"MY ABORTION MADE ME A GOOD MOM": AN ANALYSIS OF THE USE OF MOTHERHOOD IDENTITY TO DISPEL ABORTION STIGMA

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ABSTRACT

This chapter examines how women deploy gendered motherhood norms to publicly challenge abortion stigma. Drawing on a sample of 41 abortion stories from women living in Tennessee, I find that women evoke notions of intensive, total, and idealized motherhood in order to manage and challenge the stigma of an abortion. A large proportion of these stories were written by married mothers who emphasized their identities as good mothers and wives. A close qualitative analysis of these trends reveals two dominant forms of recasting abortion. First, abortion is framed as an extension of total mothering to spare an unborn baby from risky health conditions. Part of this includes casting abortion as an often-necessary choice in order for a woman to develop into the perfect mother for the benefit of her children – altruistic self-development. Second, abortion is construed as a form of maternal protection of current children to continue intensively mothering them. Both themes speak to women's strategies for reframing abortion as a health practice to promote the well-being of children. These findings have implications for the study of medical stigma, reproduction, and the impact of gender ideals on women's health choices.

Keywords: Stigma; abortion; motherhood; gender; health; reproduction

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While women are habitually subjected to scrutiny for their reproductive behaviors (e.g., Waggoner, 2011), abortion receives particular stigma in the United States. For instance, abortion is not integrated into the healthcare system like other realms of reproductive health (Altshuler, Ojanen-Goldsmith, Blumenthal, & Freedman., 2017). Instead, abortion care continues to be sequestered in separate medical facilities and it is relatively inaccessible for most women through travel and out of pocket costs (Jerman, Jones, & Onda, 2016; Joffe, 2013; Jones & Jerman, 2014; Norris et al., 2011). This stigma is also evident in the restrictive legislation introduced at an unprecedented rate in recent years. In the first quarter of 2017 alone, 431 provisions were introduced to restrict access to abortion services (Guttmacher Institute, 2016a, 2016b). While the severity of legal and bureaucratic obstacles varies by state and region, the South is considered the most hostile region to abortion; as of January 2017, 93% of women in the South live in a state hostile or extremely hostile to abortion, compared to 68% in the Midwest, 24% in the Northeast, and 15% in the West (Guttmacher Institute, 2016a, 2016b).

This medical stigma occurs in tandem with normative motherhood ideals – namely the *imperative of motherhood* (e.g., Collins, 2005; Remennick, 2000) and notions of *idealized mothering* (e.g., Hays, 1998; Lareau, 2011; Wolf, 2010). These terms refer to the pervasive cultural ideas that motherhood is the cornerstone of femininity (Gillespie, 2003), and that women have a set of rules to adhere to in order to be considered good mothers and good women. These cultural expectations have particular bearing on the health practices of women, ranging from nutrition, childbirth, reproductive technologies, and beyond (e.g., Malacrida & Boulton, 2012; Markens, 2007; Wolf, 2010), particularly how these health choices might impact their children.

While motherhood and abortion are often understood as antithetical in normative discourse, scholars have long understood abortion stigma as rooted in these hegemonic definitions of motherhood (e.g., Beckman, 2017; Harvey, Beckman, Castle, & Coeytaux, 1995; Jones, Frohwirth, & Moore, 2007; Kumar, Hessini, & Mitchell, 2009; Luker, 1984). Additionally, scholars are beginning to examine how women themselves draw upon frameworks of idealized mothering in order to manage abortion stigma internally and interpersonally through interviews or surveys (e.g., Jones et al., 2007). An area that needs further examination is how women publicly challenge abortion stigma (Allen, 2015), and how they might draw upon culturally held beliefs surrounding "proper" motherhood as a strategic framing. While anonymous interviews and surveys glean important insight on how women negotiate and manage stigma intra- and interpersonally, they do not speak to the discursive strategies women might employ to shift collective meanings of abortion, nor the narrative framings women might use without anonymity (Beynon-Jones, 2017).

Moreover, prior work on abortion and gender indicates symbolic divisions of women into disparate camps (e.g., Ginsburg, 1989; Luker, 1984; Nack, 2002). As these studies find, pervasive abortion debates – and sexual morality arguments, more broadly – organize women into either "good" girls and housewives, or "bad" girls and feminists. More specifically, social discourses often frame

obtaining an abortion as directly oppositional to normative definitions of proper motherhood – and thus womanhood. Through an analysis of 41 online abortion stories, this study seeks to complicate the binary understandings of abortion stigma by focusing on women's narratives in the gray area. I examine how women attempt to publicly bridge these contradictory discourses and symbolic tribes of women – by framing themselves simultaneously as women who are "good girls," wives, and mothers and yet chose abortion in order to perform "appropriate" mothering. Drawing upon scholarship on gender, motherhood, health, and stigma, I analyze data from the Tennessee Stories Project, an initiative that invites women in the state to share their abortion stories to tackle abortion stigma. My theoretical contribution provides a valuable framework for understanding public stigma-management strategies for women vis-à-vis medical decisions, particularly in the context of reproduction and gendered motherhood expectations. This framework elucidates how women publicly seek to destigmatize abortion by drawing upon the societal requirement that all women become mothers, and that all mothers aspire to the ideals of intensive and total motherhood.

The goals of this chapter are twofold. First, I examine the characteristics of women willing to publicly share their abortion stories to dispel stigma, particularly in one of the nation's most anti-abortion states. Second, I analyze the ways women employ cultural framings of proper gender and motherhood as a strategy for destigmatizing choosing an abortion. In the end, my analysis supports other abortion stigma research that indicates women who have obtained abortions seek to repair a damaged reputation through gendered strategies. At the same time, my findings also indicate that much like other health decisions women must make for their children – actualized or potential, abortion is symbolically woven with the cultural imperative for women to be selfless experts in the health of children and babies. Akin to the health choices women must make surrounding pregnancy (Waggoner, 2017, 2015), childbirth (Malacrida & Boulton, 2012), childhood nutrition (Wolf, 2010), and immunization (Reich, 2014, 2016), abortion is part of the neoliberal health framework in which mothers are expected to predict and minimize all risks to a child's optimal development. Before proceeding to the analysis, I will review relevant literature on stigma, health choices, and motherhood.

STIGMA AND ABORTION

Largely credited with introducing "stigma" into sociology, Goffman (2009) defines the term as a visible or invisible trait that departs from "the ordinary and the usual" and marks someone as *deviant*. The stigmatized individual is then devalued in social interactions, as their identity shifts in the eyes of society. Link and Phelan (2001) expound upon this idea, by describing the four consecutive social processes through which stigmatization occurs. Human differences are first distinguished and labeled, after which negative stereotypes are linked to the individuals who embody or enact the undesirable characteristics, by evoking dominant cultural beliefs as the scaffold. In the third step, the marked persons

are placed in distinct categories to create an ingroup and outgroup. Finally, the labeled persons experience status loss and discrimination. Herek et al. (2009) further build upon the stigma literature by disentangling the three manifestations of stigma: *enacted*, *felt*, and *internalized*. Enacted stigma encompasses overt negative actions such as spoken judgments, discrimination, hate crimes, or displays of disgust – for instance, that of protesters outside of abortion clinics. Felt stigma refers to a woman's perceptions of others abortion attitudes and the expectations of how individuals might act upon their attitudes. Finally, internalized stigma results from a woman's acceptance of negative cultural beliefs about abortions and those who have them (Cockrill & Nack, 2013; Crocker, Major, & Claude, 1998).

The concept of stigmatization has been applied in the study of various medical realms, from mental illness (Link, Yang, Phelan, & Collins, 2004) to HIV/AIDS (Castro & Farmer, 2005; Ogden & Nyblade, 2005; Parker & Aggleton, 2003) to cancer (Sontag, 1978) and beyond. More recently, literature has been brought to bear on the ways stigma manifests in the case of abortion (e.g., Altshuler et al., 2017; Bommaraju, Kavanaugh, Hou, & Bessett, 2016; Harden & Ogden, 1999; Shellenberg & Tsui, 2012). Scholarship on medicine, health, and illness continuously indicates abortion's marginalized status within the field of medicine and beyond. Though medicine is regarded as among the most prestigious professions, physicians who provide abortions are outliers given their vulnerability and relative powerlessness (Freidson, 1988; Joffe, 2014). Within the practice of medicine, abortion care is regulated in an unprecedented manner by congress through various TRAP laws (Targeted Regulation of Abortion Providers) which often result in the closing of clinics across the country (Gold & Nash, 2013). Further, abortion providers and clinic staff have been the targets of violence and harassment in recent years (Manzoeillo, 2017), which further stigmatizes abortion care and contributes to a reluctance by physicians to become trained in abortion care (Freedman, 2010; Grimes, Forrest, Kirkman, & Radford, 1991; Joffe, 2014, 1995; Joffe, Weitz, & Stacey, 2004; Russo, Schumacher, & Creinin, 2012). While the stigmatization of abortion has broad impacts on various groups, scholars argue that women seeking to have an abortion receive the greatest burden (Joffe, 2014). Due to a range of bureaucratic obstacles – including waiting periods, lack of insurance coverage, and a shortage of clinics – many women have difficulty finding a provider and affording the procedure (Joffe et al., 2004).

In addition to illuminating the various manifestations of abortion stigma in medicine and politics, scholars have also begun to interrogate the source of abortion stigma in cultural discourses (e.g,. Allen, 2015; Altshuler et al., 2017; Bommaraju et al., 2016; Joffe, 2010; Norris et al., 2011). Some of this work is informed by Schur's (1984) conceptualization of women and "femaleness" being labeled as deviant through the stigmatization of a wide range of behaviors. Schur posits that this is manifest in the stigmatization of lesbianism, sexual harassment and rape victimization, sex work, anorexia, and – notably – abortion. Luker (1984) develops this latter point by defining abortion stigma as a function of rigid gendered stereotypes, including stereotypes of "acceptable"

femininity and women's "innate" desires to become mothers (Cockrill & Nack, 2013; Kumar et al., 2009). While there are many ways to transgress these gendered expectations throughout a woman's life – for instance, through premarital sex, the use of birth control, being childless, promiscuity, etc. – abortion seems to simultaneously signal multiple wrongdoings (Cockrill & Nack, 2013). Abortion denotes a woman's participation in non-procreative sex, a lack of desire to mother or nurture, and other behaviors and beliefs considered counter to the ideals of femininity (Cockrill & Nack, 2013; Kumar et al., 2009).

In fact, Nack (2002) argues that gendered sexuality norms construct two "tribes" of women. One tribe encompasses the "good" women – the virginal girls, the wives, the mothers – and the other defines the "bad girls and fallen women." Unsurprisingly, the "good" tribe of girls and women are granted a higher cultural status over the "bad" tribe – who are seen as having *chosen* bad behavior due to their own "personal failings" (Cockrill & Nack, 2013; Goffman, 2009; Nack, 2002). The good and bad behavior tends to pertain to expectations of motherhood and sexuality – including being a sexually active woman, contracting an STD, or having an unplanned pregnancy. Hence, Kumar and colleagues (2009, p. 628) 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." More specifically, they hypothesize that abortion challenges three prevailing ideas about womanhood: an innate feminine nurturing, exclusively procreative sexuality, and ultimately becoming a mother (Kumar et al., 2009).

Due to these transgressions, negative stereotypes are applied to women who choose to terminate pregnancies. Such women are assumed to be low income and without political influence, irresponsible, and selfish (Beckman, 2017). Cockrill and Nack (2013) applied Herek's (2009) three-part model of stigma to women who have had abortions, and found that women cope with different manifestations of stigma intrapersonally by "managing the damaged self," while maintaining a good reputation or managing a damaged reputation. Managing the damaged self includes justifying one's abortion through various explanations or reasonings. One might justify an abortion by explaining that the pregnancy was the result of rape, describing the difficulty of giving up a baby for adoption, or by reframing abortion as a way of fulfilling preexisting obligations to spouses or family members – "appealing to higher loyalties" (Cockrill & Nack, 2013).

Furthermore, although the political discourse on abortion tends to be discussed in regard to definitions of life and the rights of the fetus, Beckman (2017) instead argues that the controversy lies in opposing definitions of womanhood and the importance of motherhood. More specifically, she argues that those who oppose access to abortion view it as a threat to morality, social cohesion, and motherhood (Beckman, 2017; Harvey et al., 1995). Luker (1984) describes this debate as a referendum on the place and meaning of motherhood, with abortion stripping "the veil of sanctity from motherhood." By choosing to terminate a pregnancy for any reason, a woman is rendering something – a career, education, financial stability – as more important than motherhood, thus demoting motherhood from a sacred calling to merely a job (Luker, 1984). As such, an

examination of abortion stigma is incomplete without a focus on motherhood and the complex, multifaceted place it holds in society.

MOTHERHOOD, GENDER, AND HEALTH

Despite radical shifts in gender norms in the past several decades, particularly in regard to education and the workplace, motherhood continues to be viewed as the cornerstone of adult femininity and the role of mothering is still central to normative definitions of womanhood (Collins, 2005; Gillespie, 2003). Oakley (1986) referred to this phenomenon as the "contemporary myth of motherhood," which rests upon three chief beliefs: all women need to be mothers, all mothers need their children, and all children need their mothers. Others have referenced the widely held belief that women must eventually become mothers to reach adulthood as "compulsory motherhood" (e.g., Collins, 2005) or "imperative motherhood" (e.g., Remennick, 2000). Despite the range of descriptive terms, they all point to the overarching treatment of all postpubescent women as potentially pregnant or one-day-mothers (Malacrida & Boulton, 2012; Waggoner, 2015) and the belief that motherhood is the primary means for identity and status attainment for women.

Weaving together this narrative is the idealized model of motherhood. This mythical ideal mother is a selfless, nurturing woman who will sacrifice herself and all competing goals in order to intensively care for her child (Collins, 2005; Hays, 1998; Lareau, 2011). Despite being derived from the white middle-class, this model has been projected as natural, universal, and the image to which all women should aspire (Glenn, 2016). In recent decades, this hegemonic notion of "good mothering" has expanded in its breadth, requiring women to be experts in everything a child might encounter and to predict and prevent any risks to health and development (Jackson & Schott, 1999; Wolf, 2010). Wolf (2010) refers to this cultural expectation as "total motherhood," which she argues is shaped by neoliberal health risk culture and a mother's responsibility to optimize every facet of a child's life. In this trade-off between mothers' "wants" and children's "needs," anything less than ideal is dangerous (Wolf, 2010). Further, through this lens, both the ideal mother and the ideal, potentially pregnant woman are selfless and ready to abandon their former immature selves to achieve "true womanhood" for the well-being of their children (Malacrida & Boulton, 2012; Waggoner, 2015).

In a culture of monitoring and reprimanding women for "bad mothering" (Malacrida & Boulton, 2012), the well-being of babies and children is conceptualized ecologically, wherein everything about an individual's life is potentially risky to one's health. Women are expected to begin this form of idealized mothering during pregnancy (Copelton, 2007; Reich, 2014, 2016; Waggoner, 2015), or even before conception by taking health precautions for any potential future pregnancy (Waggoner, 2011, 2015, 2017). This unattainable mothering framework impacts women across various health decisions before and after conceiving children; for instance, when considering new reproductive technologies (Markens, 2007), choosing between breastfeeding and formula (Wolf, 2010),

deciding on a birthing plan (Malacrida & Boulton, 2012), or in questioning whether to vaccinate (Reich, 2014, 2016). As many scholars have argued, elements of women's reproduction become symbolic repositories through which to express anxieties about gender, sexuality, and women's roles in society (Armstrong, 2003; Markens, 2007; Reich, 2014; Wolf, 2010). Through this framework of gender and health decisions, abortion is often conceptualized in the collective imagination as counter to these ideals – for women are ending the reproductive process through an abortion. However, this study seeks to interrogate that further, to see how women themselves view abortion as fitting into these larger cultural narratives surrounding women's health choices and motherhood – and how they deploy such views to destigmatize their abortions.

MOTHERHOOD AND ABORTION

The connection between abortion and motherhood ideals has been consistently shown in recent studies. Perhaps the most prominent analysis of this interplay, Luker's (1984) study of abortion activists argues that abortion access is contested between two oppositional groups – or tribes – of women. More specifically, Luker characterizes the abortion battle among activists as a controversy fought by "feminists" versus "housewives." She defined these two types of women as relatively mutually exclusive: women who either are committed to traditional female roles of wife, mother, and homemaker or women who seek education, class status, and careers. Many of Luker's findings are supported by Ginsburg's (1989) subsequent ethnography of the political mobilization around an abortion clinic in Fargo, North Dakota. Ginsburg's study likewise shows the use of abortion as a symbolic contestation of the societal role of women, though the two groups have more in common than in Luker's study.

While Luker's study remains formative to the corpus of work on abortion and motherhood, the cultural landscape has largely shifted since the time of her analysis in the 1980's (Freedman & Weitz, 2012). Not only is the political landscape now more heterogeneous, but the particular, socially constructed meanings surrounding this medical procedure – including reasons for needing abortions – are constantly shifting (Freedman & Weitz, 2012). Furthermore, while Luker characterizes abortion activists, the findings do not speak to the ideologies of all women who have obtained abortions. Sachdev (1993) thus builds on Luker's work through in-depth interviews with young Canadian White women who had recently had abortions. More than one in six respondents cited their reasons to abort as it being "best for the child," due to financial and other practical restraints on their "fantasy of motherhood." Other studies add support to the idea that the expectations of motherhood have a salient role in abortion decisions, with a high proportion of women citing their obligation to their current children as a primary reason for terminating a pregnancy (Biggs, Gould, & Foster, 2013; Henshaw & Van Vort, 1992; Jones et al., 2007). Most recently, Jones and colleagues (2007) found that a large proportion of the women in the sample sought abortions because of the belief children deserve stable, financially secure families who provide a high level of care.

The present research builds on the growing body of work on the interplay between abortion and idealized motherhood beliefs, by analyzing the ways women draw upon hegemonic motherhood ideologies in their own abortion narratives. Rather than drawing upon anonymous surveys and interviews, however, I examine women's constructed reasonings for their abortions, when described in a public forum. This project, then, extends beyond prior analyses, by serving as a comparison between the private and the public stories women tell about their abortions. Further, given the context of their abortion stories, I also examine their narratives from the perspective of (public) stigma management. By examining the abortion stories of 41 women living in Tennessee, I pose the following questions: other than political affiliations, what characterizes the women who seek abortions? Are they, like Luker asserts about abortion activists, feminists antithetical to housewives, who view the role of motherhood as one of many – or even as secondary to the more "masculine" roles of careers and education? How do women who have sought abortions regard motherhood? Further, given the unique nature of the data set, I pose the question: what characterizes the women who choose to come forth to tell their stories in order to tackle stigma? Lastly, how do they strategically deploy their beliefs about motherhood and health practices to counter antiabortion claims?

DATA AND METHODS

To assess the role of motherhood in women's abortion narratives and strategies to challenge stigmas, I drew upon the data from the Tennessee Stories Project created by Planned Parenthood of Middle and East Tennessee. This initiative invites women to voluntarily submit their written abortion stories for the explicit purpose of ending the stigma and breaking the silence many women have about their abortions. These stories are either entered in their online portal or orally shared with a Planned Parenthood representative to be transcribed and uploaded. These stories are then publicly available on the TN Stories website. Each woman was required to sign a consent form, and given the option to use their name and include a photo or to use a pseudonym. Since their stories are publicly available and searchable on the internet, I did not use pseudonyms in the presentation of the findings, as per the ethics board's recommendations. For this analysis, I used the 41 stories, and utilized an inductive approach, to qualitatively code each story using Atlas.ti. I conducted two rounds of coding – first to garner broad themes, and then to gain a more nuanced look at themes and sub-themes. The coding scheme included codes for demographic characteristics of each woman, reasoning for abortions, perceived social support regarding abortion, mentions of career and education, and mentions of mothering and idealized motherhood.

At the time of analysis, the website had 44 available stories. Three of these were dropped from the analysis: one that was written by the husband of a woman who sought an abortion, one that was written by a woman who sought an abortion but was convinced by a Crisis Pregnancy Center to carry the pregnancy to term, and one by a woman whose mother had an abortion. I dropped these stories as the scope of this analysis is limited to the narratives of women

who have had abortions. Because the stories did not follow a script or prompt, demographic characteristics of all participants were not fully available. However, for the data that were available, the remaining sample had the following characteristics. The average age at abortion is 22.93, though many of the stories were written a few years to many years after. Approximately 19.51% of the women were already mothers at the time of the abortion, and 46.34% became mothers at some point after the abortion. Two of the women were also grandmothers at the time of the narrative; 68.29% of the sample was married either at the time of the abortion or subsequently at the time of the narrative submission. Further, 29.27% of the sample mentioned religion, being religious, or God; of these women, the majority mentions Christianity broadly, while three mention Catholicism, two mention Southern Baptist, and one mentions Mormonism. Three of these women had later abortions, and four mentioned obtaining an abortion outside of the health system, either by "back alley" doctors or one by receiving blows to the abdomen by her boyfriend. Of the stories 26 included a photo of the woman, constituting 63.41% of the sample. Of these 25 featured women who appeared to be White, or at least White passing. Only one participant mentioned having an LGBTQ identity. As mentioned above, some of these stories feature abortions that took place many years before – even 40 years prior, before the passing of *Roe v. Wade*. Some of these stories took place in geographic areas other than Tennessee. However, each woman lived in Tennessee at the time of the story's submission. Aside from a lack of data on socioeconomic diversity, as well as a lower level of religiosity, this sample is relatively demographically representative of the women who obtain abortions in the United States.[1]

These data are useful for the research questions for several reasons. First, given pervasive abortion stigmatization, the story entry method of an online submission with the option of anonymity allows women to write freely and candidly without the fear of judgment by an interviewer or survey conductor. Further, given the purpose of the TN Stories initiative as challenging abortion stigma, these stories can be analyzed as purposeful tactics to counter stigma. This gleans valuable insight about *who* wants to challenge abortion stigma and the framing women use to tackle it – something that is understudied in the literature. Additionally, while similar initiatives have been conducted in other geographic regions, the selection of TN stories in particular adds several advantages. Tennessee not only lies in the South – the most hostile region toward abortion in the nation – but is also regarded as a state with some of the most restrictive abortion legislation. The state of Tennessee was given a D rating on reproductive rights, making its ranking 47th in reproductive rights out of 50 (Status of Women in the States, 2016). Moreover, the hotly contested Amendment 1, which contends that the state constitution does not secure a right to abortion, passed in 2014 with 53% of the vote. This indicates a current, ongoing controversy surrounding abortion, and thus an underlying widespread stigmatization of abortion. Given this context of normalized stigmatization, the stories can be analyzed through the lens of Cockrill & Nack's (2013) concept of "managing the damaged self." At the same time, it is important to note the

constructed nature of their stories; these narratives were primarily written in order to fight stigma, and thus they might not represent the complete reality but rather the versions of their reality that these women wished to convey.

In regard to the study of imperative motherhood and gender norms, Tennessee is likewise an excellent case study. Tennessee is a known red state, and is frequently listed as one of the most conservative states in the nation. Scholars have shown an overlap between republican states and states where sexist attitudes are widespread (e.g., Charles, Guryan, & Pan, 2018). In a sociopolitical context such as Tennessee, where conservative and traditional gender ideologies are relatively ubiquitous, it is safe to assume that a motherhood identity is likely held in high esteem, and that motherhood is a normative means toward gaining status and identity as a woman living in the state. The simultaneous social pressures against abortion and toward motherhood and the "correct" expression of femininity render Tennessee advantageous for the present study's research aims. It allows the posing of the question: in a state that values motherhood and femininity and adamantly eschews abortion, how do women frame their narratives of choosing an abortion? In the next section, I provide an overview of the women in the sample, in order to understand commonalities among women willing to come forward to challenge abortion stigma in this public forum. Next, I describe the strategies and values the women deploy in order to destigmatize their abortions. In the final section, I discuss the significance of these strategies within broader scholarship on motherhood, gender, and health practices.

FINDINGS

Who Are These Women?

Guiding this research is the question of which women are willing to share their abortion stories to tackle stigma and how they go about it. Notably, 66% of these women were mothers at the time of the narrative – eight women were already mothers before the abortion, and 19 became mothers at some point after.[2] Similarly, 68% of the women mentioned being married at the time of the narrative. Over half of the women who voluntarily came forth to share their abortion stories therefore have claim to two major indicators of adult womanhood and "proper" femininity: mother and wife. While some women framed themselves as mothers and wives in their narratives, seven women emphasized their identities by including photos of themselves with babies and children. For instance, Melanie, a woman from East Tennessee, included a photo of herself in an outdoor shot wading through a shallow stream, her hand held by a shirtless toddler, who appears to be leading her enthusiastically through the water. Her narrative revolves around her love for her son, saying "I get to be a mom now because I got an abortion [then]." Yet, this snippet of her narrative is particularly striking:

> I got married and had a baby, and all of a sudden, I realized things were getting easier for me. I have a higher value in our culture in the South now because I'm a married white woman with a child. I think that's also what prompted me to start talking about my abortion, because I am someone people would look to as valuable, and yet I've done this thing that is considered shameful.

While the other women did not put it in such plain terms, this trend to frame themselves as mothers and wives indicates a silent understanding among women. First, women have more value if they are "correctly" *doing* their gender through reproduction, and second, if they can shatter the mythical dichotomy that "good girls are mothers and bad girls get abortions," abortion stigma can be challenged. For these Tennessee women, it looks like dominant strategy is describing themselves as "good girls" who are mothers and yet have had abortions. It is also important to note Melanie's mention of whiteness in this quote, pointing to the value that *white* motherhood has, in particular, and the construction of "good mothering" being derived from the white middle class (Glenn, 2016). While the data cannot speak to the difference in stigmas and strategies used among women of different racial groups, the role of whiteness in the narratives must not be overlooked.

Nearly half of the women who included photos of themselves with children are women who obtained later abortion – the most stigmatized yet most rare type of abortion.

According to the Guttmacher Institute (2016a, 2016b), about 90% of all abortions take place in the first trimester, 9% at 14 weeks or later, and about 1% at 21 weeks or later. Despite comprising an extremely low proportion of all abortions, later abortions hold a prominent place in restrictive legislation and in the general stigmatizing discourse surrounding abortion. Hence, it is noteworthy that three of the 41 stories – about 7 percent – feature a later abortion, and that all three of these stories include a photo of a smiling, feminine woman, delicately holding a baby. These three women share much in common. They all mention being from religious or conservative families, they all emphasize how badly they want kids and specifically the baby that was aborted, and they all had to choose a later abortion due to fetal abnormalities and endangerment to themselves.

Moreover, all three of the women adhere to the tenants of idealized motherhood, particularly a connection to the fetus, a lifelong desire to be a mother, and making selfless choices for the well-being of others. All three women had named their babies,[3] for instance Adrianne, who said, "Even though he hadn't been born, we couldn't fathom a family and a life without Andy […] he was our life […] a living symbol of our love for each other and our family." One woman, Elizabeth, even took a maternity shoot before the abortion to remember the baby she lost, of which she included a photo in her submission. Though Elizabeth was told her baby had hydrocephalus and would likely have special needs, she mentions doing research and making preparations to raise this child – exemplifying the *total motherhood* ideal of sacrificing everything for one's child. She also mentions the multiple hurdles she and her husband encountered, while having to make the difficult healthcare choice to terminate her very wanted pregnancy – from having to travel to another state where later abortions are legal, to fighting the insurance company for coverage. This is how she ends her narrative:

> I'm not ashamed of what we did. I don't have doubts that it was the right thing to do. It wasn't a selfish choice. If I was being selfish I'd have carried her to term, and had those days or weeks or months with her […] I didn't want to give up the only time I could have with her.

> But our job as parents was to do what was best for her, even when it meant letting her go. And I'm not going to apologize for that, or try to hide it.

This mention of stigma is echoed in the other two stories, with one woman, Hadleigh, mentioning she typically does not even use the term abortion because of the stigma. Yet, she chose to tell her story in order to change such perceptions – "it's not always right or wrong, black or white." She says that choosing to keep this experience silent perpetuates a cycle: "pro-life protesters shout louder, restrictive laws get passed, and we heartbroken mothers continue to lose our rights to do what's best for our families." In these stories, all three women reframe women who obtain late-term abortions as selfless, caring mothers, and late-term abortions as a difficult health practice made for the well-being of the babies and families which abortion stigma only hurts.

Abortion as Total Mothering of Unborn Baby

> I really do want a child one day, but I want […] to be ready. I want to be financially, emotionally, and physically ready. (Max, East Tennessee)

Outside of the realm of later abortions, there is a persistent trend among the stories to frame abortion as a form of total mothering for the unborn baby – of predicting and preventing all health risks for potential children. Among the multiple and varying reasons women gave for choosing to terminate their pregnancies, the vast majority regarded the "imperfect" conditions of the home the baby would enter within nine months, which can be understood as health risks. Of the 41 stories, 25 mention relationship issues as part of the decision. For these women, they were either not married or they did not see their relationship "going anywhere," or for some, their partner was abusive or unstable. These women describe not wanting to bring a child into a split family, or into a situation where they were single mothers with no paternal support. Finances, age, and general stability were three other major reasons. Based on their narratives, these women did not feel financially, emotionally, or practically prepared to create the ideal conditions they deemed optimal for a child. This exemplifies total motherhood (Wolf, 2010), through the *predicting* of potential risk to a child's ecological well-being and *preventing* the imperfect childhood environment through an abortion. Further, the average age of abortion is about 22 in this sample, but a high proportion of these women were teenagers when they chose to terminate their pregnancies – 18 stories or 43.90%. And yet, while the trope of the pregnant teen evokes the negative sexual morality stereotypes of a selfish, promiscuous, immature girl, these women framed their choice through the lenses of idealized and total motherhood. In the health conflict between a woman's wants and her child's needs – abortion is recast not as a woman's selfish "want," but rather her child's "need" in order to be able to thrive.

For instance, consider this excerpt from Kalynn – a young woman from East Tennessee – which combines many of these themes:

> I was in no position to have a baby back then. I was not well at that point in my life; I didn't know who I was yet. I was in transition. I had no money, no partner, and I didn't know where

> my life was heading. To bring a child into that chaos and expect to be successful was not at all realistic.

Kalynn mentions that she was subsequently able to focus on school and ultimately achieved a PhD. However, she emphasizes that she is now married and has "two amazing children," indicating that she is a wife and mother and thus has the authority to speak on what it means to raise a child. This evokes the "mothers as experts" theme in Reich's (2014, 2016) interviews in which women oppose vaccinations due to their motherly expertise on a child's well-being. Anti-abortion rhetoric frames abortion as a selfish choice made in order for the woman to continue to develop herself and her career. Even feminist literature such as Luker's (1984) work indicates activists' framing of abortion as a – justifiably – selfish choice the woman must make to continue her education and career. Yet, the women in these narratives turn this idea on its head, asserting that a woman *should* choose abortion to continue to develop herself financially, emotionally, et cetera, *but* this development is actually selfless, and serves to benefit children who deserve to be raised by women who are "complete," and ready to be perfect mothers.

Sam, a woman from West Tennessee, even alludes to the white, middle-class mother ideals of "concerted cultivation," which refers to the idealized norm of wealthy white mothers carting their kids around to enriching activities (Lareau, 2011). She alludes to these norms while simultaneously reframing abortion as selfless, counter to the abortion stigma framework. She says:

> I wasn't ready to have kids because I need to know more about who I am before I commit to soccer and ballet camps, and because of my choices, I'm able to learn something new about myself every day. People tend to say women like me are self-centered, but you have to focus on yourself to be the best person for other people; I can't give myself to somebody else if I don't know what I want.

The notion of concerted cultivation is found in the mention of soccer and ballet camps, which she alludes to wanting to provide for her desired future children. She also mentions "giving herself" to somebody else, which evokes the mothering ideal of women sacrificing themselves for their children. We can thus understand this trend this as what I call *altruistic self- development* – a woman's decision to become mature, educated, financially stable, and reliably partnered, in order to bring a child into a home fully equipped to fulfill the ideals of intensive mothering. While gendered norms of women frame motherhood as the means to achieve adult womanhood, these women are changing the order of these events: women must first become adult women, and *then* give themselves fully to their families. In cases in which women have not yet become "fully actualized," abortion can be viewed as a health practice enacted in order to make this possible. This garners a novel look at abortion, and incorporates abortion to the growing body of work on how women's healthcare and reproductive choices are woven with normative gendered expectations.

> And 10 years later, when I would tour my sleeping children at night, I knew that I would never have had them if I hadn't had made that decision. That decision gave me my family, and so now I'm proud of that decision. (Elaine, East Tennessee)

An important part of incorporating abortion into the schema of the perfect mother is by discussing planning and *choice* as part of ideal mothering. Though women who get abortions are often censured as unfeminine or unmotherly by viewing a pregnancy as "unplanned" and "unwanted" rather than a fortuitous gift from fate – or God – these stories reframe this choice in a pro-mothering light. They do this by contrasting an unplanned pregnancy when they were not ready to properly mother a child to the wonderful, planned family they now have due to carefully deliberated choices. This situates abortion as a choice within the "neoliberal health framework" of motherhood – in which individual choices result in the optimization of the health of families (e.g., Reich, 2014, 2016; Wolf, 2010). Further, this reframing strategy is underscored by stating that having an unplanned child during imperfect circumstances would have hindered the woman's ability to reach this point where the perfect family is possible. For instance, Jessica, who had two abortions before she was married, financially stable, and emotionally ready to be a mother, says:

> Having a child really reinforced my belief that those were two really positive experiences and the right decision. I would not be able to give my daughter all of the great, wonderful, awesome things that I'm giving her now if I hadn't had those abortions.

These narratives assert that they would not have achieved education goals, excelled in their careers, or matured fully had they not had an abortion, which would have made their perfect family impossible. In this way, altruistic self-development is woven with the total mothering of an unborn baby, once more recasting abortion as a selfless and necessary healthcare choice for achieving the optimal, healthy family.

There is also an underlying belief that having a child then would alter one's life course in such a way that the current family would not have materialized, outside of the notions of finances and career achievements. For instance, consider Francie, a woman whose narrative begins with the first sentence listing the children she has and their ages. At the top of her narrative she included a photo of herself beaming from ear to ear, long feminine earrings dangling from her ears, and her twinkling eyes looking wistfully into the distance. She describes herself as a Southern Baptist woman and discusses her choice to terminate her pregnancy when she was 19 and in college as a result of praying to God for guidance; she says "I finally felt relief when I knew God has different plans for me […] he understood my choice and he loved me." She continuously casts herself as a religious woman whose identity and life revolves around her children, thus fulfilling the standards of "the good mother" and "the good girl." This belief that carrying an unwanted pregnancy to term would veer her life off course – and perhaps away from her fate – is evident in the following quote:

> I am thankful that I was able to get an abortion because if I had not made that decision, I literally would not have had the two children I have right now. My children are the light of my life and no one can make me regret that I had them instead of giving birth when I was a teenager.

Reading this narrative, and gazing at her joyful face, conjures a vivid image of a happy, loving mother who will do anything for her children. This image shatters

the stigmatizing stereotypes of women who get abortions as unfeminine, uncaring, and incongruous with the ideals of motherhood. By contrasting their perfect, planned, intentional families with the chaotic, unexpected family that could have been transforms abortion from anti-mother and anti-child to a necessary and selfless individual health choice for achieving the ideal family.

Abortion as Intensive Mothering of Current Children

Women who already had children at the time of their unplanned pregnancy framed their abortions as a selfless choice to protect their current children – often in tandem with protecting the unborn, potential child. For these women, an additional child would put pressure on the family's resources and thus impact the possibility of continuing to intensively mother her children. Terminating this unplanned pregnancy is hence reframed as an extension of the nurturing, protectiveness of mothering, as well as of the "total motherhood" framework of promoting the ecological health of children at all costs. This is exemplified by Dorothy, of Middle Tennessee, who refers to her abortion as "an act of love for the child I chose not to have and for the one I already brought into this world." She unexpectedly became pregnant while she was a single mother to a 10-year-old son, and chose to terminate the pregnancy because of financial and practical constraints. This is what she said:

> I could not have brought a child into this world and taken care of two children by myself. Who knows what the stress of that would have been on my son? He thanked me recently when I told him about my abortion. He understood that I was protecting him and was grateful […]

This quote encapsulates the theme across several stories, to combine both altruism for the unborn fetus *and* for the present children. By choosing to abort, one is sparing one's children – and a potential child – from the loss of the ideal, risk-free, and thus healthy home. She specifically mentions the stress of her son, rather than the stress she herself would experience if she carried to term and had two children to raise. Rather than framing the abortion as a selfish desire to not have more responsibilities, these women frame it as a health practice that fits within responsible mothering – a maternal protection of her children, and the desire to give these children everything possible. Once more, these women examine the potential risks to child development and enact both intensive and total mothering through a healthcare decision, abortion – stretching the boundaries of the literature on the balancing of gendered expectations during healthcare choices.

Another woman, Bekki, from East Tennessee, echoes similar sentiments. She mentions in the beginning of her narrative that she was raised "pro-Life Baptist," and previously held many abortion myths, such as "women who have an abortion are selfish, irresponsible, murdering sluts." Growing up in an anti-abortion home, and even harboring anti-abortion beliefs herself, she understands the framing strategies necessary to challenge this mindset. She pushes back against these stereotypes with a photo of herself smiling with her arms around two rosy-cheeked, happy kids on her lap. She then discusses at length how much work mothering requires, mentioning a time she breastfed her son for the fifth time in the middle of the night

while crying from exhaustion. She builds up this image of herself as a hardworking mother who pours herself into her children, and then frames her abortions as an integral part of becoming this mother. She says:

> […] Having my two children and having my two abortions were the best four decisions I ever made. And I am not ashamed. I am not a murderer. I am a damn decent mother who had to make a really f***ing tough choice so that my kids would have me around to care for them.

Her quote juxtaposes stereotypes with gendered ideals: not a murderer, but rather a decent – or, even, ideal – mother. Through her story, Bekki – like other women in the sample – highlights that motherhood is her most important achievement, not secondary to "feminist" or "masculine" ideals like careers or finances. By including mention of constant breastfeeding, she even evokes the "breast is best" ideologies of idealized mothering which Wolf (2010) argues is part of a total motherhood ideology. For women like Bekki, choosing an abortion is described as part of the process of shedding one's selfish, girlish ways in order to become a "true" mother and thus "real" woman. By casting herself as the pinnacle of femininity – the dedicated mother who puts her children first – stereotypes about abortion and the women who get them must be reconsidered.

In this way, these women are bridging the conceptual gap between "good" and "bad" women, as well as the gap between mothering and abortion. Their framing effectively casts abortion – rather than antithetical to motherhood or as undermining the ideals of motherhood – as a natural extension and crucial component of mothering children "correctly." Though typically regarded as the beliefs of the "pro-life" camp, these women value motherhood, and consider their families extremely important – even one's proudest achievement. Moreover, they agree with normative gendered standards for mothers, specifically intensive and total mothering; they believe a woman must invest as much time, care, and money into her children as possible, in order to minimize health risks and promote "optimal" development. Yet, they say it is *because* of these beliefs about women and mothering that they obtained abortions, and that they support abortions for other women. It is in this way that abortion is integrated to a growing list of health choices – along with breastfeeding and vaccinations – that women can choose as part of intensive mothering. Rather than antithetical to mothering, abortion can be understood as a health choice to assure one's children can have an ideal, risk-free childhood with an ideal mother.

DISCUSSION AND CONCLUSION

This study examined the role of motherhood identity in women's descriptions of choosing to terminate a pregnancy, and how idealized mothering norms are deployed in abortion stigma management. While abortion is often framed as antithetical to motherhood, the analysis shows that women who have obtained abortions draw upon the tenants of idealized motherhood in describing this health choice. This adds to literature on medical stigma management, and provides support for Cockrill and Nack's (2013) claim that women who have had abortions "manage the damaged self" by maintaining

a good reputation and managing a damaged reputation – though doing so specifically by framing themselves as mothers and abortion as mothering. As in Cockrill and Nack's (2013) sample, the women in these abortion stories "appeal to higher loyalties" specifically by framing their abortion around the needs of their spouses as well as current and future children. Since normative sexual morality divides women into the dichotomous categories of *the good girls, wives, and mothers* and the *bad girls and fallen women* (e.g., Nack, 2002), women who wish to dispel abortion stigma actively seek to bridge these two categories. As this analysis shows, women create a third category: good girls, wives, and mothers who had to choose an abortion for selfless, nurturing reasons.

To recap, of all the 41 women who voluntarily submitted their abortion stories for the purpose of dispelling abortion stigma, most women were mothers at the time of the narrative – an identity they actively constructed and emphasized in their narratives. To underscore their mother identities, a quarter of these women included smiling photos of themselves holding babies and young children. Among women who had to choose a later abortion, the most stigmatized category, due to medical reasons, all of them included such photos of themselves with babies – one even holding her pregnant belly weeks before she had to terminate a very wanted pregnancy. Further, among this constructed category of good mothers who had abortions, were two emergent themes. The first is *abortion as total mothering of the unborn baby*, which refers to sparing the unborn child from a life where idealized mothering is impossible due to financial, practical, and marital reasons. Part of this is entails choosing an abortion in order to develop oneself – which I refer to as *altruistic self-development* – for the purpose of becoming the best mother possible, and achieving the optimal, current family. The second is *abortion as an extension of intensive mothering of current children*, which refers to abortions obtained by women who already have children and for whom an additional child would make intensive mothering no longer possible. These findings add abortion to the growing list of healthcare choices women make while balancing broader cultural anxieties about gender, motherhood, and women's changing roles. Much like the health choices surrounding gestation (Waggoner, 2017, 2015) childhood nutrition (Wolf, 2010), and vaccinations (Reich, 2014, 2016), abortion can be understood through the framework of neoliberal health choices in which mothers must predict and prevent all risks to a child's optimal development.

Although this study focused on the relationship between motherhood and abortion, the results of the study have implications beyond this connection. First, it underscores the continuing emphasis of motherhood as the cornerstone of femininity and womanhood. In the state of Tennessee, one of the most conservative and anti-abortion states in the nation, the women who are the most compelled to publicly share their stories and fight stigma are mothers. This indicates the privilege and status that comes with being a mother in the state of Tennessee and beyond. Further, this analysis adds to the growing body of medical stigma literature, particularly abortion stigma;

the results indicate that individuals who have been marked as deviant manage their stigma by emphasizing their identity considered contradictory to their marked status. Since motherhood and abortion are often viewed as existing on opposite ends of a spectrum of proper femininity, women who have had abortions emphasize their feminine, motherhood identity as a form of stigma management.

It is important to note some limitations of the study. First, while relatively representative of women who obtain abortions, the results cannot be generalized to the stigma management strategies of all women. Of the women who included photos with their narrative all but one appeared to be white, or at least white passing. Additionally, only one of the women in the sample mentioned pertaining to the LGBTQ community. Lastly, there was very minimal mention of socioeconomic status, and zero mention of immigrant status. As such, the sample is somewhat lacking in representativeness. However, this sample itself speaks to stigma, and the characteristics of people willing to share their status as "deviant" to tackle stigma. The sample of the analysis, which was obtained by the TN Stories Project call for submissions, indicates that only the most privileged individuals among the deviant are willing to share their "marked" identity vis-à-vis stigmatized health decisions. Furthermore, the nature of the sample, and its lack of full representativeness points to the availability of discourses and strategies available to different women. For instance, as described in the findings, Melanie's quote spoke to the influence of whiteness on cultural narratives surrounding reproduction, by saying, "I have a higher value in our culture in the South now because I'm a married white woman with a child." Caution should thus be exerted when generalizing the destigmatizing strategies described in this study to all women, given the strong impact of race in reproduction and its myriad stigmas. However, future researchers should aim to replicate this study on a more diverse sample – particularly with women of color, immigrants, people of low socioeconomic status, queer and trans women, women in other sociopolitical climates, et cetera – to see if other groups of women similarly draw upon the idealized model of motherhood, or if other strategies are employed to tackle differently constructed stigmas.

The sociological analysis of women's experiences with abortion presented in this study extends our understanding of gender, motherhood, reproduction, health, and stigma. It is among the first to examine how women deploy norms of idealized mothering in order to publicly manage and tackle abortion stigma. While women who have had abortions are widely constructed as irresponsible, selfish, unfeminine, and antithetical to the ideals of motherhood, these stories emphasize the opposite. Instead, the women in this sample describe choosing abortions for the well-being of the unborn baby, their families, and their partners. They characterize abortion as a necessary – albeit often difficult and emotional – reproductive choice for planning and achieving healthy, loving families. At the same time, the presence of this framing as the primary destigmatizing tactic indicates a dearth of available social narratives for women. Though it is important to challenge negative associations of abortions and the women who choose them, this particular strategy perpetuates a largely unattainable model of mothering,

which has been shown to negatively impact women – particularly women of color and of low socioeconomic status. Irrespective of the selected strategies, abortion stigma negatively impacts women's lives and health via restrictive legislation, experienced prejudice, and intrapersonal shame. It is important to understand and combat the stigma surrounding abortion, in order to integrate this procedure as part of a comprehensive reproductive care for women.

NOTES

1. In the year 2014, more than half of all abortion patients were in their 20's. Additionally, White patients accounted for the highest proportion of abortions (34%), relative to Black and Hispanic patients. In terms of sexual orientation, 94% of abortion patients identified as heterosexual, versus 4% identifying as bisexual, and 0.3% identifying as homosexual. The vast majority of abortions (59%) were obtained by patients who had had at least one birth before. This sample is slightly less religious than the national average; 38% of women in 2014 reported no religious affiliation, while 24% identify as Catholic and 13% identify as evangelical Protestant (Jerman et al., 2016).
2. Of these women who became mothers later, one is a step mom and another is the primary caregiver of her niece. While not biological mothers, they still fulfill the role of mother and are thus included in this category.
3. I am using the term "baby," as this is the language that these women themselves used when referencing their pregnancies.

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REFERENCES

Allen, M. (2015). Narrative diversity and sympathetic abortion: What online storytelling reveals about the prescribed norms of the mainstream movements. *Symbolic Interaction*, *38*(1), 42–63.

Altshuler, A. L., Ojanen-Goldsmith, A., Blumenthal, P. D., & Freedman, L. R. (2017). A good abortion experience: A qualitative exploration of women's needs and preferences in clinical care. *Social Science & Medicine*, *191*, 109–116.

Armstrong, E. M. (2003). *Conceiving risk, bearing responsibility: Fetal alcohol syndrome & the diagnosis of moral disorder*. Baltimore, MD: The John Hopkins Press..

Beckman, L. J. (2017). Abortion in the United States: The continuing controversy. *Feminism & Psychology*, *27*(1), 101–113.
Beynon-Jones, S. M. (2017). Untroubling abortion: A discourse analysis of women's accounts. *Feminism & Psychology*, *27*(2), 225–242.
Biggs, M. A., Gould, H., & Foster, D. G. (2013). Understanding why women seek abortions in the US. *BMC Women's Health*, *13*(1), 29.
Bommaraju, A., Kavanaugh, M. L., Hou, M. Y., & Bessett, D. (2016). Situating stigma in stratified reproduction: Abortion stigma and miscarriage stigma as barriers to reproductive healthcare. *Sexual & Reproductive Healthcare*, *10*, 62–69.
Castro, A., & Farmer, P. (2005). Understanding and addressing AIDS-related stigma: From anthropological theory to clinical practice in Haiti. *American Journal of Public Health*, *95*(1), 53–59.
Charles, K. K., Guryan, J., & Pan, J. (2018). *The effects of sexism on American women: The role of norms vs. discrimination*. National Bureau of Economic Research.
Cockrill, K., & Nack, A. (2013). "I'm not that type of person": Managing the stigma of having an abortion. *Deviant Behavior*, *34*(12), 973–990.
Collins, P. H. (2005). The meaning of motherhood in black culture and black mother–daughter relationships. *Gender Through the Prism of Difference*, 285–295. New York, NY: Oxford University Press.
Copelton, D. A. (2007). "You are what you eat": Nutritional norms, maternal deviance, and neutralization of women's prenatal diets. *Deviant Behavior*, *28*(5), 467–494.
Crocker, J., Major, B., & Claude, S. (1998). Social stigma. *The Handbook of Social Psychology* (pp. 504–553). New York, NY: Oxford University Press.
Freedman, L. (2010). *Willing and unable: Doctors' constraints in abortion care*. Nashville, TN: Vanderbilt University Press.
Freedman, L., & Weitz, T. A. (2012). The politics of motherhood meets the politics of poverty. *Contemporary Sociology*, *41*(1), 36–42.
Freidson, E. (1988). *Profession of medicine: A study of the sociology of applied knowledge*. Chicago, IL: University of Chicago Press.
Gillespie, R. (2003). Childfree and feminine: Understanding the gender identity of voluntarily childless women. *Gender & Society*, *17*(1), 122–136.
Ginsburg, F. D. (1989). *Contested lives: The abortion debate in an American community*. Berkeley, CA: University of California Press.
Glenn, E. N. (2016). Social constructions of mothering: A thematic overview. In E. N. Glenn, G. Chgang, & L. R. Forcey (Eds.), *Mothering* (pp. 1–29). London, UK: Routledge.
Goffman, E. (2009). *Stigma: Notes on the management of spoiled identity*. New York, NY: Simon and Schuster.
Gold, R. B., & Nash, E. (2013). TRAP laws gain political traction while abortion clinics—and the women they serve—pay the price. *Guttmacher Policy Review*, *16*(2), 7–12.
Grimes, D. A., Forrest, J. D., Kirkman, A. L., & Radford, B. (1991). An epidemic of antiabortion violence in the United States. *American Journal of Obstetrics & Gynecology*, *165*(5), 1263–1268.
Guttmacher Institute. (2016a). Women in the South live in a state hostile or extremely hostile to abortion. Retrieved from https://www.guttmacher.org/infographic/2017/93-women-south-live-state-hostile-or-extremely-hostile-abortion
Guttmacher Institute. (2016b, March 9). An overview of abortion laws. Retrieved from https://www.guttmacher.org/state-policy/explore/overview-abortion-laws
Harden, A., & Ogden, J. (1999). Young women's experiences of arranging and having abortions. *Sociology of Health & Illness*, *21*(4), 426–444.
Harvey, S. M., Beckman, L. J., Castle, M. A., & Coeytaux, F. (1995). Knowledge and perceptions of medical abortion among potential users. *Family Planning Perspectives*, *27*(5), 203–207.
Hays, S. (1998). *The cultural contradictions of motherhood*. New Haven, CT: Yale University Press.
Henshaw, S. K., & Van Vort, J. (1992). *Abortion factbook, 1992 edition: Readings, trends, and state and local data to 1988*. New York, NY: Guttmacher Institute.
Herek, G. M., Gillis, J. R., & Cogan, J. C. (2009). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Journal of Counseling Psychology*, *56*(1), 32.

Jackson, S., & Scott, S. (1999). Risk anxiety and the social construction of childhood. In *Risk and sociocultural theory: New directions and perspectives* (pp. 86–107). Cambridge: Cambridge University Press.

Jerman, J., Jones, R. K., & Onda, T. (2016). Characteristics of US abortion patients in 2014 and changes since 2008. *Guttmacher policy review*. New York, NY: Guttmacher Institute.

Joffe, C. E. (1995). *Doctors of conscience: The struggle to provide abortion before and after Roe v Wade*. Boston: Beacon Press.

Joffe, C. E. (2010). *Dispatches from the abortion wars: The costs of fanaticism to doctors, patients, and the rest of us*. Boston, MA: Beacon Press.

Joffe, C. E. (2013). The politicization of abortion and the evolution of abortion counseling. *American Journal of Public Health*, *103*(1), 57–65.

Joffe, C. E. (2014). Commentary: Abortion provider stigma and mainstream medicine. *Women & Health*, *54*(7), 666–671.

Joffe, C. E., Weitz, T. A., & Stacey, C. L. (2004). Uneasy allies: Pro-choice physicians, feminist health activists and the struggle for abortion rights. *Sociology of Health & Illness*, *26*(6), 775–796.

Jones, R. K., Frohwirth, L. F., & Moore, A. M. (2007). "I would want to give my child, like, everything in the world." How issues of motherhood influence women who have abortions. *Journal of Family Issues*, *29*(1), 79–99.

Jones, R. K., & Jerman, J. (2014). Abortion incidence and service availability in the United States, 2011. *Perspectives on Sexual and Reproductive Health*, *46*(1), 3–14.

Kumar, A., Hessini, L., & Mitchell, E. M. (2009). Conceptualising abortion stigma. *Culture, Health & Sexuality*, *11*(6), 625–639.

Lareau, A. (2011). *Unequal childhoods: Class, race, and family life*. Berkeley, CA: University of California Press.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*(1), 363–385.

Link, B. G., Yang, L. H., Phelan, J. C., & Collins, P. Y. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin*, *30*(3), 511–541.

Luker, K. (1984). *Abortion and the Politics of Motherhood* (Vol. 759). Berkeley, CA: University of California Press.

Malacrida, C., & Boulton, T. (2012). Women's perceptions of childbirth "choices" competing discourses of motherhood, sexuality, and selflessness. *Gender & Society*, *26*(5), 748–772.

Manzoeillo, A. (2017, May 7). 2017 Violence and disruption statistics, December 15. Retrieved from https://prochoice.org/wp-content/uploads/2017-NAF-Violence-and-Disruption-Statistics.pdf

Markens, S. (2007). *Surrogate Motherhood and the Politics of Reproduction*. Berkeley, CA: University of California Press.

Nack, A. (2002). Bad girls and fallen women: Chronic STD diagnoses as gateways to tribal stigma. *Symbolic Interaction*, *25*(4), 463–485.

Norris, A., Bessett, D., Steinberg, J. R., Kavanaugh, M. L., De Zordo, S., & Becker, D. (2011). Abortion stigma: A reconceptualization of constituents, causes, and consequences. *Women's Health Issues*, *21*(3), S49–S54.

Oakley, A. (1986). Feminism and motherhood. *Children of Social Worlds*. Cambridge, MA: Harvard University Press.

Ogden, J., & Nyblade, L. (2005). *Common at its core: HIV-related stigma across contexts*. Washington, DC: International Center for Research on Women.

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science & Medicine*, *57*(1), 13–24.

Reich, J. A. (2014). Neoliberal mothering and vaccine refusal: Imagined gated communities and the privilege of choice. *Gender & Society*, *28*(5), 679–704.

Reich, J. A. (2016). *Calling the shots: Why parents reject vaccines*. New York, NY: NYU Press.

Remennick, L. (2000). Childless in the land of imperative motherhood: Stigma and coping among infertile Israeli women. *Sex Roles*, *43*(11–12), 821–841.

Russo, J. A., Schumacher, K. L., & Creinin, M. D. (2012). Antiabortion violence in the United States. *Contraception*, *86*(5), 562–566.

Sachdev, P. (1993). *Sex, abortion, and unmarried women*. Westport, CT: Greenwood Press.
Schur, E. M. (1984). *Labeling women deviant: Gender, stigma, and social control*. New York, NY: Random House New York.
Shellenberg, K. M., & Tsui, A. O. (2012). Correlates of perceived and internalized stigma among abortion patients in the USA: An exploration by race and Hispanic ethnicity. *International Journal of Gynecology & Obstetrics*, *118*, S152−S159.
Sontag, S. (1978). *Illness as metaphor*. New York, NY: Farrar, Strauss and Giroux.
Status of Women in the States. (2016, March 7). Tennessee report card summary. Retrieved from https://statusofwomendata.org/explore-the-data/state-data/tennessee/
Waggoner, M. (2017). *The zero trimester: Pre-pregnancy care and the politics of reproductive risk*. Berkeley, CA: University of California Press.
Waggoner, M. R. (2011). Monitoring milk and motherhood: Lactation consultants and the dilemmas of breastfeeding advocacy. *International Journal of Sociology of the Family*, *37*(1), 153−171.
Waggoner, M. R. (2015). Cultivating the maternal future: Public health and the prepregnant self. *Signs: Journal of Women in Culture and Society*, *40*(4), 939−962.
Wolf, J. B. (2010). *Is breast best: Taking on the breastfeeding experts and the new high stakes of motherhood*. New York, NY: NYU Press.