Making Moms: Production of Motherhood at Crisis Pregnancy Centers in Connecticut

by

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Mom, thank you for listening as I developed very strong opinions about topics many people don’t want to hear or talk about. Never have I felt anything but support from you, even when I bring these topics up over Thanksgiving dinner, and that has meant so much. Dad, thank you for always answering the phone and knowing exactly what to say. Jonathan, thank you for providing me with opportunities to explore these topics in deeper, more interesting ways than I ever could have found on my own and for showing me what it means to be passionate about a project (no matter how odd it may be). Ananda and Jake, you two are simply the best and everything I do is in the hope of being an impressive big sister.

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An Introduction to CPCs

“We’ve been here 25 years and we are a faith based organization, we are a Christian organization, we are a pro life organization, we are life affirming so we do not refer for abortions or perform them.”
-Interview two

Crisis Pregnancy Centers (CPCs) are pro-life, non-profit, often Evangelically-linked centers dedicated to counseling women through unplanned pregnancies, with a stated goal of convincing them to carry their pregnancies to term. CPCs operate by providing financial and material support, as well as referrals to outside resources, contingent upon a woman’s “choice” to give birth rather than accessing abortion services. The tactics employed by CPCs are powerful, coercive, and infused with misinformation. Moreover, they tend to function within some of the most vulnerable populations in contemporary US society.

In recent years there has been a movement towards “uncovering” these centers and their deceptive tactics. Magazines, online platforms, and even comedians, have all commented on CPCs and how they function (“What Some Crisis Pregnancy Centers are Really Saying”). While it is important that CPCs are receiving increased attention for their dubious methods, the dialogue that has taken shape around them tends to imagine them as extreme anomalies that blight the otherwise clean landscape of pregnancy and reproductive health. In actuality, CPCs are far from rare, existing at a rate of at least three CPCs for every abortion provider. When they are examined in the context of broader societal narratives surrounding pregnancy and motherhood, it

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1 It is important to acknowledge that not all persons experiencing pregnancy identify as women, but as all interviewees refer to pregnant persons as “women” and that the majority of the societal narratives I explore are seen as applying exclusively to cis-gendered women, I have chosen to continue with the language of “woman” and “pregnant woman” throughout this paper.
becomes clear that CPCs exist in dialogue with many other reproductive health services. In this thesis I argue that CPCs are a product of critical absences in women’s mainstream reproductive choices. The success of CPCs in growing their clientele and increasing their organizational number would simply not be able to exist if mainstream medical and legal ideas about pregnancy – particularly those that are unplanned, unwanted, or ambivalent – were more consistently held.

The argument most central to this thesis is the notion that CPCs function as microcosms of broader dialogues about how pregnant women ought to be viewed, counseled, interacted with, and policed. In fact, I wasn’t far into my research when I noticed the vast discrepancy between the language of “uncovering” these “crazy” places, and the reality of just how widespread, normalized, effective, and frequently state-funded these centers actually are. With this realization, I began to consider how and why CPCs have managed to gain increasing success in a somewhat unnoticed and unregulated manner.

In order to address this issue, the thesis provides a three-chapter framework through which to examine CPC rhetoric on its own merits and in relation to coexisting reproductive health narratives. Beginning with chapter one, I take the reader through the concepts of “maternal responsibility” and the “woman as a vessel, to show how these ideologies are already present in society, and are further exploited by CPCs. I then consider the concepts of “good” and “successful” mothering, as well as the normalized, yet unachievable, state in which these concepts exists. This chapter also begins to lay out the complicated racial and class dynamics that exist in CPCs.
In chapter two, I perform an analysis of the spaces in which the interviews were conducted at, looking at objects and images provided in the different rooms to demonstrate how they function to produce a very specific response. In this chapter, an exploration of space will demonstrate how CPCs capitalized on narratives that already exist, hijacking objects and images from medical and religious spaces to create a uniquely powerful and coercive narrative of prenatal regulation, appropriate motherhood, and fetal life.

Finally, in chapter three, I address the politics of “choice,” tackling issues such how women function as agents of choice, and how the concept of choice itself is often a misnomer for a set of limited options. In this chapter, I show how the CPCs very particular presentation of choice is particularly harmful and coercive when utilized within the populations most likely to access CPC services.

In addition, all of the chapters demonstrate how CPCs both build upon and work to transform existing societal narratives regarding pregnancy. In a landscape where the very notion of “good mothering” is often a status that is near impossible to achieve, these centers successfully help their clientele – many of whom are marginalized by way of race, class, and age – to understand themselves as proper mothers. While CPCs’ tactics may only provide short-term, superficial, options that exist for the sake of the fetus rather for than the pregnant woman, it does not follow that they are necessarily any less effective in communicating their intended pro-life mission. CPCs advertise in a way in which women experiencing pregnancy with little or no financial, emotional, or medical support are drawn in, and then fed a narrative of exactly how to become good mothers. CPCs are able to depict “good motherhood”
as an approachable status for women who have likely experienced social alienation because of their race, class, age, and so on in most aspects of their life. In this paper I will use CPCs as a lens through which to better understand the convoluted, ambiguous, and moralistic landscape of reproductive health management. Ultimately, I argue that CPCs can be thought of as microcosms of the larger institutional problems surrounding reproductive rights in the 21st century US, and that their ongoing success is a testament to the shortcomings of existing, legitimate health services aimed at pregnant women.

**Methodology**

In my approach to this project I made the deliberate decision to interview those who run and operate CPCs\(^2\). I considered this to be a group of people with a great amount power over definitions of pregnancy. Through the six interviews I conducted, I gained access to previously undocumented information. Although I strongly believe that there is a significant power in speaking to CPC employees in order to fully understand how they operate, it is also critical to acknowledge that my thesis is missing the voice of those who visit these centers and go through these experiences themselves. For the women who walk into these centers, confronting ambiguous and falsified information is indeed a difficult task. This is especially true given that CPCs typically serve vulnerable populations. At many of the CPCs that I visited, the interviewees identified their clientele as consisting mainly of youth,

\(^2\) All identifying information has been removed from the quotes, pamphlets, and analysis to protect the jobs and identities of those who I interviewed. See the Appendix for a copy of the IRB proposal and informed consent documents.
immigrant women, women with mental illnesses, women of color, women of low socioeconomic status, women with substance abuse problems, and women in abusive relationships. In speaking of the CPC as a microcosm, one must not forget who it is that is going through these experiences and just how much they are already up against before they even walk in. For these reasons, I intentionally did not seek out IRB approval to interview CPC clientele; their vulnerable status would make such a project unethical.

The six interviews I conducted were all within the state of Connecticut, each at a different location. The staff members I interviewed were all women, five of whom held management positions, and one of whom held the title of “client service manager.” As most CPCs function on a volunteer-based approach, these women often occupied one of very few paid jobs for their organization, giving them vast and diverse responsibilities. It is important to note that not one of the six centers that I visited during my research identified itself as a crisis pregnancy center. Rather, each interviewee used one of the following terms to describe their organization: pregnancy support center, pregnancy resource center, pregnancy care center, or emergency pregnancy center. Whatever the reasons behind their preferred terminology, every one of these centers is easily identifiable as a CPC through a quick Internet search on the subject. As such, the preferred and advertised term for these centers is less relevant to the women visiting their centers, and is more relevant as a tool to distance themselves from the growing attack on CPCs in the media (“Crisis Pregnancy Centers”). For the purposes of this thesis, I use the term CPC to designate a non-profit organization that is dedicated to counseling and directing women toward the choice of carrying their
pregnancies to term by providing financial and material help, and referrals to outside resources, all of which are contingent upon the woman choosing adoption or parenting as her pregnancy outcome. All of the organizations I visited met these requirements, even though at times, there were slight differences, including, for instance, how prolife sentiment was expressed, and which supplementary services were provided. I have created the following chart to demonstrate the range of services provided by each center:

<table>
<thead>
<tr>
<th></th>
<th>CPC 1</th>
<th>CPC 2</th>
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<th>CPC 4</th>
<th>CPC 5</th>
<th>CPC 6</th>
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</thead>
<tbody>
<tr>
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<td>Counseling (licensed)</td>
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<td>Medical referrals</td>
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<tr>
<td>referrals (housing, daycare, legal, food, etc)</td>
<td>Post-abortion support</td>
<td>Home visits</td>
<td>Postpartum support group</td>
<td>Childbirth classes</td>
<td>Housing options</td>
<td>Labor and delivery support</td>
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**Figure 1:** Goods and Services Provided by CPCs

In the chapters that follow, I will examine the significance of the main services offered by CPCs, as well as how these services fit into a broader political mission.
CPCs in Connecticut

Connecticut is a state that well illustrates the vast presence and widespread effects of CPCs in this country. A report published by NARAL (the National Association for the Repeal of Abortion Laws) in 2015 found that while the current number of abortion providers in Connecticut stood at nineteen, the number of CPCs had reached twenty-seven (The Right to Lie 1). In their research, the authors further discovered that: 1) 95% of these CPCs gave inaccurate information that risked the health and safety of the women visiting; 2) only 11% had a medical professional on staff, yet only 30% stated that they were not a licensed medical facility, and 20% even had staff present themselves in white lab coats; 3) 45% were located near or in professional medical areas; 4) 80% linked abortion to breast cancer, 30% linked it to future miscarriages, and 90% made some sort of claim that it would lead to mental health issues (The Right to Lie 5-25). The report went on to identify these CPCs as targeting women of color, college aged women, and women of low socioeconomic status, citing how 85% of Connecticut’s CPCs are located less than five miles from a school campus, 65% are in areas with higher than average populations of color, and 69% are located in communities living further below the poverty level than the state average (The Right to Lie 25).

These figures become even more significant when compared to broader statistics on pregnancies in Connecticut, such as the fact that 51% are unintended, and that nearly 20% of those pregnancies occur for teenage girls (The Right to Lie 6). Together, these statistics paint a picture of a reproductive and sexual health landscape with high rates of unintended pregnancy, low rates of abortion provision, and a high
prevalence of CPCs. When combined, these statistics highlight how critical CPCs are to shaping the experience and choices of pregnant women across the state.

**The History of CPCs**

Despite the huge presence of CPCs throughout the U.S., a historian has yet to produce a single stable history of CPCs, or of the foundations and major figures involved in their creation. When looking into the origins of CPCs, I encountered a history that was not only obscure but in many instances simply missing. After doing extensive research in concert with a reference librarian, I am still left with a historical narrative that leaves more questions than answers. Then again, such a history resonates with the current day-to-day operation of CPCs, which, as this thesis demonstrates, utilize ambiguous and inaccurate information in their presentation of client services. The mystery surrounding the CPC origin story is therefore not out of character, existing within a broader landscape of inconsistency and uncertainty. While the following history is lengthy, I believe it is a necessary precursor to the arguments asserted in this thesis regarding the methods and mission promotion activities of CPCs.

The most illustrative example of the types of problems that arose as I was conducting my research is the difficulty I encountered when trying to find a copy of the manual *How to Start and Operate Your Own Pro-Life Outreach Crisis Pregnancy Center*. This manual is said to be a crucial piece of writing produced by the founder of the first CPC, Robert Pearson. While comprehensive historical accounts are lacking, short acknowledgments regarding the foundation of CPCs all tend to refer to
this manual (other times referred to as a book and other times as a pamphlet, but always with the same name). After extensive searching to find a copy of this manual, the closest I came was in finding excerpts featured in a court case against the Pearson Foundation that I will speak about more extensively later in the Introduction. I was also unable to find a date of production with the closest approximation being that he wrote it in the few years following his move from Hawaii to the continental U.S. This pamphlet is referenced, but without citation, in most accounts of CPC history. This document has been cited as outlining successful tactics for deceptively maneuvering women into carry their pregnancy to term (Meehan), including ideas such as listing CPCs next to abortion providers in the Yellow Pages, operating under two names (one to trick women into visiting, and another for church and other donation purposes), and to not identify as pro-life before the woman is in the office (Haigney).

To truly understand the expansion of CPCs over time and their huge success, access to documents such as How to Start and Operate Your Own Pro-Life Outreach Crisis Pregnancy Center is critical; however, despite much effort I was unable to procure a copy.\(^3\) From roadblocks such as this one, it became very clear to me that a huge history project exists that has not yet been undertaken, the depth of which is beyond the scope of my project. Just as with the women who visit CPCs, whoever ends up taking on this project on will face intentionally ambiguous and obstructed information. With so much missing and unstable information, my account of the

---

\(^3\) Another similar issue I encountered was not being able to find a copy of a speech Robert Pearson delivered in 1994 from which a widely quoted and very inflammatory excerpt was taken and which I include later in this chapter. Beyond finding a copy, I was unable to even find information on where the speech was delivered and to whom. And then there were smaller, less noticeable, but still greatly significant gaps such as never encountering a photograph or personal history of Robert Pearson.
history of CPCs does less to relate the actual chronological history, operating instead to illustrate how these organizations have historically existed and continue to exist in a way that is shockingly undocumented and unregulated.

In tracing CPCs to their root, most information available cites a man named Robert Pearson as the founder of the first CPC in date. The story goes that Pearson was inspired to create a center for women experiencing an unplanned pregnancy directly after his home state of Hawaii became the first to enact a fully permissive abortion law in the US in 1969 (“Hawaii: Did you know?”). The history of the legalization of abortion in Hawaii is a fascinating one. Having only recently received statehood in 1959, it is curious that Hawaii became the location of the first major win in the battle for abortion rights. In their book *Abortion Politics: The Hawaii Experience*, Patricia Steinhoff and Milton Diamond attribute a handful of factors to creating the right atmosphere for this law to be passed. In particular, they assert that Hawaii’s population and geography made the government very accessible to the people both physically and socially, making it easier for the populace to share and fight for their views (Steinhoff 1). Overall, abortion was no bigger of an issue in this state than in the continental US (in fact, the consequences of illegal abortions or unwanted pregnancies could be seen much more clearly in other states), but as Hawaii’s attitudes towards abortion mirrored many changes happening in the continental US, the state became the most favorable place to respond to these changing norms (Steinhoff 1). The receptivity of Hawaiian legislature to abortion legalization was due in part to a series of unique demographics, including the facts that a large percentage of the civilian labor force that was female - 41% according to
the 1970 census; that two-income families were “the norm rather than the exception”; and that very quickly after gaining statehood, “a Democratic coalition, supported by the leading labor unions and the large ethnic community of Americans of Japanese ancestry, wrested political control from the predominantly Caucasian and Republican elite” (Steinhoff 2).

In a remarkably speedy process, Bill 61, a bill composed of the “key majority party members of the house,” and which “followed the pattern of the American Law Institute model abortion law,” went through a second reading by the House of Representatives on April 3rd, 1969, and passed with a vote of thirty nine in favor and twelve opposed. The only stipulations posed were regarding therapeutic abortions, which were required to be certified by two physicians, and were required to be reported within twenty-four hours if not performed in a hospital setting (Steinhoff 13, 18). After the mandatory waiting period of four days, the bill then passed a third reading without any issue (Steinhoff 18). Interestingly, it is recorded that the bill neither excited nor angered the public to any great degree, that it passed in a similar manner as any minor social welfare bill might have, and that the whole process occurred in a very matter-of-fact movement towards liberalizing abortion laws (Steinhoff 18-19).

Despite this “under the radar” entrance, opposition did eventually emerge. The most major forms of opposition came from two sources: Representative George Loo, who held strong personal beliefs about a fetus’ right to choose life, and the Roman Catholic Church, which had already released statements and letters to newspapers reminding both their Catholic and non-Catholic audiences that they were opposed to
the abortion law reforms (Steinhoff 29-30). Both of the aforementioned parties dedicated much of their resources towards tactics aimed at targeting both the public and the legislature, demanding that the new law be repealed, but to no avail. It was in this context Robert Pearson offered another form of opposition to the laws by founding the first CPC.

Soon after abortion was legalized in Hawaii, Pearson began to offer support to women who were looking to carry their pregnancy to term as an alternative to abortion. Pearson even went as far as hosting approximately forty pregnant women in his own home in just the first year after the new abortion law was passed. Here we get the first glimpse at how CPCs have functioned from their very start in an inappropriate, boundary-crossing manner, removing any sense of privacy for the woman, and going to great lengths to protect the unborn fetus. In 1973, Pearson turned these humble beginnings into the registered Pearson Foundation, Inc., with an office in Honolulu and the stated mission of supporting and servicing the needs of pregnant women. Advertisements for the foundation were placed in local newspapers, and Pearson additionally began to make rounds in Hawaiian public schools to administer a very strong anti-abortion message (Steinhoff 187).

Success quickly followed the establishment of Pearson’s first clinic, and he is believed to have then moved to the continental US to open several centers from his foundation’s new base in St. Louis (Stacey). One website aimed at uncovering the mission behind CPCs credits the Pearson Foundation with providing services such as “training sessions, slide shows - such as Caring: a 27-minute show that ‘includes many pictures of bloody fetuses in waste cans and one of a gurney carrying a woman
who is apparently dead and is covered by a sheet’… pamphlets… a manual entitled

_How to Start and Operate Your Own Pro-Life Outreach Crisis Pregnancy Center_”

and more, for anyone who wanted to start a center of their own (Stacey). It is believed

that in his speeches and writings, Pearson was upfront about the pro-life mission and

purpose behind his centers, but that he advocated the use of deceit when interacting

with clients on this issue. One of the quotations attributed to Pearson that was

reproduced across a variety of sources⁴ was the following: “Obviously we are fighting

Satan… a killer, who in this case is the girl who wants to kill her baby, has no right to

information that will help her kill her baby. Therefore, when she calls and says, ‘Do

you do abortions?’ we do not tell her, ‘no, we don’t do abortions’” (Taft).

Whether or not this history is an exact recount of CPCs and how they began,
or whether it stands more symbolically as a mythological origins story is not

necessarily relevant to my current study. What is significant, however, is how this

origin narrative has been continuously circulated as “truth” since the 1970s, aiding in

the fast-paced and societally broad successes of CPCs. What supposedly started as a

single person’s project quickly grew into a national movement in a matter of a few

short years. Today it is estimated that somewhere between 2,500 and 4,000 CPCs

exist in America (Rosen 1), meaning that they outnumber abortion providers by three
to one at a minimum. Moreover, as the number of abortion providers started

drastically decreasing in 1990, CPCs have continued to rise in number consistently

since then (Duane 2).

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⁴ However I was not able to find the actual 1994 speech from which this quote supposedly
originated or any information as to where this speech was given and to whom
However you look at it, the story of Robert Pearson leaves us with some interesting questions. The jump between CPCs existing as a single center in Hawaii to outnumbering abortion clinics 3:1 is an occurrence for which we have little documented evidence. The process of researching individual CPC organizations is similarly obfuscated. For instance, the history of “Birthright International,” one of the largest CPC organizations and one of the few with centers in multiple international locations, includes its own history on the “Discover Birthright” page as follows:

Birthright began very humbly in 1968, with a one-room office and only $300 in the bank. But Louise's steady leadership and powerful vision ensured that the new pregnancy service survived. In later years, Louise was glad the organization did not begin with a lot of money because it caused Birthright to rely on the "good hearts and hard work of volunteers". Over forty-five years later, Birthright International remains true to Louise's original vision of personal, one-on-one contact in helping relationships… Louise helped formulate a Charter, followed by all Birthright chapters worldwide, to define Birthright's services, to ensure that pregnant women receive the same considerate treatment at every Birthright chapter, and to help volunteers preserve Birthright's good reputation in the future…On her death, three of Louise’s daughters assumed the Co-presidency of Birthright International (“Discover Birthright”).

In many ways mirroring the Robert Pearson story, this brief history does not explain how Birthright International grew to be one of that largest CPC networks that now exists across seven different countries. There is the same gap between how this organization jumped from the personal aspiration of one woman with $300, to an extremely influential, far-reaching group of centers. Though it is easy to understand the appeal of such stories in the context of US ideals of individualism and progress, it remains a curious fact that these narratives are incredibly hard to prove.

Today, the Robert Pearson Foundation of Hawaii, Inc. is registered as a non-profit organization operating the Pregnancy Problem Centers of Hawaii, located
in Honolulu and Pearl City. On their “About Us” page, the centers refer to their foundation in 1970 by Robert J. Pearson who eventually “left this organization to work on the mainland,” noting 1986 as the year they were “incorporated as The Pearson Foundation of Hawaii, Inc.” (“Pregnancy Problem Center of Hawaii”). The Foundation is a registered 501(c)(3) with their IRS 990 form available online. As a federal tax-exempt organization, this form relates their yearly returns to the public. All forms for the years 2000 to 2015 are available anyone who wishes to view them. In their most recent statement, The Robert Pearson Foundation of Hawaii claimed net assets equaling $54,975. Their total functional expenses were listed at $29,573 and their revenue was listed as $37,070. This information can be seen in the following chart that I generated using data published online for the years 2000-2015:

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Revenu (USD$)</th>
<th>Net Assets (end of year) (USD$)</th>
<th>Revenue from Contributions (USD$)</th>
<th>Other Revenue (USD$)</th>
<th>Total Functional Expenses (USD$)</th>
<th>Advertising Expenses (USD$)</th>
<th>Other Expenses (USD$)</th>
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<td>73,144</td>
<td>39,026</td>
<td>72,143</td>
<td>1,001$</td>
<td>38,878</td>
<td>25,517</td>
<td>13,361</td>
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<tr>
<td>2001</td>
<td>56,488</td>
<td>29,130</td>
<td>55,506</td>
<td>982$</td>
<td>36,429</td>
<td>24,819</td>
<td>11,610</td>
</tr>
</tbody>
</table>

5 Same year as they are recorded as becoming tax exempt on ProPublica website
6 Categories include: program services, investment income, bond proceeds, royalties, rental property income, net fundraising, sales of assets, net inventory sales, and other revenue
7 Categories include promotion, office, dues and subscriptions, insurance, license and fees, parking, supplies, and utilities
8 $868 from investment income and $133 from program services revenue including government fees and contracts
9 $422 from investment income and $560 from program services revenue including government fees and contracts
<table>
<thead>
<tr>
<th>Year</th>
<th>Total Revenue</th>
<th>Revenue from Investment Income</th>
<th>Revenue from Net Income from Gaming and Fundraising Events</th>
<th>Other Revenue</th>
<th>Total Expenses</th>
<th>Net Revenue</th>
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</thead>
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<tr>
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<td>58,800</td>
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</table>

**Figure 2:** The Pearson Foundation of Hawaii 990 forms 2000-2016 (“Pearson Foundation of Hawaii Incorporated”)

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10 Investment income  
11 Investment income  
12 Investment income  
13 $314 from investment income $18,090 from net income from gaming and fundraising events  
14 Investment income  
15 Investment income  
16 Investment income  
17 Investment income  
18 $10 from investment income and $2,438 from net income from gaming and fundraising events  
19 $4 in investment income and $884 from net income from gaming and fundraising events  
20 Investment income
Using the information that is available, I would like to draw the reader’s attention to the advertising expenses column. The reason I have included this column separate from the other categories of expenses is to illustrate just how much of this CPC’s income is being spent on advertising to the public. The numbers are even more startling when one takes into account the fact that “advertising” and “promotion” were split into two separate categories in 2009, and in this chart only the “advertising” expenses have been included. I will touch on the idea of CPCs as “non-commercial” institutions again in chapter three, an idea made even more complicated and questionable given the percentage of expenses dedicated to advertising as indicated in this table.

Although these 990 forms give us a crucial glimpse into the structure of this CPC, there remains much that is unknown. The Pearson Foundation of Hawaii, Inc. only provides us information on two of its centers, and I was unable to locate any information on a registered Pearson Foundation existing in any other state. In addition, the amount of money listed is significantly less than one might expect. Though it is not within the parameters of this project to demonstrate that these figures are inaccurate, it is possible to speculate that additional funds exist, and are registered under another name. As mentioned above, Pearson advocated the strategic use of two different organization names for every single CPC, one which they publicize to women seeking support and help, and another which states their pro-life mission, and with which they collect donations, advertise for volunteers, and conduct other internal

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21 I was able to find 990 forms for a handful of the centers that I conducted interviews at. These forms told a similar story and begged similar questions. I am unable to include them due to confidentiality and a commitment to maintaining anonymity for all the employees I spoke with.
business. In my research, I found no proof that this had occurred as a part of CPC history, but it is certainly possible that additional assets are registered elsewhere. To be sure, such a deception would not be out of line with other CPC practices that function in ambiguous ways without state regulation.

The uncertainty surrounding CPC funding sources and expenditures is all the more peculiar when it is understood that a large portion of these organizations are state funded. Every state has different laws but, for many, CPCs are supported with state money set aside for the financing of “women’s health care,” despite the pro-life message of these centers or their inability and refusal to cover all forms of healthcare or even provide accurate, comprehensive information. In the study on CPCs in Connecticut conducted by NARAL, researchers were unable to confirm whether or not “state-authorized funding streams which benefit from the deceptive business practices of CPCs” are in existence (The Right to Lie 6). What they did find was that there are no laws specifically limiting state support or protecting women in any way from these clinics and their deceptive practices.

CPCs and the Court

There are a handful of cases involving CPCs over the years that have made it to court. These cases help us see instances of public response to CPC growth, as well as how these organizations have dealt with confrontations with the law. One of the first court cases deals directly with the Robert Pearson Foundation. In the Oversight Hearings before the Subcommittee on Civil and Constitutional Rights of the Committee on the Judiciary House of Representatives Ninety-Ninth Congress First
and Second Session on Abortion Clinic Violence that took place in 1985 and 1986, the court held a series of hearings on abortion clinic violence, specifically considering “whether, in specific instances, unlawful activities directed against abortion clinics have infringed constitutional rights of reproductive freedom.” The court’s stated purpose was “most emphatically not to debate the pros and cons of abortion…[as] a fundamental right,” but rather to “explore the impact” of protestors blocking clinic entrances, levying threats, perpetrating property damage, invading clinic spaces, and so on (Abortion Clinic Violence 1). Within this exploration of the violence occurring around clinics was the issue of how patients were deterred and ended up visiting crisis pregnancy centers instead.

At these hearings six testimonies were given from witnesses who had brought prior cases to the courts against CPCs in multiple states including Texas, California, South Dakota, and Florida, for engaging in unfair business practices, false advertising, unauthorized adoption, and attempted child abduction. The first testimony was given by a woman referred to as Jane Doe who had brought a lawsuit against a pro-life organization in San Francisco, which was later learned to be an affiliate of the Pearson Foundation. It is through this case that authorities began to take a closer look at this foundation only to find that it was already operating on a national scale in 59 cities and 28 states, that more than half of their clientele was under the age of eighteen, and that its founder advocated deceptive tactics (Abortion Clinic Violence 281). It is unclear how the reach of the Pearson Foundation had previously failed to draw anyone’s attention.
The case of Jane Doe is illustrative of many tactics used at CPCs across the country, and shows just how far these centers will go to fulfill their pro-life mission. Jane Doe was sixteen years old when she found herself pregnant with no one to turn to, and decided that she wanted an abortion. She discovered a center under the heading of “clinic” in the Yellow Pages and was drawn to one in particular because it offered free pregnancy tests “while you wait.” As a teenager she did not have access to money of her own, so the advertising of free services became crucial to her decision making process. Upon calling, there was no hint that the center was opposed to abortion and would never refer her to an abortion practitioner, despite her directly asking the person on the phone how much they charge for abortion. Once at the center, Jane was forced to watch a slideshow (presumably the same one referenced earlier in this chapter) that she said scared her. Nonetheless, she was still sure about her decision to terminate her pregnancy; when she mentioned this to her counselor at the end of a two-hour session, she was told that she had to come back for another test before taking any further steps, and that, in the meantime, she should not go to Planned Parenthood as it was a “very bad place” (Abortion Clinic Violence 280).

Jane says that she went back to the center a total of ten times; each time they tried to change her decision, and each time she was told that if she returned again the center would help her find an abortion provider. Finally, at six months pregnant, it was legally too late for her to terminate her pregnancy. The counselor at the center then suggested to Jane, who had still not told her parents about her pregnancy, that they would set up a secret adoption for the baby, and that they could make plans for

22 Most witnesses mentioned what is presumably the same slideshow, calling it traumatic, sickening, and scary.
her to leave for the necessary amount of time without her parents’ knowledge. Without holding an official adoption license, the center sent Jane home with a permission slip to be signed by her parents that provided false information about a nonexistent study abroad program with the “Pearson Foundation Overseas Education Program sponsored by the Pearson Foundation.” Jane Doe’s mother took this slip to a translator at her local YMCA, as she was from China and did not speak English fluently, and the counselor quickly noticed something unusual happening and notified the police. At this point Jane’s parents became aware that she was pregnant and kicked out of her house; she later gave birth and put the child up for adoption with a licensed agency.

It was during the police investigation that followed this case that the booklet on how to operate a CPC written by Robert Pearson was discovered. Excerpts of the booklet were read throughout the hearing, including the following statement that encourages CPC employees to help a minor to evade parental authority:

If the girl is being pressured into an abortion at her home and she is willing to go to a foster home, even though she may be a minor, take her at once. When a girl is safely at the home, call the parents explaining who you are and the center, and let them know that their daughter came to you for help and didn’t want an abortion. Try to make every effort to keep the daughter from the parents until the parents understand the significance of what an abortion really means not only to their grandchild but to the health and happiness of their daughter. She may have to get lost in this way two or three times before the parents stop pushing for abortion. She may have to slip out the back door if the parents come to take her for an abortion. Remember, it is permissible not to follow authority from parents or the state if it is against the law of God, and abortion is against his law (Abortion Clinic Violence 282).

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23 It is worth noting that Jane states that they originally explicitly mentioned Hawaii as a potential location, only to later say it wasn’t an option as she would need parental permission to travel that far on her own.

24 The CPC counselor continued to contact her saying that they had found a great family and suggesting that she use their adoption services instead.
I have included this narrative not just as an introduction to the tactics and tools utilized by CPCs, but also, to illustrate how extensive and drastic their operations had grown to be by the time they were brought to court. The Jane Doe case thus became more than a suit about false advertising or harassment, and instead was argued as a case of attempted child abduction.

These hearings provide some of the most in depth studies of CPCs and their practices that have been completed, but they are unfortunately long out of date. A large portion of the hearings were dedicated to the idea of false advertising focused largely around the Pearson Foundation’s use of the Yellow Pages; today, of course, information circulates along a greater variety of channels. Nonetheless, the arguments made and the questions asked in these hearings are still very much relevant and have remained unresolved. At the end of the hearing, the Plaintiff’s attorney representing Jane Doe’s case asked the judge to examine the presented information and intercede, noting that the “Defendants have caused and will cause immediate and irreparable injury, loss, and damage to the State of Texas and will also cause adverse effects to legitimate business enterprise which conducts its trade and commerce in a lawful manner in this state” (Abortion Clinic Violence 350). The Plaintiffs asked that the following actions of the Defendant be deemed in violation of the Consumer Protection Act:

Including but not limited to a) Passing off Defendants’ services as those of another. B) Causing confusing or misunderstanding as to the service, sponsorship, or approval of Defendants’ services. C) Causing confusion or misunderstanding as to Defendants’ affiliation, connection, or association with another. D) Representing that Defendants’ services have characteristics, uses, or benefits which they do not have. E) Advertising services with the intent not to provide them as advertised” (Abortion Clinic Violence 351).
Although these hearings succeed in bringing the problematic practices of CPCs to light, surprisingly little has changed since their occurrence. Shockingly similar to the demands made by the Plaintiffs in Jane Doe’s case, the most frequent issue brought to the court regarding CPCs in recent years relates to issues of appropriate advertising, i.e., whether or not CPCs should be required to post a visible sign outside their locations specifically stating that they do not offer abortions or abortion referrals and that there is no medical professional on staff (Duane 4). Opponents to CPCs would argue that these ordinances are only a small step in the right direction. While signage would increase awareness of exactly what the centers offer, and therefore likely reduce the number of visitors specifically seeking out abortions, it does nothing to stop the clinics from providing the women that do visit with incorrect and even dangerous information.

To this end, the first ordinance demanding transparency regarding the services provided at CPCs was passed in Baltimore City in 2009. The city was then quickly sued by The Greater Baltimore Center for Pregnancy Concerns, a CPC organization in Baltimore, under the claim that the ordinance violated their free speech (Duane 5). In an argument that many of the CPCs involved in court cases in the future would mimic, The Greater Baltimore Center for Pregnancy Concerns presented their organization as being “noncommercial,” and therefore, should not be held to commercial standards of information provision. The court decided that, “because the ordinance was only applicable to CPCs...[or, organizations] with strict moral or religious qualms regarding abortion and birth-control,” it must be considered unconstitutionally discriminatory against a “religious viewpoint” (Duane 5).
Subsequent debate has pushed back against this position, though it remains a point of controversy and continual legal revision.

Many of the ordinances that have been brought before courts in the time since have had a similar timeline. Even if they are originally approved, they are often found unconstitutional when contested. The only cities to have successfully implement legislation aimed at combating methods of false advertising at CPCs are Baltimore, Los Angeles, Oakland, and San Francisco. The first of such ordinances was put in place in San Francisco in 2011, requiring that CPCs post notices regarding their lack of abortion provision and abortion counseling, and allowing judges to fine CPCs $50 to $500 upon failure to comply (Egelko). First Resort, a CPC in the area, challenged this ordinance fairly quickly with the usual claims that it violated their free speech. However, Judge Saundra Brown Armstrong ruled “the San Francisco law ‘only restricts false and misleading commercial speech, which is not protected by the First Amendment’” (Egelko). Armstrong said that the ads are still economically motivated because “attracting clients is ‘critical to [First Resort’s] fundraising efforts.’” She further noted that First Resort pays Google for a ‘keyword’ service to bring the company to the attention of women searching for help online” (Egelko).

While this thesis is not primarily historical in its methodology or subject matter, I believe that exploring the history of CPCs is not only necessary to understanding how they exist today, but also, that it offers a surprisingly useful illustration of how the attributes of ambiguity, uncertainty, and deception have been present from the start. It is for this reason that I have included such a detailed exploration of the finances, court cases, and origin stories related to crisis pregnancy
centers, along with purpose of beginning to familiarize the reader with the mission and tactics used by these. This material lays the groundwork for the chapters that follow, which treat the methods and narratives employed by CPCs in the interest of attracting and maintaining clientele and promoting a pro-life mission.
Chapter One: The Good Mother
Narratives of maternal responsibility and the woman as a vessel

“That is our mission statement after all, to show women that they are mothers”
-Interview four

“I understand that [women] feel like that is their body... I feel like it is a separate - what I call them is, is you’re a ‘host.’ And you know when you enter into a relationship you’re going to be that host and so, you know, if you pre-know that, then take all precautions and don’t get pregnant. So that’s where I’m at. I’m like, hey, your body is your body and be responsible with it. But after you’re irresponsible then don’t claim, well, I can just go and do that with another body, when you’re the host and you invited that in” (Hatch).
-Oklahoma Lawmaker Rep. Justin Humphrey

Narratives of risk and responsibility inform the vast majority of societal dialogues regarding the woman and her pregnancy. The two quotes that open this chapter, one taken from an interview with a CPC and the other from a statement made by Oklahoma Lawmaker Representative Justin Humphrey, illustrate the heavy burdens and responsibility that we as a society place on a woman the moment she is pregnant. Despite the very different sources, each of these quotations embodies a belief that the value of the life of the unborn fetus exists in a state of greater importance than the quality of the life of the mother, her health, her right to information, and her right to pursue informed choice.

To begin the exploration of CPCs as microcosms of the larger landscape of reproductive health and rights, it is necessary to see how CPCs build off of narratives, dialogues, and means of control that are already in existence throughout society. Two such narratives, and the ones I will focus on in this chapter, are maternal responsibility and the “woman as a vessel.” Throughout this chapter I will demonstrate how these narratives manifest themselves in broader societal dialogues and institutions, then moving into the CPCs where I conducted interviews to show
how this language was co-opted and reworked in order to promote their mission as pro-life organizations. I will begin with the idea of maternal risk and responsibility, breaking the discussion down into the two points that were relied on most heavily by the interviewees 1) the notion that the moment a woman becomes pregnant, she also becomes a mother and has a responsibility towards her “child,” and, 2) abortion can never possibly be the “right” choice for a pregnant woman, no matter her situation and, therefore, if she terminates her pregnancy, she will be left with feelings of guilt, depression, and loss. I will then illustrate how maternal responsibility and the way we depict and talk about the pregnant woman all work to place her in the position of being a “container,” both further separating her from her fetus while also placing tremendous cost and responsibility on her shoulders. This chapter will illustrate how these discussions play out in the context of CPC services, while also placing them in a broader context to consider how and why CPCs have engendered such considerable success and support.

**Maternal Responsibility**

When a pregnant woman does not treat her pregnant body the way in which society believes is correct and appropriate, it is not unlikely for her to find herself steeped in accusations of neglect, irresponsibility, and blame. In her book, *Conceiving Risk Bearing Responsibility: Fetal Alcohol Syndrome and the Diagnosis of Moral Disorder*, Elizabeth Armstrong explores this issue by opening with the story of Deborah Zimmerman, a woman who, in her ninth month of pregnancy, was brought into a hospital clearly intoxicated. While at the hospital, Zimmerman stated to medical personnel that, “I’m just going to go home and keep drinking and drink
myself to death, I am going to kill this thing because I don’t want it anyways” (1). This statement that prompted the hospital to ascertain and receive permission to perform an emergency cesarean section. After the child was born and diagnosed with Fetal Alcohol Syndrome (FAS), Zimmerman was charged with attempted murder and reckless endangerment (1).

Despite Zimmerman’s suicide threat occurring in front of multiple doctors and nurses, there was no move towards psychiatric consultation, evaluation, or treatment; instead of taking her claim to harm herself seriously, those present jumped at the opportunity to save her fetus (2). In this interaction Zimmerman was seen solely as a threat and a risk to the health of her “child.” Her role was that of a “container” for her pregnancy, and to do this job well, she had to act in the ways in which society deems appropriate and responsible. The response she garnered would not have been possible if those around her had seen her health, wellbeing, and personhood as more important than that of her pregnancy.

Societal interest in controlling pregnant bodies stems from many factors, including gender, class and race. Pregnancy is constructed as a physical state of being unlike any other. In particular, because pregnancy is a gendered state, it can only occur for those with cis-gendered female anatomy. Because US society is far from existing in a state of gender equality, it is not surprising that a condition that applies only to the female body is seen as a state that ought to be heavily patrolled. In fact, most everything relating to the female body is seen as needing supervision and

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25 Although there had been previous cases of women facing persecution for engaging in legal drug use when pregnant, Zimmerman is the first person on record to face these charges related to the legal activity of drinking.
regulation. As Susan Bordo argues, we have cast attributes onto the female body related to “the mucky, humbling limitations of the flesh” due in part to our “infantile experience of women as caretakers of our bodies” (Bordo 5). The cost of these projections are extensive. After all, if we have come to believe that “the body is the negative term, and if the woman is the body, then women are that negativity, whatever it may be: distraction from knowledge, seduction away from God, capitulation to sexual desire, violence or aggression, failure of will, even death” (Bordo 5).

Throughout my interviews with CPC employees, many of these connections were expressed regarding the female body. For example, support for abstinence programs was framed in the following way:

There is enough information out there that supports a good abstinence program. It just does. That’s where choice comes in. I think everyone should have a choice as to if they do that kind of program. Because it’s not just about abstinence and it’s not just about sex. It’s about learning not to use people, it’s about learning what real love is, that kind of thing… To learn something new, to have goals, to strive for those things. And, like I said, so many of the young women I see don’t have that. I can’t tell you how many of them are sitting around watching television, it gives me the heebie jeebies just thinking about it (Interview five).

In this quotation, not only is sex being related to manipulation and a lack of love, but it is also equated with laziness. The depiction here is of a manipulative, passive woman lying around her house all day and having unprotected sex.

These types of negative associations surrounding women’s sexuality are so pervasive that they have come to be deployed and socially embodied in medicine, law, and literary and artistic representation. In one such example, Bordo includes a compelling comparison of how we see men as active-doers and women as passive-
receivers, and how this is manifested in texts such as Alan Guttmacher’s drugstore guide to “Pregnancy Birth, and Family Planning.”

Some of the sperm swim straight up the one-inch, mucus-filled canal with almost purposeful success, while others bog down on the way, getting hopelessly stranded in tissue bays and coves. A small portion of the total number ejaculated eventually reach the cavity of the uterus and begin their upward two-inch excursion through its length... the one sperm that achieves its destiny has won against gigantic odds... Perhaps the winner had the strongest constitution; perhaps it was the swiftest swimmer of all the contestants entered in the race... If ovulation occurred within several minutes to twenty-four hours before the sperm’s journey ends, the ovum will be in the tube, awaiting fertilization (Bordo 13).

In this text, cultural attitudes that imagine men as “effective and active” subjects are shown to inform descriptions of scientific processes. Bordo further relates the shock that most of her students experienced upon learning that fertilization most often occurs when the “egg...travels to rendezvous with sperm that have been lolling around, for as much as three days, waiting for her to arrive” (13).

Ideas of the woman as passive receptacle are further evident in societal constructions of motherhood. In the past few decades ideas of who should and should not bear a child, and what constitutes a “good” mother, have gone through drastic changes. With an increase in women’s rights, working mothers, divorce rates, and higher levels of education, it is not as easy to exercise control over motherhood as it was during previous moments in history. Women can now pursue pregnancy without a male partner as well as terminate a pregnancy without a male partner’s involvement. Even with all of these changes, societal obsession with controlling motherhood and generating “good” mothers has not disappeared but has simply taken on new forms.

26 Italics included in original
Reproductive justice advocate and writer Rachel Roth tells a story that illustrates how society acts to police women, while also forcing them to police themselves, by means of the dialogue around “good mothering” even before a fetus is born or conceived. This story takes place at a cyanamide chemical factory where “the plant manager told women that their work was dangerous for fetuses. If they were under age fifty they could not keep their jobs unless they proved they were incapable of becoming pregnant by getting surgically sterilized” (Roth 37). One suggestion here that I will return to later in this chapter is the idea that women exist as perpetually expectant mothers and that their potential fetus is already being viewed as a child in need of protection. As Roth notes, fetal protection policies place tremendous obstacles in women’s path to financial independence on the assumption that women are in a constant state of pregnancy, instead of accommodating all workers during times of actual conception and pregnancy (Roth 39).

This story also exemplifies how decisions regarding female reproduction are often made by weighing costs, and then placing all costs on the woman’s shoulders. The employers at the factory saw a direct risk and cost associated with having women working in the factory but instead of reducing some of that risk by improving conditions or making a plan for when/if women do choose to conceive, they put all the responsibility on their female employees.

One cannot write about issues of options and birth control counseling for without the mention of the history of forced sterilization of women of color in the United States. Sterilization campaigns, aimed mainly at women of color but also white women of low socioeconomic status, have taken many forms throughout
history including judges punishing women, most of whom were black, with sentences of temporary or permanent sterilization; legislative initiatives to compel all women with substance abuse problems when pregnant to receive a fertility regulating implant after birth; campaigns to pay women $200 if they could prove that they were sterilized permanently, specifically aimed at women of color addicted to crack; and many more (Silliman et al. 63-64).

Judith Baer, a specialist in public law and feminist jurisprudence, has called these restrictions “the chains of protection” (Baer quoted in Roth 42), or, protective measures that operate to delimit women’s freedom. These “chains” were evident at each of the centers I visited. For example, none of the locations I visited allowed a woman to receive any sort of birth control counseling outside of abstinence, nor were they given comprehensive counseling, because abortion was not considered a viable option. Despite being given extremely limited and often falsified information, these women were nonetheless still expected to make informed, correct decisions and support themselves and their future families through their decision.

The Woman as a Vessel

By shifting our view to see pregnant women as “vessels,” it is much easier to create a template and rules that all women must follow to be seen as a good, responsible mother. And if she does not, society will respond to her with accusations of bad moral character, lack of responsibility, being unfit to be a mother, and she will often be seen as at fault for any fetal complications present at birth.
The concept of a pregnant woman as a vessel responsible for creating the perfect environment for fetal development is so ingrained into our society at this point that even the most blatant examples of it often pass by unnoticed. One example very much in the public eye exists in the form of the many advertisements for pregnancy related products or procedures such as prenatal vitamin ads, as seen in figures 3, 4, 5, and 6. These vitamins are being sold to, bought by, and consumed by the pregnant woman, not the fetus, and the act of consuming the vitamin affects both the fetus and the woman. Yet, in the majority of prenatal vitamin ads out there, including the photos on informational sites such as whattoexpect.com (Choosing the Best Prenatal Vitamins), healthychild.org (Boyle), familyjournal.modernmedicine.com (Sfakianaki), momdiscuss.com (Dinges), and many more, the image included is one of the large, exposed, pregnant stomach of a white woman with one hand gently placed on top of or under the belly and the other holding a palm full of vitamins. The face and legs of the woman are completely cut out of the photo, rendering the woman unimportant and disconnected from her pregnancy. Ads like this present the message that the woman is simply a container, a holding space for the fetus. Her health is not depicted as deeply connected to fetal health; instead she provides the space for a healthy fetus. In viewing the woman as a vessel she is no longer seen as knowing best when it comes to her pregnancy, she is a temporary holding space and her personhood has, as is demonstrated in these advertisements, literally been cut out of the picture.27

27 Consumption and health is one of the most popular ways of policing women, pregnant or not, and was a tactic not overlooked by many of the CPCs I visited. Many pamphlets I was handed emphasized healthy eating, what to avoid, and how much weight one should expect to gain.
Figure 3: Article Featured on Whattoexpect.com ("Choosing the Best Prenatal Vitamins")

Figure 4: Ad featured on Healthychild.org (Boyle)
Pregnancy is the closest we ever come to seeing the body merely as a body and nothing more. In most cases excluding pregnancy, our society views the body and bodily autonomy as so critical that “according to the doctrine of informed consent, even when it is ‘for the good’ of the patient, no one else - neither relative nor expert - may determine for the embodied subject what medical risks are worth taking, what procedures are minimally or excessively invasive, what pain is minor” (Bordo 74).
While the idea of informed consent is central to my discussion in chapter three, here, I bring up these points on bodily autonomy to emphasize how the pregnant body is seen in such a drastically different manner from other bodies. Indeed, there is no other instance where a person would be forced to submit to medical procedures, or to sacrifice their health, in the interests of another (Bordo 73). By contrast, one can then turn to a seemingly infinite list of court cases involving pregnant women being forced to undergo blood transfusions, cesarean sections, drug testing, being detained against their will, and so on, in order to ensure their ability to nurture the fetus within them. Issues surrounding the control of pregnancy and pregnant women’s bodies are also deeply tied to differences of race and class.

The experience of pregnancy varies depending on one’s status, posing unique difficulties for non-white women, women of low socioeconomic status, or non-English speaking women. For example, in a national survey by the New England Journal of Medicine, it was found that in twenty-one instances in which court cases were sought regarding obstetrical intervention, eighteen were approved with “eighty-one percent of the women involved [being] women of color, all were treated in a teaching-hospital clinic or were receiving public assistance” suggesting that “just as doctors more readily breach the confidentiality of pregnant Black patients by reporting their test results, they more readily violate the autonomy of pregnant Black patients by forcing them to undergo unwanted medical procedures” (Roberts 176). Women of color and/or low socioeconomic status also tend to be seen as much more at risk of consuming drugs or alcohol, and are thus policed much more closely. These populations compose the majority of the cases of women being arrested for drug or
alcohol consumption, or having cases of fetal abnormalities attributed to diagnoses such as Fetal Alcohol Syndrome (FAS).28 The next section of this chapter will work to make connections between the narratives just introduced, demonstrating how they exist in relation to the politics of race and class. As seen above, narratives of risk and regulation negatively impact all women’s reproductive freedoms and civil liberties; at the same time, however, the distribution of cost and hardship is by no means even.

**Race and Class**

In an eye-opening exploration of the Women’s Health Clinic at Alpha Hospital, Khiara Bridges illustrates how pregnancy and reproductive health have become a way to justify state supervision, management, and regulation of the poor.

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28 Returning to Zimmerman’s story from earlier in this chapter, after the occurrence in the hospital and her emergency c-section, she faced persecution by law based on the diagnosis of her fetus as exhibiting FAS. FAS is commonly believed to be a set of birth defects that are associated with alcohol consumption by a pregnant woman leading to prenatal alcohol exposure. There are four criteria that must be met for a diagnosis to be made. It must be confirmed that the mother was exposed to alcohol, the child must show signs of “certain craniofacial anomalies” such as microcephaly, short palpebral fissures, a thin upper lip, among others, the child must also exhibit prenatal or postnatal growth retardation, and finally, the child must be suffering from “central nervous system anomalies, such as structural brain abnormalities, neurological impairment… impaired fine motor skills” and so on (Armstrong 3).

What many people do not know about FAS is that even with these specific criteria it is extremely difficult to diagnose, as there is no particular biological marker indicating that FAS is what is in fact occurring. To make things more complicated, even among alcoholic women, only around 5% of their babies are born exhibiting signs of FAS (Armstrong 4), all of this indicates that all the “facts” our society feels very strongly about surrounding pregnant women and alcohol consumption exist in a landscape of much higher uncertainty than they are presented. The point of including this example is not to state that FAS does not exist or that drinking large quantities of alcohol during pregnancy has no effect on fetal development, rather it is to bring up questions such as those that Elizabeth Armstrong asks in her book such as “how can we reconcile this fact [that less than 5% of babies born to women who drink heavily during pregnancy have FAS] with claims that all pregnant women must avoid alcohol?” Who is really at risk of having their child diagnosed with FAS? And how does knowledge get “transformed in the public imagination and then translated into public policy?” (Armstrong 4-5).
Bridge’s main critique involves the way in which pregnancy has come to engage racial resources to such a dramatic extent that it ought to be described as a racially salient event. In her exploration of these issues Bridges clearly states that all her writing is functioning on “the assumption that race is a discursive phenomenon; race is ideas about difference that become visible and tangible as they are made to be reflected in the material conditions within society” (9). Following from Bridges’ definition, my own analysis of race does not posit racial difference as an essential, biological “fact”; rather, I examine the language surrounding racial difference in relation to CPCs, and in relation to broader material inequities experienced by people of color.

Across all six CPCs that I visited, interviewees identified their clientele as largely made up of intersecting disadvantaged and/or minoritized groups, including women of color, immigrants, women of low socioeconomic status, women with mental illnesses, women in abusive relationships, and youth. At the same time, it is important to note that this information is not exact, as CPCs are private organizations that do not require the recording of identifying statistics. The employees were able to confirm that the women are mostly of low socioeconomic status; an unsurprising demographic considering the emphasis on free services, their appeal to those with little or no healthcare coverage, and the demographics of the neighborhoods in which many of the CPCs located themselves (see figure 7). A response from interviewee five is emblematic of the types of descriptions provided by CPC workers: “the median age [of clients] would be 15 to 20. We do have some from middle school…
It’s unusual to find someone over thirty that comes in” and that “most of the clients are African American or Hispanic… 97% of them are on state insurance.”

<table>
<thead>
<tr>
<th>Demographics by CPC location</th>
<th>City A</th>
<th>City B</th>
<th>City C</th>
<th>City D</th>
<th>City E</th>
<th>City F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population estimates, July 1, 2015</td>
<td>88,485</td>
<td>46,756</td>
<td>271,863</td>
<td>892,389</td>
<td>108,802</td>
<td>6,902</td>
</tr>
<tr>
<td>Persons under 18 years, July 1, 2015</td>
<td>22.0%</td>
<td>19.1%</td>
<td>21.7%</td>
<td>21.5%</td>
<td>25.6%</td>
<td>19.3%</td>
</tr>
<tr>
<td>White alone, April 1, 2010</td>
<td>68.7%</td>
<td>75.8%</td>
<td>82.2%</td>
<td>76.4%</td>
<td>58.8%</td>
<td>94.8%</td>
</tr>
<tr>
<td>Black or African American alone, April 1, 2010</td>
<td>14.3%</td>
<td>12.8%</td>
<td>5.8%</td>
<td>15.3%</td>
<td>20.1%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Hispanic or Latino, April 1, 2010</td>
<td>17.2%</td>
<td>8.3%</td>
<td>10.3%</td>
<td>17.4%</td>
<td>31.2%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Foreign born persons, 2011-2015</td>
<td>25.7%</td>
<td>11.4%</td>
<td>8.3%</td>
<td>15.1%</td>
<td>15.2%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Bachelor's degree or higher, of persons age 25 years+, 2011-2015</td>
<td>41.0%</td>
<td>36.1%</td>
<td>32.1%</td>
<td>36.3%</td>
<td>15.2%</td>
<td>36.1%</td>
</tr>
<tr>
<td>Persons without health insurance, under age 65 years</td>
<td>20.9%</td>
<td>5.9%</td>
<td>5.5%</td>
<td>5.8%</td>
<td>13.7%</td>
<td>15.3%</td>
</tr>
<tr>
<td>Persons in poverty</td>
<td>8.4%</td>
<td>11.0%</td>
<td>11.1%</td>
<td>11.1%</td>
<td>25.1%</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

**Figure 7:** Demographics of Cities of CPCs Visited (“Population Estimates”)

With the inseparable connections between race and class in the United States, it is easy to see how pregnancy and the experience of visiting CPCs has come to be such a racially salient event. At the clinic Bridges’ examined, a New York State Prenatal Care Assistance Program (PCAP) was being implemented. While Bridges states a strong belief in the argument that everyone should receive government subsidized health care, when only one group receives it, they become “exceptional” (13). It is this “state of exception” that Bridges finds problematic. By targeting “at risk women” Alpha becomes an institution where “poor, pregnant women’s bodies are excessively problematized and racial inequities are reiterated,” not necessarily because something is “wrong,” but because of “the nationally circulating discourses,
politics, policies, and practices” (15). By painting this population as at risk due to their reliance on Medicaid/PCAP, the professionals responsible for the care of these women were able to extend their control to include areas of the woman’s life that would not normally be considered as under the realm of medical care, and to act in an intrusive way that further allowed the regulation and supervision of those who are not seen as fit to be mothers.29

The program that Bridges studies existed with the noble cause of providing prenatal care to women of low socioeconomic status, yet Bridges astutely points out that the ways in which the program engages with these women and further labels and “others” them in society leads to a perpetuation of much more harmful narratives than one might realize. If this is generated from the existence of something like PCAP, one can better see how the presence of CPCs and how their engagement with such vulnerable populations is even more detrimental and enforcing of these negative stereotypes of women, their bodies, and their sexuality.

A crucial component of the situation for these women who participate in PCAP or visit CPCs is that they are unable to purchase privacy regarding their pregnancy. They are forced to step into the public sphere and are met with an onslaught of policing and regulation that those who are able to purchase private care can avoid. In the most literal manifestation of this lack of privacy, one interviewee

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29 Bridges dedicates much of her analysis to how the patients are seen by those who are in positions of power at the clinic. What she finds are dialogues about these women as unintelligent yet somehow incredibly shrewd manipulators of the system, as though they are in someway “stealing” medicaid, as welfare queens, undeserving, non-citizen outsiders, and “wiley” (202-231).
related how the most pressing issues facing the women who visit her center is homelessness:

There are not a lot of places for people to go. So if a girl comes in and she is considering carrying her child to term and her parents say you have to leave the house or her boyfriend is like you are not going to keep this baby if I am kicking you out, which we hear every day and which happens all the time, where can she go? I mean she can go to a shelter but really what girl wants to go to a shelter? (Interview two)

Later in our conversation the same interviewee elaborated on just how much these women have to enter the public sphere in order to access support in both their pregnancy and other aspects of their life they may be struggling with as well.

I don’t know if you have ever called 211 but it is the local information line. All the shelters are streamlined through 211. So if somebody is homeless no matter what they have to go through 211 first. And I have called 211 before, I am thankful for 211, but no one likes waiting. And waiting on that line, what number do I push, okay let me hang up. When we are already overwhelmed with everything else it is hard for you to do the work (Interview two).

By contrast, the interviewee saw CPCs as an alternative option for women existing in vulnerable positions. The direct, responsive, and personal support CPCs claim to offer work in opposition to public service alternatives that may leave women feeling devalued. Moreover, as a woman’s position of vulnerability increases by way of age, race, class, and so on, the more likely it seems that the services offered by CPCs would be seen as desirable. Here is where we begin to see the power behind CPCs being the one place sharing the message with these women that they can access “good” mothering and that the CPCs will do everything in their power to help them do so. With little or no support coming from other areas of their life such as aid services, family, or friends, this dialogue is an extremely potent one. From the interviews I conducted, it was clear that CPC employees understood the shortcomings
of existing public aid options for pregnant women, and therefore emphasized unique aspects of their services to attract women:

We have a crisis line that is answered 24/7 so there are 16 women that the [clientele] phone so that if anyone calls at any time they get a real person and that has been going on for 24 years so that in itself is no minor miracle. And it really has made a difference. Lots of time the nighttime is terrible for people in crisis and you can’t sleep and if you call [another service] you might get ‘we will call back after 9 in the morning’ or you might get a voicemail. Very often we answer the phone and we get ‘Oh! You’re a real person!!’ So that is huge (Interview five).

By emphasizing personal attention and genuine care, CPCs work against presumptions that women from marginal groups are unfit to mother. As one interviewee remarked, “that is our goal after all, to show women that they are mothers.” While this comment speaks to the pro-life mission of CPCs in general, here it is also important to note that by aiding and encouraging women who are not traditionally understood as being in a position to be a fit mother, CPCs are able to increase their clientele.

With an understanding of how society views pregnancy and the importance of policing it, it is no longer as difficult to see why a center with the explicit goal of showing women that they are mothers and then offering services to make them “better” and “more responsible” mothers has garnered the type of support that CPCs have been able to. The pamphlets and quotations that I will analyze in the rest of this chapter illustrate how much easier it is to control personhood and motherhood with the presence of already constructed redirects of stigma and blame that necessitate self-policing.
Extending “Motherhood”

The first step in making sure as much responsibility can be put on a woman’s shoulders as possible when it comes to the health and well being of her fetus is extending the state of “motherhood” to exist before the child is even born.\textsuperscript{30} The most direct presentation of this narrative was in the form of an article I was handed during an interview titled “Abortion, a Parenting Option.” An image of the article can be seen in figures 8 and 9:

\textsuperscript{30} Fetal imaging technology has played a significant role in attributing baby-like qualities to the fetus, a concept I will return to in greater detail in the next chapter.
Figure 8: Left Side of Abortion as a Parenting Option Article\textsuperscript{31} (Abortion: A Parenting Option?)

\textsuperscript{31} In bottom right hand corner the text reads: “Once you have been pregnant, a mother’s heart can never forget” -Dawn, An Abortion Survivor
Here, embedded within the concept of the pregnant woman as a mother, is the subtle but no less important suggestion that fetal life begins at the moment of conception. For CPCs, this is a critical link. If life begins at conception, then one can justify the view of the fetus as a baby, and if one can view the fetus as a baby, the pregnant woman is therefore a mother. In this section I will break down each of these links as well as how the CPCs effectively present these propositions to their clients.

Starting from the beginning, the first step in reaching the conclusion that a woman is a mother from the moment of conception is having a convincing argument that life begins from the moment of conception. One of the most widely used tools for communicating this message was in describing and showing fetal development.
through images and descriptions one might normally use for a child. In this chapter, I will explore how these descriptions functioned, while in chapter three, I will focus more extensively on the imagery associated with them. The most blatant way in which the interviewees assigned life to the fetus was by referring to “him,” “her,” or “the baby” while simultaneously calling the woman “mom” no matter the stage of fetal development - often even before an ultrasound would be able to detect gender. Taking this tactic a step further, interviewees stressed pointing out all the characteristics of personhood that are determined at conception such as eye color and allergies, as well as the different abilities that fetuses have at each stage of development. For example, interviewee five pointed out an article stating that “long even before the mother can feel her unborn baby move, the tiny infant wakes and sleeps, squirms about, squints, swallows, breathes fluid, hiccups, digests, hears, tries to cry, flexes his or her fingers, punches, kicks, sucks his or her thumb (or toes!) and can feel pain” (Broughton). In the following image one can see the intense focus on hands and feet, the first recognizably human parts of the fetus and frequently used as a tool for personifying the fetus at incredibly early stages of development.

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32 Italics included in original
When these institutions and others accept the concept of fetal “rights,” there tends to be a simultaneous undermining of women’s importance as citizens with their own rights to choice, information, and bodily autonomy. In other words, to increase the rights or personhood of the fetus often means decreasing those of the woman. Roth points out that one of the reasons fetal rights have been taken so seriously is because “rights claims resonate so deeply with American political and cultural values...When people make rights claims they assert their identity as individuals entitled to equality and liberty, and emphasize their essential sameness to others as persons and as members of the polity” (3). Each of these assertions is an essential component of American citizenship and are easily recognizable as such regardless of

Figure 10: Excerpt from Pamphlet on Fetal Development (Fetal Development Timeline)
one’s political values. Therefore, when rights are given to the fetus, it creates a “rhetorically powerful strategy by giving the fetus an individual identity, asserting its equality with the woman, and establishing its independent relationship with the state that bypasses the pregnant woman” (3).

Once the child has been shown to be a life that exists from the moment of conception, the next step is to help women understand that they are already mothers of (fetal) children. Here, CPCs stress that the focus is not on having the woman raise the child, but simply bringing it to term. In doing so, CPCs work to carefully construct a narrative of responsible parenting that ends at birth. This means not only that adoption can function as a successful parenting choice, but also suggests that CPCs do not see themselves as existing in a position of responsibility or importance once the child has been born as their job is complete. So, while CPCs strongly push a sense of accessibility to “good” mothering on these women, it often ends after the birth of the child when, in reality, this is only the beginning of the mothering experience for most. When asked the goal of the work she did, one interviewee answered as follows:

The most important thing for me is I would like to see if I can show them a way to keep their baby. That is basically what we want them to do. I have gone through a whole bunch of ways that we do that. We don’t want to pressure them but I want to make sure that they are making the right choice and that they know what is out there and what help they can get... Every mother has a right to have her baby. And that baby has a right to be born. And that is really what we want to achieve (Interview 1).

There is no acknowledgement here of the life of the mother and child after birth, as that is not the aim of the work done at this CPC. Once the woman agrees to take on the role of mother, it does not matter the pain, difficulty, and hardship that
may or may not accompany this role. The closest any interviewee came to acknowledging the difficulty that women might experience when carrying a planned or unplanned pregnancy to term was in the following statement: “Our hearts, we really were meant to love, and that’s not the same as using people. And once they recognize the difference between being used and what love really means, they see that there is some sacrifice involved in real love” (Interview 5). However, rather than truly acknowledging the inherent difficulties with birthing and raising a child, this statement simply works to suggest that no outcome of pregnancy other than birth could be an expression of “real love” and that any difficulty should be seen as an endurable sacrifice.

These types of statements also work to effectively obscure very important questions of cost of pregnancy itself. As Roth notes, the issue of “who should bear the costs of fetal rights - is a political question that has received very little direct public debate” (4). This statement includes not only a consideration of monetary cost, but also, all of the physical, material, emotional, and time costs associated with pregnancy and birth. Two of the most effective tools used by CPCs to enable the woman to see herself as a mother were through the use of images and distribution of material goods, both of which I talk about in depth in chapter two. Another very effective tactic was telling the woman that, now that she is pregnant, even if she aborts she will never feel the same and will always live with the guilt and depression of a mother who did not care for her child.
Abortion is never the Right Choice

Most often the dialogue around abortion as the “wrong” and “most difficult” choice stemmed directly from a discussion of the woman as a mother from the moment of conception. In both the conversations I had with employees, as well as the pamphlets I was handed, these two ideas were more often than not presented side by side, as each one greatly strengthens the other, working together to reinforce a narrative of maternal responsibility. In the booklet featuring the article “Abortion, a Parenting Option,” there was also a two page spread addressing this issue, with the left side titled, “Is Abortion Safe?” and the right side titled, “Could it Affect me Later?” On the left side, eight documented physical risks are listed: heavy bleeding, emboli, incomplete abortion, anesthesia complications, infection, RH sensitization, organ damage, and death. On the right side, there are three non-physical risks listed as having the potential to affect the woman long after her abortion is completed, even if all goes well. These are stated to be emotional, relational, and spiritual problems.

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33 Clots in the bloodstream that can travel and “lodge in the lungs, causing illness and even death”
IS ABORTION SAFE?

Serious medical risks occur infrequently in early abortions but increase in later abortions. Evidence indicates that induced abortion can be associated with significant long-term health risks. Getting complete information on the risks associated with abortion is challenging due to incomplete reporting and the lack of documentation linking abortions with complications.

8 DOCUMENTED PHYSICAL RISKS:

HEAVY BLEEDING

Some bleeding after abortion is normal. However, there is a risk of severe bleeding known as hemorrhaging. This may result from cervical tears, uterine perforations, retained tissue, or when the uterus fails to contract after it is emptied. When this happens, a scraping of the uterus (D&C) or other surgical procedures may be required to stop the bleeding. Infrequently, a blood transfusion may be necessary. Rarely, removal of the uterus (known as a hysterectomy) may be required to stop bleeding.

INCOMPLETE ABORTION

This occurs when fetal tissue remains in the uterus after the abortion is over. It can cause severe bleeding, infection, and a D&C may be required to complete the procedure.

INFECTION

The insertion of instruments or retained fetal tissue may lead to infection. Infrequently, these body tissues, known as sepsis, happen and can be life-threatening. Retained tissue can cause scarring of the pelvic organs. Antibiotics may be prescribed to fight infections and/or additional surgery may be required to fully remove the uterus. For “The Abortion Pill” on page 17 to learn about a cure, fatal infection.

ORGAN DAMAGE

The cervix and/or uterus may be cut, torn, or punctured by instruments. This may cause excessive bleeding requiring surgical repair or cause scarring of the uterine lining. If the uterus is punctured, the bowel and bladder may be injured. The risk of these types of complications increases with the length of the pregnancy.

EMBOLI

Clots may form in the bloodstream. If they break off and travel, they are known as “emboli.” These emboli can lodge in the lungs, causing illness and even death. Another form of emboli, known as “amniotic fluid embolism,” is a rare cause of death in late term abortions. In a process not well understood, amniotic fluid gets into the mother’s bloodstream and causes a severe allergic-type reaction.

ANESTHESIA COMPLICATIONS

Local anesthetics, sedatives, and pain medications may cause allergic reactions of varying degree of severity. Convulsions, heart complications, and even extreme reactions, known risks of general anesthetics. Use of general anesthetics for abortion has decreased.

RH SENSITIZATION

Pregnant women should be tested to determine if their blood type is Rh-positive or Rh-negative. All Rh-negative women who are Rh-positive should receive an injection of Rhogam® to prevent the formation of antibodies that can harm current or future pregnancies.

DEATH

In extreme cases, complications from abortion may lead to death. The risk of death immediately following an induced abortion performed at or before 8 weeks LMP is extremely low (approximately 1 in a million) but increases as pregnancy progresses. For pregnancies over 24 weeks, the risk of dying from induced abortion is 91 in 1,000,000.

Figure 11: Physical Risks Associated with Abortion (Is Abortion Safe?)
Figure 12: Long Term Risks of Abortion: Physical, Emotional, and Relational (Is Abortion Safe?)

In the same way as I used the first article on abortion as a parenting option in order to introduce the concept of pregnancy being equivocated to being a mother, I have placed this article here as an introduction to abortion as the “wrong choice,” as it
presents three of the reasons most often cited as to why abortion is a bad decision: risks to physical health, emotional health, and one’s relationship with god. During my visits, many interviewees spoke in similar terms, while also discounting all of the reasons why a woman might feel as though abortion was the right decision. At times, interviewees would go so far as to completely discredit the difficulties that would arise for these women - many of them young, in difficult financial situations, or in an abusive relationship - if they chose to pursue pregnancy. One interviewee explained:

I tell them to look more to the future, look to their future goals. How will you feel about what you’re doing three years from now or five years from now? You have to be comfortable with what you are doing and I think a lot of them say you know what, I could still be pregnant and go to college; you won’t get kicked out of college. You might have a problem for a few weeks where maybe you have to figure out daycare or something but you actually can do it and five years from now you might see your child and say I’m so glad I didn’t do that… Just be determined and have faith in yourself (Interview 1).

While it is true that the vast majority of women would not get “kicked out” of college if pregnant, the notion that the greatest difficulty a new mother might face is to spend a few days finding daycare works to completely discredit the wide variety of pressing concerns that exists. A similar portrayal was given in a pamphlet comparing the benefits of carrying a pregnancy to term with abortion. In this pamphlet, the author cites birth as associated with a “lower risk” for the following compared to abortion: breast cancer, ovarian and uterine cancer, and death from all causes including natural, accidents, suicide, and homicide as well as being a time when healthy habits are formed. The woman is additionally told that pregnancy can be accompanied by “minor aches, pains, and discomforts” (Dihle). The drastic differences in language and presentation of information is startling.
While discrediting the difficulties and risks associated with birth, the interviewees simultaneously worked to show some of the “unknown” difficulties and risks associated with abortion in order to reframe abortion as being a more difficult “long term” choice than birth. Most of the interviewees expressed serious disapproval at the production and dissemination of information regarding abortion, a topic that is the focus of chapter three. In the remaining sections of this chapter, I will unpack the claims of abortion as presenting physical and emotional risks beyond that which has been scientifically acknowledged.

1. Physical Risk

As with pregnancy, the physical risks associated with abortion have fallen dramatically in recent decades. Most scholars attribute this to the legalization of abortion, as women are now able to pursue termination of pregnancy in a clean, safe, and legal setting. Women have multiple choices when it comes to terminating their pregnancy. If they are less than ten weeks along they have the option of a medical abortion, often referred to as the “abortion pill.” This procedure involves two pills, one of mifepristone and the other of misoprostol (“The Abortion Pill”). Under the care of a medical professional, the woman will first take the dosage of mifepristone in a clinical setting which blocks the body’s ability to produce progesterone, a hormone necessary for pregnancy. Then, most likely at home, the woman will take the second pill containing misoprostol between one or two days later. This second pill induces cramping and bleeding in order to “empty the uterus” (“The Abortion Pill”). Many women compare the experience to a heavy period or an early miscarriage. This method is acknowledged as being both extremely safe and effective. The success rate
for a woman less than eight weeks pregnant is 98%, for women eight or nine weeks pregnant about 96%, and for women nine or ten weeks about 93% (“The Abortion Pill”). If ineffective, the woman is either given more medicine or referred to an abortion provider for a surgical abortion. On the website of Planned Parenthood Federation of America, a large provider of abortion pills, it is stated that “serious complications are rare, but can happen. These include: the abortion pills don’t work and the pregnancy doesn’t end, some of the pregnancy tissue is left in your uterus, blood clots in your uterus, bleeding too much or too long, infection, allergic reaction to one of the medicines” (“The Abortion Pill”).

If a woman is past the gestational age when medical abortions are still an option, or if she would rather have a surgical abortion, the pregnancy can be taken directly out of the uterus. Two methods are employed in surgical abortions: aspiration abortion or dilation and evacuation (otherwise known as D&E). Aspiration abortion is the more common procedure, using a “gentle suction” to empty the uterus, and is typically performed if a woman is less than fifteen weeks along (“In-Clinic Abortion Procedure”). D&E is used for women who are sixteen weeks or more into their pregnancy; consequently medical tools must be used in addition to suction. For both of these surgical procedures the effectiveness rate is “more than 99 out of every 100 times,” making them some of the safest medical procedures available (“In-Clinic Abortion Procedure”). Some minor risks are present, as with most any medical procedure, and are documented as increasing with gestational age and the type of anesthesia used.
In stark contrast to this information, the CPCs I visited all provided information regarding abortion as extremely physically risky and painful. For example, despite the risk of not being able to carry another pregnancy to term after an abortion being extremely slim, an informational pamphlet given out at one interview reported the following:

![Pamphlet on Risks for Future Pregnancies](image)

**Figure 13: Pamphlet on Risks for Future Pregnancies (I’ll Still be able to have a Baby Later… Right?)**

Using extreme language to speak of low-risk situations, this pamphlet demonstrates how CPCs manipulate information to influence their clientele’s decision-making process. Here, an unlikely event is posed as a probability. In many of the interviews that I conducted, incorrect and/or unsubstantiated scientific information was posed as fact. The most common example given regarding the physical risks of abortion was a
purported link between abortion and breast cancer. While no such link has been scientifically validated, four centers directly mentioned this as a physical danger associated with abortion, or handed out pamphlets which included breast cancer as a confirmed risk. Only at one center did the interviewee state that, “The breast cancer thing is still being looked at so I don’t ever address it at all” (Interview four). The presentation of unsupported “evidence” as fact is an issue that will be addressed throughout this project; in the following section, I examine it in relation to the construction of “emotional risk.”

2) Emotional Risk

As already discussed earlier in this chapter, in the cost analyses done regarding pregnancy almost all costs have been placed on the shoulders of the woman. Thus, with the monetary cost of abortion being low compared to birth and the physical risks or abortion being few and unlikely, CPCs are stuck with the task of presenting abortion as still being a more costly choice to women than birth. While dramatizing and falsifying physical risks as described above is one approach, a second and much more powerful way is to combine these physical risks with proposed emotional and spiritual risks.

Here, as with the presentation of information regarding physical risks, all information was expressed as though it was fact. At the very least, it was suggested that because “some” people experience emotional and spiritual difficulty after an abortion, it must be included as a plausible risk that all women considering abortion have the right and responsibility to be aware of. Connections were offered between abortion and risks including depression, suicide, and substance abuse, these claims
are not scientifically documented. While it is true that some women may suffer from these symptoms after an abortion, CPCs make a very different claim by suggesting that mental health problems are likely to follow from a woman’s choice to terminate her pregnancy. Many interviewees suggested that we do not spend enough time talking about the possible (and often seemingly inevitable, in their opinion) emotional trauma that comes along with abortion. As one interviewee stated:

They didn’t know, no one ever told them, number one, that they might feel any kind of sadness if they had the abortion. No one ever told them that there were options, that there was help out there, that there was support out there… Abortion has become a word now, and people don’t think about what it entails. And we don’t belabor them. We talk about the surgical procedure but that’s about all we say. But I do talk about the emotional fallout that can happen. And it depends upon the person. If the person is sitting next to me and says, you know, I’ve always thought abortion was wrong, I tell them you have to really think about what you are saying right now because if you always thought it was wrong, more than likely you are going to think it was wrong at a later period too. And it really is. A woman is the only one who has to live with her choice… She has to be the one that when she looks in the mirror and says I made the right choice for myself, and I’m okay with it. And that is really what we hope for; that people make the choices they can live with (Interview five).

One way to further reinforce and make concrete the supposed existence of emotional pain and long term suffering as accompanying abortion is through the provision of “post-abortion care” or “post-abortion groups,” a service offered at three of the six centers. At one center, the volunteers that answer the 24/7 hotline are all post-abortive women who see it as one of their most important roles to share their experiences and the trauma that accompanied their abortion with women who call. In some cases, having these women answer the phone might provide invaluable support. Any woman who is having difficulty after an abortion experience ought to have access to support and companionship from others who have had similar experiences.
At the same time, it is important to acknowledge that these centers do not address women who do not experience trauma or depression after an abortion. Not once during any interview was there even the slightest acknowledgement that a woman could possibly be making the right choice by getting an abortion, no matter her situation.

This reliance on false, exaggerated, and ambiguous information is dangerous. Presenting something as fact that has not been proven means that these women are no longer able to make a properly informed decision; in the presentation of this exaggerated information, women’s right to informed choice has been taken away. Relying on these false narratives of emotional risk is even more upsetting with the consideration that, in most other realms of reproductive health, the emotional needs and rights of a woman are painfully underrepresented and ignored. We might ask then what affect it has to present abortion as an inherently negative option, while there is little to no discussion of the emotional risk associated with carrying a pregnancy to term? What does it mean that we have this entire convoluted dialogue on emotional pain from abortion wrapped up in pro-life sentiments and missions, while very few ask about emotional risk and pain associated with the recent trend of commodification of labor and birth?

In her book, *The Woman in the Body*, Emily Martin relates to the reader how women’s wants and needs are so blatantly ignored in their pregnancy experience, with no regard given to comfort, autonomy, and pain management during labor. One of the most explored examples of this is the ever-increasing use of cesarean sections despite their danger and, often, the woman’s opposition. Martin writes,
One of the commonest reactions, especially when a woman had planned on vaginal delivery and the surgery occurred under conditions defined as an emergency, is to feel out of control... The feeling of being out of control is an intense experience of fragmentation... she is literally divided into her “self” and her “body”: people are doing things to her body but paying no attention to her self (Martin 82-83).

Feelings that accompany c-sections are often those of objectification, violation, and helplessness, yet rarely does one hear these topics brought up in relation to birth. The lack of dialogue regarding this pregnancy experience, coupled with an over-emphasis on abortion experiences, demonstrates a lack of true caring for the woman, her body, and her emotional response.

In my interviews, CPC employees disregarded the emotional risks associated with pregnancy, and chose to focus instead on negative construction of abortion. While these risks were often framed in relation to mental health, they were also connected to religion and spirituality. In many of the interviews I conducted, ideas about the impact of abortion on women’s religious faith and mental health and wellbeing seemed to converge and, for the purposes of this project, I am calling this intersection “spiritual risk.” Many of the interviewees seamlessly transitioned between talking of emotional and spiritual risks related to abortion, suggesting that they didn’t necessarily see a line as demarcating the two. The blurring of these lines served as yet another scare tactic, in cases when emotional and physical risk did not complete the task of convincing a woman to carry her pregnancy to term.

The role of religion at CPCs was one of the most interesting components of my research as it was in dialogues around spirituality that interviewees most often took already present societal narratives a step further to produce a unique and particularly coercive dialogue of control. While CPCs are in so many ways
microcosms of the larger context of reproductive health and rights, religion was where they added their own “twist” to things. The ways in which CPCs seamlessly interspersed religious symbolism in both speech and objects is absolutely fascinating and is a central theme to chapter two, where I will turn to the role of religion in much greater detail.
Chapter Two: Sit with Me
Objects, Images, and the Curation of Space at Crisis Pregnancy Centers

“The goal of religion here is the hope that the women see god in their actions.”
-Interview four

In this chapter I examine how visual and material artifacts were used by those running the CPCs in order to generate an emotional response from those in the room. Although there were variations in the amount of space each CPC occupied, the style of the decor, and the use of the space, each CPC clearly stood as a curated space that had been put together in order to produce a specific experience for those that enter. Building off of chapter one’s argument about the utilization and exploitation of broader societal narratives of pregnancy by CPCs, this chapter analyzes how these narratives are created through the use of objects and images. This is important because each CPC was designed in a way to produce a response on its own, even without the staff members there to provide the dialogue to back it up. In analyzing these spaces, it becomes possible to better understand the magnitude of the power that exists in CPCs, the extent to which they exert influence over those who visit, and to perform a deeper analysis of how those individuals in charge of these spaces saw themselves in relation to the pregnant woman and her fetus.

In the process of examining the space created by CPC employees, this chapter also references narratives of choice, particularly in regard to the room of material goods, a more detailed consideration of the politics of choice is offered in chapter three. As such, this chapter emphasizes how physical space, images, and objects, work to create an affective response from those who visit, while chapter three delves more deeply into the broader consequences of choice rhetoric.
To begin, the significance of “things,” and why I have dedicated this entire chapter to stepping back from the interviews in the interest of instead analyzing objects, images, and spaces, is well explained by Bill Brown’s “Thing Theory.” Thing Theory is a critical examination of human-object interactions in specific cultural contexts. Brown proposes a difference between “objects” and “things,” suggesting that once something no longer fulfills its suggested function, it changes from being an object to being a thing. In the same line of thought he states that “we begin to confront the thingness of objects when they stop working for us: when the drill breaks, when the car stalls, when the window gets filthy, when their flow within the circuits of production and distribution, consumption and exhibition, has been arrested, however momentarily” (4). Simultaneous to this change from object to thing comes a change in the relationship the thing now holds with human subjects (4). The items and images seen in a CPC should therefore be analyzed as things, rather than objects, as they function in a value-ridden space, and often not in their intended manner. For example, the utilization of scientific objects that might be considered “things” in a doctor’s office change in meaning when they are taken out of their intended location placed in a new setting, i.e., CPC offices. By analyzing these “things” in use at CPCs alongside the dialogue collected from the interviews, it becomes possible to access the experience and narrative the interviewees were producing on a deeper level.

Despite slight physical differences between the CPCs I visited, it was quite typical for a center to have a waiting room, a consultation room, and a room where women could collect material items for their pregnancy, birth, and baby-to-be. Two of the six centers I visited also had a room for performing sonograms. In all of these
rooms visual and material artifacts and technologies were used to achieve the following three objectives: 1) claim medical authority and suggest transparency in the work they do, 2) generate an emotional response from the woman in connection to her fetus, and 3) communicate a message of morality and spirituality in pregnancy and motherhood. The third and final point is the most important as, when it comes to pregnancy, it is unsurprising to find material artifacts functioning for the objectives of points one and two. So, while these first two points illustrate how CPCs can be understood as a microcosm of a larger landscape surrounding women’s reproductive politics, point three explores how CPCs combine “scientific” and “religious” things in order to produce a very specific narrative of maternal responsibility imbued both with secular and religious moral values. I will start by walking the reader through the sonogram room at a CPC, then through the room of “stuff”, and finally into the waiting room. The sonogram room will be used to illustrate how images and technology are exploited by CPCs in order to mimic doctors’ offices as well as produce a sense of professionalism and transparency. I will begin by looking at sonogram technology, then move into the fetal image as a “thing” to consider how it is seen by society, and how it was utilized in all rooms of all centers that I visited. Next I will move into the “stuff” room (which holds material goods free to CPC clientele) to illustrate how the commodification of birth is utilized to produce an emotional response from the woman, and ultimately, to form a “bond” between her and her fetus. As I explain below, the connections between consumerism and cultural attitudes towards pregnancy are well documented by scholars, with the exception of how these connections function in CPCs. I show how the emphasis on material goods
becomes much more dangerous in the context of CPCs, as it exploits and coerces very vulnerable populations. Finally, I have chosen to end with the waiting room, as this was often the most highly curated space, wherein the combination of religious and medical artifacts are used to transform existing and societally normative dialogues about pregnancy and into something uniquely coercive.

**The Sonogram Room**

There are many medical procedures and technologies related to pregnancy that have had a huge impact on societal attitudes towards, and women’s experiences with, pregnancy. Some of the most important examples include the development of sonograms, c-sections, and in-vitro fertilization. In various ways each of these technologies have all changed the definition both of what it means to be pregnant and what it means to be a fetus; they have all created new narratives about access to motherhood and what it means to be a “good” mother. Most of these technologies have altruistic capacities, greatly increasing the health and safety of women and the development of fetuses, while at the same time, providing new ways of policing the female body and exerting control over women’s experience in pregnancy.

Sonograms demonstrate how materials and technologies often thought of as “neutral,” especially in the medical, informational field, can be used to create very subjective forms of knowledge. (While of course there is no such thing as truly “objective” knowledge, the point here is that sonograms function in an environment

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34 It must be noted that while most of the objects and images I am studying in this chapter function exactly as such - an object or an image - sonograms can function both objects and images, causing them to stand slightly separately from everything else and require a somewhat altered analysis.
that does make a distinction between objective and subjective forms of knowledge.)
The entire experience of pregnancy has therefore been transformed by the creation of
fetal imaging.

The history of sonography begins with a man named Ian Donald in the fairly
recent year of 1958. A paper by Ian Donald, John McVicar, and Tom Brown titled,
“*The Investigation of Abdominal Masses by Pulsed Ultrasound,*” includes what are
now considered to be the first ultrasound images of a fetus (Campbell). These images
were “crude and bistable (i.e. totally lacking grey scale) and static,” with the image
being created slowly “on a cathode ray tube by rocking the transducer slowly over the
abdomen.” Nonetheless, these images became the foundation of a technology that
would prove to be incredibly fast progressing (Campbell). In just a decade, quite a
large number of new scanning machines had been created, while the number of
accurately detectable fetal abnormalities was quickly increasing.

Through ultrasound technology, sonographers are now able to see an image of
the fetus and can confirm pregnancy, identify the sex of the baby, and look for
developmental abnormalities. Fetal sonograms can be done for both screening and
diagnosis purposes, with not much difference between the two, except in the level of
expertise required to perform the exam and the occasional need for more complex
imaging technology (Ville). A woman may receive differing numbers of sonograms
throughout her pregnancy or termination of pregnancy based on state laws as well as
economic and societal factors involved in her healthcare. Most sonogram providers
claim between 40-70% accuracy for different conditions (such as congenital heart
defects or Down syndrome) but for both screening and diagnosis, the technology is constantly moving towards higher accuracy at earlier gestational periods (Ville).

The use of ultrasound technology is very safe and the medical promise it holds is substantial. Being able to diagnose fetal abnormalities such as microcephaly, or the absence of a spinal cord, clearly presents huge benefits. In writing this section I do not aim to state that sonograms ought not to be used or even that they do more harm than good. What I aim to show is that the use of the fetal imaging technology does not stop once sex has been determined or abnormalities diagnosed. Rather, fetal images have flooded our society and have become a tool with a large and powerful range of uses outside of the medical world. A secondary purpose in this section is to demonstrate another instance of how pregnant women are presented with “facts” and “information” that do not truly exist without ambiguity, that cross boundaries in fascinating ways, and that effectively operate to separate women from their fetuses.

Through visualization technology, the sonogram has been able to give life and identity to the fetus much earlier than previously possible. Prior to sonograms, the fetus often wasn’t personified until the woman was able to feel the movement and presence of the fetus inside of her. With this new technology, we now find ourselves with what Janelle Taylor refers to as the creation of the “public fetus.”

The transformation from “object” to “thing” for fetal images was quick. In 1987, Rosalind Pollack was the first to propose that new access to fetal imaging had lead to the fetishization of the fetus (Taylor The Public Life 27). Returning to “Thing Theory” to help us analyze this transformation, one of Brown’s distinctions between objects and things is “the suddenness with which things seem to assert their presence
and power,” how, while objects exist in a background state, things jump out at us and force us to confront them: “we look through objects… but we only catch a glimpse of things” (4). In this regard, the transformation from object to thing is not a material change, but is rather a relational change. Pollack’s suggestion about the fetishization of the fetus a powerful one, and one well explained within the framework of thing theory. Pollack draws attention to how, through these images, we had come to attribute life to a fetus as though it were an inherent, magical property that all fetuses hold through all stages of development, rather than as dependent “utterly and completely upon its continued sustenance by the woman who carries it” (Taylor The Public Life 28).

In sonogram technology we also see one of the strongest manifestations of the view of the woman as a vessel. Sonogram technology works not just to show a visualization of what is otherwise not possible to see, but does so with no acknowledgment of the woman carrying the pregnancy. In fact, due to the way sonogram technology is created, the provider stands with his or her back to the woman, facing the screen and the image of the fetus instead of the woman.35

Today fetal imaging has advanced to the point of 3D ultrasound imaging, which produces vividly detailed, life-like images. This sort of imaging is rarely required for medical reasons, as 2D imaging can detect most abnormalities.37 Instead, 3D imaging is often cited as being useful for depicting detailed fetal movement and

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35 Prior to this technology, it was most common to get information regarding the pregnancy by directly asking the woman whereas now she is completely bypassed in the process of information collection.
36 Also sometimes referred to as 4D.
37 The only sorts of abnormalities that 3D imaging might be able to detect that 2D cannot are non-life threatening defects such as facial clefts (Campbell).
improving maternal-fetal bonding (Campbell), presumably because of the baby-like qualities of the image. Of course “maternal-fetal bonding” is not medically measured in these interactions, nor could it be. Instead, this listed “benefit” relies simply on the notion that if a woman sees her fetus as more baby-like, she will bond with it.\(^3\) Unsurprisingly, many CPCs have begun to try and integrate this technology into their centers. In her research, Taylor found that one of the largest fundraising campaigns in recent years regarding CPCs was a push to “outfit crisis pregnancy centers with state-of-the-art 3D ultrasound equipment” (Taylor *The Public Life* 162). The following image depicts how 3D fetal images were used in one of the pamphlets I received during an interview.

\(^3\) Taylor illustrates this well in her exploration of the “keepsake” ultrasound business. These are businesses where pregnant women can receive 3D imaging technology separate from diagnosis purposes and instead solely for their enjoyment and which consequently “situate what most understand to be a *medical* technology and procedure squarely in the marketplace and outside the medical domain” (*The Public Life* 145).
Figure 14: An Informational Pamphlet on Fetal Development (Fetal Development Timeline)
Images such as this one were common in the printed materials and on the walls in the CPCs in spite of the fact that none of the centers actually had 3D ultrasound technology. The three black and white images depicting fifteen, eighteen, and twenty-two week developmental stages are images captured with 2D imaging technology while all others are 3D. Situated side-by-side one can see the significant differences in detail between the two technologies. The presentation of this pamphlet is an interesting one, as while the fetal images are presented in a scientific, informational manner, they are positioned next to a quiz entitled “Whaddya Know?” that offers a “fun” and “interactive” way of absorbing the same information showing how CPCs cross boundaries of and exist in ambiguous, hard to characterize forms.

Taylor theorizes that 3D sonograms can be seen as emblematic of where our health care and support for pregnant women stands today, as well as telling of the direction we are headed in the future. She speaks to how our healthcare system

Routinely excludes millions of women, men, and children from access to basic medical care of all kinds, while at the same time sustaining a very large and highly profitable market for all kinds of pharmaceuticals and procedures whose medical necessity is highly questionable. These conditions have allowed for the emergence of both the keepsake businesses where ultrasound is put to the task of making fetuses entertain pregnant women, and the crisis pregnancy centers that seek to make pregnant women entertain new understandings of their fetuses (Taylor The Public Life 168).

In the rest of this section I will be continuing with this argument, filling in more of the details regarding how and the extent to which CPCs utilize sonograms and sonogram images. I use Taylor’s argument as a starting point to further examine how CPCs utilize these medical technologies to mimic professionalism, imply a level medical knowledge and authority that does not actually exist, and finally, falsify a sense of transparency in their work and mission.
Although I did not come across any 3D ultrasound machines, two of the six CPCs that I visited had 2D sonograms and licensed operators at their location. In fact, one of these CPCs functions as the main provider of fetal imaging for a nearby hospital for pregnant women without insurance, no matter what their preferred pregnancy outcome. This means that at a large hospital in Connecticut that services many women of low socioeconomic status, all clients without insurance hoping to get a sonogram receive the service from an organization with the explicit goal of making sure she does not terminate her pregnancy. This fact is startling, and demonstrates how CPCs can play a significant and problematic role in shaping the experiences of women seeking medical support during unplanned or unwanted pregnancies.

At the aforementioned center, the sonogram room is designed to mimic a doctor’s office, and is slightly bare compared to some of the other rooms. There is an examination table for the woman to lie on while she receives the sonogram, all of the necessary equipment, and fairly blank walls. On one wall that is directly in front of the examination table, an extremely large television screen projects the fetal image. It is set up so that the woman cannot have anywhere else to look or anything to distract her from the projected image of her fetus. The power and coerciveness behind this set-up is blatant once one is aware of the charge society has imbued fetal images. At

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39 At the end of my interview at this location I was introduced to the nurse who performs the sonograms, the same nurse who would be performing sonograms for all the women recommended by the hospital. Although I wasn’t able to formally interview her, I spoke to her briefly and she spoke of sonograms as an extremely important part in the decision making process for a woman experiencing an unplanned pregnancy. She did not specify why, but she said that if a woman comes in for a sonogram and is still unsure, she strongly recommends that they come back with family and friends, as many people as they want. Although the nurse did not explicitly say this, the indication was that if the “mothering” instinct didn’t kick in for the woman seeing the sonogram, hopefully her partner or her own mother or a friend would step in and make a stand for her. Finally, the nurse ended by telling me that she
the second center equipped with fetal imaging technology, I was unable to gain access to the room, as there was a client inside with the sonographer. However, after the woman I was interviewing mentioned that they have sonogram technology, I asked her about the role it played in most clients’ experiences. Specifically, I asked how seeing an image was different than hearing the “facts” about pregnancy? Did it play a larger role? Her answer was as follows:

For some women it does absolutely, an ultrasound image is a powerful image and there are some women who come in and they see their child on the screen and they are like “is that a baby?” I had woman say, “Is that a baby? Is that my baby in there? Oh my gosh that’s my baby in there!” Just saying the same thing over and over again and it’s like “yes! Look!” It’s a way to connect. I’ve seen the boyfriends who were like well whatever she wants to do I don’t really care and then they see the child and they are like wow, and they connect, so it can be a really good, powerful thing... Again, they have to request an ultrasound so they have to come in here wanting an ultrasound so if you want an ultrasound most of the time you want it for a particular reason otherwise you won’t ask for an ultrasound you’d just go straight to somewhere else where you can have an abortion procedure. So oftentimes they are wanting to see what is inside so it is common for someone to say I wanna see it and that’s going to help me make my decision and then they see it and it helps them make their decision but it’s not a, it’s never a guarantee because it’s one image, it’s one tool, that we use because we believe that it’s a powerful thing for people to get a window into the womb. But every person is different (Interview two).

Although this reply is somewhat ambiguous, once the interview was over and my recording device had been turned off, this interviewee vocalized some of the strongest, most extreme anti-abortion sentiments of any of the interviewees I spoke with. In saying that a woman has to ask for an ultrasound, we are unable to know if she strongly recommends it to women who don’t ask on their own or not. In addition,

stressed to every woman that their center was most reliable because they have absolutely no financial incentive. “No matter what choice the woman makes, we do not make money, everything is free” she said, “abortion providers make hundreds of dollars off every decision to have an abortion” (Interview 3).
once they do ask, she uses this as a sign that they are looking for a reason to keep their pregnancy. She even refers to it as “one tool” and a very powerful one, presumably in “helping” a woman decide to carry her pregnancy to term. And finally, to refer to the sonogram as a window into the womb, the woman is being presented as though she exists as a container, a container that even the woman herself is not able to have accurate access to and control over without the help of a professional and modern technology.

Some women who have gone undercover to other CPCs, or who visited one by accident and then reported on it later, tell stories of the traumatic way in which their sonogram is delivered to them. In the documentary 12th and Delaware filmmakers Rachel Grady and Heidi Ewing explore a CPC and an abortion center that exist right across the street from each other in suburban Florida. In one of the opening scenes of the documentary they follow a young woman named Brittney, age 19, into the CPC with her boyfriend. Brittney says that she is considering abortion as her most likely pregnancy outcome, saying she doesn’t feel ready for a baby and has no insurance or job as well as how upset her mom would be if she found out. The woman at the center tells her that there is no reason to rush off and tell her mother and that she seems to be approximately seven weeks along, then handing her a plastic fetus which she continually refers to as “he” and informing Brittney that babies grow very quickly from this point on. She then takes Brittney for a free ultrasound saying it is a “visual” that “shows you what is going on in there.” While Brittney waits, the CPC employees whisper in the other room that their client is abortion minded and only seven weeks but “maybe we can get a heartbeat.” Brittney’s boyfriend joins for the
ultrasound where they do in fact point out a heartbeat flickering “if you look real close.” Brittney and her boyfriend are told “next week he will be twice that big.” It is important to note that they have no way of identifying the sex of the fetus at this stage of development and are using “he” as an arbitrary gender assignment. To end the ultrasound the technician prints out a photo of the fetus with the words “HI DADDY!” typed across the top.

As is the nature of the interview process, I was only able to access information that the interviewees were willing to share with me. Because of this, I cannot say for certain if a woman going into the centers I visited would have an experience similar to Brittney’s. What I do know, however, is that the centers I just spoke of had a stated pro-life mission, utilized the same small plastic fetuses, and, based on the size of the television, clearly put a lot of emphasis on the power of the image of the fetus, leading me to believe that a woman’s experience here would likely be very similar to the depiction in this documentary.

Although only one third of the centers actually had a sonogram room with fetal imaging technology, it is almost more interesting to consider the ways in which fetal images still permeated all other rooms at each and every CPC as well as all the brochures that I was handed, even when the CPC did not own a sonogram of their own. Wall decor in each room tended to consist of a combination of photos of newborn and young babies as well as fetal images from different stages of development. One purpose of this decor is as a way of further reinforcing the concept presented in the last chapter, in which motherhood becomes understood as an immediate state existing from the moment of conception. By having photos of a baby
and a fetus side by side, the CPCs are further blurring the lines of distinction between early childhood and the developmental states of the fetus.

Most importantly, the proliferation of fetal images beyond the sonogram rooms demonstrates a blurring of the lines of medical authority. Throughout history, hygiene and medicine have become very powerful means of expressing power and “othering” certain populations. This desire to police and control bodies through narratives and practices surrounding medicine is what happens at CPCs. Despite there being no medical presence at most centers, the creation of a medicalized space is crucial in instituting a sense of power and control. In a great exploration of the power attributed to medical spaces, Warwick Anderson writes about how the medical laboratory can be understood as an important “signifier of difference”:

In focusing on the laboratory as an idealized representational space, we are inclined to forget that this modern workplace had its own distinctively abstract spatial texture. It was a place of white coats, hand washing, strict hierarchy, correct training, isolation, inscription (Anderson 111).

In the emergence of the standardized laboratory creation of this space was critical for providing a certain experience and sense of control and authority. Anderson focuses on how the space of the laboratory came to be a powerful means of exerting colonial control over tropical colonies (Anderson 112).

A similar power is embedded in the space of doctors’ offices in the US; a fact that CPCs realize and capitalize on in order to gain control over populations of young women, women of color, women of low socioeconomic status, and immigrant women, many of whom might have limited access to “real” doctor’s offices, further enticing them to enter and trust a CPC. Oftentimes a woman’s experience at a CPC begins with being asked to fill out a questionnaire, as at the doctor’s office. I was able
to see the questionnaire at a few locations and I was struck by how many of the
questions listed were medical in nature, despite the fact that no medical procedures
were being completed, and that no certified nurses or other health care workers were
on staff. Another suggestion of a medical presence was in the extensive inclusion of
fetal images surrounding the spaces the clients occupied. One center, a location
without a sonogram, even went as far as adopting a logo based off a sonogram image:

We just got our very first logo. In twenty-some years we never had a logo....
That’s the logo right there and three of the people we asked said well, that’s
an ultrasound. And they were right! And the young man who does this, he said
when he explained what he meant with the colors: it’s dark becoming light.
Like when a woman has an ultrasound and she can actually see her child for
the first time (Interview five).

The tactic of claiming and repurposing medical knowledge did not end with
fetal images. The use of small plastic fetuses of various developmental stages was a
prominent feature at four of the centers. While walking past these figures, or noticing
my observation of them, three of the interviewees informed me, without prompting,
that they were the same models that are featured in medical schools and doctors’
offices. Here, again, there is a suggestion that the meaning of such ‘things’ should not
differ in these two locations, or that there is a logical relation between the two. In
other words, CPCs do not position themselves against medical authority, but rather in
concert with it. There is also the suggestion that CPCs have a “right” to include these
fetal images and figures, as they are “fact,” a suggestion that ignores how these CPCs
deploy medical knowledge in a very particular way.

According to Brown, humans become aware of an object’s thingness when it
no longer works in the intended way and we are forced to confront it. In other words,
things are “what is excessive in objects, as what exceeds their mere materialization as
objects or their mere utilization as objects,” it is what comes out in the form of “a sensuous presence or as a metaphysical presence, the magic by which objects become values, fetishes, idols, and totems” (5). When an object has turned into a thing, it is no longer simply a material presence but is now animated by a metaphysical characteristic. Even further reinforced by the dialogue of the women around them, these plastic fetuses take on metaphysical characteristics of life and personhood. Far from existing solely as information objects, they have been placed here to engage directly with woman’s conceptualization of her fetus.

The extensive use of these things and images at CPC locations demonstrates that those designing the space had an understanding that these things and images exist in a powerful state beyond their simple physical presence and which is far from value-free, an acknowledgement that we as a society and the medical community have yet to make.

The “Stuff” Room

People come in looking for what we call “stuff”. Stuff is expensive. Maternity clothes, clothing, diapers, formula- expensive, and that can be so overwhelming. And so we partner with all these organizations. We have one organization in [location] that collects baby furniture: car seats, strollers, high chairs. So we don’t do that but we work with them so we kind of have a partner in every single need that a woman comes in and says, “Where can I get that?” Well we can’t offer it, but ‘so and so’ can. This is a tough time. People need stuff. Stuff costs a lot of money. So past the emotional support, if we can get you through that then it’s like well how am I going to afford this, that, and the other thing? We can help (Interview six).

In August, 2008 a study was published in Judgment and Decision Making with the title: “The Power of Touch: An Examination of the Effect of Duration of Physical Contact on the Valuation of Objects.” The experiment was a simple one:
participants were given varying amounts of time to examine objects that they would later participate in an auction for with real dollar amounts in an open online auction. After all other variables had been accounted for, the researchers found that by increasing the amount of time a person was able to have physical contact with an item, they could also increase the likelihood that a high bid would be placed (Wolf). According to the study, retailers have been aware of this phenomenon for a very long time and have been using it to influence their buyers. One of the most interesting examples exists within Apple computer stores where the entire setup is designed for customers to touch and use the objects, to build an attachment to them. “The main reason notebook computer screens are slightly angled is to encourage customers to adjust the screen to their ideal viewing angle… the ownership experience is more important than a sale” (Cho). Whether speaking about a retail store or an online auction, it is clear that when an item is introduced into a person’s life, they are able to connect some sort of valuation to that object, oftentimes creating a psychological connection and a sense of ownership, making it harder to give up the thing, or harder not purchase it to achieve full ownership (Cho).

The underlying concepts behind the room of material goods at CPCs are no different. There is an expectation in our society that a woman simply has to understand her fetus as a baby, and that in doing so a mothering instinct will kick in, forcing her to do whatever she must to protect her baby. While images very much help CPCs promote recognition of a fetus as a baby, it is not the same as the power of touch. As the centers have no way of having the woman actually hold her fetus,
material things such as new born baby clothes and products are used to produce the desired response.

Interview one was the first time I heard the term layette, which refers to a basket of baby clothing, often accompanied with other basic necessities, that is given to a woman after birth. Not only did every CPCs employee that I spoke to point out the already constructed layettes that they offer to their clientele, they all took the idea of a layette much further. At each of the six locations that I visited, there was a space varying in size between a small walk in closet to the space of two large rooms that was dedicated solely to products. These rooms had shelves with bins up to the ceiling full of clothing, diapers, shampoos, baby blankets, maternity clothing, breastfeeding bras, and so on. I was often surprised by the extensiveness and comprehensiveness of these areas. At most locations it was explained to me that these areas are very well maintained and stocked by donors and donor organizations, including churches that perform drives and elderly groups that knit blankets. One interviewee explained the situation as follows:

We get the most like gently used clothes because everybody knows that is what we take and so community people will come in. We are grateful for it but even that, we go through it. We don’t want to give out anything that is stained or dirty. So like we inspect stuff and if we don’t like it we will give it to Good Will and sometimes we will even just throw it away… But the hardest things are the things they have to buy like the teethers and the lotions and the soap. But like I showed you downstairs, sometimes you just have people who are very generous and they want to give. And around Christmas time we will get loaded up with stuff because people will do angel trees and stuff and so we will get the lotions and the soaps (Interview two).

The connection between pregnancy and consumerism, although not greatly explored in regards to crisis pregnancy centers, is an academic field that has been explored in many other fascinating ways. In a piece titled “Fertility, Inc.:
Consumption and Subjectification in U.S. Lesbian Reproductive Practices,” Laura Mamo uses the lens of consumerism to study how choice and subjectivity have been theorized in an attempt to make us interpret “options” as “choices” (Clarke et al. 174). While “true choice” is one of the main concepts dealt with in chapter three, it is worth introducing here, specifically as it ties into the exchange of commodities. Mamo’s focus is not simply on how consumerism works to call forward consumers’ “desires and pleasures,” but more so, how it wills them to “imagine the future” (Clarke et al. 175). This is incredibly relevant to the subject matter at hand, as the purpose of placing all of these material items in front of women is to will them to visualize a future with a fetus and to reach that decision through the exercise of choice in their consumer power, going from bin to bin and picking out what they imagine their future baby wearing.

In the majority of the locations this room was designed so that women can walk around to each area and grab one of each item, browse through the maternity clothing, and rifle through the bins of newborn clothing. For many of the places, the woman was allowed to take what she needed for a child until a certain age, and then she would be allowed to return once her child was at the next stage of growth. The locations varied in terms of what age they stopped provided materials at; at some centers it stopped after a layette was needed, while at others, there was clothing for children until they reached the age of three.

In a telling analysis, Mamo proposes that the process of ‘consumption’ as it relates to purchasing sperm from a sperm bank “produces new subjectivities: lesbian mothers, gay fathers, and new family arrangements brought into being through
consumption. For any lesbians, buying sperm, and all that sperm embodies, becomes a route not only to achieving parenthood but also to realizing their imagined sense of self, their hope for the future, and a way to communicate their shared affect with others” (Clark et al. 177). In a similar manner, I propose that though the accumulation of goods, these women are meant to begin to see themselves in the role of ‘mother’ and as situated in a ‘family’ that did not exist in their mind prior to their visit to a CPC. In the case of CPCs, the emphasis on the accumulation of goods is particularly harmful as it specifically ignores other societal factors at play in these women’s lives - issues such as poverty, homelessness, abusive relationships, substance abuse, and so on - with cute baby shoes. Through the exploration of dialogues of maternal responsibility and risk, we have already seen how pregnant women are stuck in an almost oxymoronic state of trying to reach the unreachable status of “good mother.” While this status is difficult for everyone to reach, one’s chances only go downhill if poor, non-white, or disabled.

The emphasis on free services and goods is a critical component of enabling these women to see themselves as “good” mothers and speaks directly to an already vulnerable population of pregnant women of low socioeconomic status or of a younger age. A wealthy woman with little or no financial restraint regarding pregnancy related goods and services would not be swayed in the same way as a woman in a more difficult financial situation when walking into one of these rooms full of free “stuff.” This is problematic as it is disproportionately influential to women under financial strains. I do not mean to argue that material products for pregnancy and birth are not expensive, nor that women under financial strain should not have
access to free products. My point is in illustrating how these services are offered in the form of a “tool” rather than as a way to support a woman through a pregnancy decision of her own choice. No woman should have to terminate a pregnancy because she feels a lack of emotional, financial, or societal support. But, on the other hand, CPCs are able to exploit women who may not have the means to financially support themselves by having them walk through rooms filled with “stuff,” encouraging her to rifle through bins of toddler shoes before she has even made her choice for pregnancy outcome. In doing so, CPCs rely on already existing discourses of consumerism surrounding baby things to discourage women from getting abortions.

This is an especially powerful offer in a capitalist society, given that ideas of responsible parenting are often defined by the ability to consume goods on behalf of one’s children. In recent years, forms of parental consumerism have begun earlier in direct relation to fetal imaging technologies. For instance, on one website Taylor studies, women receive “babygrams,” a series of one page notices that respond to each week of pregnancy. At week 29, the woman is sent a babygram with a list of “no less than sixty-one mass-produced, commercially available items they will ‘need’ upon their return from the hospital” (Taylor “Of Sonograms” 399). Taylor points out that “of course, not all women are equally well positioned to meet all of these ‘needs’ nor to command the forms of knowledge and the resources involved in this kind of consumption” (Taylor Of Sonograms 399). The “stuff” rooms therefore both distract from existing concerns about pregnancy for vulnerable populations, while also offering women who may not meet societal definitions of acceptable motherhood the opportunity to become validated as consumers. A final point is that this provision of
“stuff” often even extended beyond the material. At one location the staff member spoke of the center’s 15 “mentors” who

Meet the girl and they take them out a couple of times a month. They will go shopping, go to the movies, keep in touch, just calling them, how are you doing and such. If they need someone, they can go to doctor’s appointments with them… just stepping into a family role really, or a best friend (Interview five).

The fascinating aspect of this is not just the mirroring of Robert Pearson’s original CPC in which he hosted women inside his own home, but also, that the average age of the clients at this location was between fifteen and eighteen, while the longest serving “mentor” had just turned eighty-eight, and the other mentors also being past the age of retirement. The extremely large gap in the demographics between the clientele and the volunteers is a topic I will return to in chapter three.

A subtle but important repercussion of this emphasis on the provision of material and immaterial goods is that this narrative allows CPCs to maintain a surface dialogue of meeting the wants and needs of the woman while also being a powerful tactic that grants them the ability to never lose their focus on the fetus and protecting fetal life. Through the dialogue of support they gain entrance into to a woman’s life on a level that is medically and professionally unacceptable in most contexts. They continually reinforce their version of the dialogue regarding pregnancy and choice, all for the protection of the fetus while claiming to address the needs of the woman.

The Waiting Room

Many of the CPC organizations in existence today have historical roots as Evangelical Christian networks deeply tied to the church, and often still receive
funding, volunteers, and donations from churches and church organizations (Rosen 1). During the six interviews I conducted, it was clear that the influence of religion was incredibly present and important at each location. God was brought up explicitly by the interviewee during five of the interviews, although only three of these CPCs openly state religious affiliation. In the one interview where God was not directly mentioned, an image of Christ on the cross was situated in a visible location on the administrative desk.

Although not all of the centers stated a direct tie to Evangelism, historically the presence of CPCs and the beliefs they promote have been tied to this particular branch of Christianity. According to the National Association of Evangelicals, anyone referring to Evangelicals in research should categorize the religion as one who strongly agrees with the following statements “The Bible is the highest authority for what I believe. It is important for me personally to encourage non-Christians to trust Jesus Christ as their Savior. Jesus Christ’s death on the cross is the only sacrifice that could remove the penalty of my sin. Only those who trust in Jesus Christ alone as their savior receive God’s free gift of eternal salvation” (“What is an Evangelical?”). In addition, the following four characteristics are identified as emblematic of a person of Evangelical faith: “Conversionism: the belief that lives need to be transformed through a ‘born-again’ experience and a life long process of following Jesus. Activism: the expression and demonstration of the gospel in missionary and social reform efforts. Biblicism: a high regard for and obedience to the Bible as the ultimate authority. Crucicentrism: a stress on the sacrifice of Jesus Christ on the cross as making possible the redemption of humanity” (“What is an Evangelical?”).
Although the purpose of this chapter is to explore objects in relation to the curation of experience, it is important to open this section with dialogue from the interviews for a more complete understanding of how the interviewees saw their position as relating to religion and God.\textsuperscript{40} Overall, their views on religion tended to be quite strong:

We don’t proselytize and we don’t really talk about religion at all unless a client brings it up. Unless a client says will you pray for me? And we do, we pray for everyone who comes in. We don’t say that out loud but of course we do. I don’t think you can talk about life and death issues on a daily basis without having some kind of mentor. And that for me would be my faith in god. I was brought up to believe that every life was precious and a gift, and a gift for someone, and I do believe that (Interview five).

Their stance on religion is even more important when one takes into consideration that at all but one location the women I spoke to and the volunteers they hired were completely unlicensed when it came to counseling. The requirements that the interviewees spoke of as being necessary to work at their centers in positions that involve direct client interaction and counseling are not degrees or past experiences, but are more along the lines of being “a good listener,” “compassionate,” and “caring.” Most of these volunteers were recruited from churches and religious groups, yet in no interview was the counseling they offered ever referred to as spiritual or faith based counseling. Some of the interviewees made an explicit point of stating the fact that they do not push their religious affiliation on clients, such as in the following statement:

\textsuperscript{40} Throughout this chapter I will use the words spirituality, god, religion, and morality somewhat interchangeably not because there is no distinction but because they were used interchangeably by those who I interviewed.
If I’m talking about religion I can say, just so you know, we are a faith-based center, we are a Christian center, and you don’t have to be Christian yourself… If you would like information on that, if you ever want prayer we find that some clients find it helpful in a difficult time to have people pray for them, then for all means we are here to do that. If you feel uncomfortable with that, if you would not like that please let us know and we will put it in your file. And that’s kind of the typical way that I would train people to do it because what we find is that a lot of clients are actually desiring those things and so from the outside some people could look in and say you guys are religious and is that awkward for people but a lot of people that we see have faith and are catholic or protestant or even if they are Muslim, we’ve had Muslim clients who are like “pray with me” and I say “but I pray in Jesus’s name” and they are like “that’s okay, I want prayer” (Interview two).

But, in general, religious beliefs tended to directly influence all the work that the women I spoke to and their volunteers engaged in. Even when they tried to make this aspect of their work seem less relevant and as more of a “side note” to what they do, the implications were drastic:

We are interdenominational. You can’t say we are nondenominational because we believe people have an aspect of their life that is their choice whether it’s believing in god or some kind of force. So we don’t say we are nondenominational but interdenominational, whatever their religion is (Interview four).

I call this drastic because, while assuming a belief in “some kind of force” is presented as a form of being open minded and understanding of different beliefs here, it is used in a very different manner in a pamphlet taken from the same interview location. When exploring the idea that “Abortion is between a woman and her God” the author reasons:

To which God does one pray for approval to [blacked out] a child’s life as in partial birth abortions? From which God does one seek blessing to dismember a child’s body as is D&C abortions? What kind of God condones the shredding of a child’s body as in [blacked out] abortions? Between a woman and her God is an attempt to impose a moral framework on an immoral act (Garton).
The open mindedness of the idea of a belief in something is now transformed into the suggestion that everyone has a belief in some sort of God and that none of these Gods would condone the decision to have an abortion. This pamphlet serves as a good reminder that the experience the women visiting CPCs have with the staff members might have included drastically different information than the interviewees chose to relate to me in their interview.

With these opening quotes it might now strike the reader as less surprising that at one interview location I was seated across from an interviewee who pointed to an empty chair in the corner and said that she always keeps that seat open for the Virgin Mary. Or that in another interview location I was asked to sit in a waiting room with a life-sized statue of Mother Theresa. The implications of counseling a woman experiencing an unplanned and potentially unwanted pregnancy in a room with a seat “saved” for a woman who experienced unplanned, immaculate conception that resulted in the birth of Jesus Christ are far from subtle, but that does not mean they are not effective. It is statements and objects such as these that I will be exploring in this section.

While extensive academic writing has been done on fetal imaging and the role of consumer ideology in ideas surrounding pregnancy, very little has been written on how these issues are presented in unique, quasi-religious ways in the context of CPCs. In these dialogues that combine religious and scientific narratives, the unique coercion that takes place at a CPC becomes visible. While the previous two sections of this chapter show how CPCs are able to build upon dialogues that already exist in society, this section shows how they then transform these dialogues through the
utilization of stronger moralized language. In modern US society, religion and science are often thought to be antithetical, yet in the spaces created by CPC organizations, the two are intentionally placed in dialogue with one another. Religious objects were tied into the overall decorations, and existed side by side with medical objects and diagrams. In this way, CPCs were able to blend these two already powerful forms of regulation to produce spaces of that produce a certain type of emotional response. As society is constantly policing women through science or moral means, it becomes a lot easier for this unique spin on things to pass by unnoticed. It is in this way that CPCs, and this project, step out of the “known” and into the more unknown and original.

The analysis included in this section is a unique one, as these centers are not doctors’ offices, nor churches, and yet they mimic the spaces of each, imbuing their rooms with great symbolic power. This pairing may seem unexpected; throughout the rest of the chapter I will be showing how and why it is effective. As this analysis is slightly more complex than the previous two sections, I will begin by analyzing just one waiting room, taking apart all the objects on the walls of this room to show how they function as things on their own, and then moving on to how they exist in dialogue with each other. Every wall and surface in this room was practically covered in colorful images and things, including:

1. Photos of babies (14)
2. Photos of fetuses (9)
3. Magazines and children’s books
4. Handwritten letters from past clientele (12)
5. Bowl of plastic fetuses
6. Pamphlets (19)
7. Crosses (2)
8. Illustrated prayer for the babies of the world

As one can see, this list is a delicate balance of medical things, spiritual things, and baby things.

Starting with items one and two, the placement of the baby and fetal photographs together blur the line between childhood and fetal development, positioning the fetus as an already existing child. While I was unable to take photographs during my time inside the CPCs, the pamphlet in figure 15 provides a good illustration of the use of fetal and newborn imaging in direct dialogue with each other. This pamphlet even goes as far as to include images of fertilization, suggesting the presence of life from the very first moment.

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41 While I did my best to count the numbers of each item in the limited amount of time I had in the room, these numbers should be seen as an approximation as I did not have visual access to all corners of the room from where I was seated and was unable to take a photo as record.
The bowl of plastic fetuses and pamphlets work to create a similar sense of medical authority. In particular, it is worth noting that most of the pamphlets featured in the waiting room addressed health-related subjects such as breastfeeding, domestic violence, and healthy pregnancy, while the more pointed pro-life pamphlets printed by the CPC itself, were stored and distributed at a later stage in the visit in a room further away from the entrance.
The shelf of magazines, children’s books, and the letters from previous clients, also works to establish the CPC as an informational center. While the letters help to show women that making the *right* choice results in positive life outcomes, they also serve to validate the centers’ work by showing credibility and past successes. Simultaneously, they reinforce the information and counseling provided by the CPC staff members, but through a different lens of common experience. One such letter thanks a center for “helping me see that abortion is not really the *easy way out.*” These letters are presented alongside a shelf of magazines and children’s books, possibly with the intention of reinforcing the letters’ narratives as “fact.” At the same time, the magazines and books can be seen as a small manifestation of the much larger room of material goods (or “stuff”) waiting for the woman inside. These items help to remind her that she can continue to come back once she has given birth, while enabling her to imagine herself and her child reading together in the waiting room.

Finally, the crosses and illustrated prayer hung on the wall add an overlying sense of “watchfulness” and a strong sense of moral policing. These items further saturate the already highly fetishized fetus with characteristics such as innocence and purity, ideas that are all well illustrated by the frequent utilization of an angel motif. In the analysis that follows, I examine the meaning of these religious objects, both as they exist on their own, and how they work in conjunction with everything else around them. To begin, not only was the illustrated prayer to the babies of the world illustrated with small, diverse angel babies, but so too were newborns pictured with angelic motifs. In another CPC, there were posters of sleeping newborns with angel wings on them. In this CPC there were photos of babies asleep on cloud like material.
These images position babies as a manifestation of godliness and purity, a concept that, while not necessarily novel to CPCs, remains symbolically powerful. In an article that examines how material culture is presented as a way to psychologically deal with the events of miscarriage, stillbirth, and early infant death, Linda Layne examines “goods purchased or made for the child-to-be during pregnancy; goods given from the child-to-be during the pregnancy; goods given to, or in memory of, the ‘baby’ after its death; and things required to memorialize the child within the family” (321). In doing so, Layne notes that angels have become one of the “most popular decorative motifs” for baby mementos, by imbuing them “the qualities of goodness, innocence, and sacredness” (336).

While I was unable to take any photographs of the angelic images within the CPCs, the image in figure 16 is very similar to ones I saw at multiple interview locations. These images provide a representation of babies as inherently good and pure. Importantly, this depiction places them in opposition to their mothers, whose own bodies, as addressed in chapter one, are often negatively valued as bad and impure. The angelicism depicted in these images also implies that all babies are worth of care, protection, and ultimately, life. Here again, the woman is only included through her role as caretaker, or vessel. The religious iconography provided alongside images of fetus and infants further drives this point home. For instance, by “inviting” the Virgin Mary into the room, the interviewee presents an opportunity for her client to sit with this saint and share an experience with her. Prayers and crosses remind the client not only of her maternal responsibility, but also of her responsibility to something bigger than herself. These images further take the choice of bringing her
pregnancy to term out of her hands, given that the associated religious perspective disallows abortion completely.

![Image of a baby dressed as an angel](image.png)

**Figure 16: Angel Baby (“Baby Pink Angel Wings”)**

In the same way the fetal images force the woman to engage with her fetus and think about it within a scientific framework, fictitious images of babies dressed as angels force her to engage with her prospective child through a spiritual framework as well. While the interviewees often mentioned that they were open-minded to the fact that many of their clients were not religious, this notion did not inhibit their use of highly suggestive spiritualized language. Instead, the use of religious imagery is seen as strengthening the effectiveness of the CPCs work. While the use of sonogram imaging produces the life of the fetus as a scientifically provable “fact,” the images of angels and the seat saved for the Virgin Mary code this life as sacred and pure.
**Keepsake Items**

Many of the CPCs I visited found ways to curate an experience that existed long after leaving the counseling room by disseminating small objects and keepsakes. I left every interview with various souvenirs, including pamphlets, images, and keepsakes. The things I collected over the months of interviewing include small plastic fetuses, bookmarks with sonogram images and large phrases such as “celebrate life” (depicted in figures 17 and 18), and a small silver pin that is “the exact size and shape of a ten-week unborn baby’s feet.”

![Celebrate Life Bookmark](image)

**Figs. 17 and 18:** Bookmarks Given to me at CPCs
All of these items worked on the level of mimicry, imitating the common experience of leaving a doctor’s office with informational packets, over the counter medication samples, drugstore coupons, and more. Yet here, in the context of CPCs, pamphlets espousing religious doctrine are often sandwiched between those that are purportedly scientific, or medically important, informational pamphlets. During one visit, I recall leafing through a pile of brochures, and finding a pamphlet relaying a story about Moses (in which Moses complains that he is not up for the tasks God has given him, and “the Lord” responds, “Who gave man his mouth? Who makes him deaf or mute? Who gives him sight or makes him blind? Is it not I, the Lord? Now go; I will help you speak and teach you what to say”) stuck between one pamphlet entitled, “Breastfeeding: Those First Weeks,” and another, entitled, “Healthy Pregnancy” (If Someone You Know Considers Abortion). The power of these pamphlets would not be the same if they did not exist side by side, each informing the way in which the others are read. They serve as an important emblem of the boundary crossing, ambiguous way in which CPCs produce information.
Chapter Three: May I ask you a Question?
Information Creation and Distribution at Crisis Pregnancy Centers

“Education, education, education!”
- Interview 3

This chapter deals with issues surrounding the creation and distribution of information regarding sexual and reproductive health, specifically pertaining to
informed consent and ideas of true choice. The main argument of this chapter is to show that, as the landscape of reproductive health and rights currently stands, there is no such thing as “true choice,” a fact that is further entrenched and reinforced by the presence of CPCs and the way in which they handle the creation and distribution of false and ambiguous information.

I have opened with the *Informed Decision Checklist* (figure 19) handed to me during an interview because of the way in which it exists as a manifestation of so many of the topics this thesis has already covered: sonograms, risks, alternatives, emotional pain, youthful vulnerability, and more. In this chapter, I continue to pursue these themes under the umbrella of informed choice. In this pamphlet there is the illusion of an extensively informed woman who has looked at the situation from all angles, knows the support available to her, and can now make the best decision for her mental and physical health and wellbeing for years to come. In reality, the women who have just been walked through the above checklist have been coerced, lied to, scared, and overburdened with information, leaving them with a list of “choices” that have been compiled, not with her health, safety, and rights in mind, but rather, as a method of policing and controlling her body. The *Informed Decision Checklist* is printed in a pamphlet that is laminated and includes three methods of obtaining further information, all of which lead to related pro-life organizations or call lines (blacked out to preserve anonymity). In the same way that CPCs mirror doctors’ offices, the stylistic presentation of this pamphlet is meant to further promote a sense of professionalism and transparency as an inherent characteristic of the information distributed, when in actuality, much of what is included in this checklist is far from
“fact.” Finally, it is worth mentioning the chosen image for this pamphlet, a very young woman covered in tattoos who presents very differently from the women I interviewed, suggesting the use of these images as a way to promote a sense of understanding and connection between interviewees and clients despite the very different demographics.

In this chapter I will begin by looking at how interviewees saw information distribution as critical to the work they do, illustrating how informational access can serve as a tool of coercion, rather than education. This leads into a discussion of the doctrine of informed consent and the concept of “overburdening of information,” in order to demonstrate how CPCs are able to distribute false, dangerous information. In examining this issue, I demonstrate how CPCs benefit from a broader societal problem: a lack of consensus (within medical, legal, and public health literature) as to how a pregnant woman ought to be counseled, what information she should and should not have a right to, and so on. I will then transition into talking about choice, proposing first that what we posit as choice is in fact only a presentation of options, most of which do not respond to the wants or needs of the woman and her individual situation. This will lead into a discussion of how we imagine women as choice makers, with a specific focus on the impact of race and class on this determination. Finally, I will end the chapter with the argument that both for all women – regardless of whether they access a CPC – there is no such thing as true, open choice within the current landscape of reproductive health.

As many of the quotations included in other chapters have already demonstrated, interviewees often emphasized “access to information” and the
importance of enabling women to make an informed decision. Throughout each of my interviews, I found that of all my sixteen interview questions (see appendix), some of the most critical responses were given to the question: *what is the most important thing you do?* Through this question I often received access to how these CPC employees saw themselves in relation to the women they service, as well as their role and responsibilities in this complicated situation. It was often with this question that I received answers explaining the importance of fully informing the clientele.

The two main points most often made by interviewees regarding information distribution were that, 1) not enough information is given, and that, 2) the information that is given is presented in a misleading way. Here, the interviewees critiqued other existing forms of information distribution, as provided by public health institutions, private physicians, and pro-choice organizations. In both point one and two, the emphasis is on the idea that the woman needs *as much information as possible* in order to make an informed decision. The more subtle additional message is that, once she has all this information, there is no chance that she will choose abortion as her “pregnancy option,” This is because ultimately, as discussed in chapter two, abortion can never be the right option.

There are two critical characteristics of the people involved in this interaction that must not be forgotten to fully understand the gravity of the emphasis on information. The first is that at five of the six centers, the women who are in charge of distributing information are neither trained, certified counselors, nor do they have any sort of medical degree. The hiring and training processes for new volunteers are far from rigorous, nor can they be as most centers stated difficulty maintaining the
needed number of volunteers to staff the clinic with volunteers often “dying or retiring” (Interview one) leaving a space that is difficult to fill.

My list of questions for each interviewee included a question on training techniques used by the centers. One center described the process as follows:

We have a volunteer training manual that explains what type of services we want to be able to offer and how to go about making someone feel nurtured and welcome when they come in here and so [once you read that] you are then just looking to get experiences. It’s helpful if during your training time a woman comes in and does a pregnancy test so you see how that goes…So it’s just getting some background. But it’s not complicated. We don’t do counseling. I’m not looking for anyone with nursing degrees or whatever. Anyone who has a good listening ear and a good heart (Interview one).

This quote encapsulates not just the relaxed, informal approach to the training program, but the characteristics that these staff members are looking for in their volunteers. Similar characteristics of being compassionate, a good listener, or dedicated were listed as desirable by other interviewees as well, whereas medical knowledge and professional experience were not. One interviewee described one of her best volunteers as a woman who

Cooked for twenty years on Sundays for the Salvation Army for the homeless, so yeah, I was like ‘she’s a shoe in.’ I knew that she would be a great person to have downstairs working with the clients because she was able to show compassion (Interview two).

For an organization that presents itself as highly medicalized, these are not the hiring and training approaches that one might expect (after one of the interviews the interviewee offered me a volunteer position as a counselor).

The second characteristic is that, for those who are visiting these centers, it is not unlikely that the center is functioning as their one and only source of information due to the nature of their situation. At the clinic where most clients were between the
ages of 15 and 18, the interviewee stated that “a lot of our younger clients are not getting medical information from the Internet, they don’t have computers at home” (Interview five). Because a huge draw of these centers is their “free” service provision, they attract a clientele with limited or no access to professional healthcare or counseling.

When talking about information regarding pregnancy options and the future possibilities for their clients, most interviewees began by saying that there simply is not enough information given at locations outside of CPCs such as healthcare providers, abortion providers, sexual education programs, and other public health institutions. That sentiment is highlighted in the following quote:

You want to make sure it is informed. That is the only thing, I don’t like having a person be discouraged to look at their ultrasound, or showing them photos of fetal development. You should know what you are doing… This one girl she had an abortion actually because she thought it was just a bunch of cells or whatever… She went to the ultrasound with her sister and she was about the same stage that girl was when she had her abortion and she looked at the ultrasound and she went “oh…” And you don’t want that. You don’t. You want people to know and then they can make their own judgment (Interview one).

The question of how much a woman must know in order to make her best decision is a complicated one. The above quotation and the entire concept of CPCs cannot be fully analyzed without a discussion of what it means to be fully informed in the context of US legal doctrine.

**Informed Consent and Overburdening of Information**

Earlier in chapter two, when noting how CPCs presented misinformation regarding post-abortion risks, the reader might have wondered how CPCs are able to
present such information, especially on such a widespread scale, without some form of governmental intervention and regulation. The answer to this question is complicated, and is connected to how CPCs must be understood as microcosms of the larger landscape of reproductive rights, rather than marginal, religious-based, politically conservative organizations. In other words, CPCs could only be expected to receive backlash from their distribution of this false and exaggerated information if there was a general legal or societal consensus in the US as to what sort of information women ought to receive when seeking counseling for, or assistance with, planned or unplanned pregnancies. Rather, the realities of prenatal information distribution and the laws regarding the governance of this information vary drastically from state to state.

To date, there is no agreed upon definition of even the most basic components of reproductive health amongst healthcare providers or legal practitioners, nor is their legislation at the national level. As such, important issues including what constitutes a legal or illegal abortion are decided at the state level. Each state has its own penalties for performing unlawful abortions, as well as its own requirements for consent, physician licensing, counseling wait time, funding, and rules regarding the use of ultrasounds. To paint a picture of just how great the lack of consensus is on these issues across state lines, I briefly compare laws in two states with drastically different laws in place: Alabama and Connecticut. In Alabama, a woman pursuing termination of her pregnancy must go through state-directed counseling, which includes information directly aimed at discouraging her from having an abortion. She must then wait 48 hours after counseling to have the procedure, and she must undergo an
ultrasound before her abortion, after which the provider is required to explicitly offer her the option of viewing the image. Her health coverage plan, if under the Affordable Care Act, can only cover abortions in this state if her life is at risk or her pregnancy a result of rape or incest. If this woman is a minor, she must receive consent from one parent or enter a lengthy legal process to circumvent this law, in which case the juvenile court system is legally able to appoint a lawyer to represent the unborn child (“State Abortion Laws”). This woman can only receive an abortion if twenty weeks or fewer have passed since fertilization, due to scientifically unproven “fetal pain” laws (“State Facts About Abortion”).

In stark contrast, a woman seeking an abortion in the state of Connecticut would face no mandatory waiting periods or obligatory sonogram, although some centers may still issue one. She wouldn’t encounter any limitations on public funding for her procedure based on the situation in which she became pregnant. And, if a minor, there is no required parental involvement in order for her to access the procedure (“State Facts About Abortion”).

When looking at abortion regulations across all states, there are seven different attributes that are important to consider and vary considerably: penalties for unlawful abortions, insurance and funding options, physician licensing requirements, underage consent requirements, counseling laws and wait time, sonogram use, and definitions of legal and illegal abortions. For the purpose of this project I have illustrated the last three attributes in figures 20 and 21 below, to both demonstrate the lack of consensus regarding abortion laws and language across state lines, as well as
to help the reader better understand how Connecticut’s regulations regarding abortion exist in relation to national trends.

<table>
<thead>
<tr>
<th>Law</th>
<th>Number of States</th>
<th>Policy in CT (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling requirements: “A woman must receive state-directed counseling that includes information designed to discourage her from having an abortion.”</td>
<td>29</td>
<td>N</td>
</tr>
<tr>
<td>Mandatory wait time of 18 hours after counseling</td>
<td>1</td>
<td>N</td>
</tr>
<tr>
<td>Mandatory wait time of 24 hours after counseling</td>
<td>22</td>
<td>N</td>
</tr>
<tr>
<td>Mandatory wait time of 48 hours after counseling</td>
<td>2</td>
<td>N</td>
</tr>
<tr>
<td>Mandatory wait time of 72 hours after counseling</td>
<td>3</td>
<td>N</td>
</tr>
<tr>
<td>Obligatory sonogram before abortion: “A woman must undergo an ultrasound before obtaining an abortion; the provider must offer to show and describe the image to the woman.”</td>
<td>11</td>
<td>N</td>
</tr>
</tbody>
</table>

**Figure 20:** Laws and Language of Pre-Abortion Counseling (“State Facts” and “State Abortion Laws”)

<table>
<thead>
<tr>
<th>Definition of Legal Abortion</th>
<th>Number of States</th>
<th>Policy in CT (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion of viable fetus permitted when necessary to preserve life of mother, or where pregnancy is result of rape or incest of minor; written certification by licensed physician required</td>
<td>3</td>
<td>N</td>
</tr>
<tr>
<td>Any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth</td>
<td>2</td>
<td>N</td>
</tr>
<tr>
<td>Any medical procedure, instrument, agent, or drug that a pregnant woman consents to use and uses to cause an abortion is legal</td>
<td>2</td>
<td>N</td>
</tr>
<tr>
<td>Pregnant woman’s decision to terminate pregnancy before viability. After viability, only to preserve life or health of pregnant woman.</td>
<td>7</td>
<td>Y</td>
</tr>
<tr>
<td>Necessary to preserve life and health of mother or where fetus is not viable</td>
<td>7</td>
<td>N</td>
</tr>
<tr>
<td>Termination of pregnancy of nonviable fetus</td>
<td>1</td>
<td>N</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Continuation of pregnancy would result in death or injury to mother; mental and/or physical retardation of child or pregnancy result of rape or incest or unlawful sexual intercourse, but must be performed within first 20 weeks</td>
<td>2</td>
<td>N</td>
</tr>
<tr>
<td>Regulated only in last trimester, where it is legal when necessary to save life or preserve health of mother</td>
<td>4</td>
<td>N</td>
</tr>
<tr>
<td>Necessary to preserve life or health of mother or fetus; after end of second trimester only legal once every reasonable effort has been made to preserve life of viable fetus</td>
<td>3</td>
<td>N</td>
</tr>
<tr>
<td>Under 24 weeks, abortion may be performed only by M.D. and only if in M.D.’s best judgment the abortion is necessary under the circumstances; after 24 weeks M.D. must provide written statement that: 1) necessary to save life of mother; 2) continuation will impose substantial risk of grave physical or mental impairment; no procedure can be used which destroys or injures fetus unless in M.D.’s opinion other available procedures would be greater risk to mother or future pregnancies and all reasonable steps must be taken to preserve life and health of aborted child.</td>
<td>5</td>
<td>N</td>
</tr>
<tr>
<td>An abortion is lawful if the doctor and facility comply with the abortion licensing requirements and it isn’t a partial-birth abortion (except to save the woman or prevent great bodily harm to her).</td>
<td>1</td>
<td>N</td>
</tr>
<tr>
<td>First 20 weeks of pregnancy no medical requirements regarding mother or fetus; after 20 weeks, must be substantial risk that would threaten life or health of mother</td>
<td>2</td>
<td>N</td>
</tr>
<tr>
<td>During first 12 weeks, no restrictions. After viability, necessary to preserve life of mother or continuance would impair her physical or mental health and must be in a hospital</td>
<td>2</td>
<td>N</td>
</tr>
<tr>
<td>1. In the first trimester anything with the pregnant woman’s consent 2. In the second trimester with the pregnant woman’s consent in a certified hospital or clinic 3. In the third trimester when necessary to preserve the life or health of the pregnant woman on the written recommendation of two doctors, and if the basis is mental health then both the two doctors and a consulting psychiatrist must agree in writing the abortion is necessary</td>
<td>2</td>
<td>N</td>
</tr>
</tbody>
</table>

42 Note this law still says the husband’s consent is required in the third trimester despite spousal consent being found unconstitutional by the U.S. Supreme Court in 1976 and, therefore, can’t be enforced.
While CPCs are dreadfully under-regulated, it is also true that counseling services at abortion clinics in some states are so greatly over-regulated that the information provided may not be that different between these two types of organizations. Indeed, the US has failed to approach informed consent in the same way regarding CPCs and abortion clinics. “In the first, reproductive rights advocates seek to regulate CPCs, forcing them to make a series of disclosures designed to give women information about the centers. CPCs are challenging these regulations. In the second, conservatives attempt to regulate informed consent procedures in clinics often forcing providers to give inaccurate and irrelevant information” (Ahmed 56). 

With this said, one must not forget to credit the spaces and ways in which this information provided as having a huge effect on the way in which the woman receives it. Even if the content is similar, the information is given in vastly different manners and contexts. The similarities one might find between mandated information given at abortion clinics, and the willingly given information from CPCs, highlights how the woman’s health and rights do not stand at the center of these laws and regulations.

Taking this into consideration, it is especially interesting to consider the particularly influential role that CPCs play in more liberal states such as Connecticut. While abortion clinics are so highly policed in more conservative states that the information presented is similar to that at CPCs, in more liberal states the information

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Figure 21: Definitions of Legal Abortions\(^{43}\) (“State Facts” and “State Abortion Laws”)

\(^{43}\) This chart includes states for 48 of the 50 states. Laws in this chart are not exact but are approximations to illustrate similarities, differences, and overall trends.
a client receives from a CPC is much more unique and specific to her visiting this pro-life center.

Many scholars and activists have explored and proven how mandatory counseling and sonograms have negative effects on the woman and her mental and physical health. The findings all suggest something similar to a study conducted at Northeastern University, where their research made clear that

Litigation on informed consent is further complicated in the clinical context due to the increased mobilization of facts - such as the gestational age or sonogram of the fetus - delivered with the intent to dissuade women from accessing abortion. In other words, factual information for ideological purpose” (“Women's Health; Reports Summarize Pregnancy Study Results”).

Or, similarly put by another researcher, how restrictions are often presented using the language of informed consent but in fact function “within a framework of pronatalism, an ideology that venerates parenting as normative and desirable, and generally disparages other choices” (Mollen). Unfortunately, as the laws are not in place to protect the woman but rather her fetus, these findings have been given little time and consideration by lawmakers. With the informed consent dialogue remaining unresolved even by those making laws regarding abortion “access,” it is no surprise that CPCs are able to take things a few steps further, by including non-factual information.

As the US legislature cannot come to an agreement on the amount, type, and mode of distribution of information in the case of reproductive choice, the general solution has been to give the woman as much information as possible and then leave her to make her “choice.” This is where the concept of “overburdening of information” comes into play, a component of the discussion around distribution of
information that was not addressed by the interviewees, and that is not well addressed in broader societal dialogues. A recent article in the *Journal of the American Medical Association* argues that “too much information can undermine effective informed consent - in other words, it is not the quantity of information but it’s the quality for the purposes of patient well-being that is critical for the purposes of informed consent” (Ahmed 52). It is the part of this quote that states “for the purposes of patient well-being” that I want to focus on here, as this is where CPCs present the greatest violation of a woman’s right to accurate and non-over-burdening information. Although CPCs are able to very effectively use narratives of emotional risk and material support to continuously place the emphasis and attention on the woman, it is not hard to see that underneath it all they are fighting for the rights of fetus, and that the vast majority of what they do and say is informed by the belief that their ultimate job is to save unborn babies.

Because most of the court cases brought against CPCs are aimed at tackling their distribution of inaccurate information that pose health risks to those who visit, many lawyers and academics have previously looked into informed consent and over burdening of information laws as they specifically apply to CPCs. As such, there is plenty of information proving that a great number of violations have been perpetrated by these centers, yet most court cases still fail to increase the regulation of CPCs or the information they distribute. One such article, looking at CPCs through the lens of the first amendment and compelled speech in disclosure ordinances, uncovers how CPCs label themselves as non-commercial establishments in order to receive lower levels of scrutiny and regulation. In these findings, the author recognizes how the
constitution’s lack of distinction between commercial speech and noncommercial speech allow for such claims to work (Duane). The author then gives evidence as to why these centers ought in fact to be seen as commercial organizations, citing how their free services effectively put even more influence on consumer decisions than if they charged, and how the services are not free of economic interest simply because they do not cost money, as distribution of services plays a large role in donation and fundraising efforts for CPCs (Duane).

In another piece exploring informed consent as it relates to CPCS, the author focuses on how frequently these centers avoid regulation due to their status as religious organizations, while in reality, the religious aspect of the centers often is not disclosed to their clientele (Ahmed). And finally, in a piece that approaches the issue from a very different angle, Bettina Heiss illustrates how organizational communities actively participate in the creation and enactment of the environment around them and how certain organizational populations, such as CPCs, benefit from an ambiguous communication of who they are and how they operate within their surrounding environment (Heiss). Here Heiss speaks to how CPCs use this ambiguous presentation of their organization to exploit the surrounding population. Her approach is unique as she studies CPCs solely using ecology terminology to effectively show how they use “mimicry strategies” such as abortion-clinic sounding names to “compete” with abortion providers for the same clientele (Heiss). Her conclusion is that these tactics are very successful and paramount to CPCs ability to survive, even though the courts fail to take this type of impactful mimicry under consideration in discussions surrounding CPC regulation.
These three articles represent diverse approaches in an extensive body of literature dedicated to how CPCs evade legal regulation, transforming dialogues of “choice” and “rights” to fit their moral and organizational objectives. This point is highlighted in the following quote (provided in full on page 90, and included here in condensed form):

The most important thing for me is I would like to see if I can show them a way to keep their baby… We don’t want to pressure them but I want to make sure that they are making the right choice and that they know what is out there and what help they can get… Every mother has a right to have her baby. And that baby has a right to be born (Interview one).

While the right to parent in a safe and healthy way is a critical tenet of a comprehensive view of reproductive justice, the right for the fetus to be born is not. By including these two “rights” side by side, the interviewee is shrouding the sentiment that she believes that women should not have the right to a legal, safe, and accessible abortion behind the guise of the argument for the woman’s right to give birth. This is one of the more transparent versions of what continuously happened through all of the interviews: the avoidance of overburdening discourse through a focus on narratives of information, support, and choice.

While this section has focused on information distribution in the context of U.S. legal doctrine, there is a strong movement by reproductive rights advocates calling for a revitalized understanding of the basic tenants necessary for a comprehensive approach to reproductive justice. Loretta Ross, one of the most influential reproductive justice advocates of today, lists reproductive justice as the human right to maintain personal bodily autonomy, the right to have children, the right to not have children, and the right to parent the children we have in safe and
sustainable communities ("Reproductive Justice"). In the following sections, any mention of a comprehensive approach to reproductive rights and choice refers to this list. The following sections highlight just how far we are from achieving this definition.

Choice?

The confusion and ambiguity surrounding prenatal information leads directly to the question of choice. Choice is one of the most intensely relied upon narratives in debates about abortion. It is seen as supplying a direct political response to the pro-life movement, while also using language that appeals to a wide range of people by not directly involving the word abortion. In this section I examine how rhetorics of “choice” have been co-opted by CPC organizations in the context of ambiguities present within broader societal definitions of the term. Finally, I ask the question of whether or not “true choice” can exist when the broader landscape of reproductive rights remains convoluted, ambiguous, and largely unregulated. To this end, I return to the discourses of maternal responsibility and the woman as a vessel as addressed in chapter one. The two questions that guide my argument about this complicated issue are 1) What does “choice” mean? and, 2) How do we see women as existing in a unique relation to choice and the ability to make an informed choice? In both cases I will be drawing direct comparisons between these narratives in greater society, and how choice is presented and discussed at the crisis pregnancy centers I visited.
1) What does “choice” mean?

The question of how to define “choice” is one that many academics in the field of reproductive justice have sought to answer. As first mentioned on page 61, one of the most prominent distinctions made by academics in this field is the notion that true choice does not really exist, and that instead, it makes more sense to speak of “options.” One of the most powerful representations of this argument is put forward by authors Loretta Ross, Sarah Brownlee, Dazon Diallo, Luz Rodriquez, and the SisterSong Women of Color Reproductive Health Project. They argue that:

Making just choices around reproductive health is difficult for women of color. Just choices are not simply a range of options, but options that make sense in order to optimize our reproductive health. We don’t expect perfect choices, but we want choices that don’t violate our sense of dignity, fairness, and justice (Silliman et al. 147).

Thus, an analysis that simply focuses on choice does not take into consideration the need for individualized care, especially in regards to a situation as delicate and personal as unplanned pregnancy, where it cannot be expected that one treatment or response will work for all women (Silliman et al. 157). Later in this section I will return to choice as it specifically relates to women of color and women of low socioeconomic status, but first, I will explore the how a limited set of options are often disguised as a matter of “choice.”

One great example of the fallacy of choice lies within women’s ability to terminate unwanted pregnancies. Yes, abortion is a right that must be available to all women, but at the same time we cannot simply present abortion as an option and leave it at that. As Marlene Gerber Fried writes in her work Abortion in the United States that
The notion of “choice” itself must be expanded to take into account the experiences of low-income women. Women who face obstacles to having children, or to having an abortion, do not see themselves as having choices. Having an abortion because one cannot afford a child in a society that privatizes childrearing is not an expression of reproductive freedom (Silliman et al. 117).

Oftentimes, by focusing on simply presenting the options and calling it choice, we are ignoring the greater societal influences that play a huge role in women’s pregnancy experience. While we see a woman with choices X, Y and Z, if the woman herself does not feel supported through choice X or Z, she will not see Y as a choice, but rather, as the only possible outcome. This result cannot accurately be called a choice. Furthermore, as the above quotation shows, if a woman does not feel financially or emotionally capable of having a child that she would otherwise choose to raise, this is not a choice. Similarly, if a woman carries a pregnancy to term because a CPC employee tells her that abortion will likely lead to substance abuse and suicide, this is also not a choice.

Throughout the interviews, many participants highlighted the fact that their clientele “chose” to come to them as a way of eschewing accusations of coercion. Yet whether or not a woman enters a CPC of her own free will is not in itself indicative of the ability to access reproductive choice. Instead, because many of these clinics participate in false advertising, and do not state their pro-life mission outright, and because their tactics of appealing to women take advantage of their vulnerability, the work performed by CPCs must be understood as a manipulation of existing options. In addition to this, these centers focus their attention on a very specific subset of women, providing little to no help to women who are not pregnant. One interviewee said “Some people walk in and say ‘do you give out condoms?’ and it’s like ‘no!
(laughing) You’ve already gotten pregnant if you’re here!’ So it’s kind of funny, we are like ‘no, it’s not what we do.’ So we get a kick out of those. It’s usually a teenager” (Interview six). This quotation is incredibly upsetting, as it illustrates how CPCs are recognized by local communities as possible sites for attaining reproductive health information. This recognition is not accidental, but is a result of the intentional mimicry described by Heiss. In this quotation, we witness a young person trying to gain options for practicing safe sex from a location that appears to be a reproductive health center, and who is directly turned away with no regard given to his or her future or right to sexual health and information. CPCs greatly capitalize on this presentation of options-as-choice because it provides a narrative that directly supports their discussion of abortion as not a viable option, and also helps them to create a dialogue where the woman is left solely with options that include carrying her pregnancy to term.

Some of the most blatant manifestations of this contrived use of the concept of choice existed in the form of charts, checklists, and diagrams that the interviewee would walk the client through, such as the one included at the beginning of this chapter. Another example was a pamphlet page entitled, “My Decision Guide,” given to me during an interview by a participant who stated that it was one of her favorite tools for helping women find the option that “best suits them.” In this guide, depicted in figure 22, one can see that the first column to fill out includes space for three options. The interviewee had already stated that she “counsels” women as having three “parenting options”: raising the child, adoption, and abortion. Assuming
that the client fills these spaces out as her counselor recommends, this list now provides a very narrow and simplistic view of possible outcomes.

Next, the woman fills out the two small boxes next to these three listed options with the heading “I’ll be proud of this” on one side and “I’ll have to adjust by plans” on the other. Underneath are listed various, seemingly random words (apart from mostly being positively associated with birth and parenting) such as protect my baby, love, spirituality, hard work, friendship, reputation, emotional stability, and love. “Pride” is a very manipulative framework to place the decision making process under, as most women are unable to associate pride with the choice of abortion, no matter how right or brave this choice may be. Certainly, abortion is not seen as an appropriate choice under societal ideologies of “good mothering” and “maternal responsibility.” At best, abortion can be seen as an unfortunate necessity. Moreover, because the women at CPCs are asked to fill out the charts under the direct guidance of a pro-life counselor, the possibility of selecting to terminate a pregnancy is made almost impossible. One interviewee presented the situation in the following terms:

No one ever told them, number one, that they might feel any kind of sadness if hey had the abortion. No one ever told them that there were options, that there was help out there, that there was support out there. No one ever told them that it was going to be an actual physical, surgical procedure and that would entail sometimes some discomfort. But I think, I really do think, abortion has become a word now, and people don’t think about what it entails (Interview five).

Here, limited “options” are presented as a form of open choice that does not actually include abortion. Choice being equivocated to an array of options is a harmful enough dialogue on its own. To pair it with the idea of options as not including safe and legal abortion shows just as far CPCs and society are willing to go
to police women, pregnancy, and motherhood. In doing so, CPCs work to reverse the usual framework of reproductive choice, which typically connotes the ability to use birth control or terminate an unwanted pregnancy. Instead, the employees I spoke with tended to imagine abortion as a constriction of choice, or a misleading choice, that is never in the best interest of the woman.
At most of the centers, staff members that I interviewed often stressed that, despite being pro-life, they are supportive of a woman “no matter what decision she
makes” (Interview three). However, it is difficult to see how this can possibly be true if all of the material objects, counseling, and reference literature provided are only given to women on the stipulation that they carry their pregnancy to term. Despite having drawers and drawers full of pamphlets in each location that many interviewees referenced as critical to their role in helping women to make an “informed choice,” the mission of CPCs are clearly and consistently tied to prolife rhetoric. As one participant stated, CPCs exist to “make sure [that women] are aware of all the resources that will help them through their pregnancy and beyond when they are a parent” (Interview two). Not one of these resources was dedicated to abortion referrals or abortion clinic contact information. The only possible good or service a woman may be offered if she makes up her mind to terminate a pregnancy is an offer to return to the center for post-abortion counseling. “If all else fails and they go out [we say] ‘if you need us even after you’ve done it, if you have any repercussions, come back, let’s talk’” (Interview one). Although this offer did not seem disingenuous, it does not seem likely that a woman who had previously experienced a full visit at a CPC would return for counseling from those who imagine that she has made the wrong decision.

Finally, while a huge responsibility is placed on the woman to make the “right” choice regarding her pregnancy, little or no responsibility was placed on volunteers by the staff members I spoke to regarding the type or quality of information they gave and how it was given to the clientele. One interviewee went as far as to state the following in a lighthearted, joking manner:

We have some [volunteers] that might get over zealous but their heart is really in the right place… I know some places get criticized that they proselytize, but
I think for the most part they really are good people. If you want to go to Washington [to protest] there is nothing wrong with that, if you want to go down on “Right to Life Day” to picket or whatever you want to do, that is up to you. Everyone has to find their own way of dealing with this. I think that for most people, their heart is really in the right place, even if they make mistakes (Interview one).

It is striking that while women are not allowed to make any mistakes regarding their pregnancy and cannot put their own needs and rights before that of the fetus, those in the position of “counseling” them appear to be under no such pressure. For these women, personal beliefs are seen as more than welcome, as long as their “heart is really in the right place,” i.e., in accordance with the CPC mission. This quotation also demonstrates how CPCs view their clientele as undeserving of true choice in regard to their future and bodies.

2) Women as Choice Makers

Often we assume that people have their mind made up, and if they have their mind made up they have their mind made up because they know exactly what they want to do and it’s their choice and they are set in it but the deeper you go and the more you see, the more you talk to women, you realize that behind every woman is someone else and sometimes it’s a boyfriend, sometimes it’s a teacher, and sometimes it’s just the choice in their head that makes them think they can’t do it (Interview two).

It is critical to look not just at how we view the politics of choice, but also how we understand women as specific agents of choice. As addressed in chapter one, long-held societal attitudes toward women – especially pregnant women – produce an understanding of female-bodied subjects as passive, irresponsible, risk-takers, in need of regulation. Yet, if this is how women are understood, how is it possible to also imagine them as agents of choice, especially in regards to issues as important as pregnancy? In many ways, societal constructions disallow the possibility that women
could ever been seen as active, responsible, and independent subjects. The above quotation demonstrates this mindset, suggesting that the woman, no matter how sure she may seem in her reproductive decision-making, is most likely being influenced and controlled by an outside source. Thus, we cannot trust what she says as being emblematic of what she really means. We must assume that she is functioning from a place of volatility and insecurity in her decisions. This welcomes anyone to enter her decision making process to an extent that would otherwise be seen as invasive and inappropriately biased.

The treatment of women in this manner does not occur only at CPCs. Ross et al. write about an example that, although very different on surface level, contains striking similarities to aforementioned quotation. Ross et al. speak to how reproductive health choices are so often not presented in a way that has meaning and importance for their target audience. For example, the United States fails to deliver Native American populations with healthcare information that is “tradition-inclusive,” or that works to “empower people in the community to take control of their health choices.” This failure has in turn lead to negative material consequences in Native American women’s health. For instance, Native American women account for 15 percent of AIDs cases in the United States, while cervical cancer effects 20 percent of Native American women, “a rate more than twice that of the US national average of 8.6 percent” (Silliman et al. 161-162). Latin American and Hispanic populations experience a similar situation as “a lack of United States citizenship often deters undocumented immigrant Latinos from using public clinics and other health facilities for fear of detection and deportation” (Silliman et al. 165). For these women,
choices are being presented to them in a way in which they would have to change the nature of their existence and relation to their own selves and communities in order to access information and assistance.

These examples further demonstrate how women of color are disproportionately harmed by poor reproductive healthcare services. For these women, it has often been the case that the idea of “choice” (i.e., the provision of limited options) has become a way to ignore drastically unfair and dangerous balances of power that exist throughout society. The reframing of narrow options as open choice is thus particularly debilitating for women of color and/or low socioeconomic status. As Roth writes in her book:

To pose the choice as one between ‘equality’ and ‘difference’ further implies that equality demands sameness. Yet I believe we can have a conception of equality that honors difference... the equality/difference debate asks the wrong question; instead, we should focus on the way that ‘difference’ becomes a justification for domination by the powerful. Eliminating domination is what matters, and that may require a number of strategies rather than a choice between two mutually exclusive alternatives (Roth 10).

A powerful, coercive manifestation of this logic in the CPC context lies in the “stuff” room. In particular, if the women walking into the centers knew that they could receive the same sort of material support from another source, the presence of such rooms would not produce the same effect. (Or, on an even deeper level, if narratives surrounding consumption, pregnancy, and maternal responsibility were questioned more broadly within contemporary US society, the power of these rooms would likely decrease.)

Due to confidentiality and the vulnerable nature of the populations CPCs work with, it was a stipulation of my research that I was not to speak directly with any of
the women that might walk into the clinics while I was there, nor seek out conversation or information from women who may have previously visited any of these centers. At one point, however, a woman stepped into the center I was conducting an interview at to pick up her layette. Upon her arrival, I excused myself to the next room so that she was able to speak to the staff member confidentially. Although I was not privy to their conversation, it was extremely short and to the point due to a language barrier. While the client was a young, Spanish-speaking woman, the staff member who greeted her was an older white woman (she introduced herself as a grandmother to eighteen) who spoke no Spanish. Once I returned to the room the interviewee noted, “A lot of the girls that come in here speak Spanish. And a lot are Haitian. Makes me wish I took more French. I took five years but they don’t speak the regular French anyways. And I’m wishing I took lots more Spanish than I did. Now I just know the basics. I’ll go ‘ropa? [clothing?],’ and then I’ll go ‘niño? niña? [boy? girl?]’” (laughing) (Interview six). Many interviewees expressed a desired for a volunteer who would be able to act as a Spanish translator, but at no clinic was this currently available.

The above instance was by no means the only acknowledgment of the barrier between those who visited the CPCs and those who staffed them. Five of the six staff members I spoke to were middle-aged or elderly Caucasian women, with the sixth interviewee being a younger African American woman. Each of these women addressed the large gaps in demographics that existed between their clientele and volunteers and employees. For the first five women mentioned above, demographics were normally referred to as a hindrance with few possible solutions. By contrast, the
African American staff member I spoke with did note the importance of working towards closing the gap in demographics:

We see...a similar amount of...African Americans and Hispanics and then Caucasian people. We don’t have a high population of Asian people; we had an influx of Korean people coming in at the same time, so I did get a translator. It’s a pretty good blend. There’s not a strong majority when it comes to race. Especially with me being an African American woman, I think about race a lot so I always try to keep the volunteers kind of mindful of having diverse people, diverse faces, for the clients that we see (Interview two).

This was the only interviewee that spoke of getting a translator for any language other than Spanish. It was also the only time it was acknowledged that the volunteers should in any way be aware of, or address the issues of, race, language, and age that pertained to so many of the clients they saw.

Yet in spite of the fact that the CPC employees I spoke with rarely remarked upon issues of racial or national difference, it is also true that the majority of the pamphlets provided to me featured people of color. In these pamphlets, people of color were represented at a ratio of 2:1 in relation to whites. This choice in demographics for the pamphlets’ visual imagery highlights how these centers seek out the most vulnerable populations as their clientele, knowing that the dialogue they present is most likely to impact those who have limited access to other information, little to no other support, and for whom the “choices” available are already extremely sparse and unrepresentative of individual wants and needs.

**True Choice**

In a final telling example of just how absent true choice is when it comes to a woman maintaining autonomy and control over, or even just accurate information
regarding, her body, I offer an analysis of a computerized application, or “app,” designed and used by one of the CPCs I visited as a counseling tool. This app was employed in the context of interviews at the CPC discussed earlier that received referrals from the local hospital when women did not have insurance to cover a sonogram. While conversing with the interviewee at this specific location, I was told once again that the employees do not pressure women into keeping their pregnancies. In response I asked how they ensured that this was the case, and was handed an iPad that displayed a pregnancy decision-making app (unnamed here to preserve the anonymity of the CPC-related manufacturer). The interviewee then told me that, as she would do with a client, she would leave the room and leave me to explore the “informational” app without her present, meaning that “obviously [I] could just sit there and not open it” or “exit from it at any point.”

This app embodies many of the themes addressed in this thesis. First and foremost, there was the proposition that the technology was neutral, as with the sonogram and other medical technologies throughout CPCs. The suggestion was that, as this information was produced from within a machine, it could not be biased, nor could it present any “false” information, despite having been created for a very specific purpose.

On the left hand side of the tablet there were three buttons related to the three options a woman was presented with: “abort,” “baby,” and an image of a heart. The “abort” and “baby” pages provided information similar to that presented within the pamphlets I received and the interviews I conducted. Upon clicking “abort,” the user is asked to enter the date of her last period, and is then given an estimated due date
with all further videos and images corresponding to her gestational age (despite the fact that the actual information given regarding abortion was the same no matter how far along she was).

![Image](image.png)

**Figure 23:** Informed Decision App “Abort” page (*Removed for Anonymity*)

If the user clicks “baby,” she is then asked to choose either “adoption” or “parenting.” The parenting option takes the user to a page that describes the pros and cons of single parenting and co-parenting. The adoption page takes the user to an “Adoption Pop Quiz,” in which one of the questions directly compared abortion to adoption, asking if it is “true or false” that abortion is emotionally easier than adoption, and providing the “correct” answer as “false.”
While these pages are fascinating to dissect, they do not necessarily bring in any dialogues that have not already been discussed at length in this thesis. Yet the third page, represented by the heart image, introduces another important dimension to CPC operations. This button leads the user to a page with the following graphic:
Figure 25: Informed Decision App “May I ask you a Question?” Page (Removed for Anonymity)

If the user clicks next, she is then walked through excerpts from the bible presenting her with evidence as to why she should not abort and what the experience of hell is like.

When the interviewee came back into the room and we began talking again, she expressed her appreciation for this app because “it puts the choices in the woman’s hands,” and that the client “is the one that chooses where to go.” While one might scoff at the navigation of this app as “choice,” choice in the broader world of reproductive rights functions very similarly. Women are often forced to work through an incredibly narrow list of alternatives presented to them in a manner that is unconcerned with their mental and physical health and overall wellbeing. While the language of heaven and hell is particularly striking and clearly infused with a Christian viewpoint, it also can be seen as just another way of policing women’s bodies, pregnancies, and mothering capabilities. This comparison is important to understand because it contributes to the ongoing, unregulated operation of CPCs, which likely would garner a lot more attention if broader societal attitudes towards, and legal language surrounding, these issues were more clearly defined.

The limitations imposed on women’s reproductive freedom through false and/or impossible choices are thus evident both inside and outside of the context of CPCs. Fixing this problem would necessitate an entire restructuring of the way in which pregnancy is viewed, including a reevaluation of maternal responsibility and rhetorics that degrade women as simple “vessels.” Yet this possible restructuring begs
the question of whether the framework of “choice” would be maintained in any form. If all of these negative narratives were broken down, and a consensus was reached on counseling, information, and the appropriate regulation of both abortion clinics and CPC settings, what would we be left with? Would we still be talking about choice as the most important aspect of reproductive rights? As the chapters in this thesis have presented numerous problems related to the current status of reproductive health and rights in the United States, I will do my best to at least begin to answer these questions in the conclusion that follows.
Conclusion: A Place for You
Crisis Pregnancy Centers as sites of Doulaing

“We are sitting here looking to help. You will come in and hopefully you will find a friendly face that will just sit here and listen. That’s what the number one thing I’m looking for in a volunteer is, someone who can just sit and listen and offer guidance, love, support, and respect for whatever that woman is going through and how we are going to eventually offer them help.”

-Interview one

The analysis included in this thesis has illustrated the way in which CPCs have been able repurpose narratives and issues already present in society in a uniquely coercive and highly successful way. I have put forward the argument that CPCs reach their ultimate level of success through being able to posit “good motherhood” as an approachable status for women who have previously been socially alienated and “othered” because of their race, class, age, and so on. After coming to this conclusion, the way I saw CPCs within the greater context of counseling for pregnant women shifted. Rather than dismissing CPCs at outposts of conservative Christian opinion, and instead of critiquing CPCs solely for their controversial and coercive methods, it is important to understand how CPCs function as a microcosm of the issues facing pregnant women in contemporary US society. As demonstrated throughout the chapters, narratives of maternal responsibility, the woman as vessel, and choice-as-options versus true choice, continue to impact medical and legal attitudes towards women’s reproductive health. These attitudes are frequently ambiguous and exist without consensus. As such, we might say that the strength of the CPCs messages is that it is, above all, certain and clear. At the same time, the undecided nature of women’s reproductive rights enables the success of CPCs, including their dissemination of inaccurate information, Before concluding the
While this project was my first time working with CPCs, it was not my first time dealing with the issue of counseling and support for women experiencing unplanned pregnancies in the state of Connecticut. For the past three years, I have worked in abortion clinics throughout the state as an abortion doula assisting women through the process of pregnancy termination. As my interviews at CPCs progressed, I was surprised by how many of the participants’ words resonated with the work I perform as an abortion doula. It is this connection that is briefly explored in the conclusion as a way of tying all of the project’s issues together. This connection also enables a deeper exploration and assessment of the possibilities of reproductive justice in unexpected places. I begin by describing the work of a doula as it is traditionally exists, then posit why I saw the work of these women as mirroring and embodying many of the same ideals, and finally, explore the significance of this similarity.

The Work of a Doula

The word doula⁴⁴ is used to describe someone in the role of providing nonjudgmental emotional support and advocacy for a woman through a pregnancy outcome. Today there are doulas for birth, adoption, miscarriage, and abortion. The idea of a doula took off in the 1980s, as women became concerned by the fast growing rates of cesarean sections (Papagni). Women responded by having a friend, Originating from the Greek word for female slave
instructor, or nurse with whom they were comfortable and familiar with stand by them to provide support and advocate for their right to go through the birthing process as they saw appropriate, oftentimes by avoiding procedures that would increase the likelihood of them needing to have a cesarean section (Papagni).

From this history, the role and demand for doulas has grown greatly. Although still most often thought of as relevant to the birth process, organizations that train doulas for other pregnancy outcomes have started to become more popular in recent years. Most studies that have explored the roles of doulas focus on how they change the birthing experience in a variety of positive ways. One study demonstrated that doula support truly does have the ability to lower the chances of cesarean section (“Women's Health- Pregnancy”), as was the original goal. Others have found that it can also reduce risks in childbirth and postpartum health associated with “psychological and lifestyle factors” (Kane), and even offer a “risk free alternative for pain relief during childbirth” (Mcgrath).

Not as much research has been done on the effect of having a doula present during abortions, largely because there are fewer abortion doulas, and women often do not know that they can request a doula for a pregnancy termination procedure. Although the concept is becoming more popular, it is still, for the most part, widely unheard of. Abortion doulas also rank low on the list of priorities in most clinics due to the financial restraint of keeping care affordable. As such, there are currently fewer than fifteen organizations in the country that offer doulas for pregnancy outcomes other than birth.
When an abortion doula works at a clinic they often work directly alongside the medical staff. As with the women running and volunteering at CPCs, every abortion doula has a slightly different approach to the different steps and regulations depending on the clinic they are working with. As there are no studies assessing the exact role and tactics used by abortion doulas nationwide, I will speak briefly from my own experience, while being careful to not break any confidentiality parameters. My interaction with a patient begins when I call her from the waiting room and introduce myself as a “non-medical support system who will be there for her throughout the entire procedure.” From that point on, I stay by her side through the entire procedure doing breathing exercises, chatting, or working through difficult questions; in other words, offering support based on the individual emotional, physical, and mental needs of the patient. Once the procedure is over, I walk with her to the recovery room before going to get the next patient. My role is that of a non-judgmental listener, making sure that there is someone there for her who has no other purpose than offering compassionate care and support through her decision.

Comparing this description to the CPC employees’ portrayal of their own work, several differences immediately emerge. Many of the foundational beliefs behind abortion doulaing rest on the idea that, when a woman is facing an unplanned pregnancy, she not only needs choices, also, a sense of bodily autonomy, an understanding that this is her decision to make, accurate but not overburdening information to aid in her choice, and systems of support that will be there for her no matter her decision. As the chapters demonstrate, these were not the priorities of the interviewees. Moreover, abortion doulas and CPC workers exist in a different
relation to their patients and clients. Abortion doulas are present solely for emotional support and advocacy purposes. They do not offer medical information to a patient, but rather act as a channel of communication between women terminating their pregnancies and their providers. By contrast, CPC volunteers pose as direct counselors and offer information without proper medical training and expertise.

For all of these reasons, I was hesitant at first to acknowledge any similarity between abortion doulaing and CPC operating roles, citing the key difference that CPCs do not extend support to all decisions regarding pregnancy, especially pregnancy termination. However, I then realized that abortion doulas do not extend their support to all realms of pregnancy outcomes either. An abortion doula is there to help a woman through her choice to terminate a pregnancy, with no acknowledgement of how the narratives of maternal responsibility or the seemingly impossible task of being a good mother might have provided pressure for the woman to have an abortion when she might otherwise have wanted to carry the pregnancy. Abortion doulas fill the role of helping women see the choice of abortion as acceptable and brave and to work through any narratives of guilt that society, family, or friends might have placed on them for pursuing a pregnancy termination. Similarly, CPC volunteers work to provide positive reinforcement of their clients’ right to pursue motherhood, especially in cases where a client’s ability to mother properly has been “othered” by way of poverty, race, age, addiction, and so on.

45 And in regards to other forms of doulaing, women who pursue having a birth doula tend to be white, of the middle or upper class, with higher levels of education, and of the age seen as “appropriate” for giving birth. These are the women for whom society is most likely to grant the title of “good” mother. While some public hospitals do have birth doulas free of charge, usually through volunteer organizations, these women are only able to provide support and advocacy for the woman during her labor, there is no prior meeting or connection and rarely any contact after the child is born.
Doulaing at CPCs

The first indication of a connection between these forms of service appeared in the mirroring of language, with women in both positions speaking of themselves as non-judgmental listeners for women in a tough situation. The following two excerpts depict this sentiment in the context of CPCs:

There is beauty in all the stories, there is beauty in the stories regardless of what they look like. I think in our society we want happy stories that there is a bow and you wrap everything up with a nice little bow but that is not reality for our clients. We’ve seen people come in here and they find out they are pregnant and then they miscarry, and it’s not a planned child but they want it. Or sometimes they are undecided but still when they miscarry it is very painful for them. Even those stories are beautiful stories because we get to be there for them (Interview two).

Someone asked me once at a seminar I went to ‘what do you want a woman to feel like when she comes in here?’ What I want is for her to feel like she can breathe. And I’ve seen it happen; I’ve watched it happen over and over and over again. There is a point in the time that they are here where they will just go (takes a deep breath) and they will breathe. And for me that is success because they are breathing. They are like, everything around me maybe seems like it is crumbling and falling into pieces and I feel like I’m really alone, but I can breathe. (Interview five).

Listening, respecting all stories, and offering the woman a space and a person to breathe with are all forms of care emphasized in the practice of doulaing. While pregnancy centers are pro-life at their core, they also see themselves as “contributing a needed, practical, women-centered approach to the pro-life movement strategy” (Hussey). Like doulas, CPC employees also work to provide individualized support that may be lacking elsewhere in a woman’s life. One participant echoed this sentiment saying:
It was so obvious that women didn’t have the support that they needed and no woman wants to go through pregnancy alone, nor should she and that really is our mantra, that no one should face pregnancy alone. So that’s how we got started (Interview five).

This women-centered, individualized approach is at the core of how CPCs define themselves, and also exists as a critical factor in their growing clienteles. CPC interviewees also expressed a high level of awareness of what they were not able to provide. Oftentimes, in response to the question of what the most difficult part of their job is, the participant would say something about not being able to “do more.” One staff member began by talking about the difficulty of not being able to give all the support she might want to give, but then immediately added, “I think that the most rewarding thing for me is just being able to provide people with a sense that they are valuable and that they are loved and that this is a safe place for them” (Interview two). In a similar vein, another stated “all we can do is love her and make sure she gets good care and be there for her and support her in any way that we can” (Interview one).

In a final point of comparison, the majority of most doula organizations and CPCs rely mainly on a volunteer based model of care delivery. Each of women I spoke to attributed the success of their center to the volunteers. Many of them talked about how the work they did drew a very specific, wonderful kind of person, and that, because of this, training was not an incredibly strenuous or involved process. Each clinic had a very different method of training new volunteers. Center three had a very specific regimen that was one of the more intense, most likely due to their status as an outpatient clinic. Center five had the mentality that you could always find something for someone to do, such as vacuuming or organization, even if they were not suited
for counseling clients. Despite the large differences in training approaches and techniques at each center, in all of the different training programs, shadowing was the final and most important step of preparation. The length of the shadowing period varied, but the idea that one learned most from watching others work with clients was a widely shared idea. And it is one that most doula projects rely on as well.

Imagining CPCs as offering a doula-centered approach to care (one that is clearly needed and used by many women) enables us to see how the right to parent - and to be respected as a parent - is a critical, often overlooked, tenant in reproductive justice projects. CPCs not only present one of the most effective promotions of this right, but they do so on a massive, nationwide scale. In this way, a proper analysis of CPCs enables a reevaluation of existing gaps within reproductive healthcare policy. As discussed throughout this thesis, CPCs utilize a wide variety of tactics, including the dissemination of incorrect information, in the interest of attaining a pro-life outcome. Nonetheless, it is also striking that any attempt to counter the work being performed at CPCs first has to account for discrepancies within mainstream healthcare policies and abortion regulations. Confusion over these very issues – which shift from state to state, court case to court case, doctor’s office to doctor’s office, clinic to clinic – creates an atmosphere of uncertainty surrounding women’s reproductive health that bears similarity to how CPCs employ “information” and aid in the process of “choice.” By considering CPC counseling as a form of doulaing, we are also faced with the question: why can’t we mobilize mass support of a similar scale when the “life” of the fetus is not seen as at risk?
Any way you look at it, no matter the very different histories and motivations behind these two forms of counseling, each one provides an answer to a large gap in our current landscape of counseling and support for women. Abortion doulaing exists as a response to harmful narratives of abortion as irresponsible, morally wrong, and more dangerous than it actually is. Doulaing at CPCs exists as a way to combat dialogues of responsible motherhood and policing female bodies that have gone so far as to “other” a certain type of woman to the point where she is no longer able to see herself as capable of being a successful mother.

Neither approach exists as a comprehensive option that satisfies all the rights of a woman under the framework of reproductive justice: the human right to maintain personal bodily autonomy, the right to have or not have children, and the right to parent the children in safe and sustainable communities (“Reproductive Justice”). Our approaches to reproductive justice, choice, health, and rights must stop falling short and failing to include and address all factors affecting these women. It ought not to be the case that CPCs garner success simply by offering forms of support that would otherwise be unavailable to many women. Nor should CPCs be allowed to flourish because they are the only organizations that present the idea of successful motherhood as an achievable status for women from vulnerable populations. If women seek out CPCs for these reasons, then CPCs are able to further their deceptive intentions, which always center around protecting the life of the baby-to-be, not the woman carrying the pregnancy. As a society, we must take the opportunity to make substantial, meaningful changes that are necessary to promote a landscape of
reproductive health and justice that actually addresses a woman’s wants, needs, and rights.
Appendix

INSTITUTIONAL REVIEW BOARD DESCRIPTION OF RESEARCH FORM
For Research Projects Involving Human Participants

GENERAL INFORMATION

This form is to be filled out by the Principal Investigator (PI) of the research project being submitted to the Institutional Review Board (IRB) of Wesleyan University for exemption or review.

The required convention for IRB project labels is YYYYMMDD-username-project (e.g., 20090215-jross-memoryproj). The project label you use here should match the name you use for the folder you create to submit this document. If you would like other members of your research team to have access to the folder you create, please put asterisks after their names below.

Project title: Interviews with CPC Employees
IRB project label: 20160605-jsahihi-interviewswithCPCemployees
Submission date: 6/5/2016
Principal Investigator: Jaya Sahihi
Affiliation: Science in Society Program
Email: jsahihi@wesleyan.edu
Phone: 646-573-4570

Faculty/Staff Advisor: Megan Glick
Advisor email: mglick@wesleyan.edu
Advisor name required for student submissions.

Research team members (investigator, affiliation, department, email):

Organizations affiliated with project (e.g., student groups):
RESEARCH OVERVIEW

(a) Describe the type of research being proposed by checking as many boxes as appropriate:

- [ ] Administrative or institutional research
- [ ] Faculty research (including student involvement in faculty project)
- [x] Thesis or independent undergraduate research
- [ ] Thesis or independent graduate research
- [ ] Course-related research
- [ ] Off-campus research
- [ ] Other (describe):

(b) If this is faculty research funded by an external research grant (e.g., from a federal agency) to the faculty member, provide the granting agency and grant number:
N/A

(c) Provide a brief paragraph overview of the proposed research including the specific goal of the research and the methods by which the goal will be achieved.

The goal of this research is to gain more information about the ways in which crisis pregnancy centers (CPCs) serve the communities they work in. CPCs are non-profit organizations, usually affiliated with the evangelical church, that were established to counsel women against abortion. Sometimes they offer additional services such as contraceptive counseling, sonograms, adoption referral, or financial assistance if a woman chooses to keep her pregnancy. Although there is ample information about what facts CPCs tell their patients and what products they do and do not offer, the research around CPCs is seriously lacking in the voice of the provider. This research project hopes to remedy this absence by conducting interviews with CPC employees, with particular focus on understanding the employees' training, professional experiences, and personal decisions to become involved in CPC work. A complete list of questions has been submitted with this document. At the beginning of the interview I would identify myself as a Wesleyan student conducting research, and explain that I would preserve their anonymity and that of their organization. To be clear, the interviews will only cover CPC employees; patients will not be interviewed due to issues of vulnerability. I will not ask CPC employees specific questions about specific patients, and any information that is provided in this vein
will be recorded with preserved anonymity. (My thesis will address patient populations through secondary research.)
RESEARCH EXEMPTION STATUS

If you believe that this research is exempt from IRB review, please check any one or more of the below that jointly describe your proposal in its entirety. You should then fill out the Participants and Research Methods sections but can omit the other sections of this form. If the Board does not concur that the work is exempt, you will be asked to complete the rest of the form at that time.

☐ Research conducted in established or commonly accepted educational settings involving normal educational practices such as: (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or comparison among instructional techniques, curricula, or classroom management methods. Research with prisoners is not included in this exemption. (45 C.F.R. § 46.101(b)(1))

☐ Research involving educational tests, surveys, interviews or observations of public behavior, unless: (i) information obtained is recorded such that subjects can be identified directly or indirectly through identifiers linked to the subjects; and (ii) any disclosure of subject responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to their financial standing, employability or reputation. Research involving children is included when limited to education tests or observation of public behavior and the investigator does not participate in the activities being observed. Research with prisoners is not included in this exemption. (45 C.F.R. §46.101(b)(2))

☐ Research involving collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that participants cannot be identified directly or through identifiers linked to the participants. Data collected from prisoners is not included in this exemption. (45 C.F.R. § 46.101(b)(4))

Feel free to further explain why you believe an exemption is appropriate, if desired:
Some questions here will not be relevant to research methods using existing records or data sets. However, even in these cases, please try to interpret the questions in such a way that they apply to your work whenever possible. E.g., describe the types of participants in the data set you have obtained, or the data collection procedure you will use for extracting information from confidential personal records, etc.

PARTICIPANTS

(a) Check all groups that are central in your study (by design or likely circumstance):

☐ Adults (18 years of age or older)
☐ Minors (below 18 years old)
☐ Economically or educational disadvantaged persons
☐ Persons with physical or mental disabilities
☐ Pregnant women or fetuses
☐ Prisoners
☐ Other (describe):

(b) Please describe what types of participants you will seek out and how you will recruit them. As applicable: How will they be recruited and how many will be recruited? Are there specific eligibility or screening criteria? Will you offer incentives or compensation? Are there circumstances that might lead to the perception of coercion or undue pressure on the part of participants and, if so, how will you ameliorate this perception? Describe or separately upload recruitment flyers, letters, and/or ads. Participants will be current employees at crisis pregnancy centers in the state of Connecticut. These individuals can be of either sex, must be over eighteen, and can occupy any position in the center. Some of the positions that the interviewees might occupy include: executive director, pregnancy counselor, family advocate, intervention advocate, or youth services program director.

I will begin by reaching out to individuals at five CPCs in CT through contact information provided on each organization's website. I will clearly identify myself as a Wesleyan student conducting senior thesis research. I will assure potential interviewees that I will safeguard their anonymity and that of their organization. I will conduct the interviews at a neutral location away from their place of work. I will not offer any sort of incentives or compensation.

RESEARCH METHODS

(a) Check all of the research methods that you will use in your study:
(b) Please describe your research procedure. As applicable: Describe the number and duration of sessions, the location where research will take place, who will interact with participants and their qualifications for doing so, what participant will be asked to do, what behaviors or other measures will be collected and how, whether audio and/or video tape will be used, and whether different participants will receive different experimental treatments. If you are using only existing data, describe the source and content of the data set and whether IRB approval was obtained for the original study. Describe or separately upload all questionnaires, interview questions, or experimental materials that you plan to use.

I will conduct all interviews myself. I will identify myself clearly as a Wesleyan student, and provide an overview of my project, including a debriefing form (included here). I will offer to meet the CPC employee at a neutral, non-work location of their choice. The interviews will last for approximately one hour and will be audio recorded. In order to protect any sensitive material gathered in these interviews, this audio recording will then be transferred to my laptop, deleted from the recording device, and coded. My laptop will be password protected and only myself and my thesis advisor, Megan Glick, will have access to the file. Once the interviews have been coded and quotations have been pulled, the audio recordings will be deleted from my laptop and I will make sure to remove all identifying information each time I refer to an interview or a quotation in my thesis.

The interview will be in a semi-structured format. I will arrive at each interview with the same list of questions. Interviewees are welcome to skip a question if they do not feel comfortable answering it for any reason, or to end the interview completely at any point.

Stop here if you have submitted a request for an exemption, otherwise continue.

INFORMED CONSENT
(a) Check all of the types of informed consent that you will use in your study:

- [x] Written participant consent
- [ ] Written parent/guardian consent
- [ ] Oral participant consent
- [ ] Oral parent/guardian consent
- [ ] I will not be documenting consent
- [ ] Other (explain):

(b) Written consent of the participant or of his or her parent/guardian (for minors) is expected unless waived by the IRB. If you will not be obtaining written consent, please explain why. For participants under the age of 18 years old, both parental consent and participant agreement to participate (“assent”) is expected unless waived by the IRB. If you will not be obtaining some form of parental consent and participant assent, please explain why.

(c) Please separately upload copies of consent forms. If oral consent is planned, include the verbal consent script below or in an uploaded file. Note that when written consent forms are used, a copy must be given to the research participant. If consent will be obtained electronically via the web, please describe below the procedure by which consent will be obtained.

Consent forms to be signed by interviewee will be presented at the beginning of each interview. I have uploaded a copy with this application.

TREATMENT OF DATA

(a) Check all that describe the privacy conditions of your study:

- [ ] No names or any identifying information will be collected or retained
- [x] Identifying information will be collected but will not anywhere be associated with data
- [ ] Identifying information will be linked to data in a file stored separately from data
- [ ] Identifying information will be collected and stored with data
- [ ] Data themselves provide identifying information (e.g., audio/video data)

(b) Check all that apply in terms of how individual data will be reported:

- [x] Names and identifying information will never be reported
- [ ] Names or identifying information will be reported with participant permission
- [ ] Names or identifying information will always reported

(c) Please explain your privacy goals (e.g., anonymity, confidentiality, giving public recognition) and how you will ensure that these goals are met. If you will be linking participant names with identifiers to data in a file separate from the data, please explain your procedure. For confidential data, be sure to
describe where data files will be stored, in what format, who will have access to them, password protection procedures, and when/how data will be destroyed.

Because of the potentially sensitive nature of the information collected, all interviewees, as well as the organizations they work for, will remain completely anonymous. Each interviewee will be given a coded identification, and all quotations or references to them will have any identifying information removed.

Audio recordings will be taken during the interview and then transferred to my computer as coded information, deleted from the recording device, and protected by a password. Once the interviews have been coded and anonymous, the audio recordings will be permanently deleted from my computer. In the process of writing my research paper the only individuals who will have access to the names of the people, the recordings of the interviews, and the names of the centers will be myself and my thesis advisor, Megan Glick. Once the thesis is written all that will remain is the anonymous analysis of the interviews.

RISKS AND BENEFITS

(a) Please check the types of potential risks, if any, that might reasonably occur with this study:

- [ ] Physical or psychological risks
- [X] Informational risk (e.g., if data were inadvertently made public)
- [ ] Risk by association with study (e.g., participant perceived as informant)

(b) Please elaborate on physical, psychological, and informational risks to participant as well as any risks of being associated with the study. What steps are you taking to minimize these risks?

My thesis will be exploring the ways in which CPCs present information to their patients and how they counsel those who visit their organizations. As in any study of an organization it is possible that an employee might reveal controversial information about the organization they work for. However, everything that is said will be completely protected and anonymized. This anonymity applies to the employees and the organizations they work for. I will be sensitive to all information that might make an employee self-identifiable. Because I am addressing multiple CPC locations, it is further unlikely that any individual would be inadvertently identifiable.
(c) Please elaborate on whether there are specific benefits to society for your study or to the participant other than cash or other payment for participation (e.g., medical study might treat illness, etc.). If necessary, explain why you believe these benefits outweigh the risks.

CPCs are a prevalent yet largely unexplored feature in the landscape of reproductive health in America. Currently, there are more CPCs in America than abortion providing facilities. In Connecticut, there are 27 CPCs, while there are only 19 facilities that offer abortions. Learning about the ways in which CPCs interact within their community is not just important in an academic setting, but also in order to construct a picture of what women's reproductive rights look like today. Because these organizations outnumber abortion providers, and have a "pro-life" stance, they constitute an important and ongoing backlash against women's reproductive rights. In a time when abortion is under attack in our country, it is very important to understand what the function of organizations like this are. It is fundamentally an issue about women's reproductive rights.

DEBRIEFING

(a) If applicable, describe how individuals will be debriefed as to the purpose of the study or provided further information. If a formal oral or written debriefing sheet will be used (required for studies involving Introductory Psychology Participant Pool participants), please upload it separately. Prior to conducting each interview I will hand out a debriefing sheet which I have uploaded with this application.

CONFLICTS OF INTEREST

(a) Discuss any conflicts of interest for any of the researchers involved in this study. How are such conflicted being removed, minimized, or otherwise managed?

CO-INVESTIGATORS, COOPERATING DEPARTMENTS, COOPERATING INSTITUTIONS

If you are working with/conducting your research at another institution or organization, upload separately a letter of cooperation from that institution. If that cooperating institution is a primary data collection site, the Wesleyan IRB will need a letter of approval from that institution's IRB (or an administrator, if there is no IRB) before you begin to collect data at that site.

ELECTRONIC SIGNATURES

As Principal Investigator, by typing my name below, I accept the following pledge:
I acknowledge the rights and welfare of the subjects of my research as described in the Belmont Report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. I acknowledge my responsibility as an investigator to weigh the risks of their participating in the research against the potential benefits of the investigation, and to take whatever steps are practicable to minimize those risks. I assure the IRB that this research will be conducted in accordance with federal regulations that govern research involving human subjects as described in the Code of Federal Regulations (Title 45, Part 46) of the U.S. Department of Health and Human Services. Any deviation from the project as described here (e.g., change in principal investigator, research methodology, subject recruitment procedures, etc.) will be submitted to the IRB in the form of a change of protocol for its approval prior to implementation. The PI agrees to report all protocol deviations or adverse events IMMEDIATELY to the IRB.

Principal Investigator: Jaya Sahihi

As Faculty Advisor (if applicable), by typing my name below, I accept the following pledge:

I have supervised my student in the development of this proposal, I have read the proposal in its entirety, I fully support the research as proposed, and I will work my student to implement the proposal. (Student proposals will not be accepted unless accompanied by this faculty acknowledgement.)

Faculty Advisor: Megan Glick

See instructions at www.wesleyan.edu/IRB for how to submit this document. Contact the IRB Administrative Coordinator if you have any difficulty submitting materials.
Research Informed Consent

Interviews with CPC Employees

Jaya Sahihi

Purpose
The goal of this research study is to gain more information about the ways in which crisis pregnancy centers (CPCs) in the state of Connecticut serve the communities they work in.

Procedures
Participation in this study will involve an interview that the participant can end at any point. We anticipate that involvement will require 1 hour of the participant’s time.

Risks and Benefits
Participants in this study may experience distress over the nature of the questions and, as in any study of an organization, it is possible that an employee might reveal controversial information about the organization they work for. Although this study will not benefit you personally, we hope that our results will add to the knowledge about the voice of the provider in CPCs, increasing our understanding of the work done at CPCs, how and why one decides to work at a CPC, and other related questions.

Confidentiality
All of the responses will be audio taped. In order to protect the confidentiality of the participant all material will be transferred to the researcher’s laptop, deleted from the recording device, and coded. The laptop will be password protected and only the researcher and her advisor will have access to the file. Once the interviews have been coded and quotations have been pulled the auto recordings will be permanently deleted and all identifying information will be removed.

Voluntary Participation
Participation in this study is completely voluntary. You are free to decline to participate, to end participation at any time for any reason, or to refuse to answer any individual question.
Questions
If you have any questions about this study, you may contact the investigator, Jaya Sahihi at Jsahihi@wesleyan.edu. If you would like to talk with someone other than the researchers to discuss problems or concerns, or to discuss your rights as a research participant, you may contact Jill Morawski at jmorawski@wesleyan.edu. You may also contact the Wesleyan University Institutional Review Board through their website http://www.wesleyan.edu/acaf/support/reviewboard.html.

Agreement to Participate
[I am at least 18 years of age.] I have read the above information, have had the opportunity to have any questions about this study answered and agree to participate in this study.

_________________________________________  _________________
(printed name)                                    (date)

_________________________________________
(signature)
Please feel free to decline to answer any questions. Thank you for your time!

1. How long have you worked here?
2. How did you first come to work here?
3. How would you describe your position?
4. What do your responsibilities include?
5. How would you describe your organization?
   a. What is the purpose of your organization?
   b. What role does your organization play in the local community?
   c. What services do you offer?
6. How would you compare your organization to other similar organizations in Connecticut?
7. What do you consider to be the skills most critical to your job?
   a. What is your professional background?
   b. What types of training did you undergo to prepare you for your position here?
8. What is the most rewarding part of this job for you and what is the hardest part?
9. Can you please walk me through a typical workday?
10. Could you please describe the typical circumstance of women who visit your facility?
    a. What do you think draws women to your facility?
    b. What are the demographics of the women that visit your facility? – age, race, ethnicity?
    c. Do the women who visit your facility typically have any sort of religious affiliation?
11. Could you please walk me through a typical interaction with a client?
    a. How many people are present? How many people from your organization are in the room?
    b. Do they normally bring someone with them?
    c. What steps do you take them through once they arrive?
    d. How do you help them feel comfortable?
12. Could you share the story of any client that you found particularly moving or exemplary of the kind of work that you do?
13. What types of information do you find most important to share with your clients?
14. What types of questions do your clients typically ask you?
    a. How do you respond?
15. Could you please describe any other organizations you are involved in and how you see them in relation to your job here?
16. Is there anything else that you could share with me about your organization or experience that you think is important and that we haven’t covered today?

Thank you!
Bibliography

Abortion: A Parenting Option? (Removed for Anonymity).


*Fetal Development Timeline*. (Removed for Anonymity).


*I’ll Still be able to have a Baby Later… Right?* (Removed for Anonymity).


*Informed Decision Checklist*. (Removed for Anonymity).

*Is Abortion Safe?* (Removed for Anonymity).


