting their abortion story to millions through social media. By attempting to shift the cultural narrative of abortion and reduce abortion stigma, advocates have had to "shout" their abortion in order to be heard.

Anti-abortion advocates and politicians use specific language to shift the cultural narrative in order to end legal abortion in the United States. In *Planned Parenthood v. Casey,* the ruling argued that the state has an interest in fetal life and can prefer the

woman give birth as opposed to have an abortion. Claiming that the state can prefer a woman give birth to a child removes the pregnant person from the decision-making conversation entirely, placing the decision in the hands of the legislature. In addition, there are also a slew of informed consent laws[8] that directly interfere with the doctor patient relationship, requiring doctors give patients false and misleading information before an abortion. Furthermore, anti-abortion advocates employ language comparing abortion to genocide and slavery. This negative anti-abortion narrative has consistently chipped away at the legality of abortion and pressured politicians to take a stance on abortion, with mostly Republicans claiming the "pro-life" contingent.

Shifting the cultural conversation has been difficult for pro-choice advocates in that not a lot of people are willing or able to talk about their own abortion experiences. Silence surrounds the procedure, and nearly two out of three patients who have an abortion do not disclose that they had one to another person (Kissling 10). Pro-choice advocates have been busily working towards counteracting some of the harmful stigma associated with abortion in a variety of campaigns. For instance, the *1 in 3 Campaign*, which started in 2011, has worked towards destigmatizing abortion and giving people an option to openly talk about their abortion experience. They use abortion storytelling to

[8] In Daniels et al., the authors argue that the state-mandated literature provided to patients who want an abortion includes a wide variety of medically inaccurate information. They discovered that approximately one-third of all statements made were "medically inaccurate," citing examples of those medical inaccuracies such as the size of the fetus during the first trimester, when the development of the spinal cord starts, and when other organs begin to develop (191). Furthermore, they note that, "A total of 45 percent of statements about the first trimester were rated as medically inaccurate" (193). This false or misleading information about the development of the fetus leads to an infringement on the rights of the pregnant person to obtain a medically accurate version of informed consent about her pregnancy. It also requires physicians who perform abortions to lie to their patients.

create “a new cultural narrative that puts *people* back at the center of the conversation about abortion and access to abortion care” (Hauser; emphasis original).

In 2015, Congress made attempts to defund Planned Parenthood, the largest abortion provider in the country, with the release of a doctored YouTube video secretly recorded by an anti-abortion protester. This led to an investigation into Planned Parenthood “selling baby parts.” Carly Fiorina, a 2016 Republican presidential candidate, posted about the doctored videos to her followers on FaceBook, stating on July 14th, 2015, “This latest news is tragic and outrageous. This isn’t about ‘choice.’ It’s about profiting on the death of the unborn while telling women it's about empowerment.” The protester was found guilty of doctoring the video and Planned Parenthood continued their services. However, the public image of fetal body parts being sold on the black market ran on the 24-hour news cycle and created a false narrative furthering their anti-abortion motives. There was, and still is, a large “defund Planned Parenthood” contingent that believes the debunked idea that Planned Parenthood sells aborted fetuses.

The #ShoutYourAbortion campaign came as a response to the federal and financial attack on Planned Parenthood in order to shift the cultural conversation of abortion and work to destigmatize the procedure. In accordance with abortion storytelling campaigns in the past, such as the Redstockings abortion storytelling campaigns or the *1 in 3 Campaign* in the early 21st century, the #ShoutYourAbortion campaign renewed the focus on abortion from pro-choice communities on a national and public scale. Amelia Bonow, co-founder of the hashtag, posted on Facebook about her Planned Parenthood abortion she had a year earlier, saying that she did not feel ashamed to speak about her abortion and instead, wanted to share her story so others would see it does not have to be

a shame-inducing act. Bonow sent the Facebook post to her friend, Lindy West, who posted it to her Twitter page with over 60,000 followers along with the hashtag #ShoutYourAbortion. Immediately, it began trending and received over 100,000 Twitter posts within 24 hours.

Twitter can be a useful tool in normalizing abortion because it provides individuals with the capacity to expand the reach of their message. Anyone is able to access anyone else's Twitter account and can interact or respond to those accounts as well, all while remaining anonymous if preferred. In addition, Twitter restricts tweets to under 280 words, so users must make their content short and get their point across quickly. Hashtags like "Shout your abortion" or "Abortion is normal" are used by individuals to "tag" their message, increasing the ability for others to find their content through a hashtag search. Using social media sites like Twitter to share abortion stories can put more pressure on people to be more politically aware and start to take action (Kingsberry). Since Twitter is one of the most popular social media sites, it provides a great resource to pro-choice activists who want to normalize abortion in the United States.

In Bonow's message, she recounts her previous abortion and makes the claim that her abortion is not something that needs to be "whispered about" because she is not ashamed of having one. She writes:

> Hi guys! Like a year ago I had an abortion at the Planned Parenthood on Madison Ave, and I remember this experience with nearly inexpressible level of gratitude. I would tell you all about the exceptional level of care I received from every single woman at the clinic on that day, but I'm going to wait because I wrote something

> which I will share down the road in conjunction with a project that Kimberly Morrison and I are working on. I am telling you this today because the narrative of those working to defund Planned Parenthood relies on the assumption that abortion is still something to be whispered about. Plenty of people still believe that on some level–if you are a good woman–abortion is a choice which should accompanied by some level of sadness, shame, or regret. But you know what? I have a good heart and having an abortion made me happy in a totally unqualilfied way. Why wouldn't I be happy that I was not forced to become a mother? #Shout your abortion. (Bonow *Facebook*)

While it is difficult to quantify how many people she reached, the hashtag kicked off a slew of people challenging the mainstream cultural narrative that abortions should be kept secret, or only spoken about in whispers. Bonow explicitly acknowledges that the "narrative of those working to defund Planned Parenthood" uses abortion stigma to make it seem like a shameful thing, or something that one should at least not talk about. Other users began Tweeting their own abortion stories and the hashtag turned into more than just a one-off post relegated to social media. It spawned in person events where people share their abortion stories and created a sense of community amongst attendees. It also led to a book with individual abortion narratives and art--paintings, tattoos, drawings--that seek to normalize talking about abortion.

Even after six years, the hashtag still is used on Twitter, showing how this particular hashtag campaign continues to grow and influence cultural conversations today. #ShoutYourAbortion is used in different ways to express a particular aspect of a person's abortion story. For instance, some users post about how abortion saved their life,

evoking the dire and life-altering situations some abortions are performed under. Twitter user @VotePulver posted:

> #ShoutYourAbortion in 05, I had an abortion at 8 wks & it literally saved my life– I would have bled to death w/o it. That allowed me to go on to have a baby in 07, 08, 09, and 12. (#PulberBears) My family was made possible bc of a safe abortion. #EndTheStigma #DrawTheLine. (@VotePulver)

In this example, @VotePulver discusses how her abortion in 2005 saved her life because she would have bled to death. This gave her the opportunity to go on to have four children after that experience. She also uses the hashtag #EndTheStigma, meaning end the stigmatization of abortion since, particularly in her case but in many other cases as well, this procedure saved her life. This narrative pushes against the idea that those getting abortions are selfish, or that they do not want children. Her story makes it clear that sometimes, abortions are absolutely necessary.

Other individuals used the hashtag to show the potentially life-threatening realities of abortion. Twitter user @saranics tweeted in response to the Texas abortion law: "My mother nearly died after a backroom abortion she had in her 20s. In my 20s, I had a safe and legal abortion. I hope that people in Texas will soon again have options like I did, and not be left to risk their lives. #ShoutYourAbortion" (@saranics). This user highlights how, before legal abortion, many people died from unsafe abortion procedures. Laws that ban abortion before many even know they are pregnant, such as the Texas law, prevent people from accessing safe abortions and risk their lives to have the procedure. Another user, @sarahndipity_00, commented: "When I found out that I was pregnant, I didn't think I was going to be able to have access to abortion care. I considered trying to

take pills/drink in order to force a miscarriage. That's what happens when abortion isn't accessible. #ShoutYourAbortion #SCOTUS #abortion" (@sarahndipity_00). This user points out what many pro-choice activists have been saying for decades: if abortion becomes inaccessible, it does not mean abortions will not happen, it means that they will once again happen in an unsafe way. Each year, nearly 20 million women across the world undergo unsafe abortions (Kumar et al.) resulting in many long-term health complications and even death. Abortion in the United States is considered much safer than giving birth, about 13 times safer, especially for people of color where pregnancy is four times more likely to end in death when compared to their white counterparts. While the United States currently does not have the same abortion complications as developing countries and countries who have criminalized abortion, in many states it is becoming more difficult to access and will result in more negative health outcomes.[9]

In addition to life-altering situations, #ShoutYourAbortion also relies on the narratives of those who see their abortions as a way to escape poverty and strained financial situations. 75% of people who have abortions are at or below the poverty line in the United States ("U.S. Abortion Patients"). Financial issues are considered one of the motivating factors for people who are considering abortion and with limited social supports in place, it becomes the most viable option for many. One user, @s_iammarino, tweeted: "Abortion was the single most influential factor (along with access to education) that got me out of the cycle of poverty. Sending my money to @AbortionRights and I encourage you to do the same. #ShoutYourAbortion" (@s_iammarino). Because of the

[9] This is no longer the case with *Roe* being overturned. There will be abortion complications once states have completely outlawed abortion, but there are no statistics or information on this yet.

Hyde Amendment,[10] federal funding cannot be used for abortion services. In addition, due to abortion stigma, a majority of people opt to not use their insurance on their abortion, even if the insurance company covers it.

Twitter users also used the #ShoutYourAbortion to show they are grateful for abortion, or to proclaim how it was not a difficult decision for them. In mainstream discussions of abortion, it is often discussed in terms of a "difficult decision" and while that can be true for some, the Shout Your Abortion campaign demonstrates that it is not always a difficult decision. Twitter user @SonjaTrauss posted, "I had 2 abortions, one when I was 18 and one when I was 30. I don't regret either one of them, neither of them were traumatic or sad at all, although I did shed a tear at the 2nd one when the Dr made me sign an arbitration agreement. #ShoutYourAbortion" (@SonjaTrauss). This response to the hashtag shows how in some cases, abortion is not a difficult, regretful, or traumatic experience. Other users made light of how easy and simple abortion can be for some. User @queenozymandias re-tweeted her original tweet about their abortion three years ago and commented: "Happy 3 years since I drove to Maryland and took a pill #shoutyourabortion" (@queenozymandias). In the original tweet, they write, "[...] I just wanted to Say It Out Loud but I had an abortion today and it was fine." This user is referring to the abortion pill, which is how over 50% of abortions in the United States are performed (Jones et al. "Medication Abortion") and making a declaration of how simple the procedure was for them. In their original post, they make it clear that they wanted to share their story with others and "Say It Out Loud," since often, people have abortions

[10] The Hyde Amendment was first implemented in 1977 and prohibits any federal monies from going to abortion services unless in certain instances, such as rape, incest, or to save the life of the mother. Each state has different regulations but overall, no federal dollars can go towards abortion.

without publicly talking about it. They also reinforce the idea that abortion is an easy choice for some and that it does not always end in "regret" or psychological issues.[11] @folkmasters also echoes a similar sentiment about their abortion, tweeting, "My abortion was great and if I hadn't have been able to access it my life would have been destroyed. Every single day I feel thankful for it which is bullshit because I shouldn't feel thankful for having access to healthcare #shoutyourabortion" (@folkmasters). This user points out how grateful they are that they were able to access abortion, but also how absurd it is to be thankful for accessing this basic healthcare. Abortion has become so polarized that it is often not thought of as a type of "healthcare." Even physically, abortions are not usually performed in hospitals or regular gynecological facilities, but instead have harsh regulations that result in independent abortion clinics that are removed from typical healthcare settings.[12]

With the Shout Your Abortion campaign, nearly anyone can read these public abortion narratives and potentially feel more empowered to share their own experience. The user @queenozymandias who talked openly about their abortion on their public page tweeted a screenshot of a direct message that stated, "Hi thank you for your tweet about it being an easy decision for you. It was for me too but I'm not… 'out' about it I suppose.

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[11] This is a common anti-abortion talking point. Often outside of clinics across the country, anti-abortion protesters will hold up signs such as "Women regret their abortion" or "Abortion pill regrets? It's not too late! Abortionpillreversal.com."

[12] Forty-Five states and the federal government have "conscience clauses" which permit physicians, pharmacists, nurses, and other medical professionals to refuse to provide and/or participate in abortion services (Sanger 7). Medical students are not always taught about abortions in medical schools and abortion procedures are usually considered "optional." This results in a lack of doctors who are able to perform abortions, with some clinics having to fly in doctors from neighboring states to perform abortions. Independent clinics also have various regulations, depending on the state laws, that require "ambulatory hallways" of 8 feet wide or require clinics to keep medications on site that is unnecessary for abortion procedures. Abortion is the most regulated medical procedure in the United States but is often found in separate physical spaces that are removed from cultural ideas of "healthcare."

Thank you for speaking for those of us who feel like we can't" (@queenozymandias). While this individual might not ever tell someone about their abortion, they bring up an important part of the discussion when we talk about measuring the effectiveness of a hashtag campaign: they appreciate someone sharing an experience that was similar to theirs in a public way to "speak" for those who cannot yet talk about their experience. Arielle Cohen shares a similar sentiment, writing, "Do you know why I won't shut up about my abortion?! Because every single time I speak someone I have long admired tells me about theirs. #shoutyourabortion" (@ariellecohen). Both of these tweets highlight how sharing their abortion narrative can influence others to feel more confident speaking about their own experiences, particularly in such a public way through social media.

The effectiveness of the "hashtag-activism" of #ShoutYourAbortion, or any hashtag campaign, is difficult to measure. In the only quantitative study of #ShoutYourAbortion to date, "Public Health Implications of #ShoutYourAbortion" by W. Ahmed, the effectiveness of the hashtag was based on a small data set collected through Twitter that reflected its nearly divided use of the hashtag for both pro-abortion and anti-abortion individuals. While this study is looking at its effectiveness from a public health perspective, it couches the campaign as having an issue with its "tone." Ahmed argues, "when devising health campaigns, it is essential to consider the tone of the campaign and whether it is likely to provoke citizens who may have opposing views" (162). It is no surprise that #ShoutYourAbortion will provoke many to oppose abortion or even about discussing the normalcy of abortion because anti-abortion activists have been utilizing social media to thwart their message to whomever will listen. Robin Marty, author of *Handbook for a Post-Roe America* (2019), comments on how anti-abortion

activists have been "killing it" on Twitter and social media broadly (Marty). Marty reasons, "the anti-abortion movement doesn't just use social media as a highly effective tool: It is a literal weapon in their hands." The anti-abortion leaders work across organizations, taking on Twitter "derailing campaigns" or inserting anti-abortion sentiments into a trending hashtag that might be unrelated to abortion. They are well connected, with the larger organizations like Students for Life or the Pro-Life Action League often share private Facebook groups with connections to smaller organizations that then co-opt a trending hashtag or derail the message in some way. In the case of Ahmed's study, this aligns with the finding that anti-abortion activists were able to derail the conversation from one that tries to show the normalcy of abortion into one that takes an anti-abortion stance. While the study found the hashtag use was nearly evenly split between pro-choice and anti-abortion Twitter users in the sample provided, this does not take into consideration the other ways in which the hashtag operates.

Hashtag activism has provided an avenue for individuals and organizations to promote a central message to a global audience about an issue. The use of social media outlets such as Facebook and Twitter has spawned a new way in which users can almost instantly create a new narrative that responds to, or pushes against, mainstream cultural narratives. Using hashtags and social media campaigns is one way to shift the narrative, creating a more robust understanding of complex social and political issues such as abortion. Sharing personal experiences of abortion on social media, where anyone can participate, re-centers the individual who is making the decision. The example of @queenozymandias, who shared their story and had someone reach out to them through a direct message, shows how hashtag activism can sometimes be difficult to quantify since

not everyone will publicly post about their experience. Some may not be ready to share their abortion story, but they can read through other experiences to feel like they are not alone in their experience. This re-centering of the individual can lead to more empathetic responses and could aid in reducing abortion stigma by empowering others to share their stories.

While there are many practical reasons for wanting an abortion, the #ShoutYourAbortion campaign highlights that individuals do not need to justify *why* they have had an abortion. The main goal of the campaign is to destigmatize abortion and make it acceptable to talk about, and with that comes people unapologetically proclaiming that they have had an abortion. Twitter user Kara Mailman writes, "Beyond tired of the B.S. abortion stigma coming out of #VVS20.[13] For all those tuning in: it's been almost a decade since my abortion, and I've never regretted it. In fact, I'm so grateful for it I wrote a whole article about it! #ShoutYourAbortion" (@KaraMailman). Mailman links to an op-ed piece they wrote in 2020 which details their abortion story as well as the need to end abortion stigma (Mailman). Many anti-abortion advocates and lawmakers claim that most women feel regret after their abortions. However, *The Turnaway Study* highlights how 95% of people who have abortions do not regret it, even after 5 years. Mailman also discusses how abortion stigma acts as a vicious cycle and that sharing abortion stories with others can lead to more truthful conversations. Twitter user @fraumeowmeow shares a similar sentiment: "I had an abortion because I was pregnant and didn't want to be. The end. #shoutyourabortion" (@fraumeowmeow). This user is responding to the idea that there is more of a stigma attached to an "ordinary" abortion

[13] VVS stands for the Values Voters Summit, an annual conference for social conservatives. This group is anti-abortion as well as anti-LGBTQ, according to the Southern Poverty Law Center.

(Watson) than an abortion that is the end result of rape, incest, or the life of the mother is in danger. People who want to have abortions just because they do not want to be pregnant are often portrayed as being selfish by anti-abortion advocates. The Shout Your Abortion campaign seeks to rectify this portrayal of "ordinary" abortions as being a bad or morally wrong option and instead highlights the bodily autonomy of individuals to make their own decisions about their bodies.

The Shout Your Abortion campaign provides a very public and unequivocal message: abortions should not be a shameful experience and should not need to be justified. This campaign is considered radical by some because of its message, as there is still a need, even among pro-choice organizations, to provide a "good reason" to have an abortion. Rape, incest, and the life of the mother are often cited as "good reasons" to have an abortion by a majority. However, most abortions in America are considered "ordinary" (Watson), meaning most people have abortions not because of rape, incest, or the life of the mother, but for external reasons. Watson states that ordinary abortions are:

> the 74% of women ending pregnancies who say having a baby would dramatically change their life, interfering with work, school, or their ability to care for dependents; the 48% who say they don't want to be a single parent or they are having problems with their husband or partner the 73% who say they cannot afford a child. I call them ordinary because they happen frequently. (20)

These abortions account for most of the 1 million abortion procedures that occur in the United States every year. However, a lot of discourse that attempts to justify abortion, even in pro-choice organizations, highlights the extenuating circumstances of rape, incest, or fetal anomalies/health of the mother to argue that abortion should be kept legal

and accessible. Shout Your Abortion allows for the "ordinary" abortion to be commonplace and reflects the reality of those who have abortions. They assert that abortion should never need to be justified and no one needs to give a reason for wanting an abortion. In this, Shout Your Abortion provides a public pro-abortion stance that extends beyond the standard pro-choice arguments.

From the Redstockings abortion speak out in 1969 to the trending Twitter hashtags, abortion storytelling is used to ameliorate abortion stigma and promote a more empathetic understanding of abortion in cultural narratives. Cultural narratives of abortion impact legislation that then impacts abortion access and creates stigma around the procedure, causing individuals to silence themselves about their experience. Since abortion stigma acts as a vicious cycle that continually reinforces itself, it is impossible to say that storytelling will eliminate abortion stigma. My argument, however, is that storytelling and using narratives can be used as a tool to help change the cultural narrative of abortion. Ever since abortion was legalized in the United States, anti-abortion advocates and legislators have been finding ways to eliminate abortion access. By changing the narrative and publicly discussing abortion experiences, we can begin to shift the conversation and provide an alternative to the often-overpowering voice of anti-abortion advocates.

While abortion narratives have started to enter into mainstream social media sites such as Twitter, this is only one medium out of many that can work to ameliorate abortion stigma. In the next chapter, I will address how graphic novels and comics can also aid in our cultural understanding of abortion and work towards creating empathy for those involved. In turn, a better understanding and a more empathetic perspective on

abortion can help to ameliorate some abortion stigma. Abortion speak-outs and social media campaigns are driven by text narratives; however, graphic novels and comics provide even more of a nuanced take on abortion through the use of graphics in addition to the textual elements.

CHAPTER III

GRAPHIC REPRODUCTION

Comics and abortion. The pairing of these two things seem absurd and perhaps even offensive to some by "making light" of abortion through portraying it in comic form. However, abortion comics have much to offer to individuals, medical professionals, and the larger community. One of the first abortion comics, *Abortion Eve*, came as a response to the *Roe vs. Wade* ruling in 1973. This comic contains information on how to get an abortion as the reader follows five fictional characters who meet in an abortion clinic. *Abortion Eve* was part of a radical contribution to the larger feminist movement that encouraged self-education and promotion of feminist liberation from oppression–medical, legal, social, and cultural. Much like the Redstockings abortion speak-out,[1] *Abortion Eve* gave its audience a perspective on abortion that was not represented in mainstream culture, especially in the 1970s. Using narrative as a tool to decrease the stigmatization of abortions, comics have continued portraying abortions in ways that promote self-knowledge about abortion, attempt to destigmatize the procedure, and portray how different the experience can be for individuals.

[1] This is discussed in chapter 2.

This chapter focuses on a variety of different comics, ranging from *Abortion Eve* (1973) to more recent iterations such as *Not Funny Haha* (2015) and *Comics for Choice* (2017). Through these comics, I demonstrate how using a medical humanities framework, specifically focusing on graphic medicine, can work to destigmatize abortion. Building off of seminal texts from scholars like Rita Charon (2002, 2006), Arthur Frank (1995), Arthur Kleinman (1989), and others, medical humanities seeks to "humanize" medicine through humanities-based education and places an emphasis on narrative as a useful tool to aid in compassionate and empathetic care. I propose that narratives, as conceptualized through a medical humanities framework, can be used as a tool to effectively counteract some of the harmful aspects of abortion stigma and assist those who have had abortion. By expanding graphic medicine beyond the medical field and out into the community using comics, we can aid in destigmatizing abortion and contribute to a more holistic understanding of the procedure.

Building off of my previous chapter where I discuss abortion stigma and using narrative as one way to work towards destigmatizing abortion in American culture, this chapter turns its focus to using comics and graphic novels. Abortion stigma operates on a number of different levels that can affect the individual as well as the community, creating harmful societal ideas of abortion and those who have them. Recently, graphic medicine has gained traction in many medical schools and other healthcare settings, providing another avenue for health communication that could appeal to a wider audience. Since the field is fairly new, its research is primarily focused on working with students who are in medical school. However, medical humanities and graphic medicine both are apt at addressing and better understanding health concerns for a larger

community. This chapter focuses on how comics present the audience with more than a traditional text in that the audience has a sense of the visual components of the medical experience, using a combination of the textual and visual elements that are present in comics. This visual aspect of comics is what can both be intriguing and informative when discussing medical information.

Graphic Medicine

Graphic medicine has formed as an offshoot of narrative medicine but focuses on graphic novels or comics that tell a story of a medical experience or illness[2] through both text and images. This is often used as an educational tool for medical students, as described in *Graphic Medicine Manifesto,* to generate more narrative understanding of illness and the experiences of both themselves as well as their patients. Graphic medicine is a term used to denote the role that comics and graphic novels can play in the study and delivery of health care. As described in *Graphic Medicine Manifesto*, "comics offer a powerful medium to bring biocultural analyses of medicine, as well as of health humanities, to a wide audience" (46). Comics can appeal to many different and diverse communities as well as across disciplinary boundaries. The combination of text and illustration provides a more interesting as well as more interpretive reading experience than just telling a narrative with no illustration. Both are used to communicate complex emotions that you cannot normally express through only the written word and the visual

[2] Medical humanities and graphic medicine rely on the language of illness or disease to talk about a medical experience. I understand this analogy could be considered problematic in some ways. However, since abortion is medicalized in American culture, I do think we can make this comparison, at least politically and culturally. There is also a larger argument to be made about de-medicalizing abortion care and allowing abortions, particularly the abortion pill, to be sold over-the-counter with no medical intervention necessary.

aspect of graphic novels and comics help to draw the audience's attention to certain details in the story. Comics can prompt productive discussions of ethical and political issues in health care to a wide audience, both inside and outside academic and professional settings.

Traditionally, graphic medicine has been discussed as ways to educate medical professionals. While this is one way graphic medicine can be used, I see graphic medicine extending out into the public sphere and being a way to engage with medical experiences that are defined moreover by the cultural, legal, ethical, and religious meanings of our society. Fields such as women's studies, disability studies, race studies, and queer studies have "a mandate for real-world commitment and engagement that comics can serve well" (*Graphic Medicine* 43). In the early 1970s, comics and graphic narratives, particularly those made by women and the LGBTQ community, have historically pushed boundaries and created new knowledge about these groups. These texts are typically grounded in the lived realities of the "other," highlighting often taboo subjects in American culture that are rarely discussed in public. The authors, some of whom wrote under pseudonyms, could face scrutiny, or worse, for publishing comics and graphic narratives about sexuality. For instance, Farmer and Chevil, the authors of *Abortion Eve* and creators of the *Tits & Clits Comix,* had to go into hiding for a year after publishing their first issue in 1973 due to obscenity laws. They were threatened with a year of jail and even the state taking their children, so they hid the remaining 40,000 copies of their comic with their friends. After a year, Farmer and Chevil re-started *Tits & Clits Comics* (Pilcher). Historically, more underground comics and graphic narratives have addressed taboo topics, such as sexuality and abortion. Continuing with that

tradition, many graphic narratives and comics today follow a similar pattern, addressing topics that often go unmentioned in society such as illness, cancer, and abortion.

Graphic medicine differs from narrative medicine in that the visual component can represent time in a way narrative medicine is unable to with just text. This better represents a patient's perception of a medical experience in that those experiences are also visual. Much of medicine relies on images: visible signs of disease and illness, medical imaging such as x-rays and ultrasounds, diagrams, and even symbols on prescription medication that show side effects. The medical field itself makes meaning through the visual, and when combining the visual representation with textual and verbal representations of a medical experience, "graphic medicine can access those aspects of illness and medicine that we experience visually and spatially, as enduring, if intractable, aspects of the patient experience" (*Graphic Medicine* 46). The visual and textual experiences that graphic medicine provides creates a more holistic understanding of a medical experience since it has the ability to *show* what that experience could be like for a particular person in ways that narrative medicine cannot. Graphic medicine can represent the moving of time with its visuals and show how time is experienced by an individual.

In addition, graphic medicine offers a particular perspective and requires an audience to actively participate in the experience. To make sense of a comic, the audience needs to attend to both visual and textual elements about a particular experience as shown through the comic. This requires skills such as close reading, communication, and critical thinking. The reader must also find connections between the text and the visual used in the comic. In *Graphic Medicine Manifesto*, the author notes, "Comics demand reader

participation–inviting readers to empathize with a subject by entering its world and seeing through its eyes–and enable the reader to gain insight from the vicarious experience" (127). In other words, comics offer a unique viewpoint that invites readers to empathize with the characters portrayed. The reader is given a glimpse of what it is like in the character's world and is provided with visuals to more deeply understand the individual perspective of that character. Since comics appeal to such a wide audience–across age, race, socioeconomic, and gender categories–they serve as an effective medium to articulate real-world experiences that are often not portrayed in mainstream media.

Medical Schools and Abortion

There is a consistent issue within medical schools excluding abortion from their curriculum or making it "optional," which leads to many intertwining issues that restrict access to abortion. This exclusion from medical schools increases abortion stigma (Smith et al.) and can lead to medical students, even those in gynecology and obstetrics, to be ignorant about abortion. In some parts of the country, such as the Midwest and south, there are not enough abortion providers in the area so they have to be transported in from neighboring states, effectively making abortion only available a few times a week or even a few times a month in states like Alabama (Henderson). This lack of abortion providers has meant a decrease in abortion clinics as well. In 2017, the most recent survey of data from the Guttmacher Institute finds that there are only about 1,500 facilities that provide abortions in the United States (Jones et al. "Abortion Incidence"). Most hospitals do not

provide abortions[3] and instead, a reliance on independent clinics[4] has led abortion to be "outside the normal" medical experiences, making it more difficult to train future abortion providers.

While excluding abortion from the medical curriculum is not the only issue, it certainly contributes to the stigmatization of abortion in the medical field and thus, contributes to the lack of access to abortion in some states. Educating medical students on abortion, as well as properly training them to perform abortions, is essential if access to safe abortions is to remain (Burns and Shaw 387). Even students who are attending religiously-affiliated medical schools desire to learn about abortion, with over 70% reporting dissatisfaction with their current abortion curriculum (Guiahi et al.). Most abortions, approximately 94%, are performed outside of the traditional training sites for medical students, requiring "concentrated efforts" to provide abortion training in medical schools (*American College of Obstetricians and Gynecologists*). The Ryan Residency Training Program, started in 1999, is specifically dedicated to integrating abortion curriculum for their trainees, with over 90 Ryan Residency Programs across the US and Canada (Burns and Shaw 390). The Ryan Residency Program helps to counteract some of

[3] This is due to many hospitals being bought and/or affiliated with the Catholic church. Hospitals that are owned or affiliated with the Catholic church do not offer abortion services which leads many rural people–who often only have one hospital in their town–seeking abortion to travel long distances for care.

[4] Independent abortion clinics are also held to strict legal standards, such as requiring ambulatory hallway sizes, even though abortions are less medically risky than a root canal. In states deemed more hostile to abortion, independent clinics must consistently work to make their facilities "acceptable" to the constantly changing regulations they must adhere to. Independent abortion clinics are also held to strict legal standards, such as requiring ambulatory hallway sizes, even though abortions are less medically risky than a root canal. Approximately 58% of abortions are performed at independent clinics. In the past ten years, the number of independent abortion clinics has fallen by 34%, from 510 in 2012 to 337 in 2020, and continues to decline. In addition, independent clinics provide 81% of abortions after 22 weeks, making them essential for some of the most devastating abortion experiences such as fetal anomalies and the life of the mother (Abrams).

the lack of attention paid to abortion in medical schools but is still a stand-alone training program not integrated into all medical schools in the United States. In a recent perspective in the New England Journal of Medicine, the authors note that, "even under current regulations, residency program directors report that only 22% of Ob/Gyn program graduates are competent in performing dilation and evacuation," the most common form of second trimester abortions (Giglio et al. 2). In addition, "only 71% of graduates are competent in performing first-trimester aspiration, 66% are competent in performing medication abortion, and 67% are competent in performing induction of labor for second- and third-trimester terminations" (2). This, as the authors point out, is "startlingly low" because of the rates of abortion in the United States. The serious lack of education about abortion for future doctors, especially those who plan to become an Ob/Gyno, contributes to a lack of access to abortion in the United States and a continuation of the harmful stigma surrounding the procedure.

Not only is there a lack of education about abortion in the traditional medical school curriculum, but often, abortion is discussed in stigmatizing ways during medical school. The term "elective abortion" has been used for decades as the opposite of "medically necessary abortions," in both curriculum and scholarship about abortion. The use of the word "elective" in the medical field is usually used to designate a procedure that does not need to be performed immediately, a procedure that could be planned and scheduled (Smith et al. 27). However, using the term "elective abortion" further stigmatizes the procedure and creates an unnecessary hierarchy of "good" reasons for an abortion. In a recent study done by Smith et al., they found that, "participants' use of 'elective' repeatedly demonstrated their acceptance of or participation in normative,

gendered judgments about women seeking abortions" (32). This terminology is harmful to not only the individuals who are having abortions but also does a disservice to current medical students who hold discriminatory and potentially life-altering beliefs. However, it provides an opportunity to demonstrate how communication about abortion can be improved upon, potentially leading to a reduction of abortion stigma and improved access to abortion in the United States. In addition, this combination of words and images requires new modes of inquiry, providing an opportunity to educate its audience on both the narrative structure and the visual presentation (*Graphic Medicine Manifesto* 69). This is useful not just for medical students but also for other healthcare professionals and even the community.

Ian Williams, in *Graphic Medicine Manifesto,* outlines three different types of ways that illness can be represented in graphic medicine: The Manifest, The Concealed, and The Invisible. The Manifest representation shows the visibility of an illness, whether that be the physical signs of an illness or the markers of scars from medical treatment. The Concealed addresses an illness or a medical condition that will not necessarily be noticed by an observer but that causes some type of psychological suffering. The Invisible portrays an illness that no one can see, such as a mental illness, where it is more of a psychological suffering (*Graphic Medicine Manifesto* 119). While abortion does not fall nicely into any of these categories, since its visual representation can change the further along in pregnancy a person has their abortion and psychological suffering is dependent on the individual circumstance, it is difficult to categorize abortions as one type of graphic medicine representation. Abortion exists as a medicalized procedure–and

therefore fits into the graphic medicine genre–and also as an internal marker that may or may not cause some type of discrimination due to abortion stigma (Kumar et al.).

Graphic medicine can aid in reducing abortion stigma within educational as well as more individualized settings. Stigmatization can isolate women who have had abortions or those contemplating abortion. The current public discourse about abortion, mainly relying on misinformation or not thinking about a person's moral agency and lived experience, can lead to feelings of isolation or that a person is doing something "wrong." However, in medical education, comics can be useful in destigmatizing abortion by creating empathy for the patient getting the procedure. It can also lead to the creation of new knowledge for the student. With so many negative attitudes towards abortion in our culture and so much misinformation about the procedure, we may not be aware of how those impact our own thinking about abortion. Often, we rely on knowledge that we see as "objective" but that is, in fact, very subjective and can be influenced by our own cultural upbringing.

Furthermore, comics can act as a useful tool in providing accurate and personal information about abortion to the public sphere, appealing to a wide audience and articulating nuances within the typically diametrically opposed pro-life/pro-choice abortion debate. In the public sphere, comics that discuss abortion can lead to a greater understanding of the abortion procedure and can articulate complex ethical, legal, and social information about abortion procedures in ways that are easier to understand than traditional narratives. In addition, comics can provide accurate medical information in an engaging way to the general public. Recently, comics have been used in communicating

health information about COVID-19, transcending language and cultural barriers that are often issues in text-based information (Kearns and Kearns).

Graphic medicine is an innovative and unique way to increase empathy and emotional intelligence in educational as well as public settings. Comics can create new knowledge to inform the public about abortion and the way we view abortions that may or may not align with our cultural attitudes towards the procedure. While there have not been many studies done on the impact comics have in an educational setting, Susan Squier (2015) used graphic medicine in her classroom and wrote about the experience her students had that semester. While none of the students she taught were medical students, she noted that, "the course may also have left them better prepared, emotionally and strategically, to address health care needs in the future, whether their own or those of a family member. And that's a course outcome we can all applaud" (22). She noted that her students had in-depth bioethical discussions about a variety of different diseases and illnesses, despite not having any students who were considering a bioethics degree. Incorporating graphic medicine into classroom spaces, such as in this study, leads to productive and informative conversations about abortion that are less about the religious and legal aspects of abortion and more about the lived experiences for the patient. While Squier did not specifically use abortion as a topic of conversation, the outcomes generated by her study could be replicated in a course that uses abortion comics. This innovative communicative tool can address abortion in ways it has not been addressed before and provide nuanced conversations that transcend a standard pro-life/pro-choice dichotomy.

Comics about an abortion experience create counterstories that push against the master narrative of abortion being a "moral failing." Hilde Lindemann Nelson (2001) explains how counterstories resist "an oppressive identity and [attempt] to replace it with one that commands respect" (6). These counterstories of abortion can provide "a significant form of resistance to the evil of diminished moral agency," and aim to "alter […] an oppressed person's perceptions of *herself*" (7). Those who have abortions are viewed in American culture broadly as being a "deviation" of the norm of motherhood (Kumar et al.). Abortion testimonies in the form of comics act to counter that master narrative. They also provide the patient with moral agency and can show them as being a person *worthy* of moral agency in the decision-making process.

Not only can comics help in reducing abortion stigma, but they provide the opportunity to re-imagine how we view those who have abortions and can work to create more empathetic abortion care. In *Graphic Reproduction* (2018), a compilation of excerpts from graphic novels and comics that highlight reproductive medical care, the authors argue that comics "do not just portray different perspectives on the world we live in; they also have the potential to imagine new worlds" (*Graphic Reproduction* 13). In other words, comics can extend beyond an example of an individual's experience and allow the audience to consider how situations could be changed. Comics that show an abortion experience typically also highlight how many barriers are in place for individuals, whether that is the stigma they face, the logistical and financial barriers of getting an abortion, or how laws play a major role in accessing care. By portraying these struggles, we can then imagine what needs to change to rectify the situation. Creating

new ways of thinking about abortion could lead us to more responsive, inclusive, and destigmatized abortion experiences.

While the field of graphic medicine is new, it provides an opportunity to engage with topics like abortion that are more complex and can address multiple aspects of abortion at the same time. In the following section, I offer a close reading of comics and graphic novels that have used the textual and visual elements to portray a more complex and nuanced understanding of abortion. There are other comics that address abortion, but I provide discussion of three that I would argue best articulate the complexities of abortion, from presenting medical information to portraying what the patient is feeling emotionally. Starting with *Abortion Eve*, I demonstrate comparisons from when the comic first came out in 1973 up to a more recent iteration as seen in *Comics for Choice.*

Abortion Comics

In this section, I build onto my previous chapter of using Twitter to create more empathetic and accurate representations of abortion. I chose to use a number of different comics and graphic novels in this section to demonstrate how close readings of comics can increase empathy in the reader as well as provide a unique perspective on abortion. The first comic I address is *Abortion Eve*. Now, *Abortion Eve* is an open access comic that was created shortly after the *Roe* ruling and follows multiple characters getting an abortion. After that, I move into a newer graphic novel, *Not Funny Haha*, which is not based on a true story but does demonstrate some of the more current barriers to abortion access in the United States. A more recent and comprehensive text, *Comics for Choice*, provides over 90 comics that are written by a diverse group and portray a wide range of stories, from personal abortion stories to comics that are written by abortion providers. I

conclude this chapter with a close reading of "I Went to Kentucky's Last Abortion Clinic," a comic that is on a more publicly accessible platform, *The Nib*, and can reach an even wider audience.

While there are many perspectives addressed in these comics and graphic novels that revolve around abortion, I found that similar themes can be found in all of them. First, each comic highlights the need to destigmatize abortion in our culture. The artists and authors use the visual and textual elements found in comics to portray how abortion is stigmatized, along with real-world concerns of those who are contemplating having an abortion. Most of the comics also highlight the many barriers to access patients face when attempting to have an abortion in the United States. For instance, *Abortion Eve* and *Comics for Choice* use legal rulings to discuss some of the challenges people might face trying to obtain an abortion.

Another theme that emerges is using medical terminology in ways that are more easily accessible to those who do not have a medical degree, resulting in less anxiety about what happens when people get abortions. *Not Funny Haha* and *Abortion Eve* both use medical terminology to help familiarize their audience with procedural terms they might hear during an appointment for their abortion. This aids in reducing anxiety for those individuals who may one day decide to have an abortion. It also helps to explain the procedure to individuals who might not understand how abortions are performed, making the procedure seem less intimidating or less scary. There is also an emotional aspect in these comics and an acknowledgement that people often feel many different—sometimes conflicting-- emotions while deciding whether to have an abortion. These themes, as well as others, that are portrayed in the comics and graphic novels addressed below provide

not only a narrative of the abortion decision making process but are also able to visually represent a variety of unique perspectives that become more palatable through the use of comics.

Abortion Eve

One of the first known comics about abortion is *Abortion Eve* (Farmer and Chevli), a 32-page comic published in 1973 by *Tits and Clits Comix*. Joyce Farmer and Lyn Chevli, feminist cartoonists, collaborated on the comic under pseudonyms. *Tits and Clits Comix* had a peak circulation of approximately 100,000, but Farmer and Chevli found it difficult to continue working in underground comics after the 1980s (Witte). *Tits and Clits Comix* produced seven issues of feminist comics, often on taboo topics, that were vividly illustrated. The visuals they used within these comics only added to the provocative nature of the topics as well. They portrayed more realistic women, as opposed to the perky-breasted and skinny Wonder Woman characters of the time, with sagging breasts, hairy legs, and natural curves (Witte).

One of their most controversial comics, *Abortion Eve*, gained notoriety as both a feminist rally for abortion access and also an informational text following the legality of abortion. *Abortion Eve* chronicles five fictional women getting an abortion shortly after *Roe* made abortion federally legal. These five women are a diverse[5] set of characters, some have a husband or children already, and vary in age, race, and socio-economic status. This counteracts some cultural narratives in the 1970s that shape the "typical abortion" patient as being someone who is young, white, unmarried, and middle-class.

[5] While the authors do represent a variety, they also rely on racial/cultural stereotypes in this comic at times.

The range and diversity presented in this comic show how different experiences have shaped their decision to get an abortion.

Abortion Eve differs than more current versions of graphic medicine in that it is a collection of voices, not just a singular experience, that allows readers to see a variety of experiences at one time. Instead of focusing on one personal story of abortion, this comic follows five women, all named different iterations of "Eve," discussing their personal experiences and reasons for not wanting a child at this time. One woman, Evita Martinez, mentions how her husband wants sons "but he's not willing to pay for them" and how she "got three daughters already with him" (3). Another woman, Eve Jones, says that she has a "husband and two kids to think about" (4). While these women are fictional, they reflect the real-world decision-making process within which decisions about abortion are made by the individual. In contrast, another woman, Evie, talks about how she's "too young to be a mother" and how she doesn't want to "get married and have a baby" (6). This character in particular reflects the normalized version of the "typical" abortion patient in the 1970s--a young, unmarried, white, middle-class woman. With these representations, it is easy for any person facing the decision whether to have an abortion or not to be able to relate to one of their circumstances in some way. *Abortion Eve* represents the many unique experiences but still creates a cohesive perspective on the abortion decision-making process, one that is rooted in a desire to demonstrate how these differing individuals arrived at their decision to have an abortion and the emotions they feel during the experience.

This comic also provides valuable medical information, reinforcing the idea of feminist self-knowledge that was gaining traction during the 1960s and 1970s. With texts

like *Our Bodies, Ourselves*,[6] there was an increase in women wanting to share valuable information about their bodily experiences in a way that was educational and applicable to the average woman. In addition, *Our Bodies, Ourselves* and other texts like *Abortion Eve* challenged the medical profession to improve the care that women receive. Along with personal narratives about each of the characters, Farmer and Chevli include medical information about different types of abortions and information about how the procedure is performed. One of the characters, Eva Flowers, discusses her prior abortion experience to the other women in the room in order to help them understand how the process will be performed. The counselor in the comic, Mary Multipary, also chimes in throughout the discussion to give medical information on anesthesia, how long it takes for a first trimester abortion, and how the abortion is performed. The details provided by the counselor, such as "the doctor has to stretch the opening of the cervix to get to the womb" (8), demonstrate language that is commonly used in a clinical setting. Interweaving this medicalized language into the more personalized conversations of the characters creates a more humanized understanding of how abortions are performed and gives readers a layman's version of the procedure. Eva Flowers, the hippie character in this comic, says her abortion "didn't hurt at all" since she was on a "super trip" (8), likely due to her receiving anesthesia, though she states she doesn't "remember what that long word means" (8). By incorporating medical terms and language about abortion procedures, the authors have created a place where the reader can not only relate to the character(s)

[6] *Our Bodies, Ourselves* was first published in 1970, a year after a female liberation conference where a workshop discussed women's experience with doctors. This grew to be a bestselling book and provided useful medical information about abortionand sexuality which, in 1970, was illegal.

portrayed in some way through their personal narratives, but they also receive medically accurate information about abortions.

Throughout the comic, practical barriers to abortion access and restrictive laws are also brought up. At one point, parental consent laws are addressed since one of the main characters, Evie, is only sixteen. She asks the other women if she will need to get her parents' permission to have an abortion and one of the characters replies that since she lives in a state where it is not required, it will not be necessary to get parental consent. Eve Jones replies to Evie's question about whether she has to tell her parents about her abortion, stating, "You're lucky you have a choice because of the state you live in--but many states do not consider a pregnant teenager able to act without her parent's permission. Hopefully that will change soon!" (15). While Evie doesn't have to ask her parent's permission in this situation, many other states at the time–and still today–had provisions in place for minors seeking an abortion that required them to receive parental consent before performing an abortion. In addition to parental consent laws being discussed in *Abortion Eve*, the comic ends with information about the *Roe v. Wade* decision: "The Supreme Court of the United States has ruled that any woman less than three months pregnant has the right to have an abortion if she can get a licensed doctor to do it. If she is between three and six months, more rules apply but it is still possible" (33). There is also a list of agencies and organizations that can assist women in finding abortion resources. Not only does this comic act as a counternarrative to some more negative abortion narratives, but it also acts as a source of information about the practical or legal barriers that have been in place when women try to access abortion.

Farmer and Chevli use visuals to show how overwhelming the decision-making process can be for some people. Throughout the comic, Farmer and Chevli use thought bubbles to show the women's internal monologue. For instance, in one panel, there is a group of text bubbles that show what types of questions a person might ask themselves through the decision-making process.

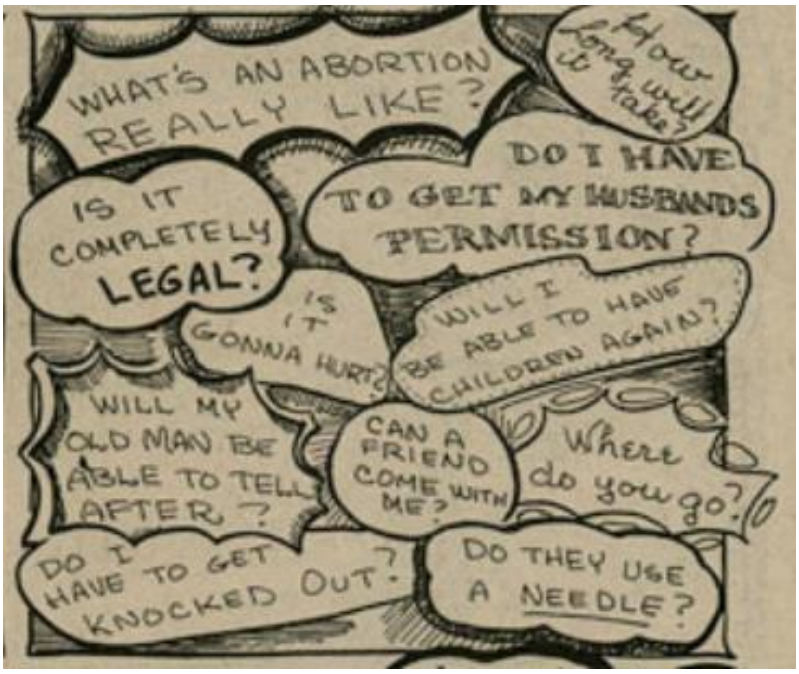

Fig. 1.1

These questions, ranging from legal to medical to personal to logistical, demonstrate the range of potential questions someone getting an abortion might have. *Abortion Eve* is highlighting how it is normal to have these questions and in this panel, the questions seem overwhelming, spilling out of the frame and into the gutters on all sides. They also use different fonts for the questions, showing that there is a diverse group asking these questions. The next panel shows the women asking Eva about her previous abortion since she is the only one in the group who has had one before, highlighting the importance of abortion storytelling. Farmer and Chevil use these visuals and the comic form to evoke an emotional response in the reader, perhaps to make the reader feel more comfortable if

they have similar questions, or at the least to show how the process of getting an abortion also comes with a wide range of questions.

Abortion Eve uses a traditional form of black and white visuals, but makes it feel unique because of the treatment of abortion. Abortion is normalized in this comic, with each woman having their own stories that, when combined, creates a powerful effect.

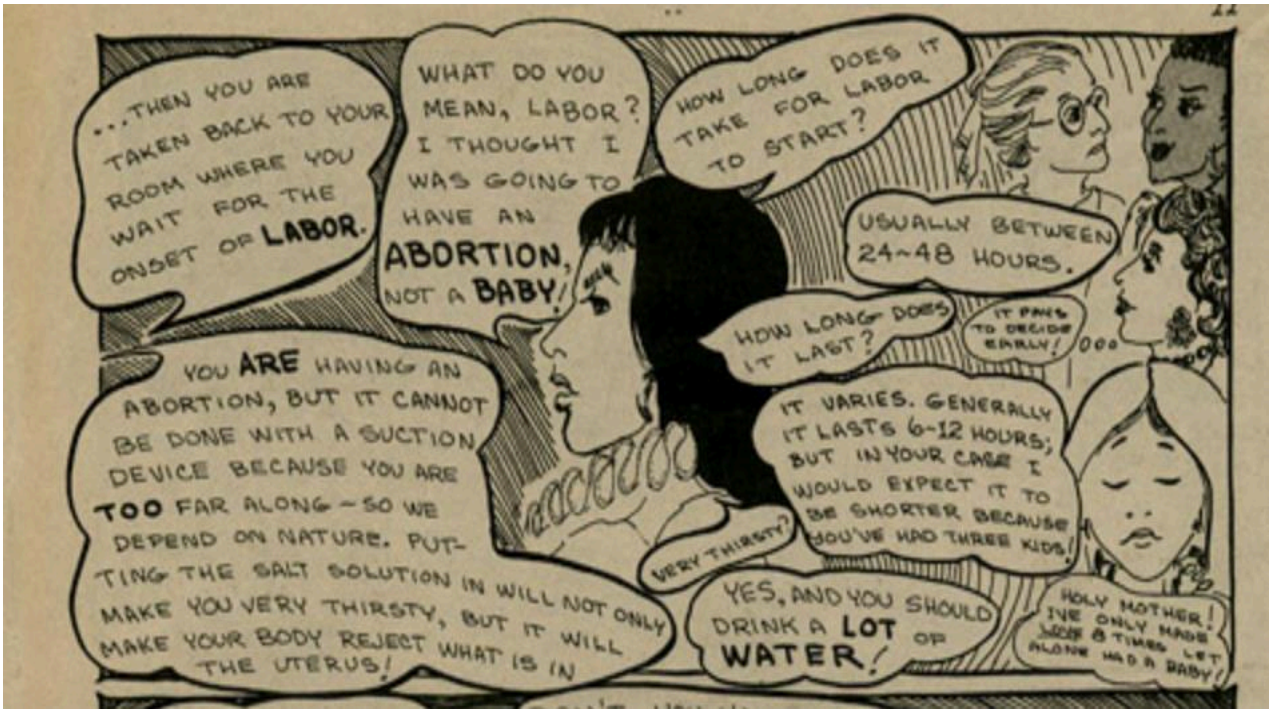

Fig. 1.2

In this panel, multiple women are asking questions about the abortion procedure and being provided useful and practical information that is medically accurate. This panel uses images of the different women speaking, but the word bubbles are overlapping, showing how people might have a lot of questions throughout this process. In addition, this panel discusses a later abortion and gives the women recommendations on the procedure. The visuals in this panel form together to create a cohesive and informative presentation of one type of abortion.

Not Funny Haha

In Leah Hayes' 2015 graphic novel, *Not Funny Haha: A Handbook for Something Hard*, she outlines the process of getting an abortion in the United States. This graphic novel is 148 pages in length, with some pages omitting text entirely and relying solely on the graphic nature of the text. Hayes creates two different stories for two different women, Lisa and Mary, both of whom decide they are going to get an abortion. The graphic novel follows the thought process and emotions that both women feel and includes medical information on the two different types of abortion procedures available. Hayes uses muted yellow and orange coloring throughout the text and the images she draws are simple but expressive. Handwritten comics evoke a more intimate relationship between the text and the reader, making it feel more authentic than typed text. In doing so, Hayes creates a visual and textual experience for her reader that can bring comfort to those who have had an abortion or those who are thinking about having one. While the novel is cautious with its medical information, constantly asking the reader to talk with their doctor about all medical procedures, it acts as a general guide for those who might not know what to expect. The graphic nature of this novel is useful in expressing more emotions through visual elements and takes the time to consider all the different emotions a person might be feeling about their decision to have an abortion or not. In much the same vein as *Abortion Eve*, this graphic novel both brings the reader into the narrative of an abortion experience while also presenting some easy-to-understand legal and medical information that the reader might not know. Both comics act as a guide and a resource, but also as a way to humanize the experience of having an abortion instead of simply talking about abortion in legal, political, or religious ways.

Hayes begins the novel by stating that the decision of whether to have an abortion or not is up to the individual. Opening the novel off in this way puts the pregnant person at the center of the plot, the main character, instead of focusing on the pregnancy itself.

Fig. 1.3

In this excerpt, Hayes portrays the woman confidently exiting the page, while a presumably-disappointed male is pictured, says, “I don’t know. I think you’re making a mistake.” In this, Hayes reminds the reader that even if it’s a difficult decision, or an easy one, that decision is yours to make. This shows, both visually and textually, how people can be shamed and stigmatized by their decision to have an abortion. By beginning in this way, she allows the reader to feel different emotions and does not restrict the range of emotions that can be felt throughout the process. In addition, she amplifies the decision-making capacities that individuals have over their own bodies and encourages the reader to be confident about their decision. Hayes centers the individual pregnant person

throughout the decision-making process while acknowledging that each experience is different.

Not only reading but also visualizing the main characters' decision-making process creates an opportunity for the reader to better comprehend what that character is going through. Hayes uses text and graphics to demonstrate what it might feel like to be making a decision like the main characters.

Fig. 1.4

In this example, Lisa is in the center of the page contemplating her emotions through both the text as well as the visual image. Her body, except for her head and arms, are completely covered, highlighting the paralyzed but contemplative expression on Lisa's face which complements the text surrounding the image. This emphasis on both the text and the visual creates a more meaningful connection to this particular individual and can lead us to empathize with her on some level. It also reinforces her role as a moral agent. The thoughtful but overwhelmed look on her face, along with the thought bubbles around

her, shows she is thinking through her choices and trying to make the best decision for herself.

Hayes then shifts her focus to discussing the two different main characters and their process for getting an abortion. She stresses that it does not matter "how" they came to the conclusion of getting an abortion, but that they both chose to get one. By acknowledging that the reason does not necessarily matter, Hayes insinuates it is up to the individual to rationalize or weigh their options on their own. Instead of creating a conversation and story around their reasons for having an abortion, Hayes chooses instead to develop how they get their abortions, not why.

Both characters choose a different procedure option for abortion in the United States. This section details what happens during both a surgical and medical procedure, giving readers a perspective on the two different choices made by her two main characters. While Hayes once again reminds readers that she is not a medical doctor, she describes both procedures in ways that are easy to understand. By following two main characters, we can gain a better understanding of how two individuals make the decision to have an abortion and what the process might look like for them.

Comics for Choice

Another useful text that demonstrates how comics can be used as a tool to destigmatize abortion is *Comics for Choice*. *Comics for Choice* (2017) is a compilation of 90 comics about abortion from a multitude of perspectives, from those who have had abortions to those who provide abortions, offering a wide lens that creates a more holistic understanding of abortion. In much the same way as *Abortion Eve* and *Not Funny Haha*, these comics also engage with the legal and medical aspects of abortion. As a direct

response to Donald Trump's election in 2016 and the constant anti-abortion legislation that seeks to end abortion access in the United States, the editors of this compilation wanted to "create a book that would educate readers about the many facets of the history of abortion in America" (1) and how we can protect access to abortion. The funding for this project was crowdsourced and individuals raised money to have it printed. This grassroots, ground-up text is similar to how zines and comics were created in the 1960s and 1970s, with smaller publishing groups producing more taboo texts than larger publishing companies. In addition, the editors created this book to represent the range of reasons people choose abortion and lend support to those who have made or are making that decision. *Comics for Choice* is unique in that it represents real, first-hand accounts of abortion storytelling but also offers other perspectives that surround this conversation.

One 8-page comic by Brittany Mostiller, "My Voice, My Choice," highlights some of the practical barriers to abortion access in America and discusses how the procedure is stigmatized. Mostiller recounts how she found out she was pregnant with her fourth child and her decision to have an abortion led her to become a reproductive justice advocate. In the first few panels, Mostiller shows herself with her children and writes that the "decision to have an abortion was the easy part" (61) but she could not afford the $900 procedure on her part-time salary. Mostiller, as a Black woman and mother, demonstrates the many barriers to accessing abortion care through both her text and the visuals she used. She was able to receive some funding from the Chicago Abortion Fund (CAF), an independent group that assists with financial and logistical barriers to abortion, but without that resource it would have been very difficult to come up with the money. Mostiller's narrative is similar to what so many individuals face when accessing abortion

in the United States. Most people who have abortions are low-income and struggle to find funding for abortions since federal funding is not allowed to cover abortions and most insurance companies do not cover abortions unless there is a health risk.

The visuals Mostiller use throughout her comic are expressive and darker than some of the other comics in *Comics for Choice.* She uses dark colors throughout the eight-page comic that make the reader feel as though they are traveling through space. In the panel below, Mostiller uses visuals to show how overwhelmed she felt at the time, especially when trying to figure out the logistical side of accessing abortion.

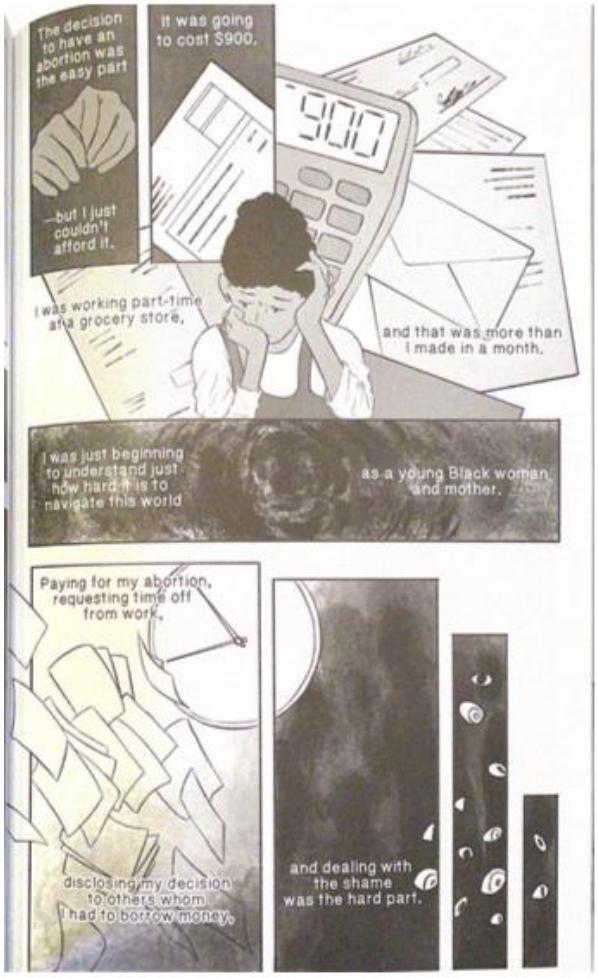

Fig. 1.5

In the middle of the page, the reader sees Mostiller with a nervous expression on her face, surrounded by images of what she is thinking about in this scene. She has to figure out

how to pay for a $900 procedure, as shown by the bill and the calculator in the top center. Below her, she highlights the time and money it is going to cost through using a clock and what we can assume are paper bills. In the bottom left portion, she shows eyes peeking through the black backdrop. This represents the shame that so many go through in accessing abortion. Whether that is shame from those she needs to tell, shame she puts on herself because of societal norms, or shame she might feel entering the clinic while being harassed by protesters. In the center, directly under her, there is a swirling, dark image, almost like a vortex, that implies how overwhelming all of these thoughts can be to some.

Mostiller's comic acknowledges the many barriers to abortion that are present in the United States, particularly for lower income mothers who are also Black, and portrays them vividly in her comic. She combines the text and the visual to create an overwhelming feeling at the beginning and moves into how she now advocates for reproductive justice and volunteers with the Chicago Abortion Fund. The last image in her comic shows her reaching out to another woman who is on the ground, with the text, "Just know that it's OK. It's actually OK" (67). While the comic starts off with a sense of shame and overwhelming emotions, it ends with her empowerment and relief.

"I Went to Kentucky's Last Abortion Clinic"

One concern in analyzing comics and graphic novels is the lack of access many people have to these mediums. Comics and graphic novels can be expensive and difficult to find in a bookstore, particularly those that address abortion. However, comics can be found throughout the internet and some of them are focused on abortion in America. For instance, *The Nib* published a comic by Arwen Donahue in 2018 titled "I Went to

Kentucky's Last Abortion Clinic" that is a perfect example of how abortion comics can also help to educate people on a larger scale than having to seek out and purchase a text. This comic follows a 40-year-old woman who lives in rural Kentucky and wants to have an abortion. She details a few reasons why she decides to have an abortion and also talks about the cultural shame she felt having an abortion. In addition, the author highlights the legal rulings that have reduced the number of clinics, particularly across the midwest and south. She even portrays short interviews she did, one with the doctor who performed her abortion and another with the Executive Director of Kentucky Health Justice Network, a reproductive justice organization that assists people in accessing abortions. Using a public-facing and free platform, the comic found in *The Nib* makes it easy to share comics immediately with those who want to learn more, or those who are having a difficult time understanding why and how people have abortions, particularly in rural parts of America.

Arwen Donahue, the author of "I Went to Kentucky's Last Abortion Clinic," uses her own abortion narrative to demonstrate the difficulties–logistical, economic, emotional, legal–in obtaining an abortion in a rural part of the country. In this comic, Donahue guides the reader through multiple legal rulings that have forced clinics across the United States to close. Not only does Donahue provide a quick overview of the laws that are easy to understand, she also gives readers a visual representation of how those laws impact the practical realities of getting an abortion.

Fig. 1.6

In the panel above, Donahue visualizes what it looks like to place so many restrictions on abortion in Kentucky. The text inside the outline of Kentucky highlight some of the ways abortions are limited in the state, such as forced ultrasounds and parental requirements for individuals under the age of 18. In this image, the person holding up Kentucky, presumably Donahue, is clearly burdened by all of these restrictions and is trying to lift or walk with these burdens. This represents how people wanting an abortion can be weighed down by all of the current restrictions in Kentucky, making it difficult to access abortion in their state.

In addition to the legal information Donahue shares with the audience, such as what legal rulings have placed further restrictions on abortion access, she also visually represents the practical implications of those rulings. For instance, Donahue discusses how the *Casey* ruling caused clinic closures across the United States, especially in the Midwest and south.

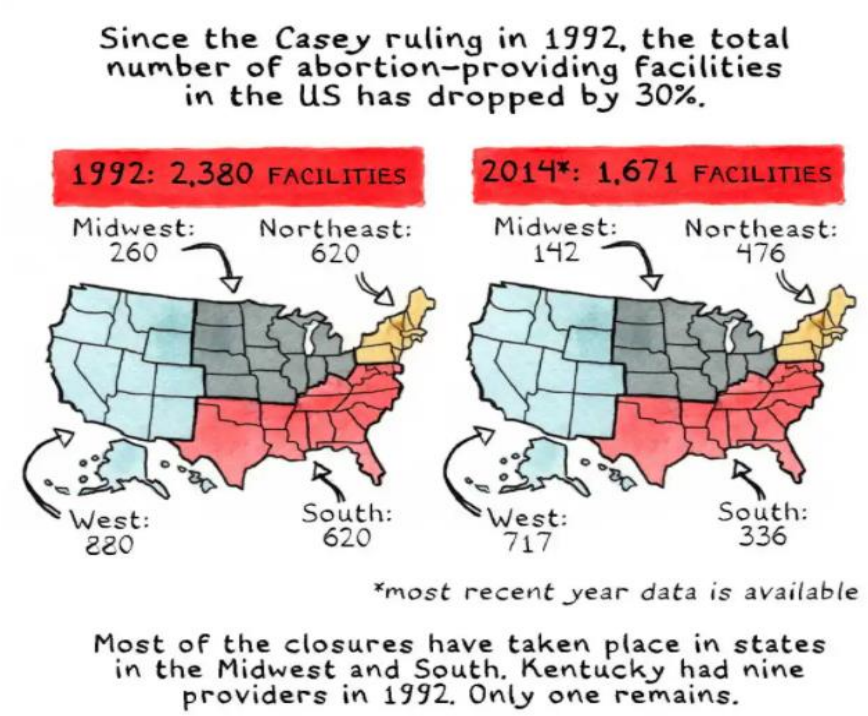

Fig. 1.7

This visual helps to highlight how restrictions have caused clinic closures across the country and uses data on the number of clinics to emphasize her argument. She demonstrates how, in only twenty years, abortion restrictions have caused hundreds of clinics to close their doors, especially in places where abortion access is limited already. These quick facts and eye-catching visuals of the statistics make it easy to understand for people not familiar with abortion access and how legal rulings have caused a 30% decrease in clinics in the United States. The last sentence in this panel, "Only one remains," creates a feeling of urgency. With only one clinic left in Kentucky, down from nine in 1992, Donahue notes how restricting and difficult it can be to access abortion in the state. Her use of both textual and visual elements in this comic combine to create empathy and understanding about abortion access in the southern and Midwestern states.

In this section, I provided a close reading of multiple comics that are used to address abortion stigma in American culture. Using these comics can help to educate

medical school students, the general public, and can even provide comfort to those who have had abortions. Comics are increasingly being used in public health settings as well as in educational settings since they appeal to a wide audience and cover a range of unique perspectives. Combining the visual and the textual elements, comics can engage readers in an empathetic and more comprehensive understanding of abortion in our culture. While I have sought out these comics, it might be more difficult to have others seek them out unless they previously had an interest in abortion or comics/graphic novels in general.

From *Abortion Eve* to *Comics for Choice*, comics have been and continue to be a valuable way to inform readers about abortion procedures in practical ways. With *Abortion Eve*, the authors provide a unique perspective of five fictionalized characters, all with differing circumstances and reasons for wanting an abortion. This multi-vocal and diverse set of circumstances allows for readers to empathize with one or more characters and along the way, the reader is exposed to information about abortion procedures, such as how they are performed. With *Comics for Choice*, the reader is also exposed to a multitude of stories and perspectives, providing the reader with many different viewpoints and aspects of abortion services. Much like *Abortion Eve*, Comics *for Choice* highlights valuable information about abortions, such as how to get funding for abortions. *Not Funny Haha* is the only graphic novel that specifically addresses abortion and while the characters are fictionalized, like with *Abortion Eve,* the graphic novel presents the reader with practical information about what to expect from the two different types of abortions—medical and surgical. Finally, "I Went to Kentucky's Last Abortion Clinic" is a non-fiction story, similar to the stories found in *Comics for Choice*, but this comic was

specifically designed to be consumed by the public and was published on a free website, making it easily shareable and more accessible. In "I Went to Kentucky's Last Abortion Clinic," the author also addresses the practical aspects of getting an abortion, especially in a state like Kentucky where it is more difficult. With all of these texts, the information-sharing is an important component to break down misconceptions about abortion and to aid in destigmatizing the procedure.

Comics offer a unique genre of delivery in that they appeal to a wide audience but have similar characteristics of traditional narrative structures and do similar "work" within larger ethical and cultural conversations. Abortion testimonies, whether through comics or in narrative form, provide a subjective experience and convey complex emotions, humanizing the experience of abortion, and re-center the individual within the larger cultural conversation on abortion, acknowledging their role as a moral agent and relaying the lived experience of the individual. One drawback to comics is that individuals must seek out this medium since it is not often publicly available. Unless someone is already interested in comics or abortion storytelling, texts like those addressed above will likely not be sought out or publicized in the same way a tweet or other social media posting would in American culture.

In the next chapter, I address another common form of media in American culture: television. Much like comics, television is able to visually display complex emotions and incorporates abortion storytelling through narratives. Combining the visual and narrative elements, as well as the popularity of television in America, aids in addressing some of the misinformation about abortion. In recent years, abortion representation on television shows have placed an emphasis on depicting a diverse set of

characters who have an abortion. Television shows like *Shrill* and *Dear White People* provide a more realistic portrayal of abortion and seek to destigmatize the procedure with their representation. While comics build on the narrative structure by incorporating visuals, television also adds another layer of inquiry due to the medium. In addition, television shows are more publicly accessible to Americans than comics that I discussed in this chapter, such as *Comics for Choice* and *Not Funny Haha.* Contributing to a larger body of abortion storytelling, in the next chapter I will address how television can be used to further destigmatize abortion for a more general audience, one that will not necessarily seek out abortion portrayals in comic or narrative form.

CHAPTER IV

ABORTION STORYTELLING ON TELEVISION

Since 1916, there have been over 400 film and television shows that have portrayed abortion in American culture, where a character either has an abortion or discusses having one in the past ("Abortion Onscreen Database"). But not all abortion portrayals are the same, and not all are an accurate portrayal of the realities of having an abortion in the United States. Moreover, in films and television shows, abortion is sometimes not even considered an option when faced with an unwanted pregnancy. For instance, in the popular 2007 romantic comedy *Knocked Up*, abortion is not even discussed as a potential option, despite the main character getting pregnant from a one-night-stand (Bigman). Or in the more recent television show *Jane the Virgin* (2014-2019), even though Jane, the main character, is accidentally artificially inseminated, there is no discussion of her having an abortion at any point.

While abortion portrayals on television or in film are primarily fictionalized, there are expectations by viewers that the latter should aspire to accurately represent the realities of American culture. Although unintended pregnancies are at an all-time low in the United States, approximately 45% of pregnancies each year are unplanned (Sawhill). This statistic, and the fact that one in four people able to get pregnant will have an abortion in their lifetime ("Induced Abortion in the United States") means that abortions

and unintended pregnancies in media are severely underrepresented. What is shown to viewers across the United States in film and television is lacking in presenting realistic portrayals of abortion which can have real-world consequences and influence public opinion. A research group from the University of California San Francisco created a comprehensive database to track when and how abortion is discussed in American film and television. The group, Advancing New Standards in Reproductive Health (ANSIRH), is primarily interested in how abortion is portrayed and how those portrayals impact public understanding of abortion. These portrayals, even though viewers know they are fictional, can impact how individuals view those who have abortions. They can also misrepresent the realities surrounding the procedure itself, perpetuating harmful stereotypes that cause abortion stigma.

In this chapter, I focus on television portrayals of abortion in American culture and argue that these portrayals need to more accurately represent the lived realities of those who have abortions in the United States. These more recent portrayals of abortion on television reflect an advancement of abortion storytelling, one that will reach a wider American audience, and although these plotlines do tell a more comprehensive story, there are still aspects that are left out, such as financial and logistic concerns when trying to access abortion. An increase in more accurate representations of abortion can lead to better public policy and cultural understanding of abortion that is contextualized. Often in American culture, discussions of abortion in our political and social spheres decontextualize the procedure and rely on false dichotomies, leading to a pro-choice/anti-abortion lens. If we had better representations of abortion, even those that are

fictionalized, perhaps this could ameliorate some abortion stigma throughout the United States.

Cultivation Theory and Abortion Portrayals on Television

Fictional portrayals on television have an impact on an audience's perception of how the "real world" operates, even if that fictionalized portrayal does not reflect reality. Cultivation theory (Gerbner) suggests that on-screen representations in television and film, even fictional ones, can impact an audience's perceptions and beliefs about reality. Fictional television shows lead people to believe certain truths about the world as portrayed through fictionalized accounts, causing viewers to understand certain issues through the lens of these imagined perspectives. Cultivation research also proposes that popular culture reinforces power dynamics by telling consistent narratives that have similar themes across a variety of genres (Swigger; Gerbner). Even social norms that are transmitted through popular culture can impact how individuals view their own reality and how people respond to real-world situations (Swigger). While viewers understand these accounts as being fictional, there are aspects of television that impact and change a person's perception of or response to real world scenarios and uphold existing power dynamics.

Abortion portrayals in television are not immune to cultivation theory, and even though the audience understands these portrayals to be fiction, it still influences how they view the topic of abortion. Researchers suggest that fictionalized scenes of abortion in television can impact viewers' beliefs about abortion and can even cause them to change their political opinions about the procedure (Sisson and Kimport "Facts and Fictions: Characters Seeking Abortion on American Television, 2005-2014"; Condit; Mulligan and

Habel). With this, it is important that we consider how fictionalized accounts of abortion are portrayed on American television. If fictionalized accounts of abortion can influence how individuals perceive certain aspects about abortion, it is necessary that portrayals of abortion both reflect the reality of the abortion landscape as well as highlight the necessity of abortion access in American culture.

Abortion plotlines are often kept within the genre of drama, reflecting how abortion is categorized as being a more serious topic of discussion. In one study that categorized abortion plotlines from 2005 to 2014, the researchers found that most plotlines, approximately 75%, occurred in dramas, specifically medical dramas. The remaining portrayals were in comedy-drama, horror, science fiction, comedy, and soap operas (Sisson and Kimport "Doctors and Witches, Conscience and Violence: Abortion Provision on American Television). However, more recent research suggests that there is a shift in the type of genres that have abortion plotlines. In one study, the author found that: "In 2016, there were four comedies that depicted abortion: *BoJack Horseman*, *You're the Worst*, *Jane the Virgin*, and *Crazy Ex-Girlfriend*. In the 32 years preceding, there had been only one comedic abortion on television; then, in the span of four months, there were four more. This represents a profound shift [in] our cultural understanding of humor and abortion" (Sisson). This genre shift is important to not only destigmatize abortion, but also to aid in seeing abortion as not always a difficult situation but one that *can* include some comedy or levity.

Barriers to abortion are often underrepresented in television portrayals and almost never force the character to not get an abortion, distorting how difficult it can be to get an abortion in the United States. In one 2017 study, "40% of television abortion plotlines in

the last 10 years portrayed barriers to abortion access…however, these challenges only rarely prevented characters from obtaining abortions" (Sisson and Kimport "Depicting Abortion Access on American Television: 2005-2015" 65). Characters who seek abortion in television are often of higher socioeconomic status than those who seek abortions in reality, largely leaving most typical abortion patients without representation (Sisson & Kimport "Depicting Abortion Access on American Television: 2005-2015"). The stories of those who have trouble accessing abortion, whether because of socioeconomic status or other barriers, are left untold. Without these stories, we will continue to see abortion being misrepresened or mischaracterized on television and lead to further misunderstandings of those who have abortions.

In this chapter, I focus on four recent examples of abortion being portrayed on television and highlight how each portrayal provides a different perspective on abortion, working to destigmatize the procedure and include more realistic abortion stories. The first television show I analyze is *Friday Night Lights* (2010), the oldest episode, but it concentrates on how abortion is perceived in a small town in Texas and the issues that surround even talking about abortion in certain parts of the United States. The next television show I analyze is an episode of *Jane the Virgin* (2016), which focuses on a Latina mother (and grandmother) getting an abortion. Latina women are underrepresented in abortion portrayals, much in the same way as Black women are underrepresented on television shows dealing with abortion, but *Jane the Virgin* is also a comedy which is a rare genre for abortion portrayals. The third episode I analyze is from *Dear White People* (2018). I chose to talk about the abortion episode in this series because of the portrayal of a Black woman having an abortion, something that is not

often portrayed. Lastly, I analyze *Shrill*'s (2019) portrayal of abortion, the most recent example explored here, which is categorized as a comedy and is unapologetically pro-abortion.

The Small Town Abortion in *Friday Night Lights*

Friday Night Lights (2006-2011) was a prime time television show that addressed many American cultural topics within the backdrop of a small Texas town. From racism to poverty, *Friday Night Lights* highlighted issues that affected American teenagers, especially those in more rural parts of the country. One plotline that extended for three episodes was when Becky Sproles (Madison Burge) decides to get an abortion, demonstrating how contentious of a topic abortion can be within small-town America in the 2000s. Within these three episodes, Becky decides she wants an abortion, but when Tami Taylor (Connie Britton) councils her about all of her options, the school board seeks to terminate her from her role as principal. The abortion procedure for Becky is quick, but the fallout of Tami's help lasts for multiple episodes, showing the stigmatization and politicization of abortion, particularly in small towns and more conservative states. Visually, *Friday Night Lights* is filmed to feel like a documentary, so the more personal scenes feel even more realistic than a standard primetime television show.

In episode 10 of season 4 ("I Can't"), Becky is faced with an unplanned pregnancy. Luke, Becky's boyfriend and the one who got Becky pregnant, has grown up in a very conservative, Christian family. Becky is young and is not sure what to do, so Tim Riggins (Taylor Kitsch), her friend, takes her to see the coach's wife, Tami Taylor. Tami, a certified counselor and principal, asks if Becky has told her parents and

recommends she talk to her mother first. Tami tells Becky that she can receive free medical care throughout her pregnancy, tells her about the teen clinic that can help, says she can refer her to an adoption agency, but Becky asks "what if I don't want to have the baby?" and Tammy responds "I can direct you to literature for that."

We then see Becky and her mother at an abortion clinic, as the still below shows. The doctor tells them, "Texas law requires that I inform you of the probable gestational age of your pregnancy at the time that we plan to do the procedure. Now, you can estimate the age by counting–" and then is interrupted by Becky's mom, saying, "We get it, Doctor." Becky's mom says that it is not necessary to go through all the procedural options because "She's not having a baby, she's having an abortion."

Fig. 1.8

However, the doctor informs her that everything he is saying is state-mandated under Texas law. Becky's mom responds, saying "I don't care what the state mandates, we really don't need to hear this information." Becky's mom is visibly upset that the doctor will not stop going through the state mandated informed consent. Throughout the scene, the camera focuses on Becky's face, often on the verge of tears. Becky looks dazed and

as though she is not paying attention to what is going on around her. She stays quiet while her mom and the doctor go back and forth. The doctor says once Becky listens to the information, then she can "decide what she wants to do," and Becky's mom responds "She's already decided what she wants to do." After storming out of the clinic, Becky's mom says that she supports her daughter and that she will get over this and continue on with her life.

This scene is a realistic portrayal of what happens in abortion clinics across America: state-mandated literature, often with exaggerated gestational images and inaccurate medical information, is required in most states before an abortion. Throughout this scene, the doctor looks as though he is annoyed at having to read this literature, knowing Becky wants to have an abortion and seeing the fear in Becky's eyes. Becky, regardless of what the doctor has to say, still wants an abortion and will still get one (Sisson & Kimport "Depicting Abortion Access on American Television: 2005-2015" 62). In addition, there is a 24-hour waiting period before getting an abortion so Becky and her mom are required to come back to the clinic for the procedure. This interaction reflects the harmful, real-world practice of state-mandated information that requires doctors to tell patients inaccurate and misleading information about abortion. It also demonstrates the 24-hour waiting period required by law, although the episode does not talk about it directly.

Becky's mom was a young, teenage mom as well, and Becky does not want to end up in the same situation. Becky shows up to the Taylor household in the middle of the night, telling Tami that she has an appointment tomorrow morning to get an abortion and that her mom is going with her. Then, Becky asks her "why do I feel so weird" to

which Tami responds “Cause this is a hard thing. This is a hard situation.” After much discussion, Becky asks, “What would you tell your daughter?” Tami states, “I would tell her to think about her life, think about what’s important to her, and what she wants. And I tell her that she’s in a real tough spot and that I would support whatever decision she made.” Later in the episode, Luke calls Becky after her abortion, although he does not know she had an abortion yet. He tells her that he will help raise their child and that he does not want her thinking it is just her problem. She says, “Luke, I took care of it, so you don’t have to worry.” She says, “It was the right thing to do.” Becky can then be seen sitting on her bed and crying, signifying the difficulty she had in making this decision. This episode portrays Becky’s abortion as a difficult decision, one that Becky is unsure about even though she is only in tenth grade and by her own admission, not ready to care for a child.

In the next episode, Luke’s mom shows up to Becky’s house, saying she wanted to meet her and let her know that she is “really sorry” about what she had to go through. At Tami’s work, where she is the counselor at East Dillon High School, the principal informs her that Luke’s mom is trying to get Tami fired because of her role in “instructing” Becky to have an abortion. Tami lets him know that the conversation did not happen on school grounds and that she followed protocol. However, they plan to hold a hearing with Tami and the school board since “this is a hot-button issue and we have a parent willing to do or say anything to be heard.” The school board said that Tami “referred her to an abortion clinic” but Tami never actually referred her to an abortion clinic since Becky’s mother is the one who ended up taking her. The school board decided not to suspend Tami for her role in counseling Becky.

In the final episode where abortion is talked about, Tami is practicing her apology speech that was pre-written by the school board due to the backlash from the community. Tami, uncomfortably, walks up to the microphone in a room full of people. She starts to read the statement that was pre-prepared for her, but then closes her notes and says she has "always put the welfare of the students ahead of everything else." Her speech is short, barely four sentences, and Luke's mom was clearly upset over her not apologizing. The next thing Tami finds out, there is an emergency school board meeting. She apologizes to her husband, Eric, that she could not apologize. Tami was put on administrative leave for six months. Tami says that she "believes it is wrong what y'all put me through and what I'd like to do is I'd like to make it right…I'd like to go where I'm needed." She recommends that she switch schools and head up the counseling program at the other high school in Dillon.

Friday Night Lights' portrayal of getting an abortion shows some of the impacts of abortion stigma on individuals, especially in states that are more restrictive of abortion. For instance, Becky's mom is apalled by the state-mandated information that doctors are required to read before having an abortion and the doctor is also frustrated at having to read it, judging from his facial expressions and annoyed tone of voice. Abortion stigma has driven a slew of anti-abortion laws that force abortion providers to disperse or read inaccurate and misleading informed consent that is generated by the state to their patients. Becky knows she wants an abortion, yet the doctor is required to state how big the fetus is at the time of her appointment. This is done to shame the patient into not getting an abortion.

Tami is also affected by abortion stigma in multiple episodes and scenes. In one scene, Tami is pulling into her work but there are dozens of people holding up signs such as "abortion stops a beating heart," showing how even talking about abortion to someone can cause a backlash from the community. Tami is also forced to resign from her role as principal because of her involvement with Becky. *Friday Night Lights* demonstrates how abortion stigma impacts not just the individual getting the abortion, but how it can impact those associated with abortion in any way. Especially in a small, rural, and conservative town, just talking about abortion can have repercussions. This reflects the reality of certain parts of the United States, leading to restrictions and public shaming of individuals.

Becky's abortion plotline gives the viewer a depoliticized perspective on abortion, one that seems to be almost neutral in its story (Lee). Although Becky does go forward with her abortion, she thinks through her options and discusses her situation with her mother and Tami. Viewers see her struggle with her decision, catering more towards a anti-abortion audience. The notion that abortion is always a difficult decision stems from misconceptions about abortions and how they are stigmatized in American culture. There is also a large anti-abortion presence in the few episodes where Tami is harassed for her involvement in Becky's decision. However, since Becky ultimately goes through with the abortion, this episode does cater to a pro-choice audience as well. Becky's decision was extremely personal and much less political in that she made no comments about access to abortion in Texas, the laws surrounding getting an abortion in her hometown, or the parental consent laws that she would need to work around (Seltzer). Since Becky's story was more personalized and less politicized, it does seem to ignore certain realistic factors

that real-life patients would have to deal with in trying to access abortion in Texas. However, the episode's emphasis on the personal over the political demonstrates how one fifteen year old might find herself pregnant, and how she might think through her decision to have an abortion.

Where *Friday Night Lights* does get political is how it portrays the fallout Tami faces in helping Becky through her decision. While Tami can be viewed as not forcing her "agenda" on Becky, the anti-choice protesters shown in the following episodes are seen trying to force their own agenda on the school board and the town by attempting to get Tami fired (Seltzer). Even though Tami is very careful in talking about abortion to Becky, she still receives pushback from anti-abortion community members who believe that even speaking about abortion or referencing literature to give to Becky would be seen as "encouraging" Becky to have an abortion. This is much like the reality of merely discussing abortion as an option in certain communities across the United States, as Nancy Northup, president of the Center for Reproductive Rights, states, "What anti-choice characters on the show want is exactly what their real life counterparts want: to deny women any information that could help them obtain an abortion and to prevent them from getting one" (Northup). *Friday Night Lights* demonstrates how, even though the conversation around Becky's abortion and her decision was not inherently political, abortion can be politicized and those who "assisted" with abortion will be chastised by anti-abortion groups regardless. The fallout of Tami's help with Becky's situation in *Friday Night Lights* reflects how some communities, especially in the Midwest and southern states, stigmatize abortion so much that even those who talk about it can be chastized.

The Already-a-Mother Abortion in *Jane the Virgin*

In one of the only portrayals of abortion in a genre other than drama, *Jane the Virgin* (2014-2019) represents not only a shift in what genres discuss abortion, but also represents the first portrayals of a Latina woman who is also a mother (and grandmother) having an abortion on prime time television (Rinkunas). *Jane the Virgin* is a satirical telenovela, where Jane Gloriana Villanueva (Gina Rodriguez), the Venezuelan-American main character, gets accidentally artificially inseminated and has a child, even though she is a virgin. Although abortion is never fully discussed as an option for Jane, being a devout Catholic herself and not wanting to disappoint her religious grandmother Alba (Ivonne Coll), there is one plotline where Jane's mother, Xiomara Gloriana Villanueva (Andrea Navedo), has an abortion. This plotline, while not a central part of the overall story, portrays a common and realistic perspective that is often not discussed on American television.

Xiomara was young when she had Jane, and still lived with her mother, Alba, while Jane was growing up. The three generations of women throughout the five seasons are very close and reflect a matriarchal household, with limited interference from men. In the episode ("Chapter 46"), Xiomara discloses that she had an abortion recently. Xiomara had been dating Esteban, a famous telenovela star, and became pregnant. Xiomara, being in her 40s and not wanting any more children after Jane, decided to have an abortion. She confides in Jane and Jane's husband, Michael, but does not tell her mother Alba out of fear. Alba is a very religious woman and Xiomara was afraid she would be very upset with Xiomara. Eventually, Alba finds out about Xiomara's recent abortion and storms out of their house, leaving Xiomara upset.

This episode of *Jane the Virgin* shows how religion can play a role in abortion storytelling. Even though Alba was upset with Xiomara about her abortion, Xiomara reminds Alba that when she was pregnant with Jane, Alba had actually told Xiomara to get an abortion because she was too young to have a child. Alba, later on, said that she felt bad for telling Xo to get an abortion, but Xiomara said it actually helped her to *choose* to have Jane. While Xiomara did not get an abortion that time, she did over twenty years later, and Alba could not understand her reasons or "put it behind" her. Xiomara eventually says that Alba "is making me feel guilty about not feeling guilty," reflecting Xo's attitude about her decision. She is not sad that she chose to have an abortion, nor does she feel any sense of guilt about choosing abortion over having a child. After a few days, Alba and Xo make amends and say that they are "just different."

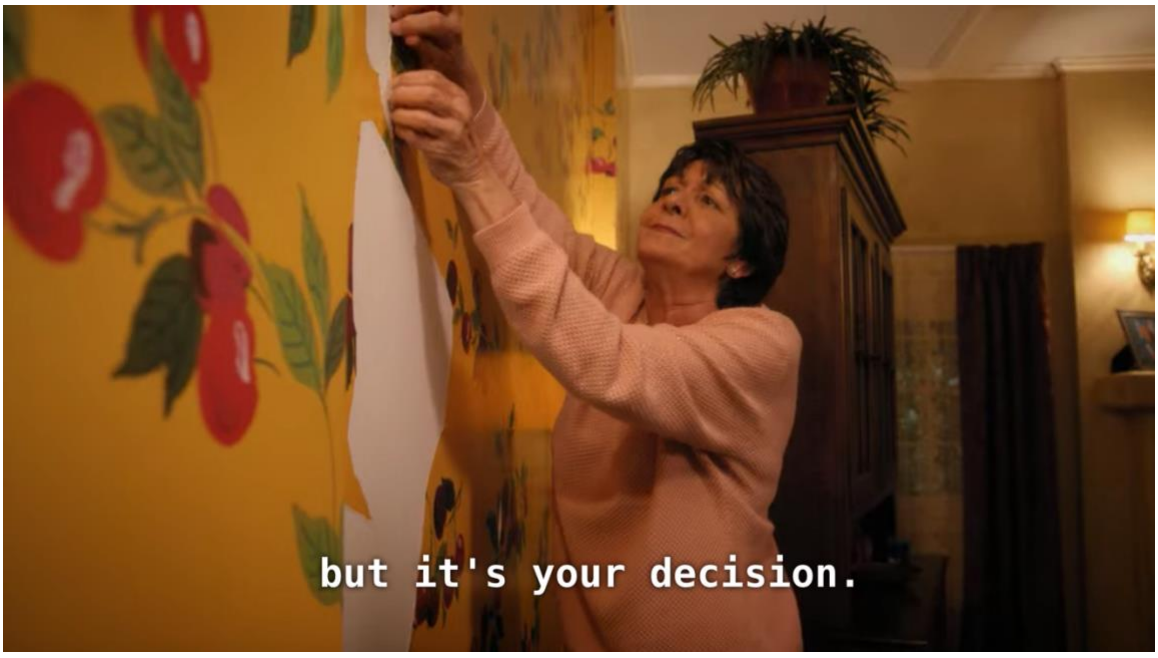

Fig. 1.9

In this scene, Alba is talking with Xiomara about her decision to have an abortion, acknowledging their differences. Alba is still visibly upset, but concedes that it is not her

decision. Also, Alba is tearing down wallpaper she stubbornly had workers put up, even though she knew it was not a good decision, just to go against Xo's opinion. Alba recognizes how she can be stubborn, both in how her house looks and also in how she responds to Xiomara's choice. Xiomara is not as religious as Alba and by the end of the episode, Alba knows she cannot force others to think about their decisions based solely on her religious notions. Alba's religion is important to her and one of the core tenets of her religion is to oppose abortion.[1]

Xiomara's abortion decision portrays an older woman of color who already has a child choosing abortion and not feeling guilty about it. This portrayal is one of only a handful of a non-white character having an abortion on television and also one of only a handful that portrays a mother having an abortion. Approximately 25% of people who have abortions are Hispanic and about 60% of people who have abortions are already parents to at least one other child ("U.S. Abortion Patients"). With this representation in *Jane the Virgin*, it gives the audience a more accurate portrayal of those who have abortions and better reflects the demographics of abortion patients. In addition, *Jane the Virgin* is considered a comedy and even though most abortion portrayals are within the genre of drama, this representation helps to extend abortion plotlines out into other genres.

Xiomara's decision to have an abortion was not one that she grappled over, contrary to many abortion portrayals on television, but she did face different reactions from her family. Xiomara knew she did not want another child and was already a busy

[1] There is a lot to be said about the Catholic Church and abortion. The first abortion clinic was opened by Catholic priests and nuns who helped women get abortions once it became legal in New York. Their pricing was greatly reduced or free, and they provided support through phone numbers for women who were trying to access abortion.

grandmother. However, the audience sees how the family responds to Xiomara's decision (Bradley), with Alba being upset about her decision but eventually coming to terms with it. This plotline has been hailed as being "revolutionary" in terms of how Xiomara does not dwell on her decision or feel guilty about it (Truong). An important part of destigmatizing abortion, especially in television, is to show how someone can have an abortion without feeling guilty or remorseful about it.

Another way *Jane the Virgin* addressed abortion in a way that destigmatizes it is that viewers do not see the abortion or Xiomara struggling with her decision. It is an easy and quick choice for Xiomara. Viewers do not see her at the clinic, talking to a doctor, or involving anyone else in her decision. Even the person who got her pregnant, Esteban, is not consulted. One critic stated that this show demonstrates that abortion portrayals on television "can be simple, it can be safe, it can be so normal as to not even need its own screen time" (Michell). Xo's decision is hers and hers alone in this episode. The producers worked with Planned Parenthood to make sure they were accurately portraying a medication abortion and doing so in a respectful way that reflects reality (Romero et al.). Portraying abortion as an easy and uncomplicated decision is not often seen on television or in movies, but it is a progressive and more realistic way to demonstrate the decision making process for many individuals who choose abortion.

Jane the Virgin places an emphasis on marginalized abortion stories. Not only does this series show a mother getting an abortion, but a Latina mother and grandmother who immediately knows what she will do when she finds out she is pregnant. These representations on television are useful to break down the stigma often attached to abortion, especially for marginalized individuals. Portraying non-white characters also

more accurately reflects the demographics of those who have abortions in the United States.

Dear White People and Breaking Generational Poverty with Abortion

In one of the only portrayals of a Black woman having an abortion on television, *Dear White People* (2017-2021) presents a more realistic perspective that accurately reflects those who have abortions and works to break down stereotypes. *Dear White People* is a comedy-drama series on Netflix that follows Black students at the fictional Winchester University, highlighting issues of race relations in American culture. In Season 2, Episode 4 ("Volume 2: Chapter IV"), Colandrea "Coco" Conners (Antoinette Robertson) is faced with an unplanned pregnancy. Coco is an ambitious and intelligent woman, the kind of female character who wears stylish clothing and always looks put together. Coco is involved in multiple clubs on campus, has a perfect GPA, and is always trying to find solutions to problems. However, when Coco became pregnant, she tried to ignore reality, avoiding making any decisions at all about whether she would continue with her pregnancy.

Once her roommate, Kelsey Phillips (Nia Jervier), finds out about Coco's pregnancy, she takes on a nurturing role and works to make Coco feel comfortable. However, Kelsey's initial response highlights how an unplanned pregnancy can happen to anyone, even to someone as intelligent as Coco. Kelsey asks Coco how this situation happened and then proceeds to acknowledge how Coco always seems "so uptight and regimented," expecting Coco to "use two condoms and a NuvaRing." This scene in the episode pushes against the myth that people with unplanned pregnancies are not using any form of birth control or that they are uninformed about birth control options. Coco

does not reveal what type of birth control she used, but this scene does reinforce the fact that even those on birth control are susceptible to an unplanned pregnancy. Furthermore, even someone as ambitious and intelligent as Coco can experience an unplanned pregnancy. The unplanned pregnancy scene ends with Coco and Kelsey lying down on Coco's bed together, with their heads touching, showing the closeness that Kelsey offers Coco in her time of need. The camera pans out and creates a touching moment for these two young women, a scene that is likely relateable for those who have had to deal with an unwanted prengnancy. This demonstrates the importance of having emotional support from someone when faced with this decision.

In the next scene with Coco and Kelsey, Coco talks openly to Kelsey about her decision. Coco is seen on her bed googling "abortion clinic," with sadness in her eyes and on the verge of tears. Kelsey lets Coco know she is there for her and will help her through whatever decision she makes. Coco responds, "Do you know what the options are for something like this? Either I have some stranger literally suck the life out of me…or I go home with a pill to face the worst possible thing I can imagine…alone." Kelsey reassures Coco that she will not be alone and that Kelsey will be there to help her through this time. Coco is visibly upset over this situation and does not seem to know whether she wants to continue with her pregnancy or not. Abortion politics are then alluded to, with Kelsey stating, "at least we're not having this discussion in Texas. Or Kentucky" and they both start listing other states that currently restrict access to abortion services. This reflects a more realistic portrayal of abortion, one that is inherently interwoven with political conversations and at the whims of legal rulings. Many portrayals of abortion on television do not address the lived realities of those faced with this decision and the logistical

barriers to abortion clinics that those individuals face, especially when incorporated with a nod to the political aspects of abortion in Amercian culture. In this way, *Dear White People* goes beyond just an individualized portrayal of abortion to a more nuanced and even politicized discussion that cannot be separated from the current reality of abortion access.

During Coco and Kelsey's abortion discussion, Coco talks about how difficult this decision is for her and implicitly addresses poverty and race. In a phone call with Coco's mother later on in the episode, her mom can be heard yelling at children running around her house and telling Coco that her cousin is pregnant again. Coco has presumably escaped the vicious cycle of having children at a young age and being stuck in a cycle of poverty, unlike her mother who had her at a young age. Coco talks to Kelsey, with tears in her eyes, about how she "came [to Winchester University] to take everything the world denied my mother and dared to deny me." While this does not explicitly address race and poverty, it implies that Coco's mother was stuck in a cycle of poverty that is inherently racialized in American society. Coco also addresses how having a choice in this situation does not make it any easier. She says, "As much as I'm not the girl who just ups and has a baby, I'm also not the girl who just…" and her voice trails off, leaving the viewer to insert the words "has an abortion." The fact that the word "abortion" is left out of every conversation reflects how many people are afraid to even say the word because of the stigma and shame that is associated with it. This scene ends with Coco and Kelsey laying on Coco's bed together, holding hands, their heads close together, as seen in the still

below.

Fig. 1.10

This shows how close they are and how Kelsey supports her friend, no matter what decision she makes when it comes to her abortion. The camera focuses on the two friends and zooms in on their faces. Kelsey's face is focused and determined, reflecting how she will support her friend. Coco's face shows apprenehsion, as though she is trying to work through her options. This scene of *Dear White People* shows how Coco struggles to make her decision, both through how she talks to Kelsey about it and the visual representation in this scene.

In the next scene, Coco and Kelsey are at the abortion clinic sitting in the waiting room. Coco looks at Kelsey and says, "Fuck this. I want to leave." They both exit the clinic and the audience sees a number of scenes where Coco is leaving Winchester University to have her child. Then, there is a flash forward to when Coco's daughter, Penelope, is 18 and has just been accepted to Winchester. Coco, as well as Penelope's father, Troy Fairbanks (Brandon P. Bell), another Black student at Winchester

University, are then shown taking Penelope to Winchester for her first semester. Penelope is excited and Coco is seen reminiscing about her time at Winchester that she was not able to finish, but Coco assures Penelope that she would be given a chance to succeed in ways that Coco was not. While Coco's facial expressions show joy and happiness for her daughter, they also show the sadness Coco felt because of the opportunities that she had to miss out on due to her pregnancy. However, this was all an imagined scene, as the viewer is then forced to come back into the present time, with Coco and Kelsey sitting in the waiting room at the abortion clinic.

The last few moments capture Coco's decision-making process in a way that feels authentic and strong. While Coco fantasizes about having a child and what her life would look like in 18 years, she recognizes that it is not the life she wants for herself at that moment. In the final seconds of the episode, the nurse calls out Coco's name as she is taken out of her daydream and we see her waiting in the abortion clinic next to Kelsey. Kelsey asks Coco what she wants to do, acting as the supportive friend until Coco makes her final decision. Coco responds to the nurse and walks towards her, her decision being made at that moment. The final seconds show Coco confidently walking towards the back of the office knowing she is making the best decision for herself at that time. Her facial expression is determined and unwavering, unlike her previous few scenes where she is thinking through her decision and weighing her options. Coco uses her abortion as "mechanisms to distance or differentiate [herself] from a combination of the 'jezebel' and 'welfare queen' stereotypes, both of which embody perceptions of reproductive irresponsibility" (Herold et al, 2020). Coco's decision to have an abortion inherently reject the stereotypes that are often forced onto young Black women who have children.

Not only does the viewer get to see Coco's daydream of carrying her pregnancy to term and what that would look like 18 years later, but it shows how Coco's desire to break the vicious cycle of having children young and living in poverty outweighed her dream of having a child just like her.

Dear White People presents the audience with a view of abortion that often is underrepresented on television. In one study, white women accounted for 87.5% of fictional portrayals of abortion from 2005 to 2014, even though in reality, white women account for 36.1% of abortions in America (Sisson and Kimport "Facts and Fictions: Characters Seeking Abortion on American Television, 2005-2014"). However, in reality, Black women are overrepresented in demographic statistics for individuals who have abortions, accounting for 28% of US abortion patients ("U.S. Abortion Patients"). Black individuals are overrepresented as abortion patients, but there is a lack of representation on television about how Blackness affects their abortion experience (Herold et al. 10). In addition, the lack of portrayals about people of color having abortions can contribute to the inacccurate and harmful perspective that abortion is not common for people of color (Herold et al. pg. 14). Terrell argues, "We need stories that realistically convey the power and complexity of Black women taking control of their own lives, on their own terms. We need humanizing stories centering Black women that show the range of emotions that go into making this type of choice and the fear of everything they will sacrifice if they don't" (Terrell). Coco's plotline in *Dear White People* provide this centering of a Black woman and the wide range of emotions she feels. This episode provided hope that perhaps the trend of portraying Black people and people of color having abortions would

continue to increase over the years, or at least start reflecting the realistic amount of Black women who have abortions.

Shrill and the Easy Abortion

In the first episode ("Annie") of the American comedy *Shrill* (2019-2021), based on Lindy West's[2] book *Shrill: Notes from a Loud Woman*, the main character Annie Easton (Aidy Bryant) has an abortion. Annie took the morning after pill after having unprotected sex, but was not aware that there is a weight requirement–a requirement the pharmacist also never mentioned. For the morning after pill to be most effective, the person taking it has to be under 175 pounds. Annie confides in her best friend and roommate, Fran, once she finds out that she is pregnant. Annie asks Fran what she should do and Fran says, "Get an abortion before it becomes illegal, or something."[3] Annie then wonders what it would be like to be a mother and how her weight plays a role in how she sees her relationships with men. She also questions whether this is her only chance to be a mother. Annie is not always confident because of her weight, a plot point in the first episode that leads into her gaining confidence as the season progresses. Since she is not confident during this episode, Annie wonders whether she will ever have a relationship with someone where they want to have children with her.

In one scene, Annie and her friend Fran are at the abortion clinic. Annie's face can be seen taking up most of the screen, as the doctor tells her that she is going to finish

[2] Lindy West is a co-founder of the #ShoutYourAbortion campaign, along with Amelia Bonow, that is discussed in chapter 2. *Shrill: Notes from a Loud Woman* is a memoir that was turned into a TV series that ran for 3 seasons.

[3] Although this response may seem like an overreaction, even in 2019 during the making of this television series, abortion access was becoming more restricted across the United States. Fran's straightforward remark reflects the reality of abortion during that time, and into the state of abortion today, where abortion could be outlawed in many states at any time.

numbing her to start the procedure.

Fig. 1.11

This scene, as the still above portrays, shows Annie's nervousness. The camera stays on Annie's face, panning in closer and closer while the doctor tells Annie that she might feel some light cramping and begins the procedure. The doctor describes what is happening throughout the short procedure, and even though the scene is only about two minutes long, it realistically portrays how quick the actual procedure takes. The next scene shows Annie and Fran smiling and lying on Fran's bed together. The next day, Annie says she feels really good. Even though Annie had an abortion the day before, she does not treat it like it was a traumatic experience or something that she has to "recover" from, but can immediately get back to her life.

This episode realistically portrays what it is like to have an abortion in America. Fran's comment about how Annie should "get an abortion before it becomes illegal, or something," reflects the reality of the politics of abortion. This creates a sense of urgency that can be felt in real-world, current discussions of abortion politics in the United States.

Annie's quick procedure takes a "matter-of-fact" stance when portraying her abortion (Butler). *Shrill*'s portrayal of abortion is also being discussed as breaking down misconceptions about abortion, such as the notion that it is always followed by sadness or feelings of guilt. Annie goes on with her life after the abortion and does not see her decision as tragic or traumatic in any way (Maple). This is an important perspective to portray on television since there is a common misconception that abortion is always a difficult decision, even though studies have shown the most common feeling after an abortion is relief (Foster*).* Annie's abortion gave her the ability to demand more from the relationship she was in and allowed her to become more confident in who she is as a person. In addition, this plot line shows a fat woman (Annie's term) getting an abortion.

One aspect of this abortion portrayal that is particularly useful in *Shrill* is the way it depicts Annie as a full, competent human who is deserving of respect. In *Ms. Magazine*, Steph Harold notes, "The mark of a revolutionary abortion episode may not be that it tells the most statistically accurate story of abortion, but that it treats the person having an abortion with compassion, love and respect" (Harold). This is an important aspect of portraying abortion stories on television. Annie goes on to write about her abortion in her job as a journalist, actually reflecting the lived experience of Lindy West, whose memoir the series is based upon. While Annie's story does not talk about the financial or logistic aspects of getting an abortion, she also lives in an area–Portland, Oregon–that is much more accepting of abortion and has multiple abortion clinics in the area. Annie is also not struggling financially or facing any barriers when it came to getting an abortion, such as childcare. However, this abortion story does give the viewers

a look at how everyone should be treated when they have an abortion: with compassion and understanding.

Abortion Portrayals on Television and Stigma

In the previous four examples, there are certain scenes that can be useful to destigmatize abortion in American culture, or at least shift the conversation about abortion from a fictionalized portrayal to a more realistic understanding. However, there is still a lot left out of these portrayals that do not align with real-world abortion access and the stigmatization of the procedure. Barriers to accessing abortion are underrepresented in portraying abortion plotlines on American television (Sisson and Kimport "Depicting Abortion Access on American Television: 2005-2015" 67). Economic barriers are severely underrepresented and are often not discussed at all in abortion plotlines, even though most people who have abortions are at or below the poverty line (U.S. Abortion Patients). Up until recently, very few portrayals of Black, Indigenous, or people of color were represented in abortion portrayals, although they make up a higher percentage of those who have abortions (U.S. Abortion Patients). While on-screen portrayals have a long way to go in portraying abortion as realistically as possible, more recent portrayals represent stories that have historically been silenced in mainstream American culture.

The frequency of abortion portrayals on television and film has increased, with more portrayals in 2020 than ever before in one year, but for the most part many of these still fail to provide a comprehensive and accurate depiction of how people in the United States access abortion. Although there has recently been a concerted effort to depict abortion in more realistic ways, portrayals of abortion continue to mischaracterize those

who have abortions and the barriers that individuals face. More abortion plotlines have included non-white charactes who have an abortion, reflecting the real demographics, but there is still a lot missing from those portrayals. Even in 2020, 74% of abortion plotlines focused on white characters, none were already parents, and in most depictions, the individual faced no economic or logistic hardships to get an abortion (Herold and Sisson "In 2020, TV and Film Still Couldn't Get Abortion Right"). For instance, even if a character is a person of color who chooses to get an abortion, the barriers of access–such as financial and logistical–are consistently left out of the portrayal even though those barriers are more common for non-white individuals.

In addition, abortion is still portrayed as being unsafe or characterized as having major complications after the procedure, but in reality, abortion is extremely safe, safer than having a cancer-screening colonoscopy or wisdom tooth removal ("Abortion Access Fact Sheet"). In one analysis, researchers found that, "About 18% of abortions on television include a depiction of a major medical complication, whereas less than 0.25% of real-life abortions result in a major complication" (Herold and Sisson . "Abortion on American Television: An Update on Recent Portrayals, 2015-2019"). This portrayal of abortion being unsafe contributes to harmful rhetoric about how abortion hurts women, but there is no research to support those claims.

There are also many television shows that could incorporate an abortion plotline but do not. For instance, a show like *Jane the Virgin*, where Jane is accidentally artifically inseminated, could have discussed Jane having an abortion even if she does not go through with the procedure. However, it was never even a question that Jane would go through with the pregnancy. While *Jane the Virgin* ends up having an abortion plotline

later on, the lack of discussing abortion in the first few episodes when Jane finds out about her pregnancy show a reluctance to discuss the hot button issue early on. If more shows included abortion plotlines, then viewers would be able to see a wide variety of abortion discussions, reflecting a realistic view of how abortion decisions are made. Even if abortion ends up not being the decision of the character, portraying these conversations can help normalize the procedure.

The four examples I chose to highlight in this chapter demonstrate how more accurate portrayals of abortion can work to ameliorate some of the stigma surrounding abortion and can lead to a better understanding of abortion in the United States. *Dear White People* and *Jane the Virgin* both portray a non-white character who has an abortion, reflecting the reality that a majority of people who have abortions are not white. *Jane the Virgin* shows viewers that mothers (and even grandmothers) can also have abortions, highlighting the statistic that nearly 60% of people who have abortions are already parenting. Both *Jane the Virgin* and *Shrill* focus on women who have an uncomplicated decision when it comes to abortion and they are very secure in their choice. *Friday Night Lights* takes place in small-town America and even though the plotline revolves around a minor needing an abortion, someone the audience is more likely to sympathize with given their young age, it turns into a politicized event that involves public shaming.

CONCLUSION

THE OVERTURNING OF *ROE*

On Friday, June 24th, 2022 around 10 AM, it happened: *Roe vs. Wade* was overturned. Immediately, trigger laws were enacted and a number of states, including Kentucky, made abortion illegal immediately. Patients at EMW Women's Surgical Center, one of only two abortion clinics in the state of Kentucky, were unable to get their abortions that day and anyone who planned to get an abortion in Kentucky will now have to travel state lines,[1] if that is even possible for them. In eleven states so far, abortion has become illegal or so heavily restricted that it makes it almost impossible to get an abortion (Sullivan). In Kentucky and other states, there are no exceptions in cases of rape or incest. Already, a ten-year-old in Ohio, who is an abuse victim, was denied an abortion because she was more than six weeks pregnant (Latifi). This will become a common occurrence in America.

[1] After a week of no abortions in Kentucky, the ACLU of KY fought the law and were granted a stay for a period of time, so abortions were able to resume. However, at EMW (one of the two clinics in KY and the only independent one) medication abortions are only being offered to patients who reside in Jefferson County. Abortions are also restricted to under 15 weeks. In addition, the National Abortion Federation, an organization that provides funding to patients in financial need, currently is not allowed to provide any funding for patients in Kentucky who need additional funding for their appointment. This is all knowledge I have because of my involvement with Kentucky Health Justice Network. Our protocols have been changing almost daily.

With that, 25 states will most certainly outlaw abortion in the coming year, with few exceptions. The states that are left, mostly on the coasts, place abortion nearly out of reach. In the south and Midwest, even without *Roe* being overturned, it has been increasingly difficult to get an abortion. Many clinics now have weeks long waiting periods due to patients traveling to other states that have access to abortion. Abortion advocates have long been sounding the alarm about the dire situation we find ourselves in when it comes to abortion access. Robin Marty, author of *Handbook for a Post-Roe America*, acknowledges that, "lack of access to safe, legal abortion *does* and *will continue* to kill those who have unwanted pregnancies—and it will be marginalized communities lacking the financial resources to find alternative methods that will suffer the most" (Marty *Handbook* 9). Marginalized communities are most likely the ones who will be greatly impacted by these legal rulings, especially considering most people who have abortions fall at or below the poverty level in the United States ("U.S. Abortion Patients"). Legal restrictions make opening clinics extremely difficult and costly, with some states regulating the widths of hallways and what type of air conditioning you can use in a clinic, a result of TRAP laws. Finding a location that will rent or even sell to abortion providers can prove to be even more difficult.

On top of legal restrictions and physical barriers to accessing clinics, there is also the financial aspects, where medication abortions started at $750 for people in Kentucky. Since a majority of people who have abortions already have other children, finding childcare during an appointment can cause issues, as well as potentially having to take off of work for multiple days. Driving hours to get to a clinic is very common. Then, when a person finally figures out how they will get to the clinic, who will watch their children,

how they will pay for a $750 + unexpected procedure, whether they are able to take off work or school, when their appointment will be, who they can confide in about their decision, and so many other things, they are faced with the shame and stigma that is attached to the procedure throughout American culture. This was all *before* some states, including Kentucky, made abortions illegal. Now, we are waiting to see how we can support this community.

As I finished up this project, it was becoming clear that *Roe* would fall in the next few months. But while abortion might still be considered illegal in a number of states, it will look different than abortion before *Roe*. For instance, we now have the internet and access to a wide variety of resources that people in need of abortions before 1973 did not have. We have local abortion funds in every state, such as Kentucky Health Justice Network, that are able to support clients who need to travel to get abortions and have been doing so for years or decades. We also have more access to abortion pills that can be mailed to your home through organizations like Plan C (PlanCpills.org), where people can order abortion pills and have information on how to effectively take the pills to end a pregnancy. Medication abortions account for 54% of all abortions in the United States (Jones et al. "Medication Abortion"). However, medication abortions are severely restricted and physicians who disperse these pills must be listed on a registry. Even though abortion pills are extremely safe and effective, they are currently under intense scrutiny by lawmakers who seek to ban abortion throughout America.

What might also look different since *Roe* was overturned, and this will vary by state, is that those people who choose abortion could be criminalized by the state they live in. This is only made easier through surveillance and the internet. For instance, when

Texas passed their 6-week abortion ban in 2021, the Texas Right to Life organization set up a whistleblower site to collect any information about people who get abortions. This site was taken down fairly soon after but does demonstrate what a post-*Roe* world might look like: citizens turning in other citizens for getting abortions. In some cases, residents of Texas can sue providers, or even the person who drives the patient to the clinic, upwards of $10,000 (Picchi). These laws that are being proposed in some states, mostly drafted by the Thomas More Society, a conservative legal organization, do in fact give private citizens the right to sue individuals who travel out of state to have an abortion if their home state considers it illegal (Kitchener and Barrett). This is untouched terrain for many professions and it is difficult to see where these cases might end.

Since this project was written while *Roe* was still in place, there are sections and arguments that I make that would only be stronger now that abortion is illegal in some states. I have included some footnotes referencing this very recent development, but since this is such a new ruling, there are still a lot of things that are unknown. There are also states that are attempting to ban abortion but have not been able to yet. State laws have been changing each day and it is difficult to keep up with the most recent changes. Lawyers, abortion providers, patients, and abortion fund staff/volunteers have been working overtime to find ways to continue their services without breaking the laws, but since the laws can be unclear, it is an extremely tenuous situation in many states.

Abortion Stigma After *Roe*

Abortion stigma is not the sole reason abortion access in America is an issue, but it certainly does not help in keeping abortion safe and legal. In our political discourse, each day, politicians wield their powers to continue stigmatizing abortion by proposing

bills that seek to "end abortion in America" to "save the babies." The amount of people who celebrated the overturning of *Roe* is disappointing to say the least, but more likely disturbing, particularly the defense of the no exception laws. Culturally and socially, we are inundated with ideas about what it means to be a woman, which even today revolves around traditional notions of heterosexual partners who have children, the wife a subservient to both husband and child. Many--if not all--of these ideas stem from a religious extremist viewpoint, primarily based in Christianity, that have infiltrated American political rhetoric. The Christian religious aspects of the abortion debate cannot be understated: Christian extremism has absolutely influenced abortion access in the United States and continues to guide harmful and life-threatening legislation about abortion.[2] The medicalization of pregnancy, and therefore abortion, continues to perpetuate oppressive ideologies and enforce a hierarchical structure. Abortion is now even criminalized–and arguably *has* been criminalized for certain individuals–which further increases the stigma. Those who are most impacted by stigmatizing abortion are already in marginalized groups: lower income people, black people, people of color, women, caregivers, trans men, and non-binary/queer individuals.

Fighting back against the *Roe* ruling, many took to Twitter to share their own abortion stories, continuing the tradition of abortion storytelling to break the stigma. Before *Roe* was even overturned, the leaked opinion a month before the decision suggested that the Court would rule in favor of overturning *Roe* because "a right to abortion is not deeply rooted in the Nation's history and traditions" (Hajjaji). Twitter

[2] While this dissertation does not fully address the religious aspects of the abortion debate, it is important to recognize the deleterious effects of Christian extremism within abortion discussions. It is especially important after the overturning of *Roe* and the legislation being proposed/passed in many states at the present moment.

users once again used Twitter to share their own personal abortion stories about how abortion has changed their lives in a positive way. People who have had abortions poured out their unique stories to Twitter to attempt to preserve *Roe*. Even those who have never shared their story before decided it was time to open up about their experience (Hajjaji).

We Testify, an organization dedicated to reproductive justice and sharing abortion stories, created multiple comics about self-managed abortions. Even before *Roe* was overturned, We Testify has been using comics to easily distribute information on how to safely use abortion pills and how to manage an at-home abortion. These resources were widely shared on social media, with politicians like Alexandria Ocacio-Cortez even sharing the comics on her own Twitter page. She was immediately reprimanded by Republican politicians, but responded by stating, "Republicans are mad because I am sharing this information. Too bad! Freedom of choice is an inalienable right. Your bodily autonomy belongs to you" (Conley). The comics that were distributed are informational and give individuals the ability to access abortion resources if they need, or at the least find out if abortion pills are a good option for themselves. These informational comics not only give individuals more agency to make the best decision for themselves, but they do it in such a way that is clear and easy to understand.

Narratives are a concrete way to conceptualize the abortion debate and provide unique perspectives about how certain rulings will impact an individual. While narratives cannot completely change the laws and bills being proposed, they can—and do—impact how we perceive abortion socially and culturally. The more we see abortion portrayed, the more normalized the procedure will become. Increasing abortion representations on television or on social media can promote deeper discussions about who is impacted by

abortion legislation and the many barriers people face when accessing abortion. Thus, it is important to accurately portray abortions in popular culture and show the many ways access can be denied in America. While narratives cannot necessarily undo harmful legislation, narratives do have a place in the abortion discussion. There is not one singular thing that can be done to improve access to abortion at this time, but a combination of many things, over time, that can result in more compassionate and empathetic ways we address abortion in the United States.

In these moments, it is difficult to predict how American culture will respond to the banning of abortions across the United States, and how that will impact abortion stigma. There is already so much stigma surrounding abortion that this ruling could add to the negative stigma associated with abortions. Making abortion illegal will also lead to more deaths because people *will* try to self-manage their own abortions by using unsafe methods. This will make abortion *seem* more dangerous than it is, increasing the stigma. However, with the outpouring of abortion stories and more attention paid to the abortion discussion, it could potentially lead to a reduction of abortion stigma. This could be the "wake up" call that good-intentioned people who support abortion in private but not publicly need in order to talk about it. As I mentioned in my introduction, I was naïve in thinking that abortion was the "law of the land" until I started researching and writing about abortion. I know I am not the only one. It was not until I started to get involved with reproductive justice organizations and began volunteering that I was able to understand the dire situation the United States was actually in. And while the future of abortion is America is uncertain, one thing is for certain: these are unprecedented times

that call for extraordinary support for abortion access and an unending thank you to those who have shared their personal abortion stories.

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CURRICULUM VITAE

Kathryn Lafferty-Danner
856-287-7426 • Kathryn.N.Lafferty@gmail.com

EDUCATION:

University of Louisville
Ph.D., Humanities 2022
Dissertation: "The A-Word: Contextualizing Abortion in American Culture"
Adviser: Ranen Omer-Sherman
Committee: Stephen Hanson, Nancy Theriot, and Ann Allen (outside reader)

M.A., Bioethics and Medical Humanities 2018

Rutgers University-Camden
M.A., English 2012
Comprehensive Examinations in Critical Theory and Twentieth Century Literature

B.A., English 2010

Camden County College
A.A, Liberal Studies 2008

PROFESSIONAL EXPERIENCE:

Administrative/Staff Experience:

Pennsylvania State University January 2020-December 2021
Writing Center Coordinator

- Oversees daily operations of the Writing Center (e.g. updates tutoring schedules, supervises and coordinates peer tutor hours, markets services to the campus, updates resources available to students)
- Tutors students in a variety of disciplines
- Collaborates with other departments and committees on implementing larger shared projects (e.g. Writing Across the Curriculum initiatives, Annual PSU Learning Center Conference)
- Facilitates Writing Center workshops and tutor trainings

Jefferson Community and Technical College summer 2016
E-Tutor

- Assisted online ENG 101 students in writing assignments

Jewish Community Center/University of Louisville summer 2016

Archival Internship

- Assisted in organizing and archiving photographs from the Jewish Community Center
- Digitalized photographs and posted onto the JCC Facebook page for identification of individuals

University of Louisville fall 2015-spring 2016; spring 2019
Study Abroad Office, Graduate Assistant

- Organized and compiled data for independent projects focusing on study abroad trips for students
- Assisted with transcript processing from foreign universities
- Edited and composed organization documents

Rutgers University-Camden October 2012-June 2014
School of Nursing Administrative Assistant for Graduate and Professional Programs

- Assisted the Associate Dean and Program Director in developing and implementing two new graduate programs (e.g. admission into program, recruitment processes, and printed and electronic materials)
- Worked with Business Manager to assist with SoN-C budget, reimbursements, and financing department events and lectures
- Maintained and updated School of Nursing-Camden website
- Generated clinical facility contract

Rutgers University-Camden spring 2012
Teaching Assistant for Undergraduate Philosophy Course, "Introduction to Philosophy"

- Organized and graded weekly assignments for 80 students
- Assisted the Professor in grading exams and student essays
- Researched philosophical concepts of the Western world to aid Professor in coursework and grading

Teaching Experience:

Misericordia University
Part Time Adjunct English Instructor fall 2019

- Develop syllabus and execute daily lesson plan assignments for writing intensive English course

University of Louisville spring 2017-fall 2019
Comparative Humanities Department, Graduate Teaching Assistant

- Developed syllabi that adhere to Cultural Diversity and Arts and Humanities requirements
- Full responsibility of course assignments, grading, and material taught

Jefferson Community and Technical College fall 2014-winter 2016
Part Time Adjunct English Instructor

- Developed syllabi and execute daily lesson plan assignments that adhere to English Department/Humanities Student Learning Outcomes
- Continual research in pedagogical and compositional methods for class exercises

Courses Taught:

Misericordia University
Women Writers (Writing Intensive course) fall 2019

University of Louisville
Cultures of America spring 2017-spring 2019 (2 sections per semester)
Cultures of America Online summer 2018, summer 2019

Jefferson Community and Technical College
English 101/Writing I fall 2014 (3 sections), spring 2015 (3 sections), summer 2015, fall 2015
English 101/Writing I Online fall 2015, fall 2016 (2 sections)
English 102/Writing II fall 2014
English 102/Writing II Online summer 2015, spring 2016
ESL English 101/Writing I spring 2015
Introduction to Humanities fall 2015, spring 2016
Introduction to Humanities Online spring 2016

PUBLICATIONS:

Book Reviews:

Lafferty-Danner, Kathryn. Rev. of *Reproductive Justice: An Introduction*, by Loretta J. Ross and Rickie Solinger, *American Philosophical Association's Newsletter on Feminism and Philosophy*, December 2019.

Lafferty-Danner, Kathryn. Rev. of *The Poetics and Politics of Alzheimer's Disease Life-Writing*, by Martina Zimmermann, *Journal of Medical Humanities*, July 2019.

Lafferty, Kathryn. Rev. of *Hysteria Today*, Edited by Anouchka Grose, Blog for *Medical Humanities*, July 2016.

CONFERENCE PRESENTATIONS:

"Make it Graphic: Abortion Storytelling as Resistance" February 2022
The 49th Louisville Conference on Literature and Culture since 1900, Louisville, KY

"Abortion Storytelling: Breaking the Stigma with Comics." March 2020
2020 International Health Humanities Consortium: The Politics of Health Conference, Vanderbilt University (Cancelled due to COVID—not rescheduled)

"Unruly Women and the 'Rejection' of Motherhood" February 2020
The 48th Louisville Conference on Literature and Culture Since 1900, Louisville, KY.

"Whispered Words: Destigmatizing Abortion Using Comics." September 2018
Eight Annual Western Michigan University Medical Humanities Conference, Kalamazoo, MI.

"The A-Word: Reducing the Stigma of Abortion Through Graphic Novels." February 2018
The 46th Louisville Conference on Literature and Culture Since 1900, Louisville, KY.

"The Textual Third Space: *Ourika* and the Psychiatric Subject." September 2016
Cultural Rhetorics Conference, East Lansing, MI.

"Patient as Doctor: Identity, Illness, and the Internet." April 2016
Arts and Health Humanities Conference, Cleveland, OH.

"Scenes of Agency: Identifying as Ill and Navigating Treatment Choice." October 2014
Cultural Rhetorics Conference, East Lansing, MI.

PROFESSIONAL DEVELOPMENT:

Safer People, Safer Places, Penn State University spring 2020
Two-hour training on LGBTQ concerns and creating safe, inclusive spaces
Diversity Circles, Penn State University spring 2021
Weekly discussions about race, ethnicity, and creating space for marginalized individuals
LGBTQ Ally Education Training, Misericordia University fall 2019
Two-hour training on LGBTQ issues and creating inclusive spaces
Online Teaching Training, Delphi U, University of Louisville summer 2018
Week-long training to teach online at University of Louisville
Grant Writing Academy, University of Louisville spring 2017
Semester-long series of sessions for selected participants designed to teach knowledge and skills of grant writing
Adjunct Academy, Jefferson Community and Technical College fall 2015-spring 2016
JCTC professional development for selected part-time instructors for one year

FACULTY AWARDS:

Nominee of "Faculty Favorite" Award, University of Louisville spring 2019
Nominee of "Red and Black Scholar Mentor," University of Louisville spring 2019
Nominee of "Faculty Favorite" Award, University of Louisville spring 2017

ACADEMIC AWARDS:

Dissertation Completion Grant (full semester scholarship and stipend) spring 2022
Department of Humanities Conference Travel Scholarship ($250) fall 2019
Graduate Student Council Travel Funding Grant Recipient ($350 fall 2018
Fellowship-Scholarship Award, Rutgers University fall 2011
Awarded for excellence in academic standing

PROFESSIONAL AND ACADEMIC SERVICE:

University Service:
Voting Member, Staff Council, Penn State University August 2020-December 2021
Assessment Reader, Arts and Humanities Cardinal Core Assessment spring 2019
Panelist, Brandeis School of Law Nov. 2018
"*Reversing Roe* Screening and Roundtable Discussion"
AAUP Graduate Representative fall 2017-spring 2018
Graduate Student Council, fall 2016-spring 2017
Department of Humanities student representative
GSC Events Committee, Committee Member fall 2016-spring 2017

JCTC Contingent/Part-Time Task Force, Committee Member 2015-2016

Department Service:

Association for Humanities Academics, President fall 2017-spring 2019
Graduate Student Mentor fall 2016-spring 2019

CERTIFICATIONS:

Delphi U Online Teaching Certification, University of Louisville 2018
Blackboard Teaching Certification, Jefferson Community and Technical College 2015

GRANTS RECEIVED:

The Society of Family Planning Research Fund, May 2022, "Assessing Reproductive Equity in Kentucky After Dobbs."

VOLUNTEER AND COMMUNITY EXPERIENCE:

Scranton Board of Ethics, Vice Chair October 2021-present

Kentucky Health Justice Network, Abortion Access Hotliner April 2017-present
Conduct intake for people accessing abortion and assist them with funding, transportation, and logistical support

Louisville Clinic Escort January 2017-July 2019
Assisted patients and companions into EMW Women's Medical Center for abortion procedures 5-7 hours per week