Social Science & Medicine 184 (2017) 75–83

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Dangertalk: Voices of abortion providers

Lisa A. Martin, PhD [a, *], Jane A. Hassinger, MSW [b], Michelle Debbink, MD, PhD [c], Lisa H. Harris, MD, PhD [c, d]

[a] University of Michigan, Dearborn, Women's and Gender Studies Program & Dept. Health & Human Services, USA
[b] University of Michigan, Ann Arbor, Institute for Research on Women and Gender, USA
[c] University of Michigan, Ann Arbor, Dept. of Obstetrics & Gynecology, USA
[d] University of Michigan, Ann Arbor, Dept. of Women's Studies, USA

ARTICLE INFO

Article history:
Received 3 November 2016
Received in revised form
25 April 2017
Accepted 1 May 2017
Available online 3 May 2017

Keywords:
United States
Abortion
Abortion providers
Workshop

ABSTRACT

Researchers have described the difficulties of doing abortion work, including the psychosocial costs to individual providers. Some have discussed the self-censorship in which providers engage in to protect themselves and the pro-choice movement. However, few have examined the costs of this self-censorship to public discourse and social movements in the US. Using qualitative data collected during abortion providers' discussions of their work, we explore the tensions between their narratives and pro-choice discourse, and examine the types of stories that are routinely silenced – narratives we name "dangertalk". Using these data, we theorize about the ways in which giving voice to these tensions might transform current abortion discourse by disrupting false dichotomies and better reflecting the complex realities of abortion. We present a conceptual model for dangertalk in abortion discourse, connecting it to functions of dangertalk in social movements more broadly.

1. Introduction

A number of researchers have described the difficulties of doing abortion work (Joffe, 1995; 2010; Simonds, 1996; Ludlow, 2008; Lipp, 2010; Harris et al., 2011). Simonds' (1996) ethnography of abortion clinic workers recounts stories of discomfort with fetal parts and the violence and gruesomeness that is part of providing abortion care. Roe (1989) found that abortion providers experience considerable ambivalence in their work. Lipp (2010) described how nurses in abortion care sometimes struggle to provide non-judgmental care, making considerable efforts to conceal judgments from patients. Collectively, this research reveals that abortion providers hold complicated feelings and attitudes about both abortion and the women they serve (Simonds, 1996; Roe, 1989; Harris et al., 2011).

One obvious source of difficulty in doing abortion work is the associated stigma. (Kumar et al., 2009; Lipp, 2011; Harris et al., 2011). Abortion is "dirty work" — a socially necessary task or occupation generally regarded by others as physically disgusting, socially degrading, and/or morally dubious (Hughes, 1951; Joffe, 1978; Harris et al., 2011; O'Donnell et al., 2011; Chiapetta-Swanson, 2005). We have previously described the psychosocial costs to individual providers of doing dirty work, including the burdens associated with disclosing their work to others (Harris et al., 2011). Many providers routinely choose not to talk about their work publicly. This self-censorship occurs for a range of reasons including the desire to avoid stressful interactions, protect personal safety, and prevent conflict within families (Harris et al., 2011).

Sometimes, however, providers also choose to remain silent to protect the pro-choice movement. In her critique of pro-choice rhetoric, Ludlow (2008) explored how the movement has created a hierarchy of abortion narratives – what she deems the "politically necessary" stories – that advocates routinely deploy to keep abortion legal (e.g., rape/incest/domestic violence victims). Also common are the "politically acceptable" narratives (e.g., contraceptive failures, fetal anomalies) that evoke sympathy. Ludlow's third category, "the things we cannot say," includes stories that are both absent from pro-choice discourse and often exploited by anti-abortion activists (e.g., multiple abortions, grief after abortion, the economics of abortion). Providers keep these stories to themselves because they fear providing fodder for anti-abortion groups'

* Corresponding author. University of Michigan Dearborn, College of Arts Science and Letters, Women's and Gender Studies, 4901 Evergreen Dr., Dearborn, MI 48128, USA.
E-mail address: martilis@umich.edu (L.A. Martin).

http://dx.doi.org/10.1016/j.socscimed.2017.05.001
0277-9536/

rhetoric (Ludlow, 2008).

Providers who speak out about these topics have, in fact, been labeled as dangerous to the movement. Harris (2008) described the violence in abortion and argued that abortion providers cannot ignore the fetus since fetal parts comprise the concrete evidence that they have done their job of ending a pregnancy. Her acknowledgment that providers sometimes have emotional reactions to the fetus' visual impact, corporeality, and moral significance elicited angry responses from both anti- and pro-choice communities, including harassing emails and threats from anti-abortion activists who seized upon her words as proof that abortion is gruesome and should be banned. Simultaneously, Harris was criticized by some pro-choice advocates who felt she should have remained quiet (personal communication, 2009). Providers' experiences may not perfectly align with pro-choice messaging, creating tension between feminist activists and those doing the work that feminists champion (Simonds, 1996; Joffe et al., 2004; Harris, 2008).

Few scholars have examined whether providers' self-silencing results in costs to the movement itself. One consequence is that nuanced *public* depictions of abortion workers are rare. The absence of providers' voices has created a vacuum in which stereotypical caricatures may dominate the public discourse. Both abortion supporters and opponents commonly construct providers in one-dimensional terms: celebrated as "heroes" and "warriors" in the fight for women's reproductive autonomy (Brink, 2015) or vilified as callous, incompetent, and greedy (Harris et al., 2013). Some restrictive abortion laws - allegedly designed to protect patients from abortion providers – rely on these negative stereotypes.

Roe (1989), one of the first to document provider ambivalence within abortion, worried that ignoring difficult aspects of abortion work would ultimately weaken the abortion rights movement. She advocated that proponents of safe, legal abortion look to providers' work experiences to help shape more resonant frameworks for understanding and conveying the complexities of abortion. Nearly 30 years later, we answer that call.

Using qualitative data from abortion providers' discussions, we explore tensions between their narratives and dominant abortion rights discourse, and examine the types of stories about which providers routinely remain silent. We seek to understand how providers' self-censorship around the difficult aspects of the work may impact the pro-choice movement, and how giving voice to these tensions might transform current abortion discourse. In addition, we consider the broad implications of suppressing dangertalk on social movements.

2. Methods

We analyzed data from two iterations of the Providers Share Workshop: a pilot study conducted in 2007, and a seven-site study from 2010 to 12 (Harris et al., 2011; Martin et al., 2014; Debbink et al., 2016). The workshop is a multi-session facilitated intervention in which teams of abortion providers explore their work experiences. See (Debbink et al., 2016) for a detailed description of the methodology. The workshop was designed and implemented to create space for conversations about the unique rewards and stresses experienced by abortion workers, including being targets of violence, harassment, and restrictive legislation. Workshop sessions addressed the following themes: 1) What abortion work means to me; 2) Stories of memorable patients; 3) Abortion and identity; 4) Abortion politics; and 5) Future directions for self-care. Eligible participants included all workers in abortion care, e.g., counselors, surgical assistants, physicians, nurses, clinic managers and administrators. There were no substantive changes between the pilot and multi-site workshops. Participants provided written informed consent for participation, audio recording, and publication of de-identified findings.

We recorded and transcribed all sessions. All study team members read the transcripts and identified major themes, using an iterative coding process for reconciling disagreements. Data collected from pilot transcripts were coded using NVivo 8 (QSR International, 2008). Transcripts from the second, multi-site study were coded using Dedoose (2015). The University of Michigan IRB approved both studies.

3. Results

Ninety-six people at eight clinic sites participated. Workshop sites represented each major US geographic region, as well as a variety of service models (free-standing clinics, clinics integrated within health systems, for-profit, and non-profit). Participants filled a range of job types within abortion care, and we use the term "provider" to mean all of those involved in direct patient care at these sites. The participants were predominantly female. Here we focus on the stories not routinely shared with friends, family, or even other abortion worker colleagues. Outside of the workshops, such stories were typically censored because of concern about affirming anti-abortion stereotypes, challenging pro-choice movement messaging, and acknowledging moral ambiguities in abortion work.

3.1. Stories we don't share

3.1.1. Judging patients

Providers revealed that they were not immune to negative stereotypes about women seeking abortions, and many admitted that they sometimes judged their patients. In particular, providers felt ambivalence and expressed that some women are less deserving of an abortion, in particular when they have multiple abortions or refuse to use reliable contraceptive methods:

> She used to come in all the time … She didn't use contraceptives and they were being offered to her. And she was not a young person. She had … 7 or 8 children. Now she's coming in without using any birth control of any type - a 'frequent flier.' She comes in [for] #15 abortion. And I just had a little problem with that.

These types of patients failed to evoke providers' empathy. Many participants spoke about the importance of confronting their negative attitudes, reminding themselves that their job was to provide care, not to judge. Providers also described efforts to conceal judgment from patients, efforts that were not always successful.

3.1.2. Moral uncertainty

While participants often commented about their pride in their work, many also identified moral uncertainties about whether or not providing abortions was always a good thing. For example, one physician stated,

> I still to this day say to myself I hope I'm doing the right thing. That never goes away. I embrace [this uncertainty] as healthy because … it lets me know that certainty about being right is not necessary to move forward … I hope we can talk about [this] because it's one of the most dangerous parts – [the] 'of course it's right to do abortions' assumption. But to talk about maybe it's not always right or doesn't always feel right … There's part of this where you need some validation [that] what you're doing is right.