THESIS

MANAGING OCCUPATIONAL STIGMA IN ABORTION CARE WORK

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ABSTRACT

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This study explores how United States health professionals who work in abortion care experience occupational stigma and enact stigma management communication (SMC; Meisenbach, 2010) in the wake of the repeal of *Roe v. Wade*. Through interviews with 24 current and former abortion workers, the results indicate that health providers experience stigma through *stigmatizing messages, stress compounded by stigma,* and *socioemotional impacts*. Workers manage stigma using a blend of SMC strategies including *accepting, avoiding, transcending,* and *challenging.* Further, the study uses intersectional analysis to identify seven factors that influence how workers manage stigma as it intersects with their social identities and context: state laws, service delivery, organizational culture, community attitudes, regional identity, privileged/ marginalized identities, and reproductive experiences. The study concludes with discussion of theoretical contributions to the SMC model and practical recommendations for healthcare organizations providing abortion.

Keywords: stigma management communication, abortion stigma, dirty work, intersectionality

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This research is my love letter to the frontline staff of independent abortion clinics and Planned Parenthood health centers across the nation. For every provider who has ever felt unseen, unheard, or unrecognized as the true heart of reproductive health that you are, I dedicate this labor to helping you secure your own rights and access to safety, rest, and support wherever and however possible. I am in your debt. Thank you for the care you are providing in your communities, thank you for speaking truth to power, and thank you for letting me hold space for your stories.

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CHAPTER 1 – INTRODUCTION

From January 21, 1973 through June 24, 2022, abortion in the United States (U.S.) was a constitutional right protected as a private health decision left to a pregnant person and their doctor. Preceding *Dobbs v. Jackson Women's Health Organization*, the U.S. Supreme Court held that a state could not enact a law for "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus" (O'Connor et al., 1991, p. 877). The *Dobbs* decision overturned that legal precedent and gave state governments license to impose partial or total abortion bans as they see fit. As of December 2023, 14 states were enforcing total bans on abortion and seven more had legislated restrictions that would have been unconstitutional under *Roe v. Wade* (Forouzan & Guarnieri, 2023). The Society of Family Planning reported that in the six months after *Roe* was overturned, more than 66,000 Americans could not get an abortion in their state of residence (Koerth & Thomson-DeVeaux, 2023). The rapidly declining availability of abortion care in the U.S. defies the statistical need: Nearly one in four (23.7%) women in the U.S. has at least one abortion by age 45 (Jones & Jerman, 2017). Without access to safe abortion, pregnant people may resort to unsafe procedures associated with higher risks of hemorrhage, infection, organ damage, and death (World Health Organization, 2021). Under the provision of a trained clinician, abortion procedures (including medication, first-trimester aspiration, and later procedures) have an extremely low rate of complications (Upadhyay et al., 2015). As a recent news headline put it, abortion medication is "safer than Tylenol" (Koons, 2022). Yet the changes to abortion laws over the last two years created an environment where many U.S. medical professionals trained in these safe, effective abortion procedures cannot expertly care for their patients—for no reason except stigma.

I argue that in order to restore and expand access to abortion care in the U.S., there needs to be a focus on how stigma harms not only people seeking abortion, but also the healthcare workers who provide this care. In this study, I use "abortion workers" to broadly refer to this group, which includes anyone who has regular, direct interactions with patients in the provision of abortion care. Even before the *Dobbs* decision, abortion workers have long experienced an intense stigma that manifests in cultural discourse, law, politics, communities, institutions, patient care, and interpersonal non-work relationships (Harris et al., 2011). Smith (2007a) theorizes that these stigmatizing messages force a social separation between a stigmatized group of people (i.e., abortion workers) and everyone else. The degree to which a person accepts the public's valuations of a stigma and applies the stigma to themself informs what communication scholars conceptualize as stigma management communication (SMC; Meisenbach, 2010). This research study contributes to scholarly understandings of SMC by exploring the theory's utility in interpreting the experiences of U.S. abortion workers who experience a unique and highly politicized occupational stigma linked to stress, burnout, harassment, physical threats, violence, and even death (Medoff, 2014).

This project has three primary goals. First, my research explores what communication strategies abortion workers use to manage occupational stigma. This study seeks to contribute to some of the gaps in knowledge around SMC strategies and outcomes (e.g., stigma reduction; Romo & Obiol, 2023) to inform recommendations for the individual, organizational, and systems-level interventions that should be enacted to address structural health stigma (Elkhalid et al., 2023). Second, the study uses a critical, intersectional lens (Else-Quest et al., 2022) to ask how experiences of occupational abortion stigma are shaped by contextual power dynamics and forces of oppression as they intersect with social identities. Critical scholarship treats both

"identity work in general, and occupation talk in particular, as social constructions that serve some interests more than others," and advocates for analysis that uncovers marginalized or silenced voices (Braithwaite et al., 2021, p. 10). This study seeks to contribute to intersectional theorizing of SMC by exploring how overlapping axes of worker identities—such as race/ethnicity, gender, sexuality, (dis)ability, and religious identity—impact stigma management at the intersection of "dirty work" (Ashforth & Kreiner, 1999) and stigmatized identity. Third, the project seeks to partner with abortion workers to inform micro-, meso-, and macro-level interventions. Within the critical paradigm, research is only as good as its "capacity to accomplish social change, thereby emancipating disempowered groups from oppressive social structures or ideologies" (Braithwaite et al., 2021, p. 11). As such, this study will illuminate recommendations for structural changes that decrease stigma and support well-being among abortion workers who are the front lines of advancing reproductive health, rights, and justice aims across the U.S.

CHAPTER 2 – LITERATURE REVIEW

Abortion stigma is the idea that "abortion is morally wrong and socially unacceptable" (Cockrill & Biggs, 2018), and it defies all leading medical understandings of abortion as a safe, common intervention. The World Health Organization (2021) holds that "lack of access to safe, affordable, timely and respectful abortion care, and the stigma associated with abortion, pose risks to women's [and birthing people's] physical and mental well-being throughout the life-course." As a social phenomenon, abortion stigma is constructed differently in local contexts rather than a universally accepted truth (Kumar et al., 2009). The moral dimensions of abortion stigma are often awash in controversies around the beginning of life, fetal "personhood," fetal viability, fetal pain, and normative sexuality, as informed by local cultural and religious norms (Kumar et al., 2009). These moral dimensions impact wide-scale debates and policies related to the legal status of abortion, how it is regulated, how it is paid for, and who ultimately gets to make the decision about a pregnancy (e.g., the pregnant person, the reproductive partner, the health professional, or a government representative) (Kumar et al., 2009).

Researchers have noted that abortion stigma affects people who have abortions, supporters of people who have abortions, and people who work in abortion care in deeply contextual ways (Norris et al., 2011). Kumar, Hessini, and Mitchell's (2009) model conceptualizes abortion stigma as manifesting at five levels: framing discourse and mass culture, government/structural factors, organizational/institutional factors, community factors, and individual factors. Examples of framing discourse highlight meaningful differences in language used to describe abortion around the world, such as "induced abortion," "termination of pregnancy," or "lost pregnancy" (Kumar et al., 2009). Government and structural factors include the status of abortion as connected to economics, education, the law, health systems, and welfare (Kumar et al., 2009). Organizational factors include how organizations may perpetuate or

challenge stigma through their policies and norms, such as the way abortion services are often physically and socially separated from other medical care and the lack of abortion training in medical education (Kumar et al., 2009). Community and social network factors include social support, negative attitudes or feelings, and expectations of silence and secrecy (Kumar et al., 2009; Cutler et al., 2022). Last, individual factors include cognition and sense-making of abortion experiences, negative emotions from internalized stigma (e.g., shame and guilt), assessment of others' attitudes and behaviors around abortion, and experiences of prejudicial behaviors such as abuse, discrimination, hate speech, avoidance, or negative emotional displays (e.g., discomfort, disgust) (Kumar et al., 2009; Cockrill and Nack, 2013).

In the sections that follow, I trace the origins of stigma research to establish how scholars conceptualize stigma more generally as a communication process (Smith, 2007a), as well as how occupational stigma has been theorized through the organizational lens of "dirty work" (Ashforth & Kreiner, 1999). I then review how a framework of intersectionality (Crenshaw, 1991; Collins & Bilge, 2016; Else-Quest et al., 2022; Weiser et al., 2023) can deepen understandings of stigma as a highly contextual phenomenon. Last, use Meisenbach's (2010) theory of stigma management communication to consider applied research on abortion stigma management and to establish the need for more understanding of how health professionals who provide abortion care manage stigma in the course of their daily work, personal lives, and relationships.

The Model of Stigma Communication

Stigmatization is the process of dehumanizing a group of people based on an attribute or identity that a society finds disgraceful. Goffman (1963) first defined *stigma* as "an attribute that is deeply discrediting" and theorized three types: physical, moral, and tribal/cultural (p. 2). Physical stigma broadly referred to physical deformity. Moral stigma encompassed "blemishes

of individual character" including mental disorder, "treacherous" beliefs, dishonesty, imprisonment, addiction, homosexuality, unemployment, and "radical" political behavior (p. 2). Tribal stigma is that of a stigmatized race, nation, or religion. Adapting Goffman, Smith (2007a) redefined *stigma* in the field of communication as "a simplified, standardized image of the disgrace of certain people that is held in common for a community at large" (p. 464). The model of stigma communication (MSC; Smith, 2007a) reimagined *stigma* as a distinct communication phenomenon that happens through content messages called *stigma communication*: "the messages spread through communities to teach their members to recognize the disgraced (i.e., recognize stigmata) and to react accordingly" (p. 464).

The MSC maps the sociofunctional process of dehumanizing specific members of a community through four message choices: *mark, group labeling, peril,* and *responsibility. Mark* is a content cue to distinguish a group of people. *Group labeling* categorizes the marked group as a separate social entity (i.e., a stigmatized *them* becomes different from the non-stigmatized *us*). *Peril* links the labeled group to physical and/or moral danger, such as the bodily threat of disease or spiritual consequences of deviant behavior. Last, *responsibility* implies that the stigmatized group members carry the blame for their own membership in the group and the associated dangers. Together, Smith (2007a) theorizes *stigma messages* activate stereotypes that cue anger, disgust, and fear among the non-stigmatized, resulting in the development of stigmatized attitudes, isolation and removal of stigmatized targets, and a motivation to share stigma messages with social networks.

The MSC has proven a valuable heuristic model in health communication, generating quantitative, qualitative, and mixed-methods research. Much of this work has examined the role of media messages in the production of stigmatized health conditions. While the MSC has not

been used to theorize abortion stigma specifically, the extant literature presents findings that have implications for any stigmatized health condition or procedure, particularly those that are strongly associated with moral danger and personal responsibility. In an early exploratory study, Smith (2007b) coded media messages for seven stigmatizing features: marks, social exclusion, responsibility, avoidance, peril, health labels, and shame/disgust. Importantly, this study noted differences in two frames: "challenge" and "stigma" (Smith, 2007b). The challenge frame promoted optimism, hope, and social inclusion (Smith, 2007c) and was associated with cancers, heart disease, and scoliosis. Individuals who have these conditions are far less likely to be seen as personally liable for their suffering, and media messages are more likely to encourage support and inclusion for people managing these health conditions (Smith, 2007c). In contrast, a stigma frame was used for illnesses like staph infection, the flu, tuberculosis, hepatitis, smoking, and sexually transmitted infections (Smith, 2007b). These conditions are more linked to individual behaviors, and people who contract these illnesses (or suffer health complications of a stigmatized behavior, like smoking or promiscuous sex) are much more likely to be held responsible for their own suffering. This research suggests that health conditions linked to personal responsibility, like STI's and unintended pregnancy, are more likely to be presented through a stigmatizing media frame that encourages blame, disgust, and social isolation.

Smith's work with the MSC has largely focused on infectious disease, challenging evolutionary theorizing about "good" or "useful" stigmas that may function to protect societies from the threat of contagious illness (Smith & Hughes, 2014). In the first empirical test of the MSC, Smith used a hypothetical infectious disease alert to demonstrate how changing message features becomes predictive of support for intervention policies (e.g., quarantine, forced treatment, or surveillance of infected persons), attitudes toward infected persons, and likelihood

of sharing the message (Smith, 2012). The study affirmed the utility of the MSC in evaluating content messages and, importantly, concluded that contagion stigma functions as a barrier to healthcare access for both short and long-term treatment of infectious disease (Smith, 2012). The experiment was replicated in an interpersonal context with deeper attention to the role of sympathy, frustration responses, and disgust sensitivity as predictive personality traits in the development of a stigma attitude (Smith, 2014). Recently, researchers applied the MSC to the novel coronavirus discovered in December 2019 (COVID-19) and theorized the stigma as it was emerging in the early months of the outbreak (Li et al., 2020; Smith et al., 2022). These studies found that exposure to messages about COVID-19, including misinformation and conspiracy theories (Li et al., 2020), led to the development of a stigma and that exposure to prolonged stress and rumination shaped perceptions of that stigma (Smith et al., 2022). Overall, these findings suggest that stigmas do not increase a community's ability to survive disease and may have the opposite effect by catalyzing public health failures, as seen in the global response to the ongoing COVID-19 pandemic (Smith & Hughes, 2014; Li et al., 2020; Smith et al., 2022). Additionally, researchers have found that holding more stigmatizing beliefs predicts a lower likelihood of seeing oneself as at risk of contracting an illness, which may cause a person to take fewer precautions and increase their risk (Smith & Morrison, 2006; Smith et al., 2007).

Overall, these studies illuminate how health stigmas can contribute to problematic disease dynamics that threaten rather than protect public health (Smith & Hughes, 2014). In the context of reproductive healthcare, perceptions of *peril* and *responsibility* are particularly salient. In cultures where sexual freedom is seen as deviant, societies have developed particularly stigmatizing attitudes around things like STIs, HIV, unintended pregnancy, homosexuality, and abortion as signs of low moral character and personal irresponsibility (Herek, 2009).

Misinformation has played a key role in contributing to false beliefs about abortion, in particular; for example, anti-abortion groups have generated myths falsely linking abortion to infertility, poor mental health, and breast cancer (ACOG; Pagoto et al., 2023). Misinformation has also contributed to myths about so-called "abortion reversal" and deliberate confusion about the differences between medication abortion, emergency contraception, and birth control (ACOG). Particularly since the *Dobbs* decision, some public health researchers have taken to calling abortion misinformation the next *infodemic,* understood as the "proliferation of false or misleading information that leads to confusion, mistrust in health authorities, and the rejection of public health recommendations" (Pagoto et al., 2023). The intersection of health stigma and misinformation has created particularly dangerous conditions for pregnant people navigating the U.S. abortion landscape.

"Dirty" Work

Dirty work (Hughes, 1951) has historically referred to occupations that are "perceived as disgusting, degrading, shameful, or morally objectionable" (Torelli & Puddephatt, 2020, p. 311). Ashforth and Kreiner (1999) introduced a typology to understand dirty work based on *social, moral,* and *physical* taint, related to the *a priori* "dirtiness" of tasks. *Social taint* applies to low prestige jobs, such as service work, and occupations that work with stigmatized people, such as prison guards (Tracy, 2005), homeless shelter workers (Torelli & Puddephatt, 2020), and U.S. border patrol agents (Rivera, 2018). *Moral taint* applies to work that is seen as lacking virtue, such as legal sex work (Wolfe et al., 2018). *Physical taint* presumes some sort of physical dirt or detritus, such as cleaning up bodily fluids or trash or working in dangerous conditions (Ashforth & Kreiner, 1999). Scholars have well established that abortion care fits the definition of dirty

work "associated with all three taints: physical (blood, fetal parts); social (contact with stigmatized patients); and moral (ambiguous fetal moral status)" (Harris et al., 2011, p. 1062).

In the last decade, scholars have introduced two additional typologies to understand taints that are not based upon the presumption of a "dirty" occupation: *emotional taint* (Rivera, 2018) and *hidden taint* (Redden & Scarduzio, 2018). Rivera (2018) theorizes that *emotional taint* is socially constructed based on workers' emotional labor. The taint comes from emotional displays that are perceived as objectionable because they are inappropriate for the situation, excessive (too much or too little), or vulnerable to feelings that most people would rather avoid, like grief or regret (Rivera, 2018). Rivera (2018) provides examples of emotional taint in healthcare, such as doctors who are seen as too stoic or uncaring, or hospice workers who work in vulnerable situations causing grief and sadness. *Emotional taint* becomes a lens by which dirty work researchers can explicate the stigmatized dimensions of emotional labor in a range of occupations. *Hidden taint* further extends dirty work by theorizing that stigma is constructed by both outside perspectives and employees themselves. Redden and Scarduzio's (2018) found that "invisible" taint can exist within high prestige occupations that are valued by outsiders but involve activities that feel degrading to employees. For example, these authors synthesized reflections from bureaucratic workers (e.g., municipal court judges and TSA agents) who felt *taint* around being seen as having more authority than they do. To this author's knowledge, abortion stigma has not yet been theorized through a lens of *emotional taint* or *hidden taint*, though certainly both may apply given the highly visible emotional labor and often invisible bureaucratic dimensions of healthcare.

The current literature suggests that experiences with the "dirtiness" of abortion care are shaped by a worker's role, specific tasks, patient interactions, and level of recognition or

"prestige" (Ashforth and Kreiner, 1999). For example, Ward's (2021) ethnographic analysis of a southern California abortion clinic highlights the unique experiences of medical assistants and nurses whose jobs involve the most *physical taint* (e.g., bodily fluids, biological waste, cleaning exam rooms) and *emotional labor* of peri-abortion interactions (e.g., counseling patients on decision-making, providing informational support, and managing recovery). Nurses and medical assistants perform much of the necessary clinical labor and patient care: taking patient histories, explaining procedures, collecting and testing urine samples, performing ultrasounds, counseling patients, administering medications, charting, preparing exam rooms, cleaning and sterilizing medical instruments, handling pregnancy tissue, and caring for patients in recovery. However, these workers may go unrecognized as abortion *providers,* which in a pro-abortion context is frequently a "badge of honor" reserved for physicians and advanced practice clinicians (Ward, 2021).

Physicians who perform clinical abortion procedures are of course directly associated with the *physical taint* of abortion work as the person who is removing the pregnancy from the uterus and examining products of conception to ensure the abortion is complete (Ward, 2021). Doctors and clinicians are also seen as the most highly impacted by the *moral taint* of abortion work as the licensed medical professional ultimately responsible for the patient's care (Ward, 2021). These different roles create tension between levels of responsibility (or blame) and levels of prestige. On one hand, doctors may be contextually valorized as abortion providers whereas the other clinical workers on their team are not, giving them greater access to *prestige* that can contribute to a positive sense of self (Ward, 2021; Ashforth & Kreiner, 1999). On the other hand, non-physicians may be seen as less culpable and therefore have more access to privacy and safety (Ward, 2021). Though all workers in an abortion setting can be harmed by clinic violence,

overseeing physicians are more likely to be singled out and targeted by anti-abortion activists (Todd, 2003). The impacts of stigma on physicians are clear deterrents to trained, licensed doctors offering abortion care: Nearly half of all U.S. OB/GYNs trained in abortion decide not to provide abortion care because of the very real social consequences (Steinauer et al., 2008). Additionally, targeted restrictions on abortion providers (TRAP laws) make it harder for doctors who want to provide abortion care to legally do so without risking jail time or the loss of their medical credentials (Hartwig et al., 2023).

It is well established that regardless of their role, U.S. abortion workers feel the effects of *social taint* through hurtful stereotypes, feelings of judgment from others, social isolation, experiences with discrimination, and marginalization within the medical community (Martin et. al, 2018). Through interviews with fourteen workers (physicians, nurses, and one social worker) in the Mountain West, O'Donnell and colleagues (2011) found that healthcare professionals doing abortion work encountered stigma with four groups of interactants: patients, professional peers, close friends/family, and strangers/acquaintances. Providers can find interactions with patients particularly demoralizing and feel pressure to "be better [than they are] because abortion care is still seen as tawdry, as a little less than" (O'Donnell et al., 2011, p. 1360). Providers reported that while they experienced support from their professional and personal networks, they sometimes experienced limits on that support because of an underlying discomfort with abortion (O'Donnell et al., 2011). In other terms, providers may have family and friends who identify as pro-choice but still find abortion "distasteful" or who "[don't] really like to hear about the details" (O'Donnell et al., 2011, p. 1361). This study seeks to build on existing understanding of abortion provider stigma in the first research question:

RQ1: How do abortion workers experience stigma?

The "Intersectionality Imperative"

Intersectionality is a framework for describing the ways social identities overlap. A term first coined by Kimberlé Crenshaw in 1989, intersectionality initially mapped overlaps of racism and sexism, challenging the dominant assumptions that race and gender are essentially separate categories (Crenshaw, 1991). Building on the work of Black feminist socialist collectives that formed during the late 1960s and early 1970s, such as the Combahee River Collective (Taylor, 2017), intersectionality has since emerged as both a major research paradigm in social sciences (McCall, 2005) and a practical organizing framework for recognizing the ways in which various forms of inequality often operate together and exacerbate each other (Steinmetz, 2020; Weiser et al., 2023) . Like feminist and antiracist methodologies, an intersectional approach places high value on subjective knowledge by starting from the experiences of marginalized groups, but diverges in (1) developing a collective, integrative analysis of oppressions and (2) engaging activism and the development of multicentered politics for social change (Bell, et. al., 1999).

Scholars invested in studying intersectional feminism have relied on analyses of race, gender, class, and sexuality as primary points of inquiry (McCall, 2005; Weiser et al., 2023). Understanding that symbolic and material inequalities are rooted in relationships defined by social categories (e.g., race, gender, nation), intersectionality is primarily interested in understanding the multifaceted dimensions of social inequality through attention to power, relationality, social context, complexity, and social justice (Collins & Bilge, 2016). Complexity is particularly important here: intersectionality is difficult for many scholars (Weiser et al., 2023), which makes it tempting to reduce analyses to single factor studies or studying overlapping identities out of context. While one social category may have salience in a particular time and place, overlapping identities structure all relationships as interlocking systems rather

than dichotomous hierarchies (Collins, 1990). Collins (1990) argues that social processes of categorization overlap to construct "matrices of oppression" which one cannot wholly understand through a feminist or anti-racist analysis alone, or through additive analysis. Weiser and colleagues (2023) emphasize that intersectional analysis should be performed critically and in context, recognizing the many facets of theorizing power and oppression.

The use of intersectionality as the theoretical framework for stigma research can provide new insights into the impacts of stigma in dirty work (Else-Quest et al., 2022; Dougherty et al., 2017). Else-Quest and colleagues (2022) argue, "Exploring participants' consciousness of their own lived experience as relating to intersecting systems of oppressions is an opportunity for intersectionality in stigma and health research" (p. 7). Intersectionality can contribute to stigma and health research by considering how workers' experiences of stigma are shaped by their social identities and their context, including community attitudes and the prevalence of violent threats against abortion providers (Medoff, 2014). Some abortion workers may feel bolstered by working in a liberal political environment or by a supportive professional community (O'Donnell et al., 2011). However, areas with liberal abortion legislation can still experience high levels of community stigma (Cutler et al., 2022), and abortion workers can find themselves the targets of high levels of harassment and violence (Todd, 2003; Medoff, 2014). For example, a survey of providers in the Republic of Ireland (which voted to expand its abortion care legislation in 2018) found that abortion workers were still highly stigmatized, particularly in hospitals, even with widespread support for expanding abortion services (Dempsey et al., 2021).

The context of one's organization also seems to have an important role in the experience of occupational stigma. For example, Martin and colleagues (2018) found that abortion workers who are part of a team may experience less isolation than individuals who work alone, and a

recent survey of nurses, medical assistants, and counseling staff suggests hospital-based abortion workers may experience a lower risk of burnout than clinic-based workers (Janiak et al., 2018). The attention to teamwork and clinic flow raises central questions about how organizational structures, practices, and discourses shape abortion workers' experiences of stigma and ability to cope with stressors. By exploring the intersections between occupational abortion stigma and other systems of oppression, scholars can deepen their understanding of dirty work in context, which may help healthcare organizations better meet the needs of a diverse workforce. With the "intersectionality imperative" in mind (Else-Quest et al., 2022), the next research question asks:

> *RQ2: How do community, organizational, and identity level factors shape abortion workers' experiences of stigma?*

Invisible Stigma, Disclosure, and Social Support

Goffman (1963) theorized that there are physical stigmas that are immediately known to the eye, differences that are invisible but perceptible through another sense, and then stigmas that are "so easily concealed that they figure very little in the individual's relation to strangers and mere acquaintances, having their effect chiefly upon intimates" (p. 31). People with invisible stigmatized differences may face a choice between concealing their difference or disclosing it (though involuntary disclosures are possible). People with invisible stigmas may enact "passing" behaviors in which they actively present as non-stigmatized or simply let others perceive them that way (Goffman, 1963). Of course, the ability of a person to "pass" is contingent on "how well or how badly the stigma is adapted to provide means of communicating that the individual possesses it" (Goffman, 1963, p. 28). For example, a "baby bump" is a tell-tale *mark* (Smith, 2007a) that a person is pregnant, signifying sexual intercourse, which becomes more difficult to conceal as a pregnancy progresses. A person who is not yet "showing" may have no trouble

hiding the pregnancy, or they may have to work harder to mask other symptoms, like nausea. Of course, whether a person is stigmatized for being (visibly) pregnant is largely dependent on context and their social identities (Roberts, 1997). A financially successful married couple with a wanted pregnancy may delight in and show off the pregnancy bump, whereas a person who is young, single, or poor may face judgments related to the stigmas of teen pregnancy, unwed motherhood, and using public welfare.

Ironically, disclosure of a concealable stigmatized identity is a process by which a person may become stigmatized (by revealing an otherwise invisible attribute), a strategy for managing their stigma (e.g., by bonding with other members of the stigmatized group or posing a challenge to a publicly held stigma), or perhaps both. Depending on the response of the interactant, disclosure has the potential to increase *social distance* related to the forced separation of stigmatized and non-stigmatized groups (Smith, 2007a). Given the potential for a confidant to be brought into a stigmatized group via *courtesy stigma*, or stigma by association (Goffman, 1963), non-stigmatized interactants may respond to a disclosure with a negative emotional response like anger or disgust (Smith, 2007a; Wang, 2019) or by encouraging secrecy (Smith & Hipper, 2010). However, disclosure can also have pro-social benefits and be a gateway to *social support* (Smith et al., 2008). For example, emotional disclosure has been shown to decrease distress among individuals who are experiencing intrusive thoughts about a secret stigma (Major and Gramzow, 1999). Scholars theorize that disclosure creates opportunity for *perspective taking*, by which confidants provide support and affirmation that helps to reduce the feelings of isolation, secrecy, and shame (Smith et al., 2014).

Interpersonal relationships and effective social support from friends, family, or stigmatized peers are important resources for managing stigma (Goffman, 1963; Meisenbach,

2010). Whereas *social distance* contributes to feelings of exclusion and isolation, *social support* broadly encompasses communication that "reduces uncertainty about the situation…and functions to enhance a perception of personal control in one's life experience" (Albrecht & Adelman, 1987, p. 19). Many types of social support exist, including emotional support, problem-focused support, informational support, and tangible support (Cutrona and Russell, 1990). Effective social support, particularly levels of perceived emotional support, have been positively correlated with health and well-being (MacGeorge et al., 2011). In the case of pregnancy, emotional support would address the person's feelings whereas problem-focused support (Cutrona & Russell, 1990) might for instance address needs for accurate health information, a referral to a quality health provider, and financial resources. Health professionals who work in abortion and other stigmatized care are often providing a significant amount of support to their patients, including emotional, information, and practical support to overcome barriers (Armour et al., 2023; Janiak et al., 2018). Where and how stigmatized health providers access their own social support is a different question that has not yet been sufficiently explored in the literature, though repeated studies affirm the important role of professional and personal networks for managing stigma (O'Donnell et al., 2011; Harris et al., 2011; Martin et al., 2014).

Abortion workers' ability to openly talk about their work impacts their ability to access the effective social support needed to reduce uncertainty, bolster a sense of agency, and reduce overall feelings of stigma. For this reason, disclosure has already been identified as a significant decision-point for abortion workers, particularly when interacting with strangers or acquaintances, and workers may develop "screening processes" to guide their disclosures (O'Donnell et al., 2011). Providers have named that "painful interpersonal disconnections" can arise both in choosing silence and choosing to disclose their abortion work (Harris et al., 2011, p.

1062). In some circumstances, disclosure is "an opportunity to counter the negativity associated with abortion work" (O'Donnell et al., 2011, p. 1361). O'Donnell and colleagues (2011) found that workers "managed their narratives of abortion work by reframing, recalibrating, and refocusing the conversation in order to resist stigmatization, especially in professional interactions and interactions with strangers" (p. 1362). Through resistance strategies, provider narratives may minimize the characteristics people associate with dirty work and instead highlight the "redeeming qualities of abortion work" (O'Donnell et al., 2011, p. 1362). Cognitive and narrative *reframing* are perhaps the most common ways that people who perform dirty or deviant work seek to *refocus* attention away from the stigmatized parts of their job and *recalibrate* the value of their role according to different moral standards (Ashforth & Kreiner, 1999; Rivera, 2018; Torelli & Puddephatt, 2020).

Growing evidence suggests that talking about stigma with colleagues in the workplace can be an effective stigma management tool among abortion workers (O'Donnell et al., 2011). The Providers Share Workshop (PSW), developed by researchers at the University of Michigan, serves as one example of a leading workplace intervention using communication to reduce provider stigma and professional burnout among abortion workers (Harris et al., 2011; Martin et al., 2012; Martin et al., 2014; Debbink et al., 2016; Hassinger et al., 2016; Mosley et al., 2020). The pilot study, conducted in 2007 with 17 workers at a Midwestern abortion clinic, used group discussion, journaling and collage-making methods to reflect on such topics as the meaning of abortion, memorable patient stories, personal identity, abortion politics, and self-care (Harris et al., 2011). Findings suggest that having a safe, facilitated space to discuss stigma within the context of a workshop can reduce feelings of stigma over time (Harris et al., 2011). The PSW has since been implemented with more than 1,000 workers across North America, South America,

East Africa, and Asia, with studies consistently reporting statistically significant decreases in abortion stigma in all regions (Providers Share Workgroup). These studies highlight that stigma management strategies may look different for workers depending on both their individual strategies for managing stress and burnout, their access to personal networks of social support, and the organizational support resources available to them.

Stigma Management Communication

Meisenbach's (2010) theory of stigma management communication (SMC) expands on both Smith's (2007a) model of stigma communication and Ashforth and Kreiner's (1999) dirty work typology to account for how stigma is managed by individuals, both stigmatized and non-stigmatized. SMC (Meisenbach, 2010) proposed to bring work on health and disability stigmas, workplace stigmas, and interpersonal research into one cohesive communication framework. The theory's primary contribution is a typology of strategies divided into quadrants along two axes: (1) the person's attitude about challenging or maintaining the public perception of a stigma and (2) the person's attitude toward how the stigma does or does not apply to them individually (Meisenbach, 2010). The theory posits that different discursive options for managing stigma, or SMC strategies, are available to a person depending on their orientation to the stigma. SMC strategies fall into the following quadrants, which reflect Brule and Eckstein's (2016) modified SMC framework: (1) a person accepts a public perception of a stigma and applies the stigma to the self, henceforth *Accept-Apply*; (2) a person accepts a public perception of a stigma but does not apply it to the self, henceforth *Accept-Reject*; (3) a person challenges a public stigma but still applies the stigma to the self, henceforth *Challenge-Apply*; and (4) a person both rejects the public perceptions of a stigma and does not apply the stigma to the self, henceforth *Challenge-Reject* (see Table 1).

Table 1

Stigma management communication strategies, adapted from Meisenbach (2010)

	Accepts that stigma applies to the self	Challenges that stigma applies to the self
Accepts public understanding of abortion stigma	**Accept-Apply** *Accepting* • Passive (silent) acceptance • Display/disclose stigma • Apologize • Use humor to ease comfort • Blame stigma for negative outcomes • Isolate self • Bond with stigmatized	**Accept-Reject** *Avoiding* • Hide/deny stigma attribute • Avoid stigma situations • Stop stigma behavior • Distance self from stigma • Make favorable social comparisons *Cooperation* (King et al., 2018)

Challenges public understanding of abortion stigma	**Challenge-Apply**
	Evading responsibility/ challenging efficacy
	• Provocation
	• Defeasibility
	• Unintentional
	
	Reducing offensiveness of
	• Bolster/refocus
	• Minimize
	• Transcend/reframe
	
	Opportunism (King et al., 2018)
		Challenge-Reject
		Denying
		• Simply
		• Logically
		  ○ Discredit discreditors
		  ○ Provide evidence/info
		  ○ Highlight logical fallacies
		
		Ignoring/displaying
		
		Advocacy (Romo & Obiol, 2023)
		
		Representing (Brule & Eckstein, 2016)
		
		Transgressive humor (Meisenbach et al., 2019)

Accepting is the overarching SMC strategy in the *Accept-Apply* quadrant (Meisenbach, 2010). In simple terms, a worker who both accepts negative public valuations of abortion as legitimate beliefs and applies that stigma to herself might think, "Abortion providers are bad people, and therefore *I* am a bad person." Of course, given the degree of autonomy in selecting an occupation, it is less likely that a person who opts in to providing abortion care would share such a simplistic view of abortion as bad (King et al., 2018); however, abortion providers may at

times feel conflicted about parts of their work and wrestle with varying degrees of internalized stigma, finding themselves episodically in an *accept-apply* mindset (Armour et al., 2023). Workers who challenge the status quo may still enact sub-strategies of *accepting*, which include passive or silent acceptance, disclosing the stigmatized attribute, apologizing, using humor to make others more comfortable, blaming the stigma for negative outcomes, isolating oneself, and bonding with other members of the stigmatized group. Research on occupational stigma suggests that disclosure, using humor, and bonding with coworkers might be particularly salient for stigmatized abortion workers (Meisenbach et al., 2019; Brandhorst & Meisenbach, 2023; O'Donnell et al., 2011; Harris et al., 2011).

Avoiding is the overarching SMC strategy in the *Accept-Reject* quadrant (Meisenbach, 2010). Someone who accepts negative attitudes toward abortion but does not apply that stigma to herself might think, "Yes, abortion is wrong—but *my* situation is different." For example, abortion providers have identified that patients can be a source of stigma when they have anti-abortion beliefs, but are also presenting for abortion care (Harris et al., 2011). Sub-strategies include hiding or denying the stigmatized attribute, avoiding potentially stigmatizing situations, stopping the stigmatized behavior, distancing oneself from the stigma, and making favorable comparisons between oneself and stigmatized others (Meisenbach, 2010). In studying the anticipatory socialization of sex educators, King and colleagues (2018) introduced *cooperation* as another strategy by which workers learn their school policies (from stigmatizers) and follow them as closely as possible to avoid stigmatization. These strategies are likely just as relevant to workers in abortion care who might hold stigmatizing views about abortion but rationalize their participation through minimization or denial. For example, a physician who offers medication abortion might think, "Well, I only dispense pills. I would never provide care after the first

trimester." A receptionist might think, "I only answer the phones. I'm not actually an abortion worker." A person who is ambivalent about abortion might shrug the stigma off as, "This has nothing to do with me, I just work here."

Strategies in the *Challenge-Apply* quadrant include *evading responsibility for* and *reducing offensiveness of* strategies (Meisenbach, 2010). Someone who challenges public abortion stigma but accepts that the stigma applies to them individually might emphasize how much the non-stigmatized public misunderstands about abortion care. *Evading responsibility* for a stigma defers agency or control away from the stigmatized person by claiming provocation, defeasibility, and/or unintentionality (Meisenbach, 2010). In applying the SMC framework to a family context of abuse, Brule & Eckstein (2016) recommended renaming *evading responsibility* as *challenging efficacy* to avoid implying that survivors are inherently responsible for their abuse and stigmatization. In the context of U.S. abortion care, *challenging efficacy* may be a salient strategy by which workers manage the structural abortion stigma (Elkhalid et al., 2023) that is enacted in restrictive government policies and political rhetoric. For example, a worker may *evade responsibility/challenge efficacy* when explaining to patients why their appointment will take several hours or why they must follow certain stigmatizing restrictions (e.g., mandatory biased counseling, mandatory 3-day waiting periods). *Reducing offensiveness of* is another overarching strategy that includes bolstering/refocusing, minimizing, and transcending or reframing. Meisenbach (2010) presents these sub-strategies as image repair, ways by which individuals seek to change how others see the stigma by shifting the focus to non-stigmatized parts of one's identity, highlighting how the stigma does not harm others, and/or highlighting how the stigmatized attribute can be valuable. For example, abortion providers have used

transcending/reframing to emphasize how providing abortion is noble, needed, and contributing to a larger project of gender equality (Harris et al., 2011; Martin et al., 2017).

Last, strategies in the *Challenge-Reject* quadrant include *denying* and *ignoring/displaying* (Meisenbach, 2010). Sub-strategies for *denying* are largely argumentative, include discrediting the discreditors, providing evidence and information, and highlighting logical fallacies. *Ignoring/displaying* might look like passive or silent acceptance but "stems from a desire to challenge rather than passively accept public stigma perceptions" (Meisenbach, 2010, p. 284). Scholars have since contributed additional strategies to this quadrant including *representing,* using one's experiences to dispute a stigma (Brule & Eckstein, 2016), and *transgressive humor,* using humor to make oneself more comfortable as opposed to using humor to make another person more comfortable (Meisenbach et al., 2019). Someone who both challenges public stigma and rejects individual abortion stigma is perhaps likely to enact these sub-strategies as they intersect with larger realms of public education and advocacy (Smith & Applegate, 2018; Romo & Obiol, 2023).

Multiple Strategies

Empirical tests of the SMC have challenged Meisenbach's (2010) original predictive framework by finding that stigmatized groups enact multiple strategies across quadrants (Noltensmeyer & Meisenbach, 2016; Brule & Eckstein, 2016; Meisenbach et al., 2019; O'Shay-Wallace, 2020; Romo & Obiol, 2023). In the first empirical test of SMC, researchers identified patterns of stigma management strategies used among burn survivors and their relational partners (Noltensmeyer & Meisenbach, 2016). Their study contributed three key findings to the SMC model: (1) Individuals shift and alternate among strategy categories (2) strategic choices about SMC use are based on relational and contextual situations (3) the patterns of strategy use across

SMC quadrants challenge the predictive framework originally proposed by Meisenbach (2010). The researchers also surmised that multiple or compounding stigmas may affect stigma strategy use, calling for a deeper intersectional analysis of SMC strategy use (Noltensmeyer & Meisenbach, 2016).

Tikkanen and colleagues' (2019) work on *buffering* strategies, understood as efforts to put something in place to soften the impact of a stigma, have also extended and complicated the SMC. These strategies include proactively sharing information (to forestall careless remarks, defend against negative assumptions, educate the public, or normalize a stigmatized condition); having preparatory conversations with a stigmatized person (e.g., a parent preparing a child with special needs to be their own self-advocate), and blocking social support in order to protect against exposure to the stigma (another form of *isolation*). Buffering strategies may be particularly salient among individuals who see themselves not *as* stigmatized, but as working with stigmatized people. For example, a person might reject that they have a stigmatized identity (e.g., abortion worker) but apply the *courtesy stigma* (Goffman, 1963), or *social taint* (Ashforth & Kreiner, 1999), of working with people who have abortions (a separate stigmatized group). *Buffering* might therefore be one way that they keep a cognitive or discursive distance between themselves and the stigma (Tikkanen et al., 2019).

Overall, the empirical SMC literature suggests that additional research is needed to support the predictive utility of the SMC model (Meisenbach, 2010) and that a revised framework may be necessary to reflect the way individuals blend strategies (Romo & Obiol, 2023), use SMC strategies strategically depending on the relational context (Brule and Eckstein, 2016), and manage stigma as it intersects with social identities like race, gender, age, social class, and educational status (Dougherty et al., 2017). Scholars have also called attention to the

gap in findings between SMC strategies and outcomes, noting where SMC strategies can fail and/or be harmful (O'Shay-Wallace, 2020; Roscoe, 2021; Romo & Obiol, 2023). That said, Smith and Applegate (2018) propose that convergence of the MSC (Smith, 2007a) and SMC (Meisenbach, 2010) have the potential to change public stigmas by paying critical attention to how prejudice is communicated through language, making meaningful content choices in messaging, and developing insight into the range of communication behaviors people use to manage stigmatizing interactions. Their essay raises questions about what is needed to effectively manage and reduce not only micro-level stigma in interpersonal interactions, but also macro-level structural and institutional stigma (Elkhalid et al., 2023; Kumar et al., 2009). Based upon this literature, the last research question asks:

RQ3: What strategies do abortion workers use to manage occupational stigma?

CHAPTER 3 – METHODS

Researcher Positionality

Tracy (2020) emphasizes the importance of researcher self-reflexivity in undertaking qualitative data collection and analysis. In conducting this research, I reflected extensively on my own relationship to occupational abortion stigma. From 2015 to 2021, I worked in external affairs for two regional Planned Parenthood affiliates, and I currently work as the communications director for a reproductive health organization. I did not enter any of these sites to conduct academic research; however, as I have observed stigma emerge as a salient issue in my work, I felt called to contribute to the field through engaged communication scholarship.

Through my participation as a full member in reproductive health organizations, I have my own personal experiences with occupational abortion stigma. I have firsthand knowledge of abortion procedures from observing medication and aspiration abortions, and stigma has come up in countless informal conversations with healthcare workers, community organizers, and patient advocates. Importantly, I experienced how workers were frequently asked to consider the ways abortion stigma shapes patient care and access without having opportunity to really process how being affiliated with abortion stigma as workers impacts us. I personally was never formally offered support around managing that stigma, though like many of my research participants, I considered myself "lucky" to have certain privileges. I recognized that I was compensated better than most clinical workers, and I also did not experience stigma or threats with the same intensity as clinical workers. It is for these reasons that I wanted to focus this inquiry on clinic staff, with an emphasis on support roles that typically receive less pay and less recognition.

As part of my reflexivity, I think it is important to plainly name my commitments to the abortion care community I called on to participate in this study. First, I am unapologetically committed to destigmatizing abortion and expanding access to abortion as a normal part of

reproductive and sexual health care. I ground this commitment to normalizing abortion in a reproductive justice framework, affirming the right of every person to have children, to not have children, and to parent the children they have in safe, sustainable communities (Ross, 2018). Second, I entered this research in solidarity with my research participants, including those laboring to unionize their workplaces. My goal in this project is to make sense of stigmatized experiences and generate pragmatic insights to ultimately improve the lives and wellbeing of people who provide abortion care. Without this clarity around my own values and my own stake in the research, I would not have been able to establish deep, authentic trust with participants. I offer this study as a contribution to understanding the unique challenges these skilled, compassionate care providers must navigate in a marginalized field of healthcare, with a goal to cocreate a more robust understanding of stigma management in reproductive health.

Participants

Study participants (n = 24) included U.S. healthcare workers who were currently working in abortion care or had done so within the last two years (2021–2023). The two-year time frame was selected to ensure that participants could recall sufficient details about their work experience and to be able to address the impacts of stigma in the current abortion climate, shaped by both the increasing legal restrictions post-*Dobbs* and the COVID-19 pandemic. To participate in a one-on-one semi-structured interview, eligible participants needed to be at least 18 years or older and fluent in English to minimize language-based miscommunication between the researcher and participants.

Participants' time spent working in abortion care ranged from four months to 11 years, with an average tenure of 1 to 2 years. Two-thirds of participants (n = 16) reported working in roles and in clinics that only provided abortion. One-third (n = 8) worked in settings where

abortion care was offered alongside a wider range of health services. Two participants (8%) worked in family practice, and three participants (12%) worked in both abortion clinics and hospital settings. Many participants also noted time spent volunteering for abortion clinics as clinic escorts or as volunteers for abortion funds as part of their overall experiences. The study intentionally included workers (n = 6) who were not working in abortion care at the time of their interview.

Ten participants (42%) were working solely in states with strong legal protections for abortion care ("protective"). Six participants (25%) worked in a state where abortion was legal but restricted ("restrictive"). Six participants (25%) worked in multiple states with a combination of legal protections and restrictions. Two participants (8%) were former clinic workers in states where abortion was completely banned. Additionally, some participants reported living in states that were different from where they primarily worked; these workers either lived along state borders or were working remotely. In total, 11 participants (46%) lived in a protective state, nine participants (37.5%) lived in a banned state, and four (17%) lived in a restrictive state at the time of their interviews.

Participants' self-reported job titles included care or clinic coordinator, certified nurse-midwife, doula, family planning fellow, health center or medical assistant, medical support, nurse, operations officer or coordinator, patient advocate, patient educator, patient navigator, and social worker. While varied, participants' responsibilities all included some form of patient contact and support, which could include performing or assisting with medical procedures, administrative support (such as front desk work), informational support (such as patient education), emotional support (such as counseling), practical patient support (such as assistance with funding or travel to the appointment), or some combination of these responsibilities.

Participants completed a short demographic survey prior to the interview, in which they completed open-ended questions about their gender, race, sexuality, political affiliation, religious affiliation, and if they identified as having a disability. Nearly two-thirds of participants (62.5%) identified as cisgender women, and nine (37.5%) identified as nonbinary, genderqueer, and/or agender. Most participants (87.5%) identified as White; the rest identified as Black and White (n = 1), Asian (n = 1), and South Asian (n = 1). Two-thirds of participants (n = 16) identified as LGBTQ+ identities and eight (33%) identified as heterosexual. Nearly one-third of participants (n = 7) identified as disabled or having a disability in some way.

Participants' political self-identifiers were mostly left of center, including liberal or very liberal, leftist, progressive, abolitionist, and anarchist. Nearly one-third (n = 7) identified with the Democratic party, and one participant (4%) identified as Republican. One participant (4%) identified as having no political identity. Over half (n = 13) of participants reported no religious affiliation; others were agnostic, atheist (n = 2), Christian (n = 2), Christian/spiritual (n = 2), Catholic, Pagan, Quaker, and spiritual.

Participants were also given the option to disclose additional identities that impact them in the workplace. Some participants used this open-ended question to identify neurodivergences (which they did not consider a disability), share family identities (such as being a single parent or an adoptee), disclose personal experience with abortion, or provide other background (such as "I was raised evangelical" or "I grew up very poor").

Procedures

All recruitment and data collection procedures were approved by the Institutional Review Board at Colorado State University. Given the specific criteria for enrollment, participant recruitment relied on purposeful and snowball sampling, with intentional effort to identify

participants in restrictive states and geographically isolated areas. Recruitment began with my professional network of contacts and key informants I identified across restrictive, protective, and banned states. I used email, Facebook, and Instagram to circulate a digital recruitment flyer and webpage to reach the targeted population. I then promoted the study through the ReproJobs newsletter, a grassroots initiative managed anonymously by and for workers in reproductive health, rights, and justice spaces. I conducted additional outreach to contacts I learned of through a regional abortion network I participate in.

The recruitment materials directed individuals to a Qualtrics survey where they completed the preliminary screening (to ensure they met eligibility requirements), informed consent, and a short demographic survey before self-scheduling a one-on-one virtual interview with the researcher using a private Calendly page. Participants received two automated email reminders sent 24 hours and one hour prior to their interview time. Both reminders contained a link to reschedule or cancel if they no longer wished to participate in the study.

Due to the exploratory nature of this study, in-depth, semi-structured interviews created an opportunity for participants to reflect and share openly about their experiences with providing abortion and navigating feelings of isolation, judgment, and/or community condemnation. The question guide (see Appendix B) probed for themes around stigmatizing encounters, stressors, and sources of social support across work and non-work contexts. The interview approach was narrative-based, which gave participants more freedom and agency to share their experiences with comparatively less structure than typical interviews (Lindlof & Taylor, 2019). Using this approach allowed participants to share holistic information about their work experiences rather than treating occupational stigma as an isolated workplace event. The interview structure was synchronous and mediated through technology using a secure video conferencing room. Eligible

participants who completed the interview were compensated with a $35 electronic gift card to a national retailer of their choice. Participants could elect to receive the gift card using their email address or via text message. One participant was asked and agreed to complete a follow-up interview, for which they were compensated with an additional $35 gift card. This participant was working in an ambulatory surgical center solely providing abortion procedures at 24-28 weeks gestation; the depth of their interview answers needed more time to explore all areas of the study, and a follow-up interview provided the opportunity to capture a richer reflection on the impacts of stigma, particularly the intense stigma surrounding abortion later in pregnancy. To ensure participant privacy, I did not retain any contact information beyond the conclusion of the interview.

Safety Considerations

Given the many threats against workers' physical safety, professional credentials, and livelihoods, I took several measures to protect participant confidentiality. While unlikely, it was always possible that participation in this research could threaten participants' real or perceived safety if the data collected were to be compromised. Measures to protect participants from being identified included limiting the number of personal identifiers, including using an online click-to-consent form instead of a signature, and permanently deleting recordings once transcribed, within 30 days of each interview. It is also for these reasons that I have elected to aggregate the demographic information I collected; although this study is interested in intersectionality, and in workers' localized experiences with stigma, there is simply too great a possibility that the publication of these details for each participant could expose them to unjustifiable risk.

I also took measures to support participants in setting their own privacy boundaries around what they were and were not willing to disclose. I very deliberately did not ask

participants where they lived or worked, though nearly all did choose to share some details freely in the interview space knowing that the specifics would be kept private. Others were more protective of their personal information, generalizing their employer (e.g., "I'm at an independent abortion clinic") and describing their community in broad strokes (e.g., "I'm in the Midwest" or "I live in a place with a lot of access"). Framing the conversation this way allowed me to probe for the impact of community attitudes on experiences of stigma without putting participants on edge and minimizing the amount of identifiable data I collected.

Additionally, the interview process had the potential to distress participants by asking them to recount difficult experiences and sensitive information. I took special care to monitor my own verbal reactions, body language, and facial expressions, as empathy felt especially critical in these vulnerable conversations. Overall, I adopted what Tracy (2020) refers to as a *remedial-pedagogical approach*: My stance as a researcher was primarily empathetic, emphasizing the humanity of the research process and engaging participants as collaborators (p. 175). My interview method was grounded in the support and validation of each participant's feelings and wellbeing; if a participant disclosed a particularly difficult experience, I would respond by saying something like, "That sounds really difficult, thank you for sharing that with me," or "You're not the first person to tell me that." I also took a firm stance of solidarity as a worker in reproductive health, and where appropriate, I sometimes relayed my shared experiences of worker stigma ("I've been through that myself—it's hard!"). I emphasized that the interview was a confidential space for participants to disclose their feelings and experiences around abortion stigma, and I took care to hold nonjudgmental space for participants to process complex feelings and sometimes traumatic experiences, including patient loss. I concluded every interview by sincerely thanking each participant for the care they provided in their community.

Analysis

The literature on stigma communication has established a typology for understanding stigma management communication as acceptance, passing, evading responsibility, reducing offensiveness, denying, or ignoring/displaying behaviors (Meisenbach, 2010). In testing this model with this population of healthcare workers experiencing a different, more intense form of stigma than has previously been tested, it is important to balance this framework with a grounded approach to the thematic analysis that may reveal other strategies or challenge the existing model. For this reason, I analyzed the qualitative data using Tracy's (2020) phronetic iterative approach, which allows for both the consideration of the existing theoretical framework and the organic emergence of a grounded theory from the data set.

The data was collected between July and November 2023. I spoke with each participant for 51-122 minutes; the average interview was 59 minutes. Each interview was recorded and automatically transcribed using the built-in features of Microsoft Teams. I wrote analytical research memos immediately following each interview; I used these documents to capture my initial impressions and make note of emergent themes (Owen, 1984) based on recurrence, repetition, and forcefulness of ideas in each participants' data set. I then spent 1 to 2 hours removing all identifying information and cleaning each transcript for accuracy, which helped to familiarize myself with the content. Once fully transcribed, the video recordings were permanently deleted. The interviews resulted in 25 hours of recorded conversation and 418 single-spaced pages of transcripts.

I waited until data collection was complete to begin open coding (Tracy, 2020). I started by generating a provisional list of codes (Saldaña, 2021) informed by my four research questions, my research memos and overall familiarity with the data set, and the SMC framework

(Meisenbach, 2010). I created a codebook in Microsoft Excel where I manually tracked codes as they appeared in each transcript. At first, I spent approximately two hours coding each transcript line-by-line; the codebook expanded quickly, adding complexity and nuance beyond my provisional list, and I noticed many overlapping codes emerging. For example, if a participant talked about how they think about their physical safety as an abortion provider in connection with being White and queer, this datum received overlapping codes *safety planning* and *identity*. After testing this coding method with two transcripts, I adjusted my approach. Rather than coding for all research questions simultaneously, I scaled back to code first for insights to the just RQ1 (*How do abortion workers experience stigma?*) and RQ3 (*What strategies do abortion workers use to manage occupational stigma?)* Guided by these two broader questions, I used a more holistic approach (Saldaña, 2021) to "chunk" the data using a mix of descriptive, in vivo, and process codes, preparing the data for more focused, interpretive coding in the next rounds. Whenever I generated a new code, I wrote a working definition and pulled a sample participant quote into the codebook.

After I had open coded one-third of my data set (8 transcripts), I paused to compare what I was finding to the SMC framework, specifically the strategies that were previously identified on occupational stigma and propositions for predictive models (Meisenbach, 2010). In revisiting the examples Meisenbach (2010) offers for each strategy, I revised some codes based on the parallels I saw emerging in the data set. Beyond this point, I generated very few additional codes, suggesting that the data is relatively saturated. Overall, open coding generated 20 codes related to how workers experience stigma (RQ1, RQ2) and 35 codes related to how participants manage stigma (RQ3).

Between primary and secondary coding, I conducted an initial categorization, splitting my 55 codes into ten categories. Categorization allowed me to assess the scope of my findings and to select the most generative second cycle coding methods. I could see which codes had very low frequencies and assess if these data points were adding an important nuance to a larger theme or if they were mere outliers. I could also see where some descriptive codes (e.g., *disclosure/concealment* and *social support*) were too broad to be analytically useful. I determined that a mix of focused and axial coding (Saldaña, 2021) would be most helpful in determining the most dominant and representative themes in the data set. Subsequent phases of the analysis included rereading individual transcripts in their entirety and collating chunks of data with the same descriptive code from across transcripts. These secondary cycles of hierarchical, interpretive coding (Tracy, 2020) built on one another to determine the most dominant themes in answer to each research question. Throughout this process, I also engaged in frequent "shop talk" (Saldaña, 2021, p. 209) with my advisor to verbalize analytical decisions and dilemmas, check biases, and clarify results.

Table 2

Participant demographics

		Number (*n*)	Percent (%)
Employment Status	Currently working in abortion care	18	75%
	Not currently working in abortion care	6	25%
Workplace Type	Abortion Clinic	15	62%
	Family Planning & Abortion Provider	4	17%
	Both Clinic and Hospital Settings	3	12%
	Family Practice	2	8%
Workplace Abortion Laws *(at the time of the interview)*	Abortion is legally protected in the state	10	42%
	Abortion is legal but restricted in the state	6	25%
	Mix of protections and restrictions across states	6	25%
	Abortion is banned in the state	2	8%
Time working in abortion care	Less than one year	1	4%
	1-2 years	17	71%
	3-6 years	4	17%
	10+ years	2	8%
Gender	Cisgender Woman	15	62%
	Non-binary	4	17%
	Agender	1	4%
	Agender, femme-presenting	1	4%
	Agender, non-binary	1	4%
	Gender queer	1	4%
	Non-binary, gender queer	1	4%
Race/Ethnicity	White	21	87%
	Asian	1	4%
	Black and White	1	4%
	South Asian	1	4%
Do you identify as disabled or having a disability?	No	17	66%
	Yes, chronically ill	2	8%
	Yes, disabled	2	8%
	Yes, neurodivergent	1	4%
	Yes, neurodivergent and chronically ill	1	4%
	No, but I have a lot of trauma history	1	4%
Sexuality	Queer	9	37%
	Heterosexual	8	33%
	Bisexual	2	8%
	Pansexual	2	8%
	Lesbian	1	4%
	Mostly heterosexual	1	4%
	Queer/bisexual/lesbian	1	4%
Political affiliation	Democrat	5	21%
	Liberal	3	12%
	Leftist	2	8%

	Leftist/Progressive	2	8%
	Abolitionist	1	4%
	Anarchist	1	4%
	Burn it all down	1	4%
	Democrat, begrudgingly	1	4%
	Democrat, progressive leftist with socialist leanings	1	4%
	Leftist/Anarchist/Very Liberal	1	4%
	Liberal Democrat	1	4%
	None	1	4%
	Republican	1	4%
	Unaffiliated Left	1	4%
	[Blank]	1	4%
Religious affiliation	None	13	54%
	Atheist	2	8%
	Christian	2	8%
	Christian/Spiritual	2	8%
	Agnostic	1	4%
	Catholic	1	4%
	Pagan	1	4%
	Quaker	1	4%
	Spiritual	1	4%
Are there any other identities that you would like to share or that impact the way you show up in the workplace?	Adopted Anti-racist Southerner & cross region network weaver. Community care practitioner. Grew up evangelical/fundamentalist I am a person who grew up in a rural community in the South. I grew up very poor. I have personally experienced accessing an abortion. I've had an abortion. I have graduate degrees. I am a manager at my facility. Neurodivergent (ADHD) Neurodivergent (OCD) and gender expansive Single mother		

CHAPTER 4 – RESULTS

Overall, the purpose of this research is to explore the nature of the stigma experienced by U.S. abortion workers (RQ1, RQ2) and what strategies workers use to manage that stigma (RQ3). This study allowed participants to voice the challenges they face in providing abortion care amid ongoing legal restrictions and asked them to reflect on the ways they manage these related stressors. The findings uphold that working in abortion care can be a particularly turbulent and stigmatizing experience that affects healthcare providers' mental and physical wellbeing, economic livelihood, and interpersonal relationships. The findings also uphold the wide array of different experiences a worker can have based on their specific positionality and sources of support. A total of 24 current and former clinic workers participated in the study; they worked mostly in roles that emphasized providing emotional, informational, and/or practical support to patients and hands-on medical support to the physician/clinician.

RQ1: How Abortion Care Workers Experience Stigma

RQ1 asked, *How do abortion care workers experience stigma?* Three primary themes emerged from the data: *stigmatizing messages, stressors compounded by stigma,* and *socio-emotional impacts* (see Table 3).

Stigmatizing Messages

The first theme, *stigmatizing messages*, encompasses how participants most directly encountered explicit verbal and nonverbal communication that reinforced a negative attitude towards abortion, extending to people who have abortions and/or people who work in abortion care. Most participants (n =19; 79%) reported encountering anti-abortion protesters outside of their workplace on a regular basis. Participants experienced direct threats against their safety, vandalism, abuse, stalking, and/or harassment. Many participants discussed protest activity as a

Table 3
RQ1: How abortion care workers experience stigma

Theme	Definition	Examples
Stigmatizing messages	Verbal and nonverbal communication that reinforces negative attitudes toward abortion, people who have abortions, and/or people who work in abortion care	Clinic protesters Patient stigma Coworker stigma Interpersonal stigma
Stressors compounded by stigma	Unique or additional psychological burdens workers experience because they perform a stigmatized job, which intensifies the impact and contributes to a more challenging workplace	Barriers to access Employment conditions Difficult patient behavior Criminalization
Emotional impacts	Negative effects on workers' physical health and emotional wellbeing as a result of stigma and its compounding stressors	Anxiety Emotional drain Burnout Enmeshment

background stressor; for example, Participant #21 said, "I know it definitely affects the patients, but at this point [the protesters are] just white noise to me." However, some participants said that clinic protesters are a daily source of stress and agitation. Participant #6 has been working in abortion care for more than five years and said, "They make me so, like, irrationally angry whenever I see them. Like I feel like that physical anger, and it hasn't really died down over time. I thought that maybe I would get used to it, but I still just get so angry." Participant #12, who worked at multiple Planned Parenthood locations over 10 years, recalled visceral encounters with protest activity at one specific health center:

> They had someone who dressed up as the grim reaper on Saturday mornings and would come stand at the parking lot. It had a lady who just, like, would scream about Hitler every day. And like I almost got into it once with her. And they would have people praying on the sidewalk [...] One experience is I came outside from my shift and every car in the parking lot had papers on it, had been papered with like, really graphic images of [fetal remains]. [...] It definitely wears on you.

Participants also noted that protest activity is heavily distressing to patients, causing higher levels of patient anxiety and fear that get passed onto workers. Participant #19 is a patient advocate at an independent abortion clinic; they shared:

> I think days that tend to be harder are days when they are a little bit more active just because right from the get, as a patient, if you're coming into our clinic, you have to kind of run this horrible gauntlet of people. You know, I'm sure that in your work you've seen, like, the signs. You've seen the pictures. They like to show the horrible things, they like to yell at people coming in who are already very, very scared and in a situation they did not want to be in. And so, I've noticed that that kind of has a knock on effect sometimes on staff, although we do get—you do get used to it pretty quickly, and you know the more anxious patients tend to feel, the more that can kind of translate to a more emotional day.

Participants also encountered stigma directly from patients presenting for abortion care. For example, Participant #21 was a medical assistant at an independent abortion clinic. They described that at their clinic, all patients talk to a social worker during their appointment and some of them reflect anti-abortion views during those sessions. Participant #21 said,

> The notes that come out can be like, "Patient, you know, reported being pro-life," but just – okay, internally we call it "My Special Abortion" because it's people who are like, "Well, my reason is the valid reason." Like, "I'm here because I can't handle another kid at this time," and it's like, that's what everybody's reasoning is, like, they're all valid. And so the antis or the people who just think that they're special are the ones who wanna push their stigma off on us like, "Well, you know, you're killing my baby, but like, it has to be done." Yeah, no, that's not what's happening.

Some participants also dealt with stigma from coworkers, which could take the form of different levels of discomfort with abortion and/or comments shaming specific patient behaviors, such as a person having multiple abortions or not knowing when they got pregnant. These stigmatizing messages were sometimes shaped by the structure of abortion care in the workplace and overall clinic flow. For example, Participant #2 works as a nurse in a family practice where medication abortion is available as part of the full spectrum of patient care, but it is only provided by a small team of staff who have all opted in to provide abortion care. She named that

this is a source of stigma in her workplace because her coworkers were allowed to have and express stigmatizing views as long as they were not relayed to patients. She said:

> I guess, I mean, I do feel stigmatized, because you do have the other employees who are like, you know, they make their own comments about, "I don't know why you're doing that. That's not what I believe." And you have to learn to, I guess non-confrontationally, which is really hard, to advise people that it's not about you and you know, you have the right feel that way, but this obviously isn't about you either.

Participant #13, who was participating in a residency in family planning and abortion care, also noted the way that stigma could show up as discomfort in a hospital setting, particularly when scheduling procedures at later gestations. She shared:

> It was always like a big thing to get [a procedure] booked. You'd have to find the right stuff, you'd have to find the right [operating room], and people just felt uncomfortable even if they were like, "I'm supportive of this, keep going." But it's just a lot of extra work and I think that, you know, putting up those barriers does sort of stigmatize it. Like people say they're supportive, and I believe they're supportive, but they feel uncomfortable. And so it not only is it just like, you know, almost make you not want to offer that care because it's like I have to do all this extra work just to get this care and provide it, and it makes you feel like you're having these slimy conversations, even though you're not—even though you're just having regular conversations about providing care because of how uncomfortable people used to get.

Many participants named that even in clinics where everyone supports, or is expected to support abortion, stigma was present whenever providers increased gestational limits, choosing to provide abortions at later stages of pregnancy. Decisions to provide later care required additional staff training and conversations to prepare staff to assist with those procedures, which sometimes raised complex feelings and values. For example, Participant #12 shared:

> When we went up to 20 weeks, 6 days from [...] 19 weeks, 6 days, we had a like staff training and there were folks in the training who were like, "I don't feel like this is OK." [...] You don't want to tell people like, "Well then you should get another job" because I think it's nuanced, right? Like you can do a job and be compassionate and supportive without necessarily agreeing with everything that everyone does, but it does make me wonder, and it always made me feel a little bit uncomfortable when, like the people that you were working with and handing patients off to, like, you knew deep down that like, yeah, they're not okay with this extra week, you know? And so, I always think about that.

> Yeah, when talking about stigma, like, what are we allowed to show in the workplace and like, what are we just keeping inside of us as workers?

While all participants reported having at least one source of social support to help them manage stigma, such as having the support of close friends or family members, interpersonal relationships were a source of stigma for many participants. Participant #4 shared an experience with confronting social isolation and rejection when she participated in her community theater—a recent experience she was still processing at the time of her interview. She had disclosed to a cast member that she had worked at an abortion clinic before abortion was banned in her state. She said:

> You know, he was understanding and all these things, but his family is, like, a big part of the theater, and they do not feel as kindly about it as he does. And I was pretty much just instantly isolated in that sense. And I still don't really quite know how to handle it just because it does hit deeper because like theater is a huge part of my being and like there is a vulnerability there that in the day-to-day world like I'm capable of handling. But I'm not quite sure how I'm going to handle it now. But it hurt. I mean, I understood. I understand now what you know my friends feel whenever their family – well, no, I can't say that, but I understand on a different level, like, what it feels like to be judged for it.

Some participants also talked about the impact of feeling misunderstood by others or not being able to share deeper feelings about work, which contributed to feelings of isolation. Participant #14 was working as an abortion doula in the South before abortion was banned in her state. She reflected:

> There is a gap of, like, especially the part of sharing, not just that this is what I do and I, you know, have my like organizational spiels. But the part of really sharing how important and how meaningful that work has been for me. I wish I could share that with my parents or with anybody, like I wish they – there's a gap, sometimes of not just knowing that I think people should have the right to have an abortion, but knowing that, what happens in clinics is so, I would say, deeply sacred and touches something important about humanity.

Overall, participants described encountering stigma in micro-level interactions with patients, protesters, family and friends, and colleagues.

Stressors Compounded by Stigma

During the interview, every participant was asked about job stressors; their answers illuminated dynamics that are not directly *stigmatizing* but are exacerbated by the stigma they experience. Therefore, the second theme, *stressors compounded by stigma,* refers to the unique or additional psychological burdens workers experience because they perform a stigmatized job, which intensifies the stressors' impacts and contributes to a more challenging workplace. For example, 21 participants (87.5%) described the barriers that patients must overcome to access abortion, and many reported an increase in patient volumes since the *Dobbs* decision. With fewer clinics and more patients traveling to receiving states to get care, participants reported seeing more patients overall and seeing more patients who presented with more complex needs, at later gestations, and with a greater need for practical support. For example, Participant #10 is a full spectrum doula in a receiving state in the Southeast; she described the impact as, "It's just been, I think, like a shitshow for lack of better words. It's just been a lot of just uncertainty and panic, really, when people are carrying a pregnancy that they no longer desire to carry."

In addition to patient volume, nearly all participants identified one or more employment conditions as sources of stress, which could include low pay, understaffing, layoffs, a lack of breaks in the workday, or other workplace conditions under the purview of one's employer. Some participants merely attributed these conditions to part of nonprofit culture; for example, Participant #6 stated very plainly, "I'm [an] overworked, underpaid, typical nonprofit healthcare worker at this point." Others blamed clinic leadership and felt unheard when bringing concerns to organizational decision-makers. Participant #5 started as a nurse, then took a promotion to nurse supervisor at a Planned Parenthood. She said that she took the supervisor position hoping to be able to make changes, but she ultimately worked there for less than two years before

quitting due to "severe burnout." She said, "I was really pushing, I was like, 'We need a lunch break.' I said, 'I'm like in procedures for nine hours at a time. I sit down for like five minutes and shove some food in my mouth,' and they just, I just kept advocating, advocating, like, 'We need either a part-time nurse or a third nurse so we can rotate.'" When the participant's needs went unmet, she determined that she could no longer work under those conditions with that high level of daily stress.

Many participants also named difficult patient behavior as a source of stress distinct from patients directly reflecting stigma. Usually, patient behavior was linked to frustration over long appointment times or circumstances that participants felt were outside of their control. For example, Participant #17 worked as a health center assistant at a Planned Parenthood for one year and shared, "Sometimes patients also don't treat you the best because they don't understand, you know, the process of these types of appointments [...] just I'm like, I'm a person too. Like, come on. Like I can't, like I'm not at fault here." Participant #23, who has worked in different roles in abortion care for more than a decade, also reflected that working with patients can be a difficult and completely different experience from roles without direct patient contact. They said:

> It's one thing to care about the issue in a political way or in, you know, just a values way. But then, like, working with patients in the day and day out, it either cements your desire to work in the, you know, in the movement and the field or it makes you, like, give up […] I think a lot of people have this idea that, like, patients are grateful. No, patients are often not grateful. Patients are often angry or upset or sad and, you know, they may have a lot of people that may be mad about the situation and here you are making them follow rules that are nonsensical because your state is, you know, anti-choice […] So you're having to deal with that as that person that is there trying to help them through this process, often at pretty great personal risk or sacrifice.

Some stressors shared by participants are particularly unique to performing abortion care procedures. These stressors were often coupled with pain management and/or products of conception, which refers to the tissue expelled from the body during an abortion. Some

participants' jobs included handling products of conception whereas other participants had no role in procedures. Participant #6 shared that their job was supposed to be primarily administrative, but short staffing meant they were frequently pulled in to assist with procedures. Their clinic provided abortions up to 14 weeks, 6 days, but it was not equipped to offer intravenous sedation, meaning some patients experienced more pain. They explained that a negative patient experience "hits us harder than say, if we were just like a normal dermatologist office." They further explained:

> I think a lot of people have in their heads that an abortion clinic is some sort of cold, unhealing mill, for lack of a better term, but I think that's the perspective that a lot of people have […] that impression of, like, causing pain to people or being like a very painful procedure, and I feel really guilty whenever someone has a bad experience, even though we do our best to explain, like, "Hey, if this isn't the right…" But if somebody has a bad experience, and like gives us a dirty look in the recovery room, like it hits harder than say like, if somebody at an urgent care had a slice on their arm and needed stitches, and was not having a good time getting stitches, if that makes sense.

In their experiences, Participant #6 illuminates how many medical procedures can certainly be painful and how that can be stressful for providers; however, because of the stigma around abortion, and the preexisting ideas that other people have about it, the stress around painful procedures could manifest more intensely, particularly if the provider was not able to offer sedation.

For participants who provided abortion beyond 20 weeks gestation, products of conception were an even greater stressor complicated by the stigma surrounding abortion later in pregnancy. Participant #9 works as a care coordinator for a provider who does abortion procedures solely between 24 to 28 weeks gestation. She shared, "I think the stigma is just that, it's like a whole ass fucking baby. When, I mean, like, it's really gross and gory, and it's stigmatizing." Participant #13 also shared her experience of wrestling with stigma while learning

later abortion procedures during her current fellowship, compared to her previous medical training:

> I think it's just, like, the associations I have with, you know, a fetus that that gestational age and in trying to rewire or rework some of that thought process. It's just really weird to think, to see a gestational age that's like 22, 23, 24 or above and in residency, like that was just a baby. That was a delivery. That was someone that needed fetal monitoring and that was a like, for lack of a better way to say it, a life that I was like intervening on. That was how I was coded to think about it. And so undoing some of that is tricky, and it's associated with that, with like the kind of feelings that I think, you know, someone who might identify as pro-life feels about that pregnancy, about that fetus […] Ultimately I'm here to provide this service or this care to a patient who's made her decision and like, that to me is like the bottom line.

Abortion providers also navigate unique threats of criminalization unlike any other health providers in the U.S. Participant #14 was an abortion doula in a state where abortion is now banned; she continues to work for the same employer but can no longer provide direct support to people seeking abortion and has encountered difficulty even talking about abortion publicly since the *Dobbs* decision. She shared:

> There have been literally times where news agencies have reached out to us at my organization wanting to do news stories about abortion. And I was too afraid to even talk to them. […] I both felt like the more public our organization was, the more likely it was gonna be that we were gonna run into some kind of like, prosecution issue or that I would end up personally being investigated for something. And also the more I was personally associated with something in a public way, the more risky it felt to me personally.

Overall, participants described high levels of stress compounded by the stigma around abortion care stemming from structural stigmas, patient behavior, and the recent criminalization of abortion care in parts of the country.

Socioemotional Impacts

Socioemotional impacts describe the negative effects on workers' physical health and emotional wellbeing because of stigma and its compounding stressors. 21 participants (87.5%) described feeling anxious, worried, or uncertain about how they might be treated if their job was

discovered in certain situations. Participant #13 said she mostly felt anxious about social situations with loved ones: “I feel the stigma more in just like my normal everyday interactions outside of the medical space when I’m talking to family members about my fellowship or new people here or even friends back home that I’m like, I actually don’t know […] how you would feel about me if you knew exactly what my fellowship was in.” Participants also shared specific situations that made them feel a heightened sense of anxiety around their personal safety. For example, Participant #12 previously described the aggressive protest activity she encountered at work. She further shared how that created a heightened sense of insecurity:

> Personally, going in and out of the clinic sometimes at night, it would just be like an underlying, like, you know, there’s just that little part of your mind who just can’t predict what people will do, right? And like, yeah, you just don’t know. One service [my employer] offered us was like getting our plates blocked. But I was like, “That feels like […] acknowledging that you have to be paranoid,” but like, it’s actually not really paranoid, right? Because especially some of the doctors would be like, “Yep, I get mine blocked. I do this [because] like, people are nuts.” You just, like, don’t wanna think the worst.

Participants, particularly those whose roles included providing emotional and/or practical support to patients, also experienced emotional drain, which Participant #21 labeled “compassion fatigue.” These workers shared that they felt a sense of responsibility to show up and “give 100%” to the patients they were supporting, which sometimes conflicted with their own emotional or support needs. Participant #7 described the stress they experienced as a medical assistant who was frequently tasked with patient education:

> Making sure that I always held enough space for patients again, the range of emotions that every single patient goes through, being able to set aside my personal problems, my issues, my family drama, whatever was going on in my personal life, truly leaving it at the door and just opening myself to my patients 100% to make sure that they got the care that they deserved. Again, it’s a lot going on for a lot of patients. Some patients will never remember that day. Some patients will remember it on that every single detail, so making sure that, like, I’m always at 100% was one of the main stressors for me. Making sure that I always had space and capacity for them as well as my coworkers. You know,

> they're going through the same things that I'm going through, and they're still leaving everything at the door.

Participant #10 shared that for her as a full-spectrum doula, self-care felt particularly important to be able to do her job effectively, and yet the stress could still build up:

> I think it can be overwhelming to support people through, so we're always just talking about always remaining, you know, firm in my, in my belief, no matter what it is, whether it's abortion or induction or C-sections or whatever the case may be, and also like making sure that my fuel meter is at 90% or above before I'm stepping into any space to support someone, whether it's at an abortion clinic or hospital, a home birth, a termination for medical reason, whatever the case may be like, I need to be my best self in order to be able to show up in the appropriate energy for other people.

For Participant #3, self-care felt in tension with the job, as they were managing a serious illness during the year they worked as medical support in an independent abortion clinic. They described how difficult it felt at times to give what was expected of them at work while tending to their own needs. They said, "The executive director picked me up once during a snowstorm so that I could come to my office and I spent the whole time, like, on the way to work just crying about, like, how I was really trying to be flexible, but there, you know, there's only so much energy that I have to give to anything, let alone this job, and [I] was feeling very frustrated by that."

Participant #4, who lost her job when abortion was banned in her state, shared that for her, the passion she had for the work combined with the emotional labor became very enmeshing. She had a difficult time finding a "balance" between work and the rest of her life, and, in a sense, she felt that work *was* her whole life. She said that she strongly felt she would move to a receiving state and return to abortion care at some point in the future. At the time of her interview, she was not "ready" to return to abortion care because, more than a year later, she was still feeling a heavy emotional impact from giving so much of herself to the work. She said,

> My best friend who I met there like, we'll tear up about it sometimes and it's like, oh…this took a long time to hit [...] I just started crying, and I was like, "Why am I crying?" And she was like, "No, I mean, that's what abortion care workers, they feel unseen, you know, like we are." And it's that dichotomy of not… like it is all about the patient, you know. And we feel that in our hearts and so it's hard to register how *we* feel about this entire situation.

For some participants, the cumulative stigma and stressors led to *burnout*, which refers to an inability to cope that can manifest in mental and/or physical health challenges. Participant #5 shared her experiences of burning out almost as soon as she accepted a promotion to nurse supervisor, which led her to quit one year later:

> I just felt *ill* when I was at work, and sometimes I would be like, "Can someone take my blood pressure?" And it would be *sky high.* And I never had blood pressure issues before, so that was kind of scary. Actually, one day it got so bad I had to go home because I felt like I was gonna pass out and had to get my mom to come and pick me up. It was like my body's check engine light was just screaming at me. But a big thing there was like, well, no, you have to sacrifice yourself for these patients because they literally have nowhere else to go. So that's a big part of the culture. And I was getting paid *really* well as a supervisor, and some days I really am like, "Man, I should have stayed there." But then I'm like, "But I have normal blood pressure now." That's, I mean, that's health or money. I don't know, but yeah, it was a lot of feeling just very ill when I was at work, and then I was very tired because of the rotations we had to do with after-hours calls. That was an extreme part of the burnout because I wasn't getting sleep for like a week at a time.

Participant #9, who had a preexisting health condition, also described feeling the impacts of the emotional stress immediately on her body. She shared,

> I have a number of times felt myself like falling asleep at the wheel [during my commute], which has been just like freaky and scary. So I do feel Type I diabetes is a disease where it's very visible. Whatever emotion you're feeling as if it relates to anxiety or fear, you can actually, you know, to see that physiological reaction […] visually on my insulin pump and my continuous glucose monitor is fascinating. I've had times where I've gotten just physically ill, and I think from stress for certain patients.

Overall, one-third of participants (n = 8) shared that stigma, stressors, and socioemotional impacts meant that the work was simply unsustainable in the long-term. Three participants (12.5%) had voluntarily left their jobs, three participants (12.5%) had involuntarily lost their jobs

and not returned to abortion care, and two participants were actively looking for or considering new job opportunities. Among these eight participants, 75% (n = 6) had worked for their employer for just two years or less, highlighting the intensity and stress of abortion work.

RQ2: Community, Organizational, and Identity Level Factors

RQ2 asked, *How do community, organizational, and identity level factors shape abortion workers' experiences of stigma?* The results revealed that participants navigated stigma among many intersecting situational factors, upholding that experiences of occupational abortion stigma can vary widely across contexts. At the intersection of community, organization, and identity, seven salient themes emerged in the data set: *state laws, service delivery, organizational culture, community attitudes, regional identity, privileged vs. marginalized identities,* and *reproductive experiences.*

State Laws

In this study, all participants were required to meet the inclusion the criteria of providing abortion legally within the confines of their state laws, which varied widely both pre- and post-*Dobbs.* Ten participants (42%) were working solely in states with strong legal protections for abortion care. Six participants (25%) worked in a state where abortion was legal but restricted. Six participants (25%) worked in multiple states with a combination of legal protections and restrictions. Two participants (8%) were former clinic workers in states where abortion was completely banned. Additionally, some participants reported living in states that were different from where they primarily worked; these workers either lived along state borders or worked remotely. In total, 11 participants (46%) lived in a protective state, nine participants (37.5%) lived in a banned state, and four (17%) lived in a restrictive state at the time of their interviews.

All participants discussed the way their work was shaped by state laws with varying degrees of specificity and forcefulness. Some participants discussed the way their state laws shaped patient access and their work conditions by imposing restrictions such as gestational limits, mandatory counseling, wait times, licensing requirements, reporting requirements, and medical exemptions. Other participants talked about being in a "protective" or "restrictive" state, letting some of that language speak for itself. A few participants discussed the way state laws intersected with their work responsibilities specifically. For example, Participant #13 spent part of her fellowship training to be an abortion provider in a hospital in a banned state, which had to follow very specific medical exemptions. She discussed seeking out this fellowship to learn how to navigate the "legal loopholes" to be able to provide care in restrictive environments. Together, these findings highlight the unique role of state laws in influencing abortion stigma.

Service Delivery

Service delivery encompasses the specific dimensions of an organization's abortion care services. In this data set, I looked for factors that seemed most consistent across delivery models and paid closest attention to factors that seemed to set an organization apart from other abortion providers. Seventy percent of participants (n = 17) were working for organizations that provided both medication and procedural abortions. One-quarter of participants (n = 6) were working for organizations that only provided medication abortion. A single participant was working in an ambulatory surgical center that exclusively performed procedures.

Organizations' *service delivery* also varied by gestational limit. One-quarter of participants (those providing medication abortion only) could only provide care up to 11 weeks. Four participants (16.6%) provided procedural care into the second trimester, but at gestations less than 20 weeks. Nine participants (37.5%) had upper gestational limits between 20-24 weeks.

The remaining participants (n = 5; 20.8%) provided care up to 24 to 28 weeks gestation. No one in this study provided care beyond 28 weeks.

The type(s) of abortion care provided, as well as a participant's specific role in care, shaped many participants' experiences of stigma. Related to procedural care, some participants highlighted the different types of pain management available to patients. Some participants in the study were able to offer their patients intravenous (IV) sedation, particularly when performing procedures at higher gestational ages. Other participants could only provide lesser pain relief using paracervical blocks, local anesthetic, over-the-counter pain relievers, and/or nitrous oxide. Some participants described the challenge of talking with patients about how much pain to expect. For example, Participant #14 said:

> When I shadowed other doulas, something I would hear would be them being unsure about how much to describe the procedure as painful. […] I saw it as maybe still rooted in some defense of abortion, this idea that it's just, like, gonna be painless and easy. And the reality of it in our clinic with those medications is that most people experience it as quite painful. And I think having had the experience of that myself, where I felt like no one had talked me through that, that no, I didn't have the expectation that it was gonna be painful, definitely not as painful as it was. So I was more quick to[…] focus more on how long it was going to last than the fact that it wasn't going to be painful.

Together, these findings highlight the role of factors in service delivery in influencing abortion stigma.

Organizational Culture

Organizational culture is a broad theme encompassing values, attitudes, systems, policies, and unspoken rules that influence employee communication and behavior. In the context of this study, organizational culture was examined particularly as it relates to stigma and compounding stressors. Five subthemes emerged most strongly in the data: *social hierarchy, self-sacrifice, unionizing, workplace support,* and *values alignment.*

Social hierarchy. Some participants described their organizations as having particular hierarchies or divides, both formal and informal. Nearly all participants named a formal hierarchy existing between organizational leaders and clinic employees. Then, there were hierarchies within the clinic teams. For example, Participant #12 described the organizational structure at her Planned Parenthood affiliate: "The healthcare assistants are kind of, like, at the bottom, people who do reception, things like that. Then you have like the [nurses]. Then you have, like, the clinicians, and you have the managers, and you have the administrators, then you have leadership." Participant #21, who described a similar hierarchy at their independent abortion clinic, described the way this hierarchy translated to workplace responsibilities and compensation from their perspective as a former medical assistant:

> I think this is true in a lot of healthcare that sort of lower you are on the rung, the more of the kind of gross stuff you have to do. Like, somebody's water broke in the hallway, so you have to go clean that up. And you know, the nurses do get a little bit less of that. Doctors are doing none of that. But they're obviously, they're doing other important things, right? So I just felt like it was a lot of responsibility for sort of the lowest amount of, I don't know, recognition or lowest rung on the ladder […] Like some of our leadership and administrative people have always been in sort of an office role. And so, they haven't experienced what it's like to be like the hardest working person in the clinic that's – hardest working is subjective. Maybe like more physical labor.

Participant #21 said this also showed up in the way people could be treated differently depending on their role. For example, they shared that physicians were able to park in a garage attached to the clinic so that they did not have to walk past protesters to get to work. Participants generally agreed that this treatment stemmed from a "larger target" being on physicians than on other staff.

Regarding administration, 42% of participants (n = 10) named that the hierarchy between leadership and clinic staff was a problem or a stressor, largely in the way that decisions were made by people who did not "really understand" the pressures of the clinic and patient care. For example, Participant #19 said:

> At the end of the day, if your job is at a desk and you are at a cubicle and you're doing kind of traditional nonprofit things versus, like, okay, like I'm, you know, talking to a teenager who's scared out of her goddamn mind and, like, you know, she had to get a judicial bypass and, like, is dealing with all of this […] those are just gonna fundamentally be two different experiences at the end of the day. I will say leadership that tends to show more support or, like, hold a little bit more space for that, whether formally or informally, tends to be people who are still kind of involved in clinic flow. And again, because we are so understaffed, it's not uncommon for managers to get pulled to counsel, to kind of do, like, recovery liaison, to like, you know, help people call their rides, whatever that might look like and as much as I wish they could do their actual jobs that they get paid for, I think that helps a lot because I think it really does help kind of maintain a sense of perspective, not only on where patients are at, but also what staff has to deal with on a daily basis.

Together, these findings highlight the role of social hierarchy in organizational culture.

Self-sacrifice. Participants generally reflected a perspective that there is a *culture of self-sacrifice* across abortion work and the reproductive health/rights movement more broadly. Some participants described how that showed up in their particular organizations as a "savior complex" or enmeshed coworkers. For example, Participant #3 said, "A lot of how people sort of understood how they were as a person was really tied to abortion, and I think that's true for myself but [...] often the particular way that manifested in this workplace was in, like, a catty drama way." Participant #5 said:

> Leadership believed that, like – they very much have a savior complex, like, "We have to see every patient. They've all had really hard lives, so we have to do everything we can for them," which is not necessarily true […] The doctors would be like, "I don't care if I'm here 12 hours. We have to see every patient." And I'm like, "Well, you're only here one day a week, the rest of us are here the whole week."

Participant #22 shared that the clinic staff at their workplace had unionized to push back against a *culture of self-sacrifice* coming from the top-down. They said:

> We recently unionized at my organization because it kind of started as like a passion project, and I think that at first the organization was growing really fast and the employer kind of maybe didn't think through all of the aspects of it. So they were like, "Oh, like, I'm super willing to, you know, have a really like self-sacrificing model of abortion care and go above and beyond" and all this stuff. But they—I don't know that they thought

> through, like, all the aspects of what, you know, the toll that it can take on you physically and mentally and emotionally.

Together, these findings highlight how expectations of self-sacrifice, counteracted by expectations of self-care, shape the impacts of stigma on organizational culture.

Unionizing. One-third of participants (n = 8) worked for a unionized workplace. Participants who were part of their unions generally reported that unionizing had overall helped to improve their workplace dynamics. For example, Participant #22 said:

> Since we've been unionized, I think that our working conditions have gotten a little better. We're getting paid better. We have unlimited [paid time off] now. We, you know, have stipends for various things. So yes, I think they're trying. I think they're trying, like I can't complain whenever there's people who, you know, work for terrible clinics with like, really corrupt owners and stuff like that. Like, I definitely feel more supported, you know, than that, but I think that because it was like a startup. They had a rough time, you know, figuring out how to prioritize employee wellbeing at the beginning.

Two participants shared being part of their organizations' bargaining teams, which had its own stressors, leading both participants to ultimately step down. For example, Participant #18 said, "I'm still pro-union and pro-worker, and I still believe that when unions win, all workers win. There were just some, like, real personality challenges and I struggled." Participant #12 quit before her Planned Parenthood affiliate secured a contract and described how that impacted her:

> The people that were there, you know, wanted to make sure that if they left, myself included in that, we were leaving it better for the people who are going to come after us. […] So like even if we don't see the benefit of a contract, you know the people that come after us will. And I think we had an almost unanimous "yes" vote, and then bargaining took ten months, and they just got a contract a few months ago. But I think over 70% of the people who were involved in unionizing had left by the time they got the contract.

Together, these findings highlight the unique potential of unionizing in shaping healthier organizational cultures.

Workplace support. Most participants talked about the availability of formal workplace supports that were in place specifically to help employees manage stress and/or tend to their

overall wellness. These supports took the form of on-site employee mental health support and referrals, the ability to take a "mental health day," having an Employee Assistance Program (EAP), and/or receiving a wellness stipend. Half of participants (n = 12) said that they had taken advantage of at least one formal workplace support to manage their stress; others commented that they knew formal support was available, or they thought it *might* be available, but that they had never personally felt the need to use a formal support program like the EAP.

Four participants (16.6%) said that their workplace engaged in formal debriefs or check-ins following difficult patient experiences. Participant #6 described what the debrief process looked like at their clinic: "We will huddle at the end of the clinic day, and we'll talk about like, what went right, what went wrong, that sort of thing. Like kind of talk about how we feel about what happened. Like validate each other and like okay, they're, was there anything else we could have done? Probably not." Participant #13 described how the check-in process was both helpful and functioned in the context of stigma, particularly around later procedures:

> Before and after, there's like this moment of check in and, "Are you okay?" And I ultimately think that's a good thing, but it does sort of create an atmosphere. You're like, "Am I okay with what just happened?" And you know, "Is there a reason not to be okay with what just happened?" And so, I think it's a hard balance, like you don't want to leave things unsaid, but it also I think breaks some of that sense of normalcy that we get in the room.

The other half of participants indicated that they could not identify any formal workplace support that existed for them to meaningfully cope with the stigma and stress of their job. For example, Participant #19 said, "It tends to kind of go more like the 'pizza party' route than anything else, which is fine – I love a free lunch – but not anything super significant."

Workplace support was also often informal, which participants described as a general sense of camaraderie among the workers and/or developing friendships with coworkers they could use for support. For example, Participant #17 said:

> I received the most support from my peers, frankly, because we all kind of knew what we were all going through, cause, like, every [health center assistant] had their own story […] We were all, like, having, you know, fun. There was always, like, some candy or food. So it was always like kind of like a nice, you know, friendly environment to work in […] If anything it was just, like, knowing that like I'm not alone, you know? Like everyone's going through these days. Everybody has tough days.

Some participants also discussed where culture and staffing structures came into tension with formal benefits. For example, Participant #22 shared that unionizing had secured unlimited paid time off; however, within their role, they did not feel like they could really use it. They said, "If I take time off, you know, I know the couple people that are gonna feel the weight of my workload on them and the way that you know, they're already exhausted. […] I don't think that we're at a place as an organization where I feel like I can actually prioritize my well-being." Together, these findings highlight the role of formal and informal workplace support in organizational culture.

Values (mis)alignment. Most participants described abortion care as being values-centered work, and they cared about their personal values aligning with their employers' values. For some participants, perceived *misalignment* was a source of tension in the organizational culture. For example, Participant #12 said:

> Planned Parenthood outwardly says all these things about what they stand for, what they believe in, and then when it turned and looked inward, you had staff that were just making no money, you had people doing three jobs. You had nowhere to breastfeed. Just like the values and things that you know were toted for donations. It was just kind of like, well, okay, like put your put your money where your mouth is.

Participant #24 assessed their organization as having "a pretty toxic culture" that largely stemmed from a misalignment of values. They described negative workplace dynamics including nepotism, racism, transphobia, and abuses of power among the executive team, which they said had led them to search for other employment. They shared:

> I have applied for jobs outside of repro care because I realized, and I see that there is a reckoning right now, not just in my own clinic, but in repro care in general with the racism, with the White supremacy that is going on, and how specifically, Black workers – but honestly, so many workers. Indigenous workers, trans workers, gender nonconforming [workers], all of them are being treated right now. I am seeing, even within my own community, kind of a mass exodus from repro care, which then is just leaving a lot of the people who cause a lot of the harm left, and that's really sad to hear and sad to see. I will say, I think abortion funds are very different, though, than the clinics themselves. The funds are usually run by Black women or, you know, other women of color, and they usually really have the workers and the volunteers and the callers' sense of self at the forefront of everything. And, like, they really live by their values. It's the clinics right now that I'm seeing this massive exit from.

Participant #22 shared a similar assessment that while their organization outwardly branded themselves as a "reproductive justice organization," they did not "live out those values." They shared an example that, while the organization focused on getting people access to free abortion, they did not have a policy or a process for employees to access a free abortion if they needed to. Participant #22 said they experienced this firsthand when they got pregnant:

> We were all being severely underpaid, like a $500.00 medical bill isn't nothing to me. It's a significant amount of money. So I, you know, emailed our leadership and was like, "This is what's going on and why isn't there a policy?" Nothing happened. They were just like, "Oh, we support you, whatever you want to do!" I'm like, imagine if we said that to our patients like, "We support you, whatever you wanna do! But we're actually not gonna, like, help you."

Together, these findings highlight the importance of values alignment in organizational culture.

Community Attitudes

Every participant was asked about their community's attitudes on abortion during the interview process. Answers varied widely and revealed a large degree of complexity as no participant could give a simple or straightforward answer, instead talking through different aspects to make sense of their larger community attitudes. Several participants in restricted or banned areas felt that their local communities were actually somewhat or quite supportive of the

clinic and/or abortion overall. For example, Participant #23 works for a clinic that is the only one in its state, where an abortion ban had been passed but then enjoined by the courts. They said:

> There's a very strong, kind of classic libertarian belief of like, you know, nobody's – it's my business and nobody should tell me what to do, particularly not the government. So in a lot of ways, like the community is pretty supportive. There is a really, really solid group of volunteers and like, community support around the clinic, which is so helpful and so nice. So, it's really interesting because in a lot of ways, it feels a lot more supportive than and a lot more welcoming and open than some of the communities I've worked in in the past, even though we still had an arson attack and we had somebody just walking along the street throw rocks at the windows and break one of them. And you know, there's always protesters every day, generally, but the wider community does feel more welcoming and accepting.

On the flip side, some participants in protective states highlighted examples of negative community attitudes interfering with clinic practices. For example, Participant #9 provided care in a state with strong legal protections but described how local parties had succeeded in preventing another abortion provider from opening a clinic in her city. She said:

> I've worked at clinics and in many spaces where antis travel from, you know, hours away to protest. I know that they are a movement that is not afraid to get in the car and wreak havoc somewhere that is not their own community. But it's interesting, and in some ways, I think about it in the same way as, like, pushback with, like, methadone clinics. Like you know, people who identify as Democrats being like, "I don't want these people in my backyard, right? I paid a lot of money for this house. I don't need this later abortion care clinic to open."

Together, these findings highlight the role of community attitudes on occupational abortion stigma.

Regional Identity

Regional identity shaped the way that many participants thought about abortion access and their relationship to work. Four regional identities were strongest in the data set: Appalachian, Southern, Midwestern, and Northeastern. A few participants worked in other parts of the country but did not talk about their experiences through a lens of regional identity. *Regional identity* was particularly emergent around regions with heavily restricted or no abortion access because it shaped the way that some participants related to the larger abortion access landscape. For example, Participant #22 said, "I currently live in a state with abortion protections […] but that's not actually where I'm from. So I've spent the majority of my life in the South, and I grew up in the South, and that's the majority of the patients that we serve at this time. So I think that that is easily the most important part of my identity for showing up for patients."

Participants living in restricted areas also spoke to the way that their communities are perceived in the larger pro-abortion movement. For example, Participant #18 strongly identified as an Appalachian and pushed back firmly against the language of "hostile and haven states" being used to describe states where abortion was illegal and legal, respectively. She said, "Our homes are not necessarily hostile, and safe havens are not something that other people get to define for us, so I use the language of 'receiving' and 'restricting' or 'restrictive.'" Participant #20, also Appalachian, expanded on this tension:

> The way that they talk about the state that I'm from and the other states around me is just absolutely – it just boils my blood. It's so frustrating. It's so infuriating that folks who are sitting here in their complacency see the struggle the folks like me […] are going through. And they sit there and say, "Well, you should have voted better." So there's always a little bit of an attitude of like, "You deserve this because you didn't do anything to keep this from happening," not realizing that we are out here fighting for our lives to get even basic like health infrastructure […] Like my entire county until within the last six months did not have a single OB/GYN or midwife. My entire county of 15,000 people? Nothing. You had to drive 20 or 45 minutes to go and see a basic health care

> provider. So, tell me how somebody in that area like that is not out here fighting for their lives to get even access to basic things like birth control.

Participants who identified with Northeastern communities also reflected similar perspectives on and frustrations with members of their community who they saw enacting that "complacency." For Participant #6, this particularly emerged in the wake of the *Dobbs* decision when the people around them were "shocked" that *Roe v. Wade* could be overturned. They said, "[My state] is so used to being comfortably blue, comfortably liberal, if not fully progressive, that I hate to say it, the coastal elite stereotype rings true very much." Participants working in the Northeast or more protected regions also sometimes invoked what they imagined working in more restrictive communities would be like to minimize their workplace stressors. For example, Participant #12 described the intense protest activity she encountered, but then added, "But then I think about the people who work in the South and in other parts where it's just, like, you can't take the same route home every day like. And I think that it's so much worse in other places, I do kind of feel like I don't have a huge right to be like, 'Oh my work conditions are so hard.'" Together, these findings highlight the importance of regional identity in experiences of abortion stigma.

Privileged/Marginalized Identities

Privileged/marginalized identities refer to the intersecting axes of identity, such as race, ethnicity, gender, sexual orientation, age, education, socioeconomic status, religion, and (dis)ability, that are seen as inside or outside of the dominant culture. A few participants directly used the framework of "intersectionality" to talk about their identities and the ways they moved through the workplace, and about one-third ($n = 9$) used the word "privilege" in referring to one or more of their identities. The most salient axes of identity in the data were race/ethnicity, gender/sexuality, class/education, and faith identity.

Race/ethnicity. The majority of participants in this study (87.5%) were White. Some of these participants talked about White privilege, particularly when working in clinics that were largely or predominantly staffed by and/or serving large populations of people of color. For example, Participant #14 reflected on the way that patients frequently assumed she was the doctor. She said, "I've experienced this as a birth doula in hospitals, too, that I just think that […] some patients or their partners are more quick to take me seriously in that environment as a White person, even if I'm the least qualified person medically in the room." Other White participants commented on the ways they know their experiences are different than their colleagues and patients of color. For example, Participant #15 said, "Our protesters will say awful things to our patients like, 'If Black lives really matter, then why are you killing this baby?' Like, they just hear awful things that, like, I don't have to deal with."

Participant #10 is Black/Biracial and spoke to how that can shape the way she relates to or supports Black patients who specifically request a Black doula. She said,

> I mean, the data shows that people, not just Black folks, but any marginalized community, is better served by a care provider who identifies with that community. So just like Asian Americans are better served by Asian Americans, Black folks are better served by Black folks. Latinx community is better served by somebody who speaks their language. Refugee community, same thing, right? I think that there is almost immediate, like, trust and rapport built when somebody when you know that somebody is from your community. So, that, like, emotional overcoming that you have to do, like, "Can I trust this person, can I not trust this person," doesn't exist because you have that automatic connection with them. I know that I went back to my abortion provider [...] because he was a Black man, and I was so grateful that he was still in practice.

Participant #8 is a Korean American who was adopted and raised by White parents in a predominantly White, rural community. She reflected on the way that some East Asian patients have assumed she is "second generation" and therefore shares a specific cultural understanding. She said that she detects a "a sense of relief" from some Asian patients and said, "I generally don't correct people, though. I just kind of let people think what they wanna think because

anything that make people more comfortable on their bad day is fine by me." Together, these findings highlight the importance of race and ethnicity in experiences of occupational abortion stigma.

Gender/sexuality. Nearly two-thirds of participants (62.5%) identified as cisgender women, and the rest (37.5%) identified as nonbinary, genderqueer, and/or agender. Additionally, two-thirds identified as LGBTQ+. Many participants who held marginalized gender and/or sexual identities talked about the way being queer shaped how they moved through the work and related to abortion. For example, Participant #20 said, "Being queer and trans is a huge part of it, because I get deeply and viscerally offended every time somebody talks about 'women's issues' and 'pregnant women' and just leaves me out of that." Participant #16 also named that their encounters with protesters intersected with transphobia. They said, "I changed my name about two years ago now, and they used to yell my name at me all the time when I was walking into the building […] Now, sometimes they yell my actual name, and sometimes they yell my dead name at me and, like, try to give me lectures about gender from the sidewalk."

Participant #11 shared that she largely experienced acceptance within abortion spaces and that Planned Parenthood is the first workplace where she has been "out" as a queer/bisexual person. However, she said that not all her coworkers felt the same level of acceptance, which she knew from participating in an LGBTQ+ affinity group. She said, "Like I have sat back a bit just because I feel like my experience is so different, and because I'm also the only cis person in the group. So, like, it's one of our rules for the group that, like, your experience is valid. It's just not universal." Together, these findings highlight the significance of gender and sexuality in experiences of abortion stigma.

Class/education. Differences in class, related to education and professional identity, emerged in about one-quarter of interviews. For example, Participant #18 shared the way that different backgrounds could create interpersonal tension at her organization: "I'm somebody who has been in this work for a really long time and worked really hard to build, I think, pretty solid name for myself, but I've never went to one day of college. So, I feel like I'm in a different position than a lot of my coworkers […] Some of them have master's degrees but are new to repro, so there's been some tension."

Participant #22 also shared the way that class differences impacted their ability to be their "authentic self" in the workplace: "I think that I share a lot in common with our patients, and my coworkers – not always. Like, my coworkers who have always grown up with financial resources […] Those dynamics are still apparent to me that we didn't grow up the same way." Participant #23 also said that they "grew up very poor" in a small rural community and shared how this has been fundamental to why they work in abortion care:

> [I] really saw what lack of access to choice and lack of access to things like birth control, contraceptives, that sort of thing did to people's lives. And just the way that, you know, it kept people stuck in poverty and in situations that weren't the best. And then when I was in high school, there were about 40 people in my graduating class, and I estimated one time that roughly one-fourth had either been pregnant, had a baby, or fathered a child while in high school. And just, you know, you know, lack of access, lack of information, lack of resources. And you know, I saw, like, what effects that had on my classmates' lives and the lives of the people around me. And, you know, not to say that there's necessarily anything bad with having a child as a young person, but it does tend to limit your opportunities, and knowing that that was something that filled me with this kind of an existential horror, the idea of kind of being trapped in my small town, you know. It really cemented for me that I really cared about this issue very deeply.

Some participants also recognized the way class privilege intersected with their professional identities and helped to shield them from some aspects of stigma. For example, Participant #5 said, "I am kind of protected because I'm White and I'm a nurse. So, I don't think people have a lot of ammunition to come at me in some respects. […] I've been kind of lucky, but again, I'm

surrounded by a lot of people who are educated or in healthcare or are liberal just because that's my bubble." Together, these findings highlight the significance of social class and education level in experiences of abortion stigma.

Faith identity. One-third of participants (n = 8) had a faith identity related to Christianity, Catholicism, Paganism, Quakerism, and/or spiritualism. All but one of these participants said that their faith plays a role in why they work in abortion care. While some were cognizant of tension between their religion and their work, these participants generally felt that their faith was not in conflict with the work that they do. For example, Participant #19 said:

> I am still a practicing Catholic. I don't really attend mass right now because of many and most things that the Catholic church has done, but I do feel that this work is spiritual in some ways, like, that this is a space of healing. This is a space where people can find support they may not be able to find somewhere else. And just for me personally, like, I see this as a way of, like, working with God and working in the favor of humanity and trying to make the world a better place, I guess.

Participant #4 also shared that while she had been raised in an atheist household, she became more spiritual by working in abortion care. She said, "[This] might rub people the wrong way, but when I started at the clinic and when I started meeting patients that felt differently than me, I found *my* faith. And, you know, in my head it makes perfect sense. Like, if you're gonna find God or whoever, it's gonna be in a space where they're needed." Participants who had faith identities also acknowledged that for many of their coworkers, religion was a source of stigma and trauma, and this awareness shaped the way that they did or did not bring that part of themself into the workplace. For example, Participant #23 is a pagan who said that they felt a "strong spiritual calling" to the work but did not "ever wanna, you know, make a lot of people feel uncomfortable [by] talking about spirituality in any sense." Together, these findings highlight the significance of spiritual identity in experiences of abortion stigma.

Reproductive Experiences

Many participants talked about their own reproductive experiences as an important part of their identities and perspective on abortion. Nine participants (37.5%) disclosed that they had personal experience with one or more abortions, and three participants (12.5%) disclosed that they had given birth. Some of these participants shared that they had gotten pregnant and had abortions or given birth while they were also providing abortion care. For example, Participant #16 said:

> Being a person who has had an abortion really influences the way I provide care. Not that it changes things drastically, but it expands my perspective specifically as a mental health provider and how I can best support people […] I had a patient just a few weeks ago. I was talking with her, and I was actually training another social worker at the time, and we were talking and she was kind of, you know, she had her walls on. She was kind of on guard, and she was asking me about pain or something, and I was like, "Well, when I had my abortion, you know, this is kind of the medication I got, and this is how I experienced it. And, like, everybody's a little bit different, and this is kind of the range of experience for pain control." And she looked at me and she said, "You, like, you really had an abortion? […] I was really worried that I would come in here and be judged. You really care. Thank you." And disclosing that little piece of information did more work to help her experience than anything else I could have, all my clinical fields, all that. The shared lived experience is profound.

Participant #10 is a single mother who also had two abortions. In discussing her three pregnancies, she described how each involved stigma. During her first abortion, she shared that she was young, walked through a line of intense protesters, and had limited social support. She said that this experience shaped her decision to become a doula and include abortion in her spectrum of care:

> [I] realized that the lack of support was pretty like emotionally taxing, and, like, the spaces in which you could express emotion and be vocal and find non-abusive care related to abortion was really hard, particularly in the area of the world that I'm in. And so that is what made me feel like, if I'm gonna support pregnancy, then I need to support all of the outcomes of pregnancy, no matter what they are. And having personal experience with abortion was definitely one of the main reasons why I chose to be a full spectrum doula.

Participant #10 then shared that she decided to carry her second pregnancy to term and become a parent. She then encountered a different stigma during childbirth because she is Black and did not have a partner. Her third pregnancy, and second abortion, happened when her son was less than a year old. She shared that this abortion experience was much less stigmatizing because of her community of support and the therapeutic work she has engaged with over the years. She said, "Sometimes because of my personal experience with abortion, [work] can trigger, you know, some emotions. But I feel like that's really the only most challenging part."

Reproductive experiences also included miscarriage, or spontaneous abortion. Participant #8 shared that she got pregnant when she was younger and did not know it until she sought medical care for heavy bleeding. When she learned she was pregnant and having a miscarriage, she said she cried tears of relief. She said, "It was a big moment in my life because it really sparked a lot of thinking for me around unplanned pregnancy and what my life was at the time." She said she talks openly about her experience to educate other people about abortion:

> I think it leads to interesting conversation because usually where it goes from there is talking about miscarriage management and talking about miscarriage, criminalization, and how when we start saying we're going to regulate one thing, we're really opening the door to a lot of other things. So, I think it's also a safe entry point for people who are kind of uncomfortable with things. I think it's, you know, it's such a misnomer in some ways when people say they're "anti-abortion" because abortion just means end of pregnancy. Like, you're not anti-something that happens whether people want it to or not.

Participants in this study strongly identified with being able to make their own personal reproductive choices, whether they had had abortions or not. For example, Participant #6 described how their decision to be childfree intersected with their decision to work in abortion:

> Working in a field where you can, like, help people with advocating for the right to their own self-determination and health care, and especially such a stigmatized field of healthcare, and, like, help people not feel judged always felt like a calling to me. And especially with my own personal feelings towards parenthood, being able to, like, help facilitate people, being able to make that decision and not feel forced to carry through the pregnancy or, you know, not carry through the pregnancy, either way. Like, people

> knowing that they have options and feeling educated on them. Like, that's always been very appealing.

Participant #6 also shared how respect for one another's reproductive choices was fundamental in many ways to a healthy organizational culture:

> The very few coworkers that I've had that have maybe been like, "Oh, just wait. Oh, you'll change your mind [about having kids]." They didn't last long. Like, turnover was pretty quick for them. But like say, like my coworkers who have had like, who had children and they say like, "Oh no, you're good. If you know you don't want them, don't have them." And I'm like, "Good for you. God bless you. I could never be a mom. You're stronger than me." Like we have that like connection there, like everybody's very respectful of each other's family planning choices.

Together, these findings highlight the significance of reproductive experiences in shaping impacts of abortion stigma as it intersects with other overlapping identities.

RQ3: How Abortion Workers Manage Occupational Stigma

RQ3 asked, *What strategies do abortion workers use to manage occupational stigma?* The results revealed that participants enacted a variety of strategies to manage stigmatizing encounters. Many of these strategies fit into established categories of *challenging, transcending, accepting,* and *passing strategies.* Challenging strategies included *disclosing, displaying, resisting, defanging,* and *ignoring.* Transcending strategies included *reframing/refocusing, recalibrating, refusing,* and *depersonalizing.* Accepting strategies included *using humor, deferring blame,* and *passive acceptance.* Passing strategies included *avoiding/concealing, exiting*, *and changing roles.*

Table 4
RQ 3: Stigma management strategies, adapted from Meisenbach (2010)

	Accepts that stigma applies to the self	Challenges that stigma applies to the self
Accepts public understanding of abortion stigma	**Accepting Strategies** • Forming enclaves • Using humor • Deferring blame	**Passing Strategies** • Avoiding/concealing • Changing roles • Exiting

	• Passive acceptance	
Challenges public understanding of abortion stigma	**Transcending Strategies** • Refocusing • Recalibrating • Depersonalizing • Refusing	**Challenging Strategies** • Disclosing • Displaying • Defanging • Resisting • Ignoring

Challenging Strategies

Displaying. Fifteen participants (62.5%) described enacting *displaying,* which refers to engaging in unapologetic displays of a stigmatized attribute or flouting a stigma. For many participants, this looked like wearing a visible pro-abortion T-shirt while going about their regular activities in the community or participating in visible forms of community engagement or activism. For example, Participant #20 lives in a rural part of a state where abortion is currently illegal. They said, "I will stand on the corner, out on the only stoplight in town, with my little sign that says, 'You can still get an abortion even if you live in [state], ask me how.'" Uses of *displaying* can look different, using verbal and/or nonverbal communication, but share a common intent to challenge a stigma.

Resisting. Two-thirds of participants (n = 16) described *resisting* abortion stigma by choosing to engage in an interaction when stigma was present or felt. For many participants, this meant being willing to have conversations with people expressing anti-abortion views in order to correct misinformation or refute stigmatizing arguments. Many participants described how *resisting* for them could look like a heated disagreement with an anti-choice family member. Participant #19 shared that *resisting* could be a "tricky line to walk" when managing stigma from patients during education sessions:

> I'm obviously not there to get into a political argument with anybody. I wanna make sure that they feel affirmed and supported in the choice that they are making. But it does get

> frustrating when they talk about other patients or when they talk about someone who's had multiple abortions or, you know, something like that where they – that own internalized kind of judgment and stigma can spill out onto other people. And that's where I do wanna emphasize to them that people have the option to make this choice and their circumstances are different and you don't ever know what anyone is going through unless you're in their situation.

Resisting was frequently blended with other SMC strategies, such as *denying* via simple or logical refutations. However, *resisting* emerged as a new strategy that specifically highlights where an intentional choice is made to engage in a potentially negative interaction for the purpose of challenging stigma.

Discrediting/defanging. Approximately one-third of participants described using *discrediting,* which refers to poking holes in a detractor's argument or challenging their credibility, or *defanging*, in which a participant used cognitive reframing or self-talk to make a threatening person or situation seem less harmful. This finding is different from *resisting* because participants enacting *discrediting/defanging* typically did not challenge a detractor's credibility directly; rather, this is a strategy that usually happened between co-workers, within a protective *enclave,* or within the person's own cognition. Participants who enacted *discrediting* or *defanging* frequently applied this strategy to clinic protesters without responding to them directly or initiating a confrontation. For example, Participant #3 said:

> I watched [the protesters] for a year. I, you know, I could like peer out the recovery room window and, and see sort of directly on that. And I saw people, like I saw someone piss in a Mountain Dew bottle once and then put it back in their car and go back to their protesting and like, really no shade to that. Like I've lived out of my car before, but there's something about, like, seeing a grown man piss into a Mountain Dew bottle and then put it back in his car and go back to protesting something that you care a lot about that really makes you feel like these people aren't shit. Like, they're not doing anything. They're just fundamentally pretty nonthreatening. And I know that's, like, not true of everyone's experiences with abortion protesters. I, like, understand, you know there's lots of, like, actual bombings and actual murders that have happened. But my specific cohort of protesters, I feel like I sort of had to come to the conclusion that they were non-threatening, otherwise I couldn't keep going into work and so it was sort of, it was like an easy narrative to keep selling myself in my head.

For Participant #16, *discrediting* was not about minimizing the harm that protesters could cause and have caused; it was more about not internalizing the stigmatizing things protesters said. Participant #16 shared, "I think seeing just the hatred and the vitriol there, you know, I can't take it seriously. Like, I take the fact that they're dangerous seriously. But I don't take anything they say seriously because it is so over the top and ridiculous and bigoted, hateful, and nonsensical." Participant #10 applied the same strategy more broadly to the larger anti-abortion movement: "I'm in the space where like I feel like pro-lifers are, like, laughable at this point. Like, I feel like there's something wrong with them, so I don't take offense to, like, anything at this point coming from that side of the spectrum." This quote illustrates the use of *defanging* as a new SMC strategy.

Ignoring. More than half of participants (n = 14) used *ignoring*, or intentionally putting something stigmatizing out of one's mind and moving on as normal. In the context of this study, *ignoring* usually meant that participants would pass protesters or encounter direct stigma from a patient and continue providing abortion care anyway. *Ignoring* is distinct from *passive acceptance* as it reflects participants' intentional choices to not let the presence of stigma deter them from doing their stigmatized jobs. For example, Participant #6 said that protesters made them feel "irrationally angry," but "once we pass by them it's like out of sight, out of mind. I can be like, 'Okay, cool. Let's distract ourselves and just go forwards to do something else.'" In their assessment, "nobody likes the protesters" but *ignoring* was the most effective way to prevent abortion stigma from further blocking people's access to care.

Disclosing. Disclosure is an area where all participants were keenly aware of the public perceptions of abortion stigma and navigated their own stigmatized identity. In some cases, I prompted participants to tell me about their disclosure patterns; in many other cases, participants

themselves proactively named having to decide when and what exactly to disclose as an area where stigma shows up in their lives. Approximately one-quarter of participants described an overall pattern of *disclosing* frequently and openly as a strategy for destigmatizing abortion; another quarter of participants shared that they infrequently *disclosed* outside of their closest friends and family. The remaining half of participants said that "it depends" whether they enact *disclosing* in a given situation.

Many participants discussed how they handle interpersonal encounters with strangers or acquaintances who ask, "What do you do for work?" Participant #4 worked as a patient advocate at an independent abortion clinic in the South until June 2022, when her state enacted a total ban on abortion care. Despite the restrictive climate, her disclosure decisions reflected a position of greater comfort with *disclosing* compared to most participants. She reflected, "I would either say that that's where I worked, you know, or I would say I was in pregnancy options or things like that. But I was pretty much, I was very comfortable saying it because I was proud of it." Similarly, Participant #8 shared a conscious decision to disclose her workplace whenever someone asked, even if it was sometimes uncomfortable: "From the beginning, I just decided that I was not going to be quiet. I was just going to go all in, and I think that, you know, that was a really interesting experience for me. I think what was surprising to me in a lot of ways is a lot of the response was positive." Participant #9 shared a particularly assertive mindset on disclosures, shaped by her experiences in generally supportive political climates:

> I've always lived in quote unquote blue states. And so I think, like, the way I interact with the world is I assume everyone I meet is pro-choice, and if people ask me what I do here, I say I work in abortion care […] I think it's often easier to say that to a stranger than, you know, my partner's uncle, who's a Trump-loving, abortion-hating Republican. But that's how I interact with my community. […] When I say I work in abortion care, I say it with a lot of pride and the response I expect to receive is, "Thank you so much for your work."

Some participants shared that talking about abortion as an occupation overlapped with sharing their own abortion stories. Participant #21 shared, "I'm pretty loud about what I do and my own abortion experience and things like that […] I feel like it's my duty, in a way, to destigmatize it and like also, you never know who you're talking to. Maybe someone who's like, 'Oh shit, I was literally just looking for how to get an abortion. What a coincidence,' you know." Participant #10 shared a similar outlook: "There's not a single person who knows me that like, doesn't know that I've had multiple abortions in the past […] I feel like it's my responsibility to talk about it because if we don't, then things are just gonna remain the same, if not worse." Participants emphasize that under certain conditions, *disclosure* provides an opportunity to educate and advocate for a less stigmatized view of abortion as well as to connect with other people who likewise disagree with the status quo.

Passing Strategies

Concealing/Avoiding. Nearly all participants reflected that they navigated disclosure choice points and practiced different degrees of *concealing/avoiding* at one time or another, depending on the context. Participants reported enacting *concealing/avoiding* to avoid conflict or an "emotionally intense" conversation, protect oneself, preserve a relationship, and/or prioritize another person's comfort. Most participants described their own schemata for mentally calculating whether to *disclose* or *avoid/conceal* (or partially conceal) their stigmatized identity across interpersonal contexts. With some variation, those mental calculations usually considered the following: Who is asking? What is the nature of our relationship? Do I know anything about their views on abortion, or will any clues tell me? What is the context? Am I safe? Do I "feel like getting into it" right now? What might this person do with this information if I tell them? Will

disclosing change the way that they see me and the dynamic of our relationship? If it does, do I care?

These mental calculations, applied in context, led participants to *disclose* in some circumstances and *conceal/avoid* in others. For example, Participant #16 shared that they were "very outspoken" around colleagues and in professional circles as well as on social media. However, they avoided talking about work with their deeply religious family and also regularly made disclosure decisions on a case-by-case basis: "If it's someone I genuinely don't know, where there's no like professional relationship or public relationship, like I would never tell somebody […] that I was an abortion provider unless I had other people with me or unless they, you know, made it very clear that they were supportive." By "supportive," participants described typically assessing verbal and nonverbal cues that a person or group was "progressive" or "not conservative." As Participant #20 put it, "I have a whole process on how to like figure out exactly how much I'm going to tell people and a lot of it is on *vibes*." Participant #20 reflected that while they might like to be able to destigmatize abortion by talking openly about their work, the reality of their circumstances usually made that feel too unsafe. They shared:

> I live in a rural area in a banned state. And so it is, if you tell the wrong person what you do as your job, like I'm in a very small community. People know where I live, people know who my family is. They know, you know, where I work at a separate job. And the balance between like, well, somebody has to do this job and we should be able to talk about it and be able to bring visibility to this. But also like, yeah, if I mess up here, people do know where I live. People can find me, and they can do something about it.

Participant #20's concerns were largely shaped by their past experiences as a volunteer clinic escort outside an independent abortion clinic where protesters were often armed and unafraid to be physically confrontational. They also shared how that previous community work made them vulnerable to involuntary disclosures and the anxiety that followed: "I was actively on the news several times […] and people would be like, 'Oh yeah, I saw you on the news and the story about

this.' And I'll be like, 'Yep, that was me.' Okay, cool. I get to sit here and be concerned about what you're gonna do with this information." While Participant #20 shared that they are willing to be "obnoxiously progressive" in many spaces that feel hostile and still volunteer actively in their community, they drew a hard boundary around their employment, actively concealing that information both online and offline for their own sense of safety.

Other participants talked about the need to protect not just themselves but also their families. Participant #15 is a nurse-midwife working at an independent abortion clinic; prior to this job, she occasionally assisted with abortion procedures at a hospital, but she was able to keep that part of her work concealed and "choose when [to] have those conversations." At the time of her interview, she was navigating having to submit a paystub, and therefore disclose her employer, to her "very conservative" daycare provider. She said, "I'm very anxious to have to turn in that pay stub. Not because I'm ashamed of what I do or I'm embarrassed, but just because I don't want any of that stigma to impact the way my children are treated." As a parent, Participant #15 said that she was already having conversations with her children about abortion to correct the misinformation rampant in her community. She also shared that she had an aggressive encounter with a protester who recognized her from the abortion clinic when one of her children was present:

> She said some really, really graphic things about abortions and the process of them that my 7-year-old heard. And so there's been a lot of challenge in that. I'm just trying to explain to him that what she said was not accurate. That that's not what I do. That's not what anyone that provides abortion does. That that was to scare people. Kind of like, a story just to make people feel really scared of abortion. And that was really confusing to him because she was a grown-up, and you're supposed to be able to trust what grown-ups say. But sometimes grown-ups don't have really good intentions. That was a lot for him.

Other participants shared similar concerns when the stigma had the potential to impact their loved ones. Participant #8, who had already decided to "go all in" on talking about her work,

shared that moving in with a partner changed some of her *displaying* behaviors, specifically wearing pro-abortion T-shirts when out walking in her conservative suburban neighborhood. For this participant, the decision to deliberately *not* wear a certain T-shirt represents an *avoiding* strategy. She explained, "I moved here with my boyfriend, and he has very different feelings around the safety and stigma than I do. He has a lot more protective sense than I do, and I respect that. So, it's less about protecting myself and more about protecting the home and him." In contrast, Participant #24 felt that *disclosing* carried a greater risk than *displaying.* This participant was working and volunteering in a community that is legally protective and largely supportive of abortion, where they felt comfortable *displaying* the stigma with pro-abortion shirts. However, for them, *concealing* employment was the safest strategy. They said they "never share" their occupation and rationalized, "I'm not just protecting me. I'm also protecting the people that I'm in community with 'cause a lot of my friends work in abortion or volunteer for abortion or have had an abortion. […] I don't wanna ever put them into a space where someone might find them through me."

Another pattern that emerged in the data was using *concealing/avoiding* in order to protect oneself *from* one's family. For most participants who feared their family members, the stigma was almost always rooted in anti-abortion religious beliefs. For example, Participant #22 shared that their parents are active members of a fundamentalist church. As a result, they avoid talking about their job with anyone outside of their closest friends. They said of their parents, "If I told them what I did for work, I don't know how much of a relationship I could have with them. I'm not close with them, but like it would kind of not even be like going home for the holidays type of thing." Participant #22 held both safety and interpersonal concerns that disclosing their job could both endanger the work they do along the border of a banned state and cut them off

completely from their immediate family. Participant #19 did not express fear of their family, but was certain that, "This is not a job that I am going to ever tell my extended family about. I was raised very, very, very Catholic and you know, I do have relatives who have abortion as a big political talking point." Participant #19 did not go into detail about what they thought might happen if their extended Catholic family learned they were working as a patient advocate at an abortion clinic. Participant #6, however, shared an experience of managing social isolation and rejection after word of their employment spread via family gossip:

> My family's very culturally Irish Catholic, and communication happens, like, without me involved. So, my dad, like, I mentioned the name of the company I just started working for to my dad. I don't say anything about what we do because it was just a brief mention. I suddenly get cc'd on emails to my whole family that, "Oh no, [Participant #6] is working in an abortion clinic. I urge you to rethink these choices." And just now I've been for the past five years, like, treated differently at family gatherings, like people don't interact with me as much […] it's that exclusion almost that's weird.

For Participant #6, *concealing* would have been a preferable strategy. Because they have family members who are actively involved with anti-abortion groups, Participant #6 managed additional security concerns about family members showing up to protest at their place of work and/or leaking their personal information to anti-abortion networks.

For other participants, *concealing/avoiding* was less explicitly about safety and more about avoiding conflict. Participant #17 took a job as a health center assistant right out of college and shared, "Both sides of my family are more conservative, and I did not tell them I worked at Planned Parenthood. I said I worked at 'a woman's clinic' [..] because I didn't want to create attention that – I didn't wanna, you know, like stir the pot cause I'm not a person to stir the pot." Using vague language such as "healthcare," "women's health," or "reproductive health" was a common strategy that nearly all participants reported using to avoid a stigmatizing encounter at one time or another. None of the participants said that they tell outright lies about their

employment, but they did sometimes avoid explicitly saying "abortion" if they felt unsafe, anxious, or did not want to "get into it." Participants also described using vague language to assess whether disclosing would cause a conflict. As Participant #3 described:

> I often don't tell people that I do work in abortion. I'm sort of often vague and that you know, I work in reproductive healthcare or I work in a healthcare clinic. Or I work, like, writing about reproductive healthcare and sort of hoping that, like, the people who are cool will read between the lines and that, you know, the people who might not be as chill about it will just sort of take that at face value […] I think that a lot of that probably has to come from my own internalized stigma and conflict avoidance of, like, not really wanting to deal with this fact and wanting to keep it more private and only wanting to share it with like the people that I'm closest with. I think that's something that I should probably own, but I don't know. It would be, I guess, in an ideal world, I can tell everybody, but we don't live in that world.

Participant #3 reflects an acknowledgement that their avoidance might be indicative of feeling internalized stigma and not wanting to be outwardly associated with abortion stigma. Like Participant #20, they shared that a lot of their negative experiences with stigma came from community engagement outside of the clinic itself. They described volunteering as a political canvasser for abortion rights and encountering verbal abuse that made them anxious about getting into situations where they could experience additional conflict. These findings suggest that *avoiding* may, at times, be less about fear of the immediate interactant, but rather stem from anxiety developed in previous experiences with stigma.

Changing roles. Nearly half of participants (n = 11) described either *changing roles* within their organization or moving to another clinic as a means of reducing the amount of stress and stigma that they personally experienced. Frequently these changes consisted of seeking out positions that were more administrative, better compensated, and/or more flexible, such as remote/hybrid work or roles where staff could more easily take time off. Participant #21 was hired as a medical assistant at an independent abortion clinic and then moved into a new administrative coordinator role after two years. They described their reasons for the change:

> It came with a pay raise, which is hard not to want, and I had to think about it for a long time because […] I'm pretty good at the bedside compassion part. But my partner is a pediatric ICU nurse, and they kind of get the same thing where it's like, "You're really good at this, and so you should do it forever." And they're like, "Okay, but it's, like, hurting my heart." And so, there were times where I was like, "I am really good at this but, like, at what cost to my own mental health?" So that was part of the reason that I applied.

Participant #11 shared that she had briefly worked in a medical role in a clinic but quickly found that "the medical side of it is not for me; the social determinants of health and like the social support side of it is where I am best." She then elaborated on what was challenging about the role: "There was a lot of inherent knowledge that was required that I was having a really hard time picking up, and I'm just super squeamish. [...] I was like, no, this definitely isn't a moral thing. Like, I can't even watch myself get a shot. I can't support someone in that role the way that they need." Instead, she moved into a patient navigator role that allowed her to provide practical and emotional support to patients traveling for abortion care while also working remotely and having more flexibility to design her own workday.

One participant had not yet changed roles but shared that she was actively considering new employment, reflecting that she knew her current job was not sustainable long-term. Participant #9 was working as a care coordinator at the time of her interview and described in detail why working with patients was meaningful to her, but she also noted that the job was incredibly taxing. She said, "It's really special, but I have to pace myself. I don't know how much longer I'll be able to work in direct clinic care, though it is by far my favorite compared to any of, you know, the nonprofit policy work." During her follow-up interview three weeks later, she shared that she had since applied for a public health job that was still related to abortion but offered higher pay for fewer hours and no direct patient care. She shared, "I don't feel necessarily ready to leave yet, but it also kind of feels like there could be one, you know,

detrimental patient experience that could push me over […] I'm mindful of that as someone who needs to be working for many more decades and who hopes to be working in this clinic for longer."

Interestingly, Participant #8 was at a different point in her career and shared the way she enacted *changing roles* in order to work with patients. She described getting burnt out in an administrative leadership role at a reproductive health organization and seeking out a part-time clinic job as a patient advocate:

> I realized that what I wanted to do was have some kind of work/life balance where I could do more of what actually feeds me to do the less interesting or exciting or sexy parts of the work. But being in the clinic isn't actually a sustainable job for someone who is 44 years old like me; you know, everyone I work with is 26 and under, and it's a hard job. It's a really hard job, and I couldn't do it full-time, so my goal was to find a way to do it where I could go in a couple days a week and do that to fill my cup, and then the rest of the week I do my consulting work to pay the bills.

Participant #8 acknowledged that she can manage her burnout and design her career in this way "mainly because I have a lot of privilege, honestly." This finding contributes new meaning to the SMC sub-strategy, *stopping the stigma behavior,* by illustrating where stopping the behavior may be less about avoiding stigma and more about making a living or defending against burnout.

Exiting. While less common, a few participants chose to leave their organizations as a means of managing the occupational stigma. Four participants (16.6%) voluntarily left their jobs; two participants left their employer for a similar job at another organization, and two left abortion care altogether. The former might be considered enacting both *changing roles* and *exiting* an organization; the latter are the best exemplars of *exiting* as a stigma management strategy, similar to proclaiming oneself *ex-stigmatized*.

Participant #17 quit her job as a health center assistant after just one year at a Midwestern Planned Parenthood. She shared that she had experienced a great deal of stress and stigma, and

an encounter with a patient's violent partner that required police intervention was the "nail in the coffin." She described:

> I realized that, I mean, I am capable of handling those situations, but it is not something I wanted to do again. And I think that that was just kind of the turning point of I have [...] learned and experienced all that I had intended to, so I was kind of ready to move on from it […] I was at the point where I'm just like, I need to step away. Like, I dreaded going into work because I thought that one of these situations is gonna happen again. And it was, you know, unfortunate cause, you know, like they were short staffed as it is and can use all the help, but I think that I just for my own, you know, wellbeing and mental health, I felt that finding a new job would be like the best course of action because I had, I think after that day and getting in my car from that clinic, I had already decided I was like, "I'm gonna look for a new job," because it was just too much.

Participant #5 also quit after just two years as a nurse supervisor at a Southeastern Planned Parenthood. She described the way she had tried other strategies to reduce the overall amount of stress she and her coworkers were experiencing at their high-volume clinic. However, she ultimately determined that exiting the organization was the best decision:

> I took a leadership position so I could advocate for my nurses, and I did a lot of good, I would say. But, I mean, the working conditions are kind of terrible. We didn't even have a lunch break, so it just got to be too much. And then when I saw that how *Roe v. Wade* was going to go down, and it seemed our leadership didn't really have a clear plan, I was like, I need to move to a less stressful job. I actually ended up with like, really high blood pressure and now my blood pressure is normal. I mean, it really physically affected me. Even though I was super gung-ho about the work, and my nurses were amazing, and we had this great team. I was just, like, I can't function here anymore.

I asked Participant #5 if she would consider returning to abortion care under different circumstances with more organizational support. She answered that she sometimes thought about it but felt it would just be the same experience: "I'm not sure what I'm gonna do in the future, but I actually don't think I'm gonna do abortion anymore. I think it's just, it's too hard, even though it should be normal health care and it should be an easy process." Like *role change,* this finding expands understanding of stopping a stigmatized behavior in an organizational context.

Accepting Strategies

Forming enclaves. Two-thirds of participants (n = 16) described forming *enclaves,* a strategy for insulating oneself against stigma by cultivating a protective social "bubble" of friends who are also stigmatized and/or like-minded around abortion. For example, Participant #22 said, “I try as much as I can to surround myself with people that are supportive of me and, you know, whatever type of work that I want to do.” Many participants also discussed how their *enclaves* overlapped with other marginalized or stigmatized identities, such as queerness or disability, and how those groups tended to form around shared progressive values. For example, Participant #3 said:

> I feel very embedded in the queer community and the way the queer community is, in general, is pretty receptive to abortion. I often don’t cultivate close relationships with people who would be anything less than supportive of abortion, and part of that is because I’ve, like, been certified as an abortion doula since 2017, and I know that it’s important to me [...] I know that I don’t wanna be friends with people who don’t share that value and that, like, that’s probably gonna bleed into like other values around, you know, consent and bodily autonomy. And so I have sort of shaped my life and my friend group around these things.

While *enclaves* are largely a protective, accepting strategy, some participants did share things about how these subgroups can function both to insulate members from larger group stigma and bolster strength to participate in activism. For example, Participant #18 is in rural Appalachia and described her community as follows:

> So, I am queer, cis – when people ask me about my gender identity, I say that I am a ‘rugged femme’ – so that is to say that I am part of communities where I’m, you know, welcomed and belong with all those things. Most of my friends are queer and/or trans or nonbinary. Not all of them, for sure, but we have found each other and work really hard to strengthen what we call our “we save us” muscle. So, actually, a bunch of us who used to be clinic escorts here are now doing community safety team responses, too. We’ve done some drag events that were catching heat. We’ve done drag queen story hours. There was just a Palestinian solidarity rally. We’re gonna do another action next week.

These results indicate that enclaves are an important strategy for many stigmatized workers that may have some crossover between accepting and challenging.

Humor. Nearly half of participants (*n* =10) described using humor, particularly dark or gallows humor, to cope with the stressful and stigmatizing elements of their job. Some participants made jokes or shared their specific dark jokes in the interview; for example, Participant #21 described bonding with their partner over work stresses and said, "I mean, this is our morbid joke, but like you know working in the NICU and working in abortion care, it's like just dead babies everywhere." Other participants refrained from sharing what exactly their dark humor looks like and instead described it in broad strokes. For example, Participant #9 said, "I'm part of a [digital platform] chat. It's been less active, but it's abortion workers around the country, and there's some really dark shit in that. Like, really dark, funny shit. But like, stuff that we wouldn't, you know, wanna get out? And people who work in abortion care, and especially later care, you know, can laugh at that. And also, like, cry." Findings here support the emergence of humor as blurring the lines between challenging and accepting stigma.

Deferring blame/agency. One-quarter of participants described their relationship to parts of the stigma in a way that *defers agency/blame*, reflecting a sense of helplessness or not having a solution to the stigma. Often this strategy emerged as a feeling that the challenges, or a specific challenge, was greater than the participant or their employer could address alone. For example, Participant #15 said, "When you're talking about protesters, there's just – there's no solution. There's no solution that's been provided globally or nationally, or there's just no working solution to insulate from those people. And so, it just feels like such an unjust and unanswerable anger that there's really not a lot of productive conversation." This comment was in specific reference to local city ordinances blocking the clinic's efforts to build a fence to shield their patients and workers from protest activity; the tension between clinics and protesters exercising their First Amendment rights came up in many interviews, however. Largely, participants in this

study just accepted that protest activity came with the work and there was nothing they could really do about it.

Passive acceptance. *Passive acceptance* refers to situations when a person remains silent and accepts, or appears to accept, a stigmatizing remark. Nearly half of participants (n = 11) described needing to manage stigma in conversations with patients and passively accepting stigmatizing remarks from those patients. For example, Participant #12 was a patient navigator who also worked reception for many years at a Planned Parenthood. She described the way that patients' own stigma management strategies could constrain workers' ability to do anything but passively accept varying degrees of stigma in the course of providing care. She said:

> It's almost like the patients themselves are aware of the stigma and want to put themselves in a camp like right away. So, I think that the patients also will do this thing of, like a hierarchy. Like they'll be like, "Well, I'm working. I already have five kids. I can't afford it. I'm not just, like, some young teenager who just got pregnant." And I'm like, "I didn't need to know any of that actually, but okay. We're still gonna be kind and compassionate to you, as well." Or patients will do the like, "Do you think God will forgive me?" And I'm like, "I am a stranger that you have never met. And like, that's a heavy question." I always would say like, "This is between you and your God. And my thought is that God forgives and wants us to be happy and take care of families, and that's between you, you know?" Because what a loaded question to ask us. But then sometimes I'm like, should I just say yes because you know that would make them feel better? So, it's almost like juggling the different stigmas.

Participant #14 also enacted *passive acceptance* when supporting patients as an abortion doula. She shared that she also encountered patients who held religious anti-abortion views, and her acceptance strategy was rooted in compassion:

> I could imagine the suffering that that person must be experiencing from having to hold that, and how I would perceive it is like they're really holding that view against themselves […] It's all so hard that, the way they would talk is someone, you know, being rude to our staff or to the doctor to anybody. Part of me would want to be, you know, protective of that and be disdainful, you know, back to them. But at the same time, they're the one in the real vulnerable position […] I think I was really aware of that.

Participant #4 also described using *acceptance,* but a more active form of *acceptance*, to not only receive patient stigma with grace, but to better support patients who were experiencing the cognitive dissonance of having an abortion when they largely did not agree with abortion. She said:

> It's kind of funny because I do not think I'm in the majority in this, but [...] I loved it whenever I got patients that were pro-life because in my head, I was like, "This is probably your last stop where you're going to be capable of having support." You know? But I grew up in a really liberal household, and so I had to learn how to help them, like the language to use that helps them.

Within this overall strategy of *acceptance,* Participant #4 highlighted a clinic strategy that many participants echoed, which is to mirror patient language even if that language felt stigmatizing. Some participants also named that this was something they were specifically taught to do when training for their position.

Transcending Strategies

Refocusing. Nearly all participants (n = 22) engaged in *refocusing* when talking about the work they do. As a stigma management strategy, *refocusing* works to transcend abortion stigma by framing abortion work through a positive lens, emphasizing patient outcomes and job satisfaction. For example, Participant #15 is a nurse-midwife who worked a few days a week at an independent abortion clinic. She reflected that abortion felt the "most macro effective." She further explained:

> Just even doing medication abortions only, just the positive impact that happens with education rates, violence, crime, poverty, they just – it has so much more of an impact than one positive impact birth can have or one positive impact heart surgery. And so, I feel like it's probably some of the most impactful medicine that I could provide to people, some of the most impactful midwifery care that I could provide. And it's honestly a very simple job from a mechanics perspective, particularly with mifepristone. It's probably the most rewarding job that I've ever had, to be honest.

When asked how they felt about their job, many participants responded, "I love my job." Their more detailed explanations described how they found a sense of meaning and purpose in the work, how it was rewarding to help people, and how they took a lot of pride in the work. For example, Participant #7 said:

> I love everything from, like, the patients. Talking to them, getting to know their stories, helping patients through, like, the roughest time of their lives. For some, some of them it's the roughest day of their life. Some of them, it's the best day of their life. They, you know, release so much. It's a roller coaster of emotion for people, so being an empath, it's always so lovely for me to be able to help people through that transition and kind of helping them again, regardless of what their scenario is.

Asserting one's agency in choosing to work in abortion care was a strong current throughout participants' use of *refocusing.* Many participants described feeling an urgent sense of wanting and being able to help. For example, Participant #13 actively sought out clinical training in abortion procedures amid a challenging political climate. She said, "I felt how important the work was, especially because my third year is around the time when the challenges to *Roe* were coming down through the courts […] I was already sort of feeling this, like, call to action to be a part of this community in such a critical time." Some participants also used *refocusing* to emphasize the non-stigmatized pieces of their professional identities and extend them to abortion care. Participant #2 is a nurse in a family practice that only started providing medication abortion two years ago. She did not intentionally seek out abortion care, but when the opportunity arose to be part of the abortion care team within her clinic, she chose it. She said:

> I didn't get into healthcare or nursing for me, I got into it to help others, whatever that path may be in their life. I've assisted in many different roles, so I feel like if people are gonna give us stigmatism about that, then I can step up and I can be a person that, you know, if this is what you choose and you need somebody to hold your hand, by all means, I'll hold your hand. I will do whatever I need to help you through this, because that is my role and I choose this role every day.

Recalibrating. As a stigma management strategy, *recalibrating* works to change the standards by which stigmatized occupations are judged and imbue them with new value hierarchies that lessen the stigma. Many participants in this study emphasized that abortion care is values-centered work for them, and they talked about the ways that their organizations were working to provide a higher standard of care aligned with progressive values, such as equity, inclusivity, autonomy, compassion, and empathy. For example, Participant #16 is a social worker and part of the leadership team at an independent abortion clinic. They shared, "I love the human rights space work that we're doing to allow people to actualize their autonomy. It fits in not only with my professional values, but also my personal values and morals." Participant #24 expressed the opposite—a large sense of *dis*satisfaction that their clinic leadership was *not* practicing the values they espoused—but still used *recalibrating* to emphasize the responsibility of abortion clinics to do better and to underscore the work of organizations who are holding themselves accountable. Participant #24 said:

> The best people in this movement and the best people who've been doing this work are people who dream of a world where this work isn't needed, where abortions are just seen as healthcare, and there is not a stigma. And those people I have a lot of respect for and a lot of care for because they're showing up to this work really steeped in reproductive justice values and really steeped in that care for themselves, the care for the workers, and the care for the patients.

Other participants who did see their organizations practicing care that aligned with values systems like reproductive justice used *recalibrating* in framing the care they provide as a corrective to issues in the larger medical system. For example, Participant #19 said:

> A lot of this job, too, I think is also emphasizing to patients that they have certain rights during medical care. And it can be so frustrating, especially talking to women about experiences with giving birth, how their wishes are disregarded, how they are not treated like the person receiving care, like their husband or boyfriend is asked questions before they are. And the amount of women that I've talked to who had asked to get their tubes tied the most recent time that they gave birth and just did not have that happen and were not told that by their provider at the time only to become pregnant, you know, a few

> months after giving birth is astonishing. It is the most frustrating and horrible thing in the world and I'm grateful that we're able to see them and we're able to give them that care [..] This job has emphasized to me more than anything like these deep, deep systemic issues in our medical care system. And how women and like people who can get pregnant and give birth are often just not treated as full human beings, and it's so horrible to hear stories like that every day. But I'm hoping that in the work that we do, we can kind of counteract that at least a little bit or at least let people know that that is not okay and that is not normal.

Refusing to engage. Approximately one-quarter of participants (n = 7) described situations in which they had *refused* to engage in an interaction when stigma was present or felt. *Refusing* is understood distinctly from *accepting* or *ignoring* stigma because there is a clear and intentional *refusal.* For example, Participant #1 is a social worker who provides all-options counseling and abortion support at a family practice clinic. She shared that her employer only started providing medication abortion in the last two years, but that she was providing all-options counseling for many years prior and took the initiative to institute a resource and referral list for patients who were seeking abortion before her clinic was willing to provide that care. She described her *refusing* strategy as follows:

> There are some people I know outside of work who know that that is something that I support, and that I talk with patients about very openly, and I think they have great concern about my feeling like that's okay. I am not afraid to say I am a Christian, and so this is something that goes against a lot of Christian belief, but I am unwavering in my opinion that that is important, and I'm really glad that we offer the care here. But I have had people, you know, want to pray for me because I'm doing those kinds of things, which I have just… politely declined […] I've just said, you know, "No, I'm okay. I don't need to see passages in the Bible or anything like that."

Other participants described using *refusing* instead of *resisting* to preserve their own energy and mental health when it felt to them that a person was being intentionally disagreeable and acting "in bad faith." For example, Participant #11 shared that she refused to discuss abortion or her job with her stepfather because she was already familiar with his anti-abortion views. She said,

> Like he knows I work at Planned Parenthood. I'm pretty open about it, and he'll be like, "Oh, how's work?" And I'll be like, "Oh, it's fine, thank you."" Like we don't have a hostile relationship, but like, I don't trust being able to talk to him about it [...] Like what I was taught was "debate" I realized was antagonization. And to protect myself, I no longer engage in that "debate."

Depersonalizing. Nearly half of participants (n = 11) engaged in *depersonalizing,* a strategy that manages stigma by focusing more on the way the stigma applied to patients than to themselves. For example, this exchange with Participant #5 reflects how *depersonalizing* was a cognitive strategy for rejecting the stigma as it applied to providers:

> Interviewer: Like when people said mean or untrue things about abortion care, did you feel like they were talking about you?
>
> Participant #5: No, I thought they didn't realize they were talking about people around them that had abortions, because when I do reveal that I work at Planned Parenthood, so many people have told me their abortion stories. And so, when someone says something negative, I'm like, "You don't realize that the people in the room have had an abortion, and you don't think that because you think they're, like, Christian or religious or whatever, or no one you know would actually have an abortion." So, I didn't feel – it didn't feel judgmental to me, it felt judgmental to the people around me.

In another example, Participant #10 talked about the way she had experienced abortion stigma intensely as a patient and how she had done a lot of therapeutic work to be able to move past that stigma. In her role as an abortion doula, she used *depersonalizing* to put distance between herself and that stigma by focusing on her client. She said, "I always just remind myself that it is their story and not mine. And then I'm simply there to support and just help them weave through like the masses essentially, because I remember very much what it felt like walking up to the abortion clinic. So just really being like their umbrella and their protector is kind of like how I how I visualize it." By seeing herself as *protecting* a stigmatized person instead of *being* a stigmatized person, Participant #10 managed feelings that might otherwise trigger her own past trauma and abortion stigma.

Table 5

RQ3: Strategies abortion workers use to manage occupational stigma

Theme	Definition	Exemplar
Accepting Strategies		
Forming enclaves	Forming a social "bubble" of friends who are exclusively like-minded around abortion.	Sometimes it's like, well, you're really only surrounding yourself with people who agree with you, and I'm like, well one's inner circle can be people that just agree with you. (12)
Using humor	Using humor, particularly dark or gallows humor, to cope.	I mean, this is our morbid joke, but like you know working in the NICU and working in abortion care, it's like just dead babies everywhere. (21)
Deferring agency	Reflecting a sense of helplessness or accepting negative consequences of stigma as they are.	When you're talking about protesters, there's just there's no solution. There's no solution that's been provided globally or nationally, or there's just no working solution to insulate from those people. And so it just feels like such an unjust and unanswerable anger that there's really not a lot of productive conversation. (15)
Passive acceptance	Staying silent or passive when another person expresses stigma.	A lot of patients will kind of outwardly just state like, "I don't believe in abortion" […] I'm obviously not there to get into a political argument with anybody. I wanna make sure that they feel affirmed and supported in the choice that they are making. (19)
Passing Strategies		
Avoiding/concealing	Avoiding situations or concealing the stigma to avoid conflict, protect oneself, or preserve a relationship	If for whatever reason I have to Uber to work that day and the driver's trying to make small talk, I'm not saying anything. I'm saying I work at, like, a gynecology office. (6)
Changing roles	Seeking a different position that reduces stress and/or feelings of stigma.	I did work briefly at a clinic in 2021 and I realized that […] the medical side of it is not for me. The social determinants of health and like the social support side of it is where I am best. (11)
Exiting the organization	Leaving one's organization.	For my own, you know, wellbeing and mental health, I felt that finding a new job would be like the best course of action because […] it was just too much. (17)

Transcending Strategies		
Refocusing	Framing the work through a positive lens, emphasizing positive outcomes and the elements of one's job that provide a sense of satisfaction.	I didn't get into healthcare and or nursing for me, I got into it to help others, whatever that path may be in their life. I've assisted in many different roles, so I feel like if people are gonna give us stigmatism about that, then I can step up and I can be a person that you know, if this is what you choose and you need somebody to hold your hand, by all means, I'll hold your hand. I will do whatever I need to help you through this, because that is my role and I choose this role every day. (2)
Recalibrating	Changing the standards by which abortion care is judged; creating new value hierarchies that lessen the stigma.	I love the human rights space work that we're doing to allow people to actualize their autonomy. It fits in not only with my professional values, but also my personal values and morals. Yeah, I absolutely love the work I do. (16)
Depersonalizing	Focusing more on the way stigma harms others more than oneself.	When someone says something negative, I'm like, you don't realize that the people in the room have had an abortion, and you don't think that because you think […] no one you know would actually have an abortion. So it didn't feel judgmental to me, it felt judgmental to the people around me. (5)
Refusing	Declining to engage in specific interactions when is stigma is present.	I have had people, you know, want to pray for me because I'm doing [options counseling], which I have just politely declined […] I've just said, you know, "No, I'm OK. I don't need to see passages in the Bible or anything like that." (1)
Challenging Strategies		
Disclosing	Disclosing one's job in order to normalize and destigmatize abortion.	I find myself more and more saying 'I work in abortion care' because I'm both proud of it and because I like to get a reaction from people. That tells me everything I need to know about how to, like, move forward in that conversation or not. (9)
Displaying	Engaging in unapologetic displays of abortion support.	I will stand on the corner and out on the only stoplight in town with my little sign that says, "You can still get an abortion even if you live in [banned state], ask me how." (20)

Defanging	Using cognitive reframing to make a threatening person or situation seem less scary.	There's something about, like, seeing a grown man piss into a Mountain Dew bottle and then put it back in his car and go back to protesting […] that really makes you feel like these people aren't shit, like, they're not doing anything. (3)
Resisting	Choosing to engage in an interaction around abortion when stigma is present	I've changed a lot of people's minds just by talking to them and just by listening and, you know, it wasn't hard for me […] and if not changing their mind, at least making them think of it from a different perspective. (4)
Ignoring	Intentionally putting something upsetting out of one's mind and moving on as normal.	People will call you a baby killer if you support folks who get abortion, tell you you're going to hell and you're gonna burn and die […] I experienced it as a consumer of abortion care first. So now it's like I don't even see them or hear them at this point when I'm supporting other people. (10)

CHAPTER 5 – DISCUSSION

The purpose of this study was to critically examine how people who work in abortion care experience and manage occupational stigma in the context of their communities, organizations, and personal identities. This study allowed participants to voice the challenges they face in providing abortion care amid ongoing legal restrictions and asked them to reflect on the ways they manage these related stressors. First, the findings uphold that working in abortion care can be a particularly turbulent and stigmatizing experience that affects a healthcare provider's mental and physical wellbeing, economic livelihood, and interpersonal relationships. Workers reported common negative socioemotional impacts including anxiety, emotional drain, and symptoms of burnout, including physical health issues. The findings also illustrate how intersectional positionalities can complicate individuals' experiences of stigma; a wide array of different experiences is possible, shaped by factors in a worker's specific community, organization, and personal identities.

Second, the findings from the study reveal that abortion workers use a mix of communication strategies to manage stigmatizing encounters and maintain a positive self-image. Working in healthcare created an inherent tension between prioritizing the needs of patients (who also experience an intense stigma) and tending to one's own needs around stigma management. Additionally, there were tensions for workers who see abortion care as a form of political advocacy for a cause they deeply care about but who are lacking support to advocate for themselves as employees navigating real or perceived organizational inequities, misalignment of values, and mistreatment by their employers. Workers' ability to choose their own stigma management strategies is impacted when their own needs are overshadowed by the needs of

patients, organizations, and/or the larger movement. These dynamics can put workers into tension with the care that they deeply want to provide.

In this chapter, I highlight the most significant findings of this study in four sections. First, I discuss abortion workers' experiences of occupational stigma and offer an intersectional analysis to bring light to deeper nuances of stigma and stigma management in abortion care. Second, I discuss contributions to SMC theory (Meisenbach, 2010), including proposed strategies and how participants' strategies signify their relationship to stigma via SMC strategies. Third, I review the limitations of the findings and propose an agenda for future research. Last, I conclude with pragmatic recommendations for abortion providing organizations in enacting stronger workplace supports for a diverse workforce navigating this uniquely challenging stigma.

Features of Occupational Abortion Stigma

Outcomes of this study reveal deeper insights into the unique stigma that some abortion workers are experiencing in the wake of the *Dobbs* decision that overturned the Constitutional right to an abortion. Conversations with providers revealed that they experience stigma through *stigmatizing messages, stress compounded by stigma,* and *socioemotional impacts*. Stigmatizing content messages largely reflected the previously identified features of stigma communication—mark, group label, responsibility, and blame (Smith, 2007a)—and were designed to evoke fear, disgust, and anger toward abortion providers. These messages share a common root in beliefs that abortion is both a blemish of a person's moral character and a barbaric "abomination of the body" (Goffman, 1963, p.2). In particular, the anti-abortion movement's use of heavily altered graphic images, including gruesome, dismembered fetal remains, has provoked a strong negative response to abortion (Shrage, 2002) and has contributed to a more intense stigma around abortion later in pregnancy (Becker and Hann, 2020).

Abortion has been contested for centuries, and yet the emphasis on fetal development images in U.S. anti-abortion rhetoric is relatively new, coinciding with advances in embryology and photography (Stormer, 2015). The use of visuals in anti-abortion protests emphasizes the *physical taint* of abortion work by attributing meaning to otherwise "ambiguous" products of conception (Becker and Hann, 2021). Not every participant handled or even saw products of conception in their daily work. One-quarter of participants in this study were only involved in the provision of medication abortion, in which the patient passes the pregnancy hours later at home, and others were serving in different clinic roles that shielded them from some of the physicality of abortion procedures. In a few cases, participants specifically named feeling too "squeamish" to be involved in a medical role, raising questions about how these workers might balance their political support for abortion with their desire to stay disconnected from the hands-on procedural care. However, all participants were familiar with the type of imagery deployed by anti-abortion activists and how that deliberately contributes to a stigmatizing image of abortion workers as, both literally and metaphorically, having "blood on their hands."

Anti-abortion protesters were a common source of stigmatizing messages that many participants tried not to give that much attention to but accepted as a fundamental occupational hazard. However, some clinics were able to function under the radar of anti-abortionists, shielding workers from encountering these visceral *stigmatizing messages* from protesters directly at their place of work. Four participants worked for a provider that was delivering medication abortion care solely via telehealth and through the coordination of mobile clinics. These workers reported encountering some online hostility, but without a brick-and-mortar clinic, neither patients nor providers had to navigate protesters during appointments. Two providers worked for a family practice that provided medication abortion to existing patients, but

their parent hospital system did not externally talk about abortion care being available; as a result, these two participants largely felt that their community did not know they were providing abortion and so they were able to do their jobs without much interference from anti-abortionists. Stigma and stress were also affected by the nature of a clinic's working relationships with local law enforcement and city officials. For example, several participants described needing to involve law enforcement to keep protesters from trespassing and/or to handle violent individuals who accompanied patients to their appointments. Participants' sense that these unsafe work conditions have been normalized is in one sense unique to their stigmatized care services. In another sense, workplace violence is a pervasive hazard against healthcare workers around the globe (Havaei, et al., 2020) that has been widely linked to job satisfaction, turnover, burnout, and social support (Duan et al., 2019).

Participants also reflected an awareness when their experiences could not be generalized to all workers. For example, clinic protest activity is pervasive across the U.S. and the threat of violence is palpable to most clinic workers (Todd, 2003). However, many participants were inclined to make comparisons and say things like, "Our protester activity is not that bad compared to other places" or "I'm sure people elsewhere have it so much worse so I don't feel like I can really complain." These statements, while they might reflect a stigma management strategy akin to *defanging* or *depersonalizing,* might also indicate an awareness of having protections not afforded to everyone who works in abortion care. For example, some participants described practicing within an insulated office park on private property that protesters could not access, similar to participants in an earlier study who encountered "limited protest activity" (O'Donnell et al., 2011). Other participants worked for a clinic that has unsuccessfully petitioned

its local government to be able to build a fence around their parking lot, leaving patients and workers more vulnerable to *stigmatizing messages*.

Intersectionality and Stigma

The use of intersectionality (Crenshaw, 1991) as the theoretical framework for stigma research can provide new insights into the impacts of stigma and stigmatizing messages in dirty work. By examining stigma in the context of social forces at play, this study helps to theorize differences or similarities among the impacts of stigma and resources needed for stigma management communication. Black feminist scholars have long used what Collins (1990) called the "matrix of domination" to highlight the constraining, overlapping forces of white supremacy and patriarchy. The overlapping constraints of racism and sexism was explicitly present in the study when participants shared racialized content messages such as, "If Black lives matter, why are you killing this baby?" that use a *tribal* stigma to invoke a particular shame and undermine Black feminist activism (Norwood, 2021). Participants in this study shared experiences that also speak to the forces of cisheterosexism, ablism, classism, and spiritual abuse. This study further found that occupational abortion stigma is not a "one-size-fits-all" experience; rather, it is a nuanced communication phenomenon influenced by how oppressive forces coalesce via *state laws, service delivery, organizational culture, community attitudes, regional identity, privileged/marginalized identities,* and *reproductive experiences* (see fig. 1).

Applying an intersectional lens further reveals the way structural stigmas (Elkhalid et al., 2023) can exacerbate tensions for people who perform different types of "dirty work." Most participants in this study fell into roles that could be considered medical assisting or patient support, meaning there was not enough variation to assess how stigma management might vary among clinic administrators, physicians, clinicians, nurses, and medical staff. However, the data

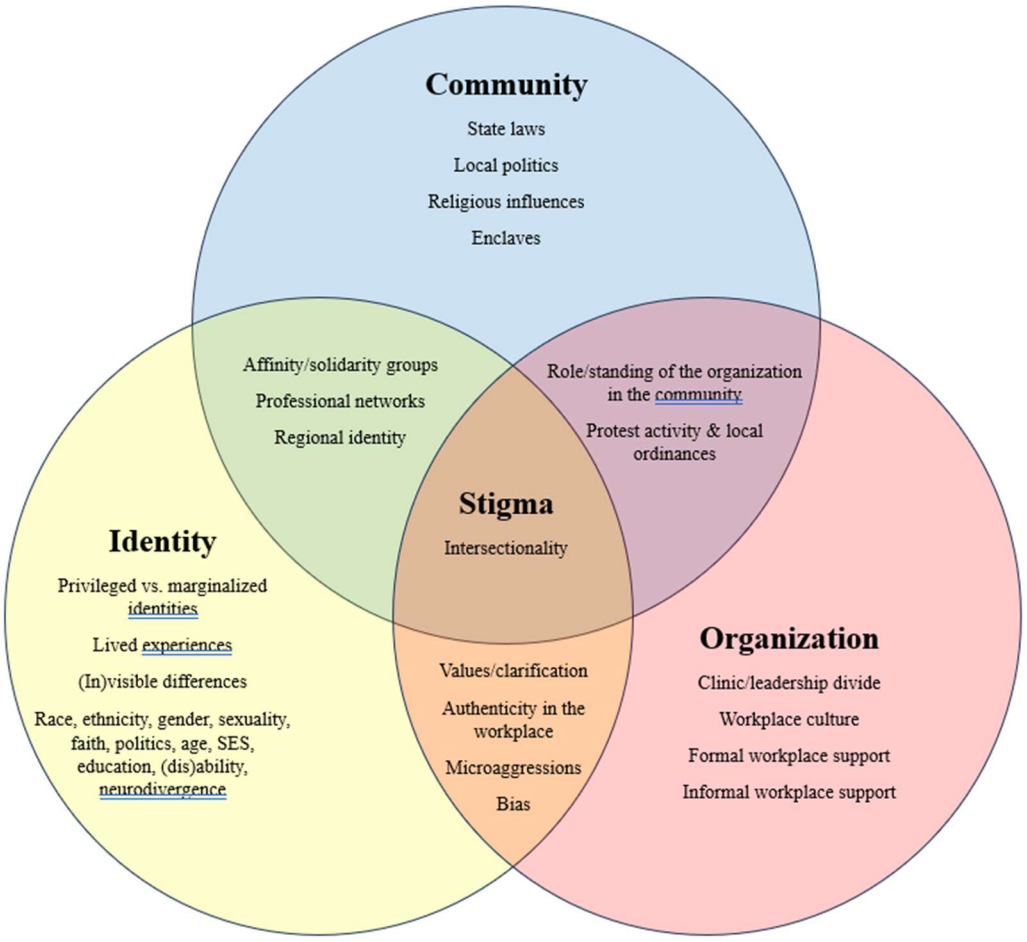

Figure 1
RQ2: Overlapping factors in occupational abortion stigma

did include some insights into the way that participants experienced stigma differently depending on their specific job responsibilities. For example, discussions of handling fetal tissue arose among medical assistants, and there were data points about the added fatigue for workers who had to be on-call for patients. Social workers, patient educators, and patient navigators reported higher amounts of emotional fatigue compared to nurses and clinicians. Participants who had the ability to work remotely discussed being shielded from protest activity and having added flexibility, but also named that they felt more isolated from their coworkers. Overall, more research is needed to fully address if there are consistent patterns in stigma management among groups of abortion workers by role. That said, this study highlighted the utility of an

intersectional framework for understanding how "dirty work" manifests differently for individuals across organizations and communities.

Participants described the way that their identities did or did not feel salient in the workplace, largely around divisions of *privileged vs. marginalized identities.* For participants who held one or more privileged identities, such as whiteness, there was an awareness of how that privilege often functioned to protect them from some aspects of stigma. Some participants directly named race, class/education, and able-bodied privilege as resources for challenging stigma, which may highlight the importance of intersectionality as not just an academic lens but also a pillar among reproductive justice values (Ross, 2018). Providers who hold one or more marginalized identities can face additional layers of stigma management, shaped by the (in)visibility of their relative differences. Recent scholarship has proposed a theory of intersectional stigma management communication (ISMC; Mann, 2020) to explicate how people engage in "specific strategies to respond to intersecting stigmatized subjectivities" (p.8). This work highlights how individuals can engage in strategic disclosure decisions about multiple stigmatized identities, finding that this was the most common stigma management strategy among adults who held subjectivities at the intersection of LGBTQIA+ identities and autism (Mann, 2020). Participants who held LGBTQ+ identities overall reflected little to no anxiety about being "out" in their workplace, which might reflect the emerging alliance of people experiencing sexuality-based stigmas (Mosley et al., 2021) or speak to intentional work making reproductive health organizations more welcoming and inclusive of LGBTQ+ people. However, these same participants did not hold the belief that abortion work was universally welcoming everyone, particularly transgender employees. Participants also were split on whether they disclosed other stigmatized identities in the workplace, such as neurodivergence, mental health

issues, and growing up in poverty. This data supports the development of an ISMC framework to more deeply investigate how participants enact strategies to manage both a stigmatized occupation and one or more stigmatized identities.

As anticipated, positionality influenced the way participants did or did not feel accepted and valued in the workplace, a finding that complements decades of scholarship on social ostracism (Sias, 2009) and discrimination in the workplace (Allen, 2009). However, one emerging finding is the role of *regional identity* as a source of stigma, ostracism and tension within the pro-abortion movement. Specifically, participants who identified strongly with the South, Appalachia, or the Midwest reflected a tension about "being looked down on" by people in so-called "blue states," coupled with experiencing a stark disparity in the funding going to different areas for practical abortion support. These participants were more apt to talk about the regional impacts of their work and to advocate for the reproductive health needs of their home communities, even if those communities were at times unsafe and unsupportive of abortion. Participants in red states described their community's views in nuanced ways, sometimes highlighting paradoxes where rural and small-town communities could be both protective and threatening at the same time. Importantly, state abortion laws (or the simple eponyms "red state" and "blue state") are not sufficient for understanding the climate around abortion in a given area. Participants highlighted that *state laws, local politics,* and *community attitudes* together create a unique community-level stigma (Cutler et al., 2022). Stigma toward "red states" creates more stress for providers who may fight within their own communities, but still identify with those communities and care deeply about restoring abortion access for the people around them.

Structural Stigma, Emotional Labor and Burnout

Since the *Dobbs* decision, the U.S. has seen the development of regional "abortion deserts," including the Southeast (Society of Family Planning, 2023). The enforcement of abortion bans has put a great strain on the entire reproductive health care system, and many participants shared that they do not have the capacity to keep up with the need. It is for this reason that this study identified *stress compounded by stigma* to explain how that stigma has created overall conditions of pervasive misinformation (Pagoto et al., 2023) and scarcity. Recall that 21 participants (87.5%) described the barriers that patients must overcome to access abortion, and many reported an increase in patient volumes since the *Dobbs* decision. These participant reports are backed by national abortion data which identified both an overall increase in the total number of abortions between July 2022-June 2023 and "surge states" that experienced the largest cumulative increases in the total number of clinician-provided abortions (Society of Family Planning, 2023). While social and economic barriers to access exist in nearly all realms of healthcare, abortion workers know that many of the additional barriers their patients encounter—including informational barriers and being forced to travel—would not exist if abortion was not so stigmatized (Kavanaugh et al., 2019; Myers et al., 2019). Some patients may always experience certain barriers, such as lack of insurance, but many of the challenging elements that are specific to abortion care (such as mandatory wait times delaying access to care) would not exist without stigma.

In some organizations, scarcity is then used to justify poor *employment conditions*, like low wages, lean staffing, and scant benefits. For example, participants described the way Planned Parenthood organizations have used scarcity to justify a *culture of self-sacrifice,* which exacerbated negative *socioemotional impacts* like emotional drain, burnout, and enmeshment (Tracy, 2009). These participants described a phenomenon akin to "passion exploitation" in

which employers seek to legitimize unfair management practices by assuming that the work is its own reward, and that "passionate" workers would volunteer for it if given the chance (Kim et al., 2019). Passion exploitation, or the myth of the "labor of love," is especially common within helping professions that are viewed as feminine, disproportionately harming and exacerbating the pay gap for women and people of color (Jaffe, 2021). However, participants reported some abortion clinics have begun to recognize the harms of the self-sacrificing model and instead implemented formal workplace supports for staff to be able to care for their mental and physical health through paid time off, on-site counseling, and/or wellness stipends. The benefit of these policies is supported by research suggesting that healthcare providers' perceived support from their organizational is associated with lower burnout and greater well-being (Reitz et al., 2021).

Findings in this study contribute to the vast literature that already exists on *compassion satisfaction* and *compassion fatigue* (Teffo et al., 2018), *burnout* (Tracy, 2009), and *emotional labor* (Riforgiate et al., 2022). These concepts are theoretically distinct, but often interrelated in studies with providers in obstetrics and gynecology (OB/GYN), including abortion providers (Teffo et al., 2018; De la Fuente-Solana et al., 2019). Compassion *satisfaction* "refers to the positive feelings a person derives from helping or caring for others" whereas compassion *fatigue* "refers to the negative aspect of helping people who experience suffering, trauma or stress" (Teffo et al., 2018, p. 1203). Several studies have found that stigma itself is a predictor of low compassion satisfaction and high burnout among abortion providers (Teffo et al., 2018; Martin et al., 2014). However, factors shown to counteract compassion fatigue include finding work stimulating, belief in making a difference, collegial relationships with other nurses, and years of experience in abortion care (Teffo et al., 2018). That said, finding work stimulating and

philosophical reasons for working in abortion care (i.e., beliefs in women's rights and allowing informed choices) were also predictors of secondary traumatic stress (Teffo et al., 2018).

Burnout is a pervasive impact of care work that can have serious health consequences for providers, particularly employees who have frequent, intense interpersonal contact with others (Tracy, 2009). This study suggests that symptoms of burnout can onset incredibly fast in a high-stress environment, particularly when compounded by stigma. Across the literature, nurses in OB/GYN present high levels of burnout syndrome linked to work-related variables and psychological variables that have important bearing on this study (De la Fuente-Solana et al., 2019). In particular, OB/GYN nurses experience burnout related to long workdays, imbalanced nurse-patient ratios, high demand for care, incidence of miscarriage and abortion, anxiety, stress, and verbal violence (De la Fuente-Solana et al., 2019). Burnout has implications for individual workers, but there are limits on how much individuals can practice "self-care" to manage their own burnout (Tracy, 2009). Rather, burnout is an issue that organizations need to take seriously in relationship to their processes, structures, expectations, and culture. As Participant #8 bluntly put it, "It's not burnout when a broken movement is lighting its workers on fire."

Stigma Management Communication

The present study provides new insights into the applicability of SMC theory (Meisenbach, 2010) to workers in abortion care. Participants shared that they enacted a variety of strategies to manage stigma across contexts, which upheld existing categories of *challenging, transcending, passing*, and *accepting* strategies. Participants described engaging in more *transcending* and *challenging* strategies than *passing* and *accepting*, which tracks with SMC's assumptions about individuals who wish to alter or challenge public perceptions of a stigma (Meisenbach, 2010). However, the results also suggest that workers make several "mental

calculations" throughout a given day to decide how to navigate their workplace, community, and interpersonal interactions with a relative amount of safety and comfort.

Overall, the findings contribute three key findings to SMC theory. First, findings support that SMC strategy use is situational and relationally dependent (Noltensmeyer & Meisenbach, 2016). Participants engaged in safety planning when selecting their stigma management strategies, and every participant identified instances when they needed or wanted to *pass* as non-stigmatized by lying, avoiding, or only disclosing "half-truths" about their work. Participants also described situations where they had to *ignore* protesters or *passively accept* stigma directly from a patient in order to remain "professional." These findings reveal that even workers who both "challenge public perceptions of the stigma and its applicability to them as individuals" will sometimes enact other strategies because of their own safety calculations or because of external constraints.

Second, findings support the most current understandings that patterns of SMC strategy use do not fit neatly into Meisenbach's (2010) original four quadrants (Meisenbach et al., 2019; O'Shay-Wallace, 2020; Romo & Obiol, 2023). Participants enacted multiple strategies across quadrants, challenging Meisenbach's (2010) proposition that individuals who challenge public perceptions of a stigma are likely to mostly, or exclusively, engage in denial strategies. While participants did mostly enact strategies in the bottom half of the SMC model (Meisenbach, 2010), they strategically used tactics from every quadrant as needed. This empirical evidence supports the revision of the SMC model to better reflect how stigmatized individuals enact multiple strategies and frequently blend (Romo & Obiol, 2023) SMC strategies as situationally and relationally appropriate across interactions with patients, friends/family, professional networks, strangers/acquaintances, and anti-abortion protesters.

Last, this study expands on the SMC model (Meisenbach, 2010) by theorizing new SMC sub-strategies and enriching understanding of previously identified strategies. New SMC strategies that emerged in this study include *forming enclaves, resisting, refusing,* and *defanging*. Previously identified strategies that presented new understanding in an occupational context include *disclosing*, stopping the stigmatized behavior (via *role change* and *exiting*), using *humor*, and challenging efficacy (via *deferring blame/agency*). I briefly discuss the significance and theoretical implications of each of these below.

Forming enclaves. Previous literature has identified "bonding with stigmatized" as a sub-strategy of *acceptance* (Meisenbach, 2010). Participants in this study did heavily rely on coworkers who share the stigma as a source of social support and coping; however, they also strategically built *enclaves* of people who did not necessarily share the stigma but held shared values around challenging the stigma. The use of *enclaves* sheds light on how members of a stigmatized group might use strategic disclosure or nonverbal cues to engage sympathetic members of the non-stigmatized group and/or build coalitions among groups with related but different stigmas (e.g., coalition building between people impacted by abortion stigma and/or LGBTQAI+ stigmas).

Resisting versus Refusing. This study introduces *resisting* and *refusing* as distinct but closely related sub-strategies for challenging the public perception of a stigma. Coupled together, these strategies reflect the decision point of a stigmatized person when confronted with stigmatization. *Resisting* is choosing to engage in an interaction when stigma is present, which was frequently blended with other strategies including simple and logical denials. *Refusing* is strategically declining to engage in a specific interaction to conserve cognitive and emotional resources. A person's decision may be a verbal and/or nonverbal refusal, but *refusing* is

conceptually different than passive ignoring or avoidance (Meisenbach, 2010) because the intent is to conserve resources rather than avoid being stigmatized. Drawing a distinction between *resisting/refusing* might provide some clarity for SMC scholars parsing the differences between behaviors that look outwardly similar but reflect different cognitive processes and strategic choices.

Defanging. This study introduces the SMC strategy *defanging* to explain cognitive reframing intended to make a threatening person or situation seem less scary. *Defanging* was highly relevant to abortion providers because of the ongoing threats of clinic violence levied against abortion workers (Medoff 2014; Todd, 2003). *Defanging* is conceptually related to *discrediting the discreditors* (Meisenbach, 2010) except that it is not necessarily communicated outwardly. *Defanging* might blend with enclaves and humor, for example when coworkers poke fun at their protesters together. It also might be a largely therapeutic and individual process, such as when Participant #3 discussed observing the protesters and crafting an internal narrative that they were "fundamentally pretty nonthreatening." *Defanging* is likely less transferable across all forms of stigma but may be relevant for stigmatized groups that face episodic or ongoing threats of physical violence.

Disclosing. This study theorizes *disclosing* as largely a means of challenging a stigma where previous literature has treated disclosure as a sub-strategy of acceptance (Meisenbach, 2010). Participating in abortion care is, itself, a challenge to abortion stigma, and participants identified talking openly about their work as abortion providers as one of the biggest strategies they have for normalizing and destigmatizing abortion—a finding already documented in literatures outside of SMC scholarship (O'Donnell et al., 2011; Harris et al., 2011; Ingraham & Hann, 2022). While research has found that many abortion providers are hesitant to disclose their

job to acquaintances outside of the clinic (Ingraham & Hann, 2022), several participants in this study discussed using strategic disclosures to resist the shame and secrecy associated with abortion, including participants who openly disclosed having abortions themselves. This finding suggests that more empirical research is needed to understand the function of disclosure as an SMC strategy across contexts for different stigmatized groups.

Stopping the stigmatized behavior. Meisenbach (2010) previously identified stopping the stigmatized behavior as a sub-strategy of *avoidance.* This study extends and complicates that understanding by exploring the use of *role change* and *exiting* as means of stopping an occupational stigma. For some participants, such as Participant #17, *exiting* abortion care was the final SMC strategy when they could no longer cope with the stigma, stress, and socioemotional impacts. However, other participants *exited* an unhealthy organization or *changed roles* to remove a specific stressor but stayed in abortion care. In the latter examples, these participants are not motivated by *avoiding* stigma, but are working to find ways that they can continue to challenge abortion stigma while also tending to their own needs. Additional research is needed to understand the versatility of *exiting* and *role change* across stigmatized occupations, but the findings in this study suggest that stopping a behavior is not necessarily avoidant and may instead serve a longer-term stigma management strategy (e.g., conserving resources to avoid burnout and fuel a decades long career in abortion care).

Humor. As other empirical tests of the SMC have found, *humor* can function as an accepting strategy, or *transgressive humor* can be a way of challenging stigma (Meisenbach et al., 2019). Lash (2022) identified that as an SMC strategy, *humor* has three uses: managing the internal effects of stigma (e.g., enabling coping and maintaining a positive attitude), managing the interpersonal effects of stigma (e.g., making others more comfortable and easing awkward

moments), and defending against stigma (e.g., "gently" educating or challenging assumptions). In this study, gallows humor was always limited to in-group interactions among abortion workers for the purpose of coping and fostering resilience, suggesting that *transgressive humor* can blur boundaries between accepting and challenging a stigma. This study suggests that SMC should distinguish between humor that is designed to put non-stigmatized interactants at ease versus *transgressive humor* that stigmatized individuals use to make themselves more comfortable.

Challenging efficacy. In the context of a deeply embedded structural stigma (Elkhalid et al., 2023), some participants used *deferring blame/agency* to reflect a general sense of inefficacy. This strategy feels aligned with *challenging efficacy,* a label proposed by Brule and Eckstein's (2016) to replace *evading responsibility for.* This study supports the use of "efficacy" language given that participants using strategies, like *deferring blame/agency*, are not deflecting responsibility for their own personal choices; rather, they are acknowledging the limitations of their individual power to change public attitudes or policy when abortion stigma is so deeply embedded across government and healthcare institutions. This finding suggests that SMC can expand further to account for how individuals navigate micro-level stigmatizing interactions in the context of macro-level stigma (Elkhalid et al., 2023).

Mental Calculations

The results suggest that workers make several "mental calculations" throughout a given day that inform their use of SMC strategies, a finding that Harris and colleagues' (2016) "screening process" for deciding when to tell someone about their abortion work. Many participants felt conflicted or guilty that they did not feel safe or have the energy to *disclose* their occupation in all situations; most identified that they were still trying to find the right "balance" of their safety and being "an ambassador" to their work. For example, Participant #15 was one of

very few parents in this study; her experiences reflect the way that individuals' efforts to destigmatize their work can come into tension with their desire to protect their children. Some of the most insightful data points also illustrated how two providers could do the same general mental calculation but end up with different strategies. For example, recall that Participant #8 assessed that wearing an abortion T-shirt around her neighborhood was riskier than talking to strangers about her work, whereas Participant #24 was willing to *display* but not to *disclose* for fear of endangering their inner circle of fellow abortion workers and activists.

Participants also described how they sometimes used more ambiguous language (e.g., "I work in women's health") as offering an opportunity for people to "read between the lines, " which is a more passive strategy of making oneself visible to other supporters using coded language while defending against a potentially hostile encounter. If a communicative recipient was receptive and/or similarly minded about abortion, these disclosures could open the door to conversations where individuals could share their own story or connection to abortion in a positive, affirming way. These types of interactions positively reinforced participants' desires to engage in more *disclosing* behaviors, using either straightforward disclosures or coded language, when individuals passed the "vibes check."

Importantly, even participants who regularly disclose made note of exceptions where they have enacted *avoiding* strategies to protect themselves. For example, Participant #10, who was otherwise very open about her abortion experiences and work as a full spectrum doula, did not list abortion on her website because of "hateful emails from all the pro-lifers." For her, removing abortion from her business' website defended against a specific disruptive form of online abuse but did not prevent her from talking about abortion on social media or in her community. In describing their concealing strategies, nearly all participants underscored that hiding the stigma

was not a reflection of how they actually felt about abortion. When Participant #7 described hiding their work to prevent the stigma from negatively impacting their parents' livelihood, they asserted, "Keeping what I do as a hush hush […] does not mean they're not proud of me, does not mean that they don't support me. I am so thankful to have parents and family that support me endlessly." What felt important in this data was how participants felt about the social support they received, even if that support was coupled with pressures to conceal their stigma for physical and/or economic safety reasons.

These examples illustrated how for some workers, maintaining a certain level of privacy and self-protection felt in conflict with wanting to destigmatize the work, which was subject to interference from social networks. For instance, recall that Participant #23 had worked in various roles at abortion clinics for more than ten years, but no one in their hometown knew about their work aside from their parents. They described their parents as "actually very supportive" of abortion, but Participant #23 made the decision to shelter them from the direct impacts of abortion stigma by concealing the stigma from even "friends as close as family." In doing so, Participant #23 missed out on relational closeness. They shared, "You can't be fully honest about your life and the things that you're proud of and the things that you struggle with." These findings suggest that family members who are willing to privately support stigmatized loved ones, but not challenge the status quo or be vocally supportive in their larger social networks, may limit the stigma management strategies available to their loved ones. The larger implication raises questions about the role of social support in stigma management, particularly related to how stigmatized disclosures are received and positively reinforced (or not) and how social group members may pressure stigmatized individuals to conceal a stigma to avoid their own courtesy stigma (Goffman, 1963).

Overall, the results of this study indicate that while most participants agreed that disclosure can be a powerful strategy for destigmatizing abortion, concealment behaviors do not necessarily indicate acceptance of a stigma. Rather, episodic concealment can be indicative of past trauma or threats to one's personal safety, interference from one's social network, and/or managing limited emotional and cognitive resources for stigma resistance.

Resources and Constraints around Stigma Resistance

Because individuals' experiences with occupational stigma and stress were in some ways very different, the resources workers needed for stigma management were different, as well. Smith and Bishop (2019) hypothesize that having a greater sense of "meaning in life" correlates with enacting stigma resistance. Constructing a positive "meaning of work" associated with passion and engagement also are protective factors against burnout in nursing (Gomez-Salgado et al., 2018). For care providers, sources of meaningfulness in work can include skillfulness, contribution to patients' quality of life, personal development, and rich relationships, noting that interactions with patients and interpersonal relationships can both facilitate and constrain workers' ability to speak about and access meaningfulness in their work (McAllum et al., 2024). The results of this study largely reflect this literature. Recall that most participants (83.3%) expressed a strong sense of overall job satisfaction; this is deeply connected to *refocusing* and *recalibrating* strategies that emphasize positive outcomes and where providers derive meaning from their work.

The results suggest that when a provider feels a deeper "calling" to the work and/or draws personal fulfillment from working with patients, that sense of meaning serves to ground them in a positive association with abortion and guards against the more destructive impacts of stigma. Supportive communication through close interactions with these groups, such as the

enclaves participants described, can help individuals cultivate this positive sense of their work and develop a sense of perceived control over their stressors (Tracy, 2009). In speaking to their experiences with me, participants *recalibrated* the standards by which they valued their own work by highlighting how abortion helps people actualize their autonomy and take control of their health and futures by deciding if, when, and how to have a child. They highlighted issues within the larger medical system—particularly the way women and birthing people are mistreated by other providers, including OB/GYNs—and affirmed the way that their work in abortion care put power back in the hands of patients. Of course, nearly every participant described an inherent tension in their work—the balance of experiencing job satisfaction from meaningful care work versus experiencing the cumulative stress and emotional fatigue of being a care provider. The four participants who expressed a strong sense of *dis*satisfaction with their job were not able to draw on that sense of meaning as a resource for stigma management, which seemed to contribute to them enacting more *avoidance* and then *exiting* abortion care.

This study also identified how spirituality, including Christianity, can intersect with the meaning of work to be both a resource for stigma management and a source of stigma itself. For abortion providers who hold spiritual beliefs, faith can bolster resilience and aid the *reframing* of abortion as a moral act. One-third of participants in the study had a faith identity, including one participant who is both a queer abortion provider and a practicing Catholic. When these participants leveraged their own faith to assert that for them, providing care is spiritual work and God-aligned work, they challenge the presumed underlying *moral taint* (Goffman, 1963) of abortion care. In these conversations, abortion was reclaimed and *reframed* as a moral act, emphasizing that abortion providers are not acting immorally by harming babies, but are compassionate medical professionals fighting the good fight to center patient autonomy and

provide necessary healing. Christian hegemony, however, also functions as a political force shaping conservative attitudes toward sex and gender minorities (Todd et al., 2020) and at times inflicting deep shame (Downie, 2022). Many participants described the messages they encounter from clinic protesters as invoking threats to one's moral salvation, such as when Participant #10 recalled hearing, "You're going to hell, and you're gonna burn and die." The extent to which a person believes in the existence of a punishing God, or feels pressured to cosign the abortion beliefs of a religious organization, shapes the particular emotional and cognitive impact of that message.

Within the workplace, expectations of "professionalism" emerged as constraining providers' choices around responding to stigma. While "professionalism" can help people in stigmatized occupations manage the social taint (Ashforth & Kreiner, 1999) of associating with and serving a stigmatized population, it also can lead to emotion suppression and impersonalization in ways that negatively impact worker mental health (Brandhorst & Meisenbach, 2023). Many workers shared that their organizations have non-engagement policies around protesters; these workers did not get to select their own stigma management strategy because the directive was to *ignore* it. *Ignoring* can feel like and/or appear to be a form of passive acceptance, but in this context, it feeds two larger resistance strategies: (1) abortion workers see the stigma, but do not let it interfere or deter them from providing care; (2) abortion workers and clinics uphold their own positive face as non-violent, non-confrontational, and professional. In that respect, *ignoring* can be a way of challenging a public stigma via *displaying* and *transcending*. When stigma is reflected by patients, however, protocols were based in empathy and compassion, frequently resulting in *passive acceptance.* For instance, participants shared that patients frequently invoke their own religious beliefs when they ask questions like,

"Do you think God will forgive me?" Participants who are atheist reflected that it would generally be considered unprofessional or callous to respond by saying, "Well, I personally don't think God exists." These findings suggest that providers may feel pressured to perform certain emotional responses, to invoke a particular spiritual identity, or to affirm patient beliefs that they themselves may or may not hold.

These are all manifestations of emotional labor (Riforgiate et al., 2022) that constrain workers' ability to challenge stigma during micro-interactions but fuel a macro strategy of repairing the damaged image (Meisenbach, 2010) the public holds of abortion providers. The message behind these actions essentially comes down to this: We see you, we hear you, we are going to do our jobs anyway, and we are going to do them at a higher standard of care than most other providers in healthcare because we are compassionate, dedicated professionals. As other scholars have found in the literature on abortion and "dangertalk" (Harris et al., 2012), participants reflected a heightened awareness that because of pervasive abortion stigma, their words and actions are subject to intense scrutiny and could "take away from the cause." The pressure to uphold a pristine image of professionalism and the highest quality care came through when participants said things like, "making sure that like I'm always at 100% was one of the main stressors for me." Participants felt pressure to bring the best versions of themselves to every interaction, which constrains workers' ability to take care of themselves by forcing them to "leave [their] own stuff at the door." Even when patients chose to manage *their* stigma by making excuses and reinforcing the stigma to justify how abortion stigma did not apply to them specifically, providers had to uphold a caring, compassionate face so as not to leave themselves vulnerable to further criticism. These constraints on stigma management serve to resist the

perception that abortion clinics are a "cold, unhealing mill" by going above and beyond for patients even when they are rude and/or stigmatizing.

Given the pressure to be "on" all the time, it is unsurprising that many participants also resisted stigma by engaging in *depersonalizing* and compartmentalizing strategies to manage how much they personally experienced stigma. *Depersonalizing* as an SMC strategy presents a unique predicament for stigmatized care workers. On one hand, participants reflected that they often focused on how stigma negatively impacted patients, which may be related to tensions around prioritizing patient needs over workers. By focusing on the ways that patients are harmed by stigma, providers can create buffers (Tikkanen et al., 2019) to soften how much *they* feel personally implicated in the public's imagination of abortion stigma. This cognitive work can help workers preserve a sense of self outside of the stigma and to draw a boundary between their work and the other important pieces of their lives and identities. Without these boundaries, participants felt they and their coworkers were likely to become *enmeshed* with their organizations in unhealthy and unsustainable ways. On the other hand, when taken to an extreme of negative, callous, or excessively detached responses to the job, depersonalization borders on cynicism and becomes a dimension of burnout (Tracy, 2009). More research is needed to further investigate the tension between the protective function of *depersonalization* as stigma management vs. the harmful function of *depersonalization* as a sign of burnout.

Stigma Management in the Research Process

Throughout recruitment and data collection, I leveraged my position and experience with abortion work to quickly build trust with participants so that they would feel as comfortable as possible to speak candidly about their experiences, both positive and negative. However, there was still a looming awareness that what participants said to me, and what I choose to put into

writing, are themselves reflections of stigma management. I speak first to how I perceived stigma management happening in real-time during interviews. I then write about how my own stigma management in the crafting of this analysis.

In the first round of primary coding, I included a code labelled *public relations.* I used this code whenever a participant explicitly named that they were cognizant of or concerned about how the things they said could be misinterpreted or misrepresented as being against abortion, akin to Harris and colleagues' (2012) concept of "danger talk." For example, in one of my earliest conversations, Participant #4 shared, "This [job stress] is one of those difficult things to kind of talk about because, you know, as a community of abortion workers, you don't want to put anyone else down because then it feels like it's taking away from the cause." In the end, the *public relations* code was not strong enough to stand as its own theme in the data, with these kinds of statements occurring in only five interviews (20.8%). However, this did make me consider the way that participants were balancing their own stigma management needs in speaking with me. To that effect, what was more common was a strategy I coded as *affirming*—message chains in which a participant made critical or negative statements immediately followed by a statement of support for abortion. An example of this type of message chain occurred in my first conversation with Participant #9 when she was describing an incident at a conference for abortion providers:

> The question was, 'Should people get care earlier in pregnancy?' [...] And the folks in my group were like, 'People should get care whenever they feel ready.' And I immediately started thinking about this patient [who died] and like, just not knowing, right, if she would have still be alive if she had been ready earlier on. Right, it doesn't mean that I don't – of course, obviously, you know, I don't think there should be limitations or anything like that. Like, I am so pro-choice.

Participant #9 was grieving the loss of a patient—and at the same time, she is clear that the loss of this patient is not a reason to ban abortion later in pregnancy. She needed to tell this

story to illustrate how isolated she felt within the abortion provider community among folks who did not work in later abortion care like she did. At the same time, she knew that to talk about her experience was a departure from pro-abortion movement rhetoric that emphasizes that abortion is safe and uncomplicated at all stages of pregnancy. Participant #9 balanced her intimate knowledge of her patients' circumstances with the talking points she herself had previously used to justify the need for abortion later in pregnancy for more palatable reasons (e.g., that abortions after 20 weeks are statistically rare and needed for devastating situations when a serious complication arises during a wanted pregnancy) (Dubriwny & Siegfried, 2021).

Understood thematically, the *affirming* strategy functions as a way for participants to speak to the messy, challenging, nuanced, and sometimes heartbreaking aspects of their work while also guarding against being misunderstood as holding or endorsing an anti-abortion position (Harris et al., 2012). Participant #9 knew that the risk of life-threatening complications increases as pregnancy advances; patients also risk these complications during childbirth. Patient loss also happens and is incredibly devastating to providers across health care fields. The unique challenge of this loss is that stigma makes a provider vulnerable to their deep sorrow and grief being weaponized to outlaw the procedure altogether. The logic of stigma management may lead providers who have suffered loss to either keep that grief inside, to be incredibly selective about disclosures, and/or to cache the critique in *affirming* statements.

When sharing particularly vulnerable experiences, participants reflected a real sense of caution in *what* they were willing to disclose and *who* they were willing to say these things to (Harris et al., 2012). I believe participants trusted me with the things they shared because I was clear about my pro-abortion position and was clear that I was not there to misrepresent their experiences for a political agenda. That said, inevitably there are things that participants chose

not to reveal in their interviews, both because of time constraints and perhaps stigma management or privacy considerations about what could be used to harm them, their organization, or the larger abortion movement. Concerns about consequences to individual participants and/or their organizations were easily mitigated by deidentifying the data and exercising caution around participant demographics. However, I could not guarantee participants that the findings of this study would not in any way "hurt" the larger cause if the data revealed problematic dimensions of abortion care or if an anti-abortionist were to read this study with an intent to weaponize it for their own gains. In crafting this analysis, I have worked to be judicious and conduct my research with the utmost integrity. While I am engaging in my own stigma management, I have done my due diligence to share the most significant truths of what I have uncovered. I believe that anything less would be both shoddy academic work and a disservice to abortion workers who deserve to speak their truths, even when those truths are messy.

Limitations and an Agenda for Future Stigma Research

This research is largely exploratory and interested in the nuances of stigma management for individuals working in abortion care. By design, results are not generalizable to all abortion workers; however, the data affirms that stigma *is* impacted by a worker's specific role and responsibilities (Ward, 2021). While there is more to learn by replicating the study with a larger, more diverse sample that includes more nurses, advanced practice clinicians, physicians, and administrators, this study contributes an important perspective on the unique needs of medical assistants, social workers, doulas, patient navigators, and other clinical support whose voices are often deemphasized in the literature on abortion provider stigma (Ward, 2021). Findings might also shed light on stigma and stigma management for other stigmatized groups of workers,

including health providers offering other stigmatized services and workers in high-stress, high-pressure environments (Brandhorst & Meisenbach, 2023).

The study generated a rich qualitative data set that surfaced many areas for deeper exploration in future stigma research, including but not limited to burnout in stigmatized care work; further intersectional analysis with underrepresented populations; the role of social support; and organizational stigma management. Considering these limitations, I offer the following research agenda as being particularly fruitful for deepening understandings of stigma management through a critical, intersectional lens.

Mitigating Stigma and Burnout in Abortion Care

One strength of this study is that it considered the role of environmental factors in workers' experiences of stigma and selection of SMC strategies. While it was incredibly useful to explore how the intersections of community and organizational factors may impact stigma and stigma management, narrower studies would help to better understand how *specific* environmental factors impact stigma. Future studies might ask what factors make the most difference in effectively mediating stigma to have the greatest impact on employee satisfaction. The next iteration of this study might consider a quantitative or mixed-methods approach to better define the predictive relationships between factors and stigma management strategies. One might also test the relationship between specific SMC strategies and measures of wellbeing, such as burnout. Burnout was not a focus of the study but did emerge as an impact of doing stigmatized work. A future study may assess if there is a relationship between measures of stigma and measures of burnout within stigmatized care work, or if any stigma management strategies correlate with reduced burnout.

Intersectional Analysis of Underrepresented and Marginalized Populations

This study was interested in exploring participants' "consciousness of their own lived experiences as relating to intersecting systems of oppression" (Else-Quest et al., 2022). I believe this is a particular strength of the study in contributing to an under-researched area of stigma and health communication scholarship. However, this study barely scratched the surface of bringing intersectionality into conversation with stigma management (Dougherty et al., 2017) and could have benefited from recruiting more providers of color and/or focusing more explicitly on specific underrepresented populations. For example, a future intersectional analysis might be limited to Black and Latinx providers, who make up a significant population of abortion workers and whose voices were missing from this sample. Research focused more narrowly on the experiences of transgender, disabled, and/or neurodivergent workers would also contribute to gaps in this study and a greater understanding of stigma management.

Testing the Relationship between Social Support and Stigma Management Strategies

The present study demonstrated that occupational abortion stigma is not a one-size-fits-all experience, and that providers need a toolbox of different resources for effective stigma management. The data shows that all providers engaged in a mix of *accepting, passing, transcending,* and *challenging* strategies. However, participants who described higher, more consistent levels of positive reinforcement from their social groups seemed to have more cognitive and emotional resources to engage in stigma resistance. This may be because close interactions with support networks can help individuals make sense of their work and develop a sense of perceived control over their stressors (Tracy, 2009). Participants who received lower, or inconsistent, levels of reinforcement seemed to have fewer resources for stigma resistance and engaged in more *passing* or *avoiding* behaviors. Thus, this study suggests that social support

(Albrecht & Adelman, 1987) may be a mediating factor in SMC and could be a fruitful area of future study for stigma researchers.

Organizational-Level Stigma Management

SMC looks at how potentially stigmatized individuals relate to and manage stigma (Meisenbach, 2010). However, one question that emerged from the data is about larger spheres of stigma management at movement and organizational levels, and how organizational communication impacts the stigma management resources that are available for individual clinic workers. Consider that this study identified poor *employment conditions* as a stressful byproduct of stigma that individuals were expected to manage on their own, which for some participants correlated with a *culture of self-sacrifice.* Are employers creating these conditions out of greed or malice, intending to exploit workers' passion (Jaffe, 2021)? Or are poor workplace conditions indicative of the larger pro-choice movement's (failing) stigma management strategies? An organizational-level approach to theorizing stigma management might shed some light on this tension.

For example, organizational leaders who adopt a *culture of self-sacrifice* often framed themselves as *challenging* abortion stigma by performing as many abortions as possible. One participant shared how their clinic provided abortion care for 48 consecutive hours after the *Dobbs* decision was leaked to signal that they had no intention of backing down. This was one instance I identified where a clinic is *displaying* a stigma at an organizational level. The participant shared how the patient flow was thoughtfully designed and staffed to allow workers to take breaks and to take extra time to restore themselves after the one-time "blitz" was done; as a result, this participant described the one-time experience as positive and was proud to have taken part in it. However, this was an exception to what most other participants shared. Most

other participants described that their workdays were simply getting longer and heavier to see as many patients as possible with no reprieve in sight. Considering the harmful impacts of overwork (Tracy, 2009), organizations who prioritize patients over workers in this way may simply be resigning themselves to the status quo of abortion care as a "shitshow" (a direct quote from Participant #10) and passing the brunt of the stress on to their frontline workers rather than meaningfully resisting abortion stigma. Future research could explore in more depth how such organizational structures and processes function as (in)effective forms of stigma management by, for instance, examining where organizations deflect blame to anti-abortion forces to justify extracting more labor from their workers.

Practical Recommendations

The practical implications of this research come from both my understanding as a researcher and what participants in this study offered as solutions. In summary, reproductive health organizations can provide healthier models for how stigma management can function alongside the provision of abortion care. Post-*Dobbs*, the abortion landscape is challenged by scarcity of services, misinformation, and fears of criminalization. Abortion providers in turn are impacted by overwhelming patient volumes, higher needs for practical support, and difficulty retaining staff. One solution many participants named was simply needing more providers – more staff, more clinics, and a greater availability of abortion care overall, particularly at later stages of pregnancy. This study illuminates, of course, why that is not a simple feat and why abortion providers need to take stigma management seriously if abortion care is to be a sustainable line of work.

Take Burnout Seriously

The literature is clear: burnout recovery is incredibly difficult, if not impossible (Tracy, 2009). Unaddressed, burnout has many negative individual and organizational impacts including mental and physical illness, interpersonal conflicts, higher rates of absenteeism from work, higher rates of job turnover, lower morale, and lower productivity (Teffo et al., 2018). The best way to help providers recover from burnout is to prevent burnout in the first place. Organizational leaders—particularly those who have decision-making power over clinics and clinic staff, but whose day-to-day work is relatively removed from clinic flow—are advised to genuinely empathize with the experiences of frontline workers. Making sure that staff needs are prioritized alongside the needs of patients is a more effective way to ensure that an organization can retain its providers and challenge stigma more effectively in the long run. Compensation is, of course, an important consideration for all employees; however, the data in this study upholds that a high salary alone will not prevent burnout. Providers need to be able to meet their basic daily needs, like adequate food and rest, and they need to be able to "have a life" outside of work (Gomez-Salgado et al., 2019). Recall that most overworked participants were not asking for large raises; they were asking for relatively small things, like a daily lunch break and the ability to take their paid time off, ideally *before* they hit a breaking point. Research suggests that having a supportive supervisor and active participation in decision-making in addition to individual factors (like coping skills and empathic distance) contribute to workers' well-being in the workplace (Tracy, 2009).

When organizations talk to workers about self-care, it is critically important that they are designing the work in such a way that staff can actually take care of themselves (Gomez-Salgado et al., 2019). A benefit, like unlimited paid time off or paid family leave, is not really a benefit if workers do not feel like they can access it without harming their coworkers and/or patients

(Kirby and Krone, 2002). Participants in this study suggest that healthier workplaces are those that are not touting "self-care" as a trendy buzzword, but are actively modeling care for staff, asking staff what they need, and then delivering on their promised support. For some clinics, this has successfully looked like having mental health providers on-staff who can both counsel patients and provide support for staff. Importantly, if social workers are caring for staff in addition to patients, this should be named in the job description so that it is recognized as a valuable and compensated part of the work. Otherwise, staff who are trained as counselors can suffer worse burnout by providing staff support as an "extra" responsibility that adds to their stress but is not seen as a "real" part of their job. Having a *team* of carers in every role of the organization also felt like a significant recommendation so that 1) there are carers for the carers and 2) workers can again prioritize their own rest and wellness without feeling like they are the only person who can fill a particular need. This recommendation is supported by literature that has identified *instrumental support* – the exchange of time, resources, or labor – as particularly helpful in preventing emotional exhaustion (Tracy, 2009).

Of course, the abortion care workforce is not a monolith, and the specific needs of a given staff are best expressed by workers themselves. Participants indicated that when they felt unheard or uncared for, or when their concerns went unaddressed by leadership, they felt more stress and more symptoms of burnout. When organizations avoid accountability for the additional stress that frontline workers must navigate, it feeds the perspective that executives who have "desk jobs" are too disconnected from actual clinic work to lead effectively. Ultimately, when workplace issues compounded by stigma were not effectively managed, some participants defaulted to changing their role or leaving abortion work altogether – which many recognized feeds back into the overarching condition of scarcity. To that effect, one of the most

important things a reproductive health organization can do is voluntarily recognize, support, and engage in good faith negotiations with their labor union(s). While this sample has limited generalizability, it is worth noting that participants who successfully unionized report that this strategy has been the most effective in improving their working conditions and securing the resources to manage stress and resist stigma more effectively.

Rethink Hierarchies

While organizational communication was not the focus of this study, one theme that emerged in the data is the way participants experience formal and informal hierarchies within organizations and how these dynamics complicate their experience of stigma. Hierarchy is a feature of most, if not all, healthcare systems (Ehrenreich & English, 2010). True to form, participants discussed their work and their role in relationship to others, painting a consistent picture of a social hierarchy that divides "leadership" and/or "administration" from clinic staff. There also is a medical hierarchy that ranks nurses, medical assistants, and clinic support below physicians and clinicians (Noyes, 2022). This hierarchy both implicitly and explicitly denigrates the important emotional labor and medical care that nurses and "support roles" provide (Ward, 2021), which is intertwined with long histories of racism and sexism in all medicine broadly and reproductive healthcare specifically (Roberts, 1997). As a result, physicians are typically the only people with access to the prestige of being an abortion *provider*, which we know from the literature can be an important resource for stigma management (Ashforth & Kreiner, 1999; Ward, 2021). In light of the way that different roles encounter and experience stigma, it is really no surprise that when many workers feel burnt out in their clinic roles, they look to "move up" into administrative positions that come with higher paychecks, more prestige, more flexibility, and much less stress. The value that organizations seem to place on certain types of

administrative work, like fundraising, versus the way they treat entry-level clinic jobs as almost disposable reinforces classist ideas about "skilled labor" and devalues the very necessary labor of frontline clinic staff.

Additionally, in the wake of *Dobbs,* the movement has developed a particularly problematic binary shorthand for describing the abortion access landscape (e.g., red state/blue state, hostile/haven, restrictive/receiving). I recognize that even my own use of "protective" and "restrictive" to describe participants' locations is somewhat problematic in that it erases important nuances of both abortion attitudes and stigma management in context. At the highest abstraction, the clustering of "red states" with abortion bans presumes that there is far less support for abortion in many areas of the country than there actually is—and also presumes that access is virtually a non-issue in "blue" states. Speaking with participants on the ground in rural, Southern, Midwestern, and Appalachian communities reveals the depth of these workers' passion for destigmatizing abortion, holds that local knowledges are powerful, and contributes understanding that what communities need is an equitable distribution of resources, not more disenfranchisement (Smith et al., 2023). At the same time, speaking with participants in receiving states shows that stigmatizing messages are ubiquitous and that there is currently no abortion law shielding workers anywhere from the destructive effects of stigma and its compounding stressors.

What does this mean for the reproductive health movement and its members? This study suggests that the project of resisting abortion stigma is not served by discursive binaries or hierarchies. It holds that abortion seekers and medical providers—*all* medical providers—are the experts on their own experiences and deserve both discursive *and* practical support to effectively manage stigma. It implores both movement and organizational leaders to take care with the

content of their messages and to shift power to the folks on the ground who are experiencing the intersections of systems of oppression and movement disenfranchisement.

Build Shared Pro-Abortion Understandings

One important finding of this study was how much participants can experience *stigmatizing messages* from their coworkers and how workers in abortion care are often navigating complicated feelings about their own stigmatizing views, particularly around abortion later in pregnancy. Since the *Dobbs* decision, many clinics in receiving states have expanded their gestational limits to accommodate the barriers that are pushing patients further into their pregnancies before they are able to access care (Society of Family Planning). Family practice providers in receiving states can help ease the burden on abortion clinics by incorporating abortion care–even just medication abortion–into their scope of care so that more abortion seekers can simply be seen by their primary physician. However, the experiences of participants in this study underscore how stigma can and will show up in even the most "progressive" workplace. Organizations that are endeavoring to institute or expand abortion care must equally be mindful and intentional about building a shared pro-abortion understanding and supporting workers in managing abortion stigma. This study suggests that recoding understandings of pregnancy and abortion stigma can be a slow process and that stigma management will be ongoing, but that this is necessary work to demystify and build support for abortion throughout the healthcare system and to lessen the stigma on abortion providers.

Conclusion

This study offers new insight into how U.S. health professionals who work in abortion care experience and manage stigma since the repeal of *Roe v. Wade*. The results indicate that health providers experience stigma through *stigmatizing messages, stress compounded by stigma,*

and *socioemotional impacts* that were shaped by seven intersectional factors: state laws, service delivery, organizational culture, community attitudes, regional identity, privileged/ marginalized identities, and reproductive experiences. Participants enacted a variety of *challenging, transcending, passing,* and *accepting* strategies to manage micro-level stigmatizing interactions with patients, protesters, colleagues, friends/family, and strangers/acquaintances across interpersonal and workplace contexts.

This project had three primary motivations. First, the research explored abortion workers' use of SMC strategies (Meisenbach, 2010) and contributes new understandings to the SMC framework, supporting the call for a revised framework to better reflect the use of multiple and blended strategies. Second, through the application of a critical, intersectional lens, the study sought to illuminate how occupational stigmas can be shaped by contextual power dynamics and forces of oppression as they intersect with social identities. Given the minimal research applying intersectionality to SMC, this study contributes to scholarly understandings of how overlapping axes of worker identities—such as race/ethnicity, gender, sexuality, (dis)ability, and religious identity—impact stigma management at the intersection of dirty work and stigmatized identity. Third, the project sought to partner with abortion workers to inform micro-, meso-, and macro-level interventions. As such, this study has offered robust recommendations for organizational interventions to increase well-being among abortion workers on the front lines of advancing reproductive health, rights, and justice aims across the U.S.

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APPENDIX A: RECRUITMENT MATERIALS

Recruitment Webpage

https://beccaleesimpson.com/stigma-study

Social Media Graphic

Flyer


Do you work in
ABORTION CARE?
We are seeking licensed and non-licensed clinical staff who work in abortion care to participate in a research study on stigma.
Participation is completely confidential.
Participants must be 18+, have worked in abortion care in the U.S. in the last two years, and be able to complete a virtual interview in English.
$35 gift card compensation for your participation in an hourlong interview conducted over Microsoft Teams.
SCAN TO LEARN MORE!
PI: Meara Faw, Associate Professor Co-PI: Becca Lee-Simpson, Graduate Student
Department of Communication Studies, Colorado State University

Recruitment Email Template

Dear [recipient],

My name is Becca Lee-Simpson, and I am a graduate student at Colorado State University conducting a research study on how people who work in abortion care manage abortion stigma. The study seeks to understand the unique challenges abortion workers experience in their work-lives, their sources of social support, and how their experiences with stigma are shaped by their workplace, community, and personal identities. I hope this research will help people better understand abortion stigma and contribute to strategies to reduce negative experiences for people, like yourself, who work in abortion care.

I am reaching out to respectfully ask you to share the attached flyer with your staff and/or colleagues who work in abortion care. The study is completely confidential and voluntary and asks participants to complete a 60-minute interview about their experiences with stigma. Participants will receive a $35 gift card as compensation for their time.

I understand that safety and privacy are top concerns for your organization. I want to reassure you that every precaution will be taken to protect the privacy of all participants. This study is being conducted under the approval of the CSU Institutional Review Board. More information detailing the research and data protection procedures can be found here: https://beccaleesimpson.com/stigma-study.

Thank you for your time. Please let me know if there are any questions I can answer.

Respectfully,

Becca Lee-Simpson
she/her/hers
Colorado State University—Department of Communication Studies

Stigma Study Contact Information:
970.829.8881
becca.lee@colostate.edu
https://beccaleesimpson.com/stigma-study

APPENDIX B: SCREENING, INFORMED CONSENT, AND PRE-INTERVIEW SURVEY

Managing Occupational Stigma in Abortion Care

This research study is interested in how people who work in abortion care cope with abortion stigma—the idea that abortion is morally wrong or socially unacceptable. The study seeks to understand the unique challenges abortion workers experience in their work-lives, their sources of social support, and how their experiences with stigma are shaped by their workplace, community, and personal identities. We hope this research will help people better understand abortion stigma and contribute to strategies to reduce negative experiences for people who work in abortion care.

If you are interested in participating in this research study, please complete this short, confidential survey. You will be guided through the following sections:

- Eligibility Screening
- Informed Consent
- Pre-Interview Survey
- Schedule Your Interview

This process should take no more than 15 minutes to complete. To get started, click "Begin."

Eligibility Screening

1. Are you 18 years of age or older? (yes/no)
2. Do you currently work in a clinical role where abortion care is a significant part of your job? (yes/no)
    a. If no → Did you previously work in a clinical role where abortion care was a significant part of your job between the dates of June 1, 2021-present? (yes/no)
3. Participating in this study requires you to complete an interview in English. Are you able to complete a video interview in English without translation assistance? (yes/no)

If no to any question, the survey ends and displays this message:
Thank you for your interest in this research study. Unfortunately, you are not eligible to participate. We thank you for your time. -The Research Team

Informed Consent

You are eligible to participate in the research study, "Managing Stigma in Abortion Care Work," being conducted by Becca Lee-Simpson, a graduate student in the Department of Communication Studies at Colorado State University, under the advisement of Associate Professor Dr. Meara Faw.

Please read through the following information, which details your rights as a research participant and provides an overview of what to expect, should you decide to enroll. If you would like to enroll as a participant after reading this information, please select YES at the bottom of the screen. If you have any questions or would like to speak with the researcher before enrolling, please call (970) 829-8881.

Purpose of the Study

This study is interested in how people who work in abortion care cope with abortion stigma—the idea that abortion is morally wrong or socially unacceptable. The study seeks to understand the unique challenges abortion workers experience in their work-lives, their sources of social support, and how their experiences with stigma are shaped by their workplace, community, and personal identities. We hope this research will help people better understand abortion stigma and contribute to strategies to reduce negative experiences for people who work in abortion care.

Research Procedures

If you agree to participate in the study, you will be asked to participate in a 60-minute interview using Microsoft Teams, a secure video conferencing platform. The audio of the interview will be recorded, saved to a secure location, and transcribed. The transcription will be de-identified, meaning it will not include any names, places, or descriptors that could be used to identify you. Once the transcription is done, the audio recording will be permanently destroyed within 30 days from the date of the interview. No one except the research team will ever have access to the audio recording or the de-identified transcription.

The next paragraphs describe the types of questions that you will be asked in the interview. You can skip any question you do not want to answer. If at any time you would like to pause or stop the interview, you may do so. If you change your mind about participating and want to withdraw from the study, your data will be destroyed.

The focus of the interview will be your experiences working in abortion care and your experiences with stigma. Some of these experiences may be emotional or stressful to talk about. The interview is a confidential, judgment-free zone. Nothing you say will ever be "used against you" or your employer in any way. Your employer also will not know that you participated in this research unless you yourself choose to tell them.

I also will ask you some questions to understand the context of your experiences, such as the type of health care facility where you work (e.g., clinic, hospital, private practice), about your role (e.g., physician, NP, nurse-midwife, medical assistant), and about the characteristics of the community where you work. At no point will you be asked to name your employer or provide specific details about where you live. If you do say anything that could potentially be used to identify you later, it will be redacted in the data set to protect your privacy and ensure your safety.

During the interview, I will ask you some open-ended questions about how you identify your race/ethnicity, gender, sexual orientation, religious affiliation, political affiliation, and if you identify as having a disability. These questions are asked to understand how the identities we hold may shape our experiences with stigma.

Depending on the depth of your answers, you may be asked to complete a 60-minute follow-up interview if more information is needed. You have the right to say no. Declining a follow-up interview will not impact your participation in the study. If you consent to a follow-up interview, it will also be audio recorded and transcribed using the same process as the first interview.

Risks & Benefits

The interview has the potential to distress participants by asking them to recount difficult experiences, and information shared may be sensitive in nature. The interview is a confidential, nonjudgmental space for participants to disclose their feelings and experiences around abortion stigma, and it is perfectly normal and acceptable for a range of feelings to come up. Participants who experience distress will be provided a list of counseling resources; participants may also stop the interview at any time that the distress is overwhelming or if they simply do not wish to continue. You can ask to withdraw and have your data destroyed at any time.

By sharing potentially distressing experiences, it is possible you may feel some relief after the interview as talking about stigmatizing experiences in a supportive environment can increase well-being. The benefits of the research are that it may yield insights to help you and your colleagues in the future. For example, if the study helps us identify activities that are helpful in processing/coping with stigma and activities that are not, we may be able to generate a list of recommendations for organizations (e.g., group discussions, one-on-one mental health support, BIPOC-specific resources) to implement to help their workers navigate stigma more effectively.

It is unlikely, though possible, that a participant and/or their employer could be identified in the event of a data breach, causing risks associated with social or economic well-being. We are taking every step to prevent this from happening by limiting the amount of identifying information collected, de-identifying transcripts, keeping questions about participants' specific workplaces general, and destroying recordings.

Compensation

There is $35 gift card compensation for your participation in an interview lasting approximately one hour.

Confidentiality

Your participation in this study is completely voluntary and confidential.

Your privacy and safety are of the utmost importance. Any real names, places, organizations, or other identifying details you name in your interview will be redacted in the data set. We will not publish any information that could be used to identify you or your employer.

You have the right to ask any questions about the research. You can contact the researchers, or you can call the Human Research Protection Program at Colorado State University at 970.491.1553 or email CSU_IRB@colostate.edu if you have any questions or concerns about your rights as a participant.

Do you consent to participate in the research?

- I consent to participate.
- I do not consent to participate.

If no, the survey ends and displays this message:
Thank you for your interest in our research. Since you have elected not to consent to participate in the study, your data will not be saved. You may now exit the survey.

Pre-Interview Survey

*All questions are open-ended. *Requires a response*

This short survey is designed to capture some basic information prior to your interview. Your answers to these questions are entirely confidential. Note: If you are not currently working in abortion care, please answer the questions for the time that you did work in abortion care.

1. What name would you like to be called during the interview? (This can be your real first name or a pseudonym.)*
2. What kind of healthcare facility do you primarily work in?*
3. What is your occupation or job title?*
4. How long have you worked in abortion care?*
5. Generally speaking, how would you describe your location relative to other healthcare facilities that provide abortion? Is there anyone else who provides abortion in your community/state/region?*

This study is interested in how the identities we hold shape our experiences with stigma. This set of questions will ask you about some of the identities you hold. You can answer these questions however is most true for you. You can skip any question you do not wish to answer.

6. What is your race?
7. What is your gender?
8. What is your sexual orientation?
9. Do you identify as disabled or as a person with a disability?
10. What is your religious affiliation, if you have one?
11. What is your political affiliation, if you have one?
12. Are there any other identities that you would like to share or that impact the way you show up in the workplace?

Submit Your Responses

Thank you for completing the eligibility screening, informed consent, and pre-survey sections. If you would like to edit your survey responses before submitting, click "Back."

When you are ready, please click the button to complete your enrollment in the study. You will then be redirected to Calendly, an online scheduler, to choose the interview time that works best for you. *End of survey redirects to https://calendly.com/stigma-study/interview*

APPENDIX C: INTERVIEW GUIDE

Interview Guide

These questions are designed to guide the interview and elicit data to answer each RQ, but if the participant is forthcoming, the flow of conversation should generally follow their lead and allow for them to share as much of their story in as much detail as time allows. Probing questions are included throughout for participants who may need more prompting.

I. Experience as an Abortion Worker

1. I want to start by asking you to speak generally about your experiences with providing abortion care. Can you tell me about your job?
    1. How did you get involved in abortion care?
    2. (If unclear) what tasks do you do related to the provision of abortion care?
    3. How do you feel about your job?
    4. What are the things that are stressors in your job?
    5. (How) has your job changed since the *Dobbs* decision?

II. Stigma and Stigma Management Strategies

2. In this next set of questions, I want to ask you some questions specifically about abortion stigma—the idea that abortion is morally wrong or socially unacceptable. Many people who work in abortion care report feeling stigmatized. Have you ever felt this way?
    1. Where does abortion stigma show up in your work/life?
    2. Do you ever feel personally stigmatized as an abortion worker? (When people talk about abortion, do you feel like they're talking about *you*?)
    3. How do you generally manage these feelings of stigma?
    4. What strategies, if any, do you use to resist or challenge abortion stigma?
3. When someone (stranger or acquaintance) asks you where you work or what you do, do you feel comfortable telling them you're an abortion worker?
    1. How do you navigate disclosure decisions?
4. Are there people close to you in your life who are unsupportive of abortion?
    1. Do they know what you do for work? How do you navigate that situation?
5. Have there ever been times where you felt physically unsafe or threatened because of where you work? What did you do to manage these feelings / get to safety?
6. Have there ever been times where you felt emotionally unsafe, shamed or judged because of where you work? What did you do to manage these feelings?
7. If you can, recall a specific experience with stigma that felt particularly challenging or intense. Describe what happened and how you felt. What did you do to manage those feelings?

III. Contextual Factors

8. How does your organization handle stigma?
    1. Does your organization talk about abortion stigma openly in the workplace?
    2. Do you receive any support around managing stigma from your colleagues?
    3. Do you receive any support from other providers in your field?
    4. What, if any, organizational programs or policies are in place to support you?
    5. What changes, if any, would help you feel more supported at work?

9. How would you describe your community's views on abortion?
    1. Do you feel like your location plays a role in your experience of stigma?
    2. Do you feel like your local politics play a role in your experience of stigma?
    3. Have you noticed anything different in your community's attitudes about abortion since the Dobbs decision? If so, has that made your experience better/worse?
    4. (If unclear) How do you define your "community"? Are there communities you belong to that hold different views on abortion?
10. This study is interested in how the identities we hold shape our experiences with stigma. Are any of your identities particularly salient for you in the workplace?
    1. Do you feel like you can be your "authentic self" at work? Are there any pieces of your identity that you feel like you have to change or hide to be accepted by coworkers or patients?
    2. You mentioned that you hold [insert identity]. Are there other people in your workplace who hold that identity?
    3. Does your organization talk about race equity or LGBTQ inclusivity? How does that make you feel?

IV. Wrap Up

11. Thank you for sharing your experiences with me, [Name]. I want to be respectful of your time and start to wrap up this interview. But before I do that, is there anything else you want to say today about your experiences with providing abortion or with stigma?
12. Thank you. That completes our interview today. As I mentioned during the informed consent process, you will receive a $35 compensation for participating in this research study. I can send you a link to an electronic gift card.

Thank you for your time today! You have my contact information. Please don't hesitate to get in touch if any questions come up or you need anything else related to the study.