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Medicalization and Naturalization: Understanding Abortion as a Naturecultural Phenomenon

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Abstract

This article offers a naturecultural intervention to the abortion literature, which characterizes abortion as a standard procedure, from the perspective of both biomedical and social scientific research. In contrast, by examining interviews with feminists and pro-choice people about their recent abortions (n=27) and my own experiences as an abortion counselor, I find that no singular "abortion" exists; rather, there are many embodied abortions. I discuss how participants negotiate medical and natural ideologies, arguing that these ideologies produce the conditions under which people come to experience abortion in the United States. I also discuss the material consequences of defining abortion as a standard event. I find that universalizing abortion leads to the underrepresentation of marginalized stories, a lack of personalized support, and racialized and classed disparities in who can achieve their desired biosocial state ("normal" or "natural").

Introduction

As an abortion counselor, people ask me what to expect from their abortion, so I walk them through the details. I answer questions about everything from cervix dilation and vacuum aspiration to aftercare techniques. And while this information is usually well received, people also want to know what an abortion

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feels like; my medical scripts do not prepare me to answer these questions. I can only offer a vague qualification, that bodies react differently and that each person has their own pain tolerance. Which is true. But after a number of these exchanges, I began to consider how little we know about people's embodied abortion experiences. At the same time, while pregnant people[1] vary in how they frame abortion, internalizing messages (abortion as a medical procedure or as murder) that align with their worldview (Luker, 1984; Keys, 2010), movement actors across the political spectrum still talk about abortion in the singular. Someone might ask, "what does an abortion feel like?" or "what are the side effects of abortion?"

In this essay, I wrestle with the question of whether or not a standard abortion exists, drawing on interviews with feminist and pro-choice people about their recent abortions (n=27). Participants vary across age and reproductive histories, as well as abortion method—people in their first trimester can typically select between an in-clinic vacuum aspiration (manual extraction of the pregnancy) or a medication abortion (a combination of mifepristone to end the pregnancy and misoprostol to expel it from the uterus). Alongside these interviews, I include my own reflections as an abortion counselor. I am interested, for example, in both how individuals make meaning from their abortions and how providers[2] participate in this process. I find that no singular "abortion" exists; rather, there are many embodied abortion experiences. I examine this variation and its consequences for abortion care. How scholars and activists talk about and understand abortion has the potential to radically transform and improve people's experiences.

In its current state, most abortion research is segmented into one of two camps: biomedical research studies the effect of abortion on bodies, and social scientific research focuses on how legal and cultural context shapes abortion experiences. Separated in such a way, both camps reinforce the myth of a singular, biological abortion. In contrast, I provide what feminist technoscience scholar Donna Haraway (1992) calls a *naturecultural* perspective. Naturecultures refute the notion that an object or experience can be purely "social," or conversely, innately "biological." The concept of biosociality, developed by anthropologist Paul Rabinow (1996) also rejects the nature/culture divide. In this paper, I examine abortion as a naturecultural and biosocial phenomenon, both fleshy and embodied but also existing in social contexts that shape its materiality.

Under varied conditions, abortion itself takes on entirely new forms and

meanings. For example, in the United States, abortion has been medicalized, which is to say that many people discuss and experience abortion as a medical procedure (Halfmann, 2011). Describing abortion and aborting bodies as "normal" acknowledges a lack of biomedical complications and combats anti-abortion stigma. At the same time, people also discuss and experience abortion—particularly the medication abortion—as "natural" (Simonds et al., 1998; Purcell, 2015). *Natural* usually refers to the perception that the medication abortion is "less invasive" than an aspiration abortion, as well as the preference for a "private" abortion experience. In fact, such discourse relies heavily on the framework of natural childbirth, which Simonds et al. note is "the only medical intervention [besides abortion] discussed in terms of degree of naturalness" (1998, p. 1316).

I have broken my analysis into three sections, each of which integrates interview and autoethnographic data in order to examine biosocial variation. In the first section, I review how participants conceptualize the beginnings and endings of their abortion experiences. By deconstructing the category of abortion, we can understand patients' individualized needs and thus provide better abortion care. In the second section, I show how pregnant people perform interpretive work, reinforced by interactions and their social environments, to achieve "normal" and "natural abortions." "Normal" and "natural" are regulatory categories that not only produce the *possibility* of abortion as we know it, but also set unrealistic expectations that can be harmful for people whose experiences deviate from their desired biosocial state. Lastly, I argue that social inequalities produce differentiated access to "normal" and "natural abortions." Using the framework of "stratified reproduction" (Colen, 1995), I situate this form of exclusion within a wide web of mechanisms that differentiate which groups of people have control over their reproduction and which do not. Without attention to biosocial variation, scholars and activists could neither acknowledge nor combat such embodied inequalities.

Literature Review

Abortion Studies: State of the Field

Contemporary abortion research "reflects dominant framings of abortion as a public health or healthcare provision issue" (Purcell, 2015, p. 591). This framing limits the kinds of questions that researchers can ask and has also produced two broad methodological clusters, each more or less siphoned off from the other. Biomedical research, for example, studies how abortion affects bodies and how providers can more safely perform it. Topics include the safety of aspiration

abortion performed by nurse practitioners (Weitz et al., 2013) and the efficacy of medication abortion during early gestation (Kapp et al., 2018). Social scientific research, on the other hand, focuses on how social context shapes abortion experience. For example, abortion scholars discuss how legal and cultural barriers restrict abortion access,[3] particularly for low-income people and communities of color in the United States (Upadhyay et al., 2014; Foster, 2020).

While these literatures have had tremendous impact, the separation of biomedical and social scientific research limits our understanding of embodied abortions. By embodiment I mean that bodies produce meaning through everyday experience: "who we are cannot be separated from how we are embodied" (Turner, 2001, p. 254). Without engaging social context, most biomedical research fails to account for the subjectivity of lived experience. At the same time, undertheorizing materiality, most social scientific research focuses on emotional variation at the expense of embodiment. Both approaches falsely presume that abortion is a stable category, that despite its variation in efficacy or emotional tenor, one person's abortion is the same "thing" as another person's.

Some feminist abortion scholars have begun to highlight the variation in people's abortion experiences, resisting this tendency to homogenize abortion (Lie et al., 2008; Purcell, Brown et al., 2017; Purcell, Cameron et al., 2017). Unfortunately, these accounts of physical and emotional variation rarely address the *production* of embodied difference, or why people experience abortion the way that they do. In one notable exception, Ganatra et al. find that someone's experience "depends more on [their] expectations about the method and the level of emotional and logistical support they receive than on inherent characteristics of the method [they choose]" (2008, p. 1). Altshuler et al. (2017) agree that one's preferences for their abortion depend on sociopolitical context.

Other scholars discuss how abortion stigma (Cockrill & Nack, 2013) and ideologies (Keys, 2010) structure people's experiences. For example, they argue that "negative emotions" result from internalized and enacted stigma, not from the abortion itself. Similarly, Kimport et al. (2012) find that the presence of anti-abortion protestors, elaborate security measures, and interactions with staff account for their participants' self-reported negative experiences of abortion. But like the bulk of social scientific research, this literature almost exclusively focuses on the emotional dimensions of abortion. To more fully understand embodied variation, however, and to combat hidden indignities and inequalities in abortion provision, we must adopt a naturecultural perspective. I elaborate on this

framework in the following section.

Thinking Abortion as a Naturecultural Phenomenon

The Scientific Revolution in Europe created a knowledge system that presupposes a division between nature and culture. Haraway quips, however, that "nature is not a place one can go," meaning that no pre-given "nature" exists outside of culture, and vice-versa (1992, p. 296). Because we cannot study nature or culture as separate objects, Haraway proposes the concept of *naturecultures*, simultaneously material and discursive. One way of thinking natureculturally includes the concept of biosociality, developed by Paul Rabinow (1996) to subvert the nature vs. culture debate and to bridge the fields of biological and social anthropology. According to Ingold and Palsson (2013), humans are embedded in a web of *biosocial relations*, which are the mechanisms and processes through which we create and refashion life. Biosociality extends Haraway's (2008) notion that life is always in the process of "becoming." In this paper, I use the theories of biosociality *and* naturecultures to examine the discursive-material realities of abortion.

Another way of thinking natureculturally includes the concept of biopossibilities. Angela Willey describes sexuality, for example, as a "context-specific possibility," "real, but not exhaustive or inevitable" (2017, p. 148). Matter, she argues, becomes intelligible only within certain histories and discourses. In other words, naturecultural phenomenon are always contingent and "other biopossibilities exist coterminously" (Willey, 2017, p. 148). Below, I argue that the processes of medicalization and naturalization produce the *possibility* of abortion as people living in the US experience it today.

In the US, the medicalization and demedicalization of abortion occur simultaneously, impacting discourses, practices, and even the way people conceptualize their identities. For example, in the *Roe v. Wade* decision, the courts both medicalized abortion by giving doctors the sole authority to perform them, and also demedicalized abortion by lifting the requirement that pregnant people must go before hospital committees to "request" an abortion (Mohr, 1978; Halfmann, 2011). Over the past fifty years, some feminist activists have sought to further demedicalize abortion, forming private clinics to combat anti-abortion sentiments in mainstream medicine (Frankfort, 1972; Baehr, 1999). In this paper, however, I focus on how anti-medical perspectives specifically invoke natural ideology. Companies market the medication abortion (mifepristone/misoprostol combination) as a "natural" alternative to vacuum aspiration, and pregnant

people also experience it this way (Simonds et al., 1998; Harvey et al., 2001). Mobilizing the term *natural* to describe abortion relies on the logic of the natural childbirth movement, which encourages pregnant people to follow their natural instincts and to take responsibility for the birth (Dick-Read, 1933; Karmel, 1959; Gaskin, 1975).

How do naturecultures fit into all of this? By examining medicalization and demedicalization as ongoing processes, we can see that biomedical and natural objects do not exist outside of their social context. They must be constantly produced. For example, within the medical encounter, patients are encouraged to abide by a different set of norms than may otherwise govern their social lives, and these norms, and the patient role itself, are "negotiated at every step" (Lupton, 1994, p. 121). Galasinksi and Ziolkowska (2007) discuss how people come to accept the touching of their genitals during a gynecological exam. Rituals associated with childbirth also reinforce biomedical ideology; for example, wearing a hospital gown, while involving access to the cervix, also "communicates that one is no longer autonomous, and [is] dependent on the institution" (Davis-Floyd, 1992, p. 82). When medical experts control how an event occurs and the dominant meanings of the event, people's situated experiences "become the reality with which they have to work" (Rothman, 1978, p. 127). This is not inherently a problem. To combat the marginalization of patients, in the 1980s medical sociologists investigated medical or "illness narratives" from people's own experiences (Kleinman, 1988). It becomes a problem, however, when we treat these situated realities or knowledges as inevitable.

Similarly, whereas proponents describe natural childbirth as instinctual, various scholars discuss the ways in which natural birth must be achieved. Natural childbirth literatures, as well as talk from peers, family, and midwives, socialize pregnant people to accept the assumptions of natural ideology (Annandale, 1998; Mansfield, 2008). For example, in a birthing center where a pregnant person can transfer at any time to a hospital, workers and clients must continually work to uphold a definition of the experience as natural. This can include engaging in "natural interventions," such as switching positions or using castor oil, to *induce* the birth. "All birth," Becky Mansfield declares, "is both social and natural" (2008, p. 1084). Moreover, to talk about birth—or abortion—as a universal experience that exists outside its social context fundamentally masks variation to the detriment of pregnant people, their health and their well-being.

Fieldwork and Methods

Drawing from my professional background, I am interested in the range and complexity of people's abortion experiences, particularly in how they make meaning out of the process. To understand this variation, I include two sources of data: semi-structured interviews and an autoethnographic account of my work as an abortion counselor. Thinking about bodies (and abortions) as naturecultural rather than biological objects raises the question of knowledge production and informs my decision to use abortion narratives as my primary research tool. On one hand, I acknowledge what symbolic interactionists see as the limitations of narrative (Goffman, 1956; Scott & Lyman, 1968; O'Brien, 2013). Because people always present themselves in consideration of potential reference groups, this mediates their "true feelings," limiting what interviews can tell us about biosocial realities (O'Brien, 2013). On the other hand, feminist materialisms remind us that nature does not exist outside the process of scientific discovery. From this perspective, abortion narratives produce body knowledges neither more nor less legitimate than those produced in the laboratory or by medical doctors. I believe embodied knowledges uniquely capture the range of needs associated with abortion, and therefore can improve the quality of abortion care.

I conducted these interviews from August 2017 to July 2018 (n=27), restricting eligibility to individuals over the age of eighteen whose abortions occurred within the past five years. Each interview revolved around a reflection exercise where I asked participants to describe what they were thinking, how they were feeling physically, and how they felt emotionally *before, during,* and *after* their abortions. Each intensive, semi-structured interview lasted between 50 and 120 minutes. Because people typically share abortion stories in small, private settings, I found that the intimate nature of a semi-structured interview closely mirrors how people share their abortion stories. Each participant consented to our conversation being voice-recorded and received a twenty-dollar gift card to a major retailer.

My recruitment process involved two approaches, both of which allowed potential participants to self-select into the study. First, I contacted around fifty community centers and organizations in two northeastern US cities, both with relatively low barriers to abortion access per state laws. I requested that these organizations share my call for participants with their membership and nineteen of them agreed, mostly student groups and explicitly feminist organizations. From there, I used a participant-driven sampling method, asking participants to share my study with their networks. Overall, forty-two people reached out to inquire about my study, seven of whom did not meet the eligibility requirements and nine who did

not schedule an interview. Due to the geographic spread of referrals, I introduced the option of a video rather than in-person interviews and did not notice any difference in the quality of these interviews.

Table 1. Demographic Information

Demographic Question	Response
Gender	Cisgender women (24); Genderqueer (3)
Race	White (14); Black (3); White Latina (4); Asian (2); Mixed (2)
	Hispanic (1); Laguna Pueblo/Mescalero Apache (1)
Age	Range: 19-48. **Average: 27.2 years old**
Household income	< $50k/year (14); > $50k/year (13)
Education	In college (3); Associate's (1); Bachelor's (13); Master's (9)
Reproductive histories	Current parents (5); One abortion (23); Two abortions (4)
Elapsed time since abortion	One year (8); Two years (3); Three years (8);
	Four years (3); Five years (5). **Average: Three years**
Religion (current)	Christian (1); Jewish (2); Hindu (1); Buddhist (3)
	Catholic (1); Spiritual (2); Atheist, Agnostic, None (17)
Religion (growing Up)	Christian (9); Catholic (5); Jewish (3); Hindu (1)
	Traditional (1); Buddhist (1); Atheist, None (6)

Of the twenty-seven people I interviewed, eighteen specifically identified as part of the pro-choice or reproductive justice movements. The remaining nine either self-identified as feminists or pro-choice, mobilizing popular feminist slogans (such as, "my body, my choice"). My sample includes both cisgender women and genderqueer individuals, most of whom were highly educated and from a middle-class household across a range of racial and ethnic backgrounds. With the exception of one participant who terminated at fourteen weeks and another at twenty-one weeks of pregnancy, the rest had first trimester abortions (<13 weeks). Fourteen participants opted for the in-clinic "vacuum aspiration" abortion; ten had the mifepristone/misoprostol combination at the clinic, otherwise known as the "abortion pill"; and three participants acquired misoprostol outside the clinical context, two by preference and one because her country of residence did not offer legal abortion services.

After completing and transcribing the interviews, I conducted line-by-line coding using NVIVO. In my first round of coding, I identified key themes, particularly focused on how participants made sense of their abortion experiences—for example, as a routine medical procedure or as an opportunity for growth. After a brief period of reflection, I conducted a second round of line-by-line coding,

breaking up or combining codes based on theoretical salience and trends in the data. Finally, I used matrix analysis to compare the distribution of particular codes across race, abortion methods (aspiration vs. medication abortion), parenting status, and number of abortions.

I also include autoethnographic reflections on my experiences as an abortion counselor for local and national financial assistance hotlines, where individuals who cannot afford abortion call to receive information and support.[4] Since 2015 I have spoken with several thousand individuals before or after termination from all over the US and Canada. These interactions occur over the phone and focus almost entirely on abortion access, so callers know little about me. For example, I do not disclose my gender and use a generic pseudonym like "Alex," so by my voice, people attribute different gendered pronouns and honorifics (sometimes I get called "ma'am" and "sir" in the same call). For this autoethnography, I avoid specifics from any particular call, as I am bound by the Health Insurance Portability and Accountability Act to protect callers' confidentiality. Rather, I focus on how I participate in medical and anti-medical ideologies as a counselor, generalizing from the types of conversations I have on the line. Carolyn Ellis describes autoethnography as "systematic introspection" (1991, p. 33). For this paper, I reflected on how I do and do not talk about bodies during each stage of the counseling call, as well as my training as a counselor and my observations at the call center. These experiences inform my analytic and political critique. I also offer these rigorous reflections as a form of "situated knowledge," to show how I have developed these critiques and produced these analyses (Haraway, 1988).

Destabilizing Abortion: A Case for Individualized Care

Abortion contains many steps and stages, each of which involves its own process of embodiment. Depending on the method, this might include dilation, aspiration, and recovery, or taking mifepristone, cramping/bleeding, passing the pregnancy, and so on.[5] Other expected services include counseling, blood testing, and an ultrasound. When we break an abortion experience into these smaller, micro-processes, it becomes apparent that the type of support someone might need at one stage differs from another. For example, Lucy wants less information when it came to the ultrasound and more when it comes to managing cramps; Sandy, meanwhile, wants company while acquiring the medication but prefers solitude when passing the pregnancy. These stages can also vary among participants. During my interviews, I asked participants to describe their experiences before, during, and after their abortions, encouraging them to begin and end their stories

however they desired. Their stories vary widely, so despite the singularization of abortion in biomedical and social scientific literatures, I am skeptical that participants have in fact experienced the same "thing." When we let go of what we think we know about "abortion," scholars and activists can better understand people's individualized needs.

As a case study for examining embodied variation, let us discuss how people conceptualize the beginning of their abortion. One "starting point" occurs when someone takes the first pill in the series. Sasha recalls being at the clinic with a nurse, receiving her dose of mifepristone. "She tells you, OK, this will start the abortion. There's no going back if you take these." For RJ, the threshold of her abortion experience began a little bit later. "I could feel the cramps within an hour and a half of taking that [first] pill. When the first significant cramp radiated across my stomach, I almost burst into tears, thinking like, 'Oh my God, that it. It's started…this is what it feels like for a baby to die.'" Maria actually marks an earlier beginning to her abortion. For her second pregnancy, Maria had a lot of difficulty deciding whether or not she wanted another abortion so she prayed and meditated a lot in the weeks preceding. On the morning before her abortion, she "woke up bleeding." "I don't know," Maria explains, "Once I saw that in the morning, to me that was the sign I'd been asking for the night before."

My participants also worry about whether the abortion is complete. RJ's bleeding, for example, lasted for a month afterwards. "I would call my doctor," she remembers, "and be like, '*Is this normal*?' My body was not letting me move on." Susan expected that passing the blood clot would signal the end of her abortion, so like RJ she worried about completion: "I remember passing a pretty large clot, but I don't know. I guess I thought it would be bigger, so I worried that it didn't work. I was really freaked out afterwards and continued to be nervous." Like others, Holly experienced a staggered set of endings. First, after taking misoprostol, she remembers thinking, "OK, I guess it's over now…but it wasn't over-over until a month later [when I had my first period]."

Why does it matter that participants conceptualize different "starting" and "ending points" for their abortion? It might be tempting to think of such boundary drawing as a social process that imposes meaning on a pre-existing phenomenon. Abortion, however, does not exist prior to or outside of someone's embodied conceptualization of the event. Try as we might, we lack the tools for measuring the experience of ingesting a pill, seeing blood, or enduring cramps without also taking into account the feelings of relief, anticipation, or anxiety that participants

also describe. So when participants offer different accounts of what comprises "the abortion," there is no way of knowing whether or not two people have experienced the same thing.

Explaining the medication abortion to our clients, my colleagues and I would usually say that the pregnancy passes several hours after misoprostol and the bleeding might last for another week. But for participants worried about completion, "the abortion" can last a number of weeks and even up to a month, something rarely considered in popular discourse or abortion scholarship. Lack of knowledge about abortion compounds the marginalization of lived experience. For example, Astrid says, "I've never heard much about what it would look or feel like. To me it was always that you take this magic pill, or have a quick procedure, then you're done and you're fine." Failing to discuss embodied variation, scholars and activists leave people underequipped to navigate the particularities of their own experience. Moreover, when we assume that all abortions are the same, we lose the opportunity to provide individualized support.

Person- or patient-centered care "understands the patient as a unique human being" (Balint, 1969, p. 269). Some providers already practice this by offering counseling, education, and doula services to those who want them (Gould et al., 2012). Destabilizing the category of abortion and recognizing embodied variation, however, opens up new possibilities of patient-centered abortion care. In other words, scholars and activists need to take more seriously the body knowledges of people who have abortions. Doing so, we would know, for example, that many people feel their abortion lasts until their next period, or until confirmation at their follow-up appointment. We can develop education and support materials to reflect such needs, and also must consider how raced, classed, and gendered bodies transform the meaning and experience of abortion.

Regulating Bodies: The Embodiment of a "Normal" and "Natural" Abortion

Some participants (18/27) describe abortion as "normal," which has multiple meanings, both literal (does the abortion occur as expected/are there complications?) and ideological (many argue that only its stigma separates abortion from other medical procedures). These participants tend to trust in medical knowledge and feel comforted by doctors' presence, occupying what medical sociologists call the patient role (Parsons, 1951). Other participants (10/27) describe their experiences, particularly of the medication abortion, as "natural," contrasting it to the "invasiveness" of dilation and aspiration. "It

seemed less invasive, that's really the key," Hermione explains, "the pills didn't seem like such a big deal." "If I could just take a pill and have a really bad period, I'd prefer that to anything that involves being with more doctors and vacuums," Lucy adds. Despite these declarations, "normal" and "natural" abortions do not occur intuitively. Rather, they require the participation of social actors, and are also reinforced through social environments and interactions with clinical staff. In fact, the ideological categories of "normal" and "natural" regulate abortion experiences by building expectations and providing the resources to embody abortion in particular ways.

Pregnant people do significant interpretive work before, during, and after their abortions. I was surprised to see how often participants described abortion proceedings as "normal," despite their discomfort with other aspects of the abortion process. Lucy, for example, feels deeply conflicted about fetal personhood. For her and many other participants, the ultrasound elicits complicated feelings: "My first instinct was that I just didn't want to associate this [pregnancy] with humans or children." Yet thirty seconds later, she sums up the ultrasound experience by saying, "But it was fine, and it was pretty run of the mill." Dylan confesses that while they felt somewhat powerless during the vacuum aspiration, "everything else kind of seemed normal." Sasha compares her bleeding after taking misoprostol against an imagined norm: "I guess it was a reminder of what had happened," she says, "But I don't remember it being like a traumatic reminder or anything. It just felt like, OK. I'm still bleeding."

Each participant expresses ambivalence about a particular activity—a transvaginal ultrasound or non-menstrual bleeding—but then resignifies the experience as normal. Abortion becomes "normal" when participants interpret their experience through a medicalized framework, and through this act of interpretation the abortion itself comes into being. Similarly, abortion becomes "natural" when someone interprets abortion through the framework of natural ideology. Judith Butler (1990) argues that we interpret (and construct) realities through the discourses available to us. Anti-medical discourse, for example, popularized by the natural childbirth movement, offers someone the language to be able to imagine and embody a "natural abortion." This language permits one to imagine taking mifepristone and misoprostol as natural or holistic, while considering dilation and aspiration to be unnatural. Medical discourse, meanwhile, enables someone to experience their abortion as "normal."

Participants internalize these ideologies in multiple ways. First, as mostly self-

defined feminists, participants inhabit communities that promote medical and natural ideologies, so are thus more likely to use them as benchmarks for their own experiences (Keys, 2010). Pro-choice media, including digital abortion storytelling projects, might reinforce certain frames (Allen, 2015).

Pre-abortion counseling sessions also prime people on how to think about their options (aspiration vs. the medication abortion). Counseling varies based on state-mandated policy, institutional norms, and the styles of individual counselors. In my experience, there exists a spectrum between feminist- and business-minded clinics, which shapes how counselors are trained to facilitate options counseling (including how many minutes to spend with each person, what questions to ask, and what language to use). Some clinics softly promote medication abortion—"it feels more natural"—because it requires less attention from the provider and thus turns a quicker profit for the clinic. The vast majority of people, however, use natural discourse because of its availability and intelligibility.

While discourse does structure our naturecultural worlds, participants also use available meanings toward their own ends. For example, Rosie reflects on why the discourse of "natural" appealed to her during her abortion three years earlier. "I think I played a mind game with myself to make me not feel bad about it," Rosie shares with a laugh, "and it worked! Because of the pill, I felt like it was more natural. It was like I had a miscarriage, and not an abortion like I promised myself I would never do again." For Rosie and other pregnant people, selecting a more "natural" alternative can make the abortion seem passive, something that happens to a participant rather than something they did or initiated. In other words, anti-medical discourse functions as a tool for navigating abortion-related shame, suggesting that participants exercise a degree of agency in the processes of medicalization and naturalization. The biosocial states of "normal" and "natural," therefore, may be overdetermined but are not predetermined.

As Drew Halfmann (2011) explains, discourse is not the only site of medicalization and demedicalization; other practices, such as interacting with clinical staff, also make possible the experience of a "normal" or "natural" abortion. For example, several participants describe how clinic workers reinforce medical frameworks during the visit. When Hermione questions the necessity of an Rh test to determine her blood type, since she's "not keeping the baby," the staff member on duty replied that, "It's just procedure. We do this with everybody." When Chelsea resists having a transvaginal ultrasound, the nurse tells her that "this is

standard procedure." Most likely, clinics train workers to respond in this fashion. Therefore, I am not suggesting that these workers have poor bedside manner; nor am I denying the medical necessity of these practices[6]—for example, people conduct ultrasounds to find the location of the pregnancy before extraction. Rather, the repetitive appeal to medical standards offers an insight into how the clinical environment, the patient role, and interactions with staff compel pregnant people to interpret and experience their abortions as "normal."

Just as social environments can be medicalized (all but three participants had their abortion at an independent clinic or a Planned Parenthood, a nationwide provider with over six hundred sites in the US), they can also be naturalized. Natural childbirth movements, for example, encourage parents to create their own individualized spaces (Annandale, 1998), and sociologist Barbara Katz Rothman (1981) argues that there is no such thing as a "natural" childbirth until parents and activists create one. My participants perform similar work to achieve "natural abortions," personalizing the experience through various rituals. Sam dimmed the lights and prepared for a quiet evening at home with their partner: "I didn't want to be alone in a sterile room with a bunch of people watching me go through this. If I was going to have this experience, I wanted to feel like I was doing it. And also have my partner there with me." Holly, who valued having an abortion outside the clinic and even considered menstrual extraction (an aspiration technique often referred to as a "do-it-yourself" abortion), planned to set up a mini-altar to commemorate the abortion. Of course people should maximize their comfort during a potentially difficult experience, but doing so does represent another kind of work that goes into creating a "natural abortion."

When people internalize medical and anti-medical ideologies, expecting to have a "normal" or a "natural abortion," anything else can provoke anxiety and frustration. Holly, for example, recalls her own medication abortion: "I was just writhing on the floor all day, not paying attention to my crystals or my tea. It's humbling. I had all these rituals, but on the day of…none of that shit mattered." She laughs, comparing the experience to the unrealistic expectations set by people during childbirth. Lucy also found her plans diverted by the urgency of her body: "I thought I was going to spend the day watching movies, but I couldn't watch anything suspenseful or my body would tense up and the cramps would get worse." Natural discourses, such as comparing the medication abortion to "a heavy period," leave some people unprepared for the degree of cramps and pain they will experience. Sasha mentions that if she needed to have another abortion

she would actually opt for the vacuum aspiration instead. Susan concurs. "The idea of being able to do it at home—in an absent theoretical way sounds nice," she shares, "but retrospectively, it was actually pretty scary. If I were to, God forbid, have to do it again, I don't think I'd want to do it at home." Unfortunately, our current system of abortion provision facilitates these kinds of mismatches between expectation and reality.

As an abortion counselor, I recognize that I play a role in either reifying or challenging the categories of a "normal" or "natural abortion." Many people in their first trimester want clarification about what distinguishes vacuum aspiration from the medication abortion. While I mention that some people feel comfortable having a doctor by their side and others feel that a medication abortion is more "natural," I also try to point out some embodied differences. For example, that vacuum aspiration takes less time and has a faster recovery period, or that the medication abortion can occur at home with friends and loved ones. I want them to know what they might be opting into.

Medical and anti-medical ideologies may support abortion access on the macro level, but also impact people's decision-making processes and structure their abortion experiences at the micro level. In some ways—similar to anti-abortion ideology (Kimport et al., 2012)—these ideologies are self-fulfilling prophecies, producing the discursive and material conditions that lead people to have the kinds of abortions that these ideologies anticipate. As universalizing ideologies, "normal" and "natural abortions" purport to be applicable to everybody, indifferent to race, class, and other forms of difference. But as I argue below, in their absence of racial and class discourse, "normal" and "natural" ideologies are deeply raced and classed in that they refuse to acknowledge the impact of white supremacy and capitalism on abortion experiences. Abortion ideologies also produce negative outcomes for people who cannot attain their desired biosocial state, or the feelings (such as normal or natural) they that wish to embody.

Biosocial Exclusion: Another Form of Stratified Reproduction

Medical institutions simultaneously abuse and exclude people of color. On one hand, disadvantaged Black and Indigenous communities have endured forced sterilization and the coercive use of long-term birth control (Roberts, 1997; Briggs, 2002; Silliman et al., 2004). On the other hand, disadvantaged communities of color also lack access to new reproductive technologies and, increasingly, to abortion itself (Ross & Solinger, 2017). For most advocates, abortion access refers

to the financial and legal barriers that either close clinics or prevent someone from receiving their services. When we think about abortion as an embodied experience rather than a standard procedure (that one either has or does not have), new dimensions of access emerge. In particular, I show that unequal conditions produce different embodied experiences, enabling some groups of people and foreclosing others from the possibility of a "normal" or "natural" abortion.

While many participants found encouragement or support in their interactions with clinic staff, for others, the patient role fails to uphold their dignity. Ethiopia, Venus, and Valerie, three Black participants, remark on how racism and classism shaped their experiences. Valerie believes that the demographic make-up of the clientele (mostly low-income women of color) resulted in a purposefully low standard of care: "You have to urinate before you go into the room with everyone, and I remember my pee cup being unlabeled with a bunch of other pee cups in this drawer, without tops…You don't even take the time to label our things; that shows your disregard for us as human beings."

Valerie describes being shuffled from room to room without explanation: "whenever I tell this story, I say that we were herded like cows." She also recalls the doctor getting blood on her socks: "I only remember because I had to throw those socks away; how could you be so careless?" Her experiences stand in stark contrast from the many white participants who describe positive encounters with clinical staff. One white participant, Julie, says that there was a "person whose job it was [at the clinic] to hold [her] hand and look into [her] eyes, which was very comforting." Frances, another white participant, remarks that "the staff said I was a good patient, very low key. That made me feel strong." One possible explanation for these disparities could be that staff members draw upon medical scripts that cast people of color as always, already deviant: certain bodies are seen as worthy of health while others are seen as expendable. For example, while white women's complaints are perceived as legitimate, staff dismiss Black women as "wily patients" who lack intelligence and try to work the system (Bridges, 2011).

Economic inequalities also constitute an assault on participants' dignity. Ethiopia, for example, comments how shocked she was to learn that sedation costs extra money. Although she had the resources, Ethiopia sees the high cost of sedation as "punishment" for those who cannot afford it, and as an abortion counselor, I know that people regularly opt out of sedation or select a different abortion method due to the financial burden.[7] Such barriers can heighten a person's anxiety and

transform the experience altogether. For example, Venus recalls waiting for almost six hours at the clinic to confirm assistance from a local abortion fund, worried that she would need to reschedule. Told that the clinic was about to close for the day, Venus had started her car and put on her seatbelt when she finally got a call back from the abortion fund. Her abortion differs substantially from someone who has insurance or can swipe a credit card for payment. Erica, a white participant, punctuates our discussion of middle-class privilege by joking that she was disappointed that she would not receive 1 percent cash back on her abortion.

In previous sections, I showed how participants reinterpret uncomfortable experiences as "normal." The possibility of a normal abortion, however, hinges on a successful negotiation of the patient role, and participants cannot disappear into the patient role when they are continually marked and racialized as "other." Put differently, the microaggressions that Valerie experiences at the clinic prevent her from achieving a normal abortion, as does the forced waiting time that Venus endures because of her inability to pay for a five-hundred-dollar appointment. Of course, not all white, middle-class participants have positive abortion stories. Yet they do not contend with the extra indignities associated with being a low-income client and/or a patient of color in the US (Roberts, 1997; Schulz & Mullings, 2006; Washington, 2007). Social and political context create specific forms of exclusion. For example, if Venus lived in one of the sixteen US states or many countries where state insurance covers abortion, her experience would shift.

Unequal conditions also shape the possibility of having a "natural abortion." Natural ideologies emphasize the active role of pregnant people in controlling the childbirth experience (Davis-Floyd, 1992), and in the previous section, I showed how participants personalized their space as one way to achieve a "natural abortion." Not all people, however, have the ability to control their social environment. Nor does everyone have the resources to interpret their abortion through a framework that centers their needs and comforts. For example, I have worked with clients who cannot have a medication abortion because they lack a stable housing situation or a private place where they can pass the pregnancy. Perhaps they have a parent who will disown them or an abusive partner who will inflict harm on them if they find out about the abortion. These barriers foreclose the possibility of a natural abortion because without control over the physical space or social environment, how can one claim to be having a "natural" experience?

Of course, biosocial exclusion does not occur randomly. As Shellee Colen argues,

structural inequalities produce differential experiences of reproduction on the basis of "race, ethnicity, gender, and place in the global economy" (1995, p. 78). My research offers one illustration of how overlapping systems of oppression overdetermine embodied abortion experiences. By discussing biosocial exclusion as a matter of access, I affirm the importance of quality abortion care and its responsiveness to patients' needs. Due to alienation from medical institutions, some women of color invest in alternative health practices (e.g., Black Women Birthing Justice) and subscribe to non-medical forms of knowledge. For example, Valerie mentions that her favorite part of the abortion was talking to other Black women in the waiting room about their experiences. However, to the extent that minoritized groups desire to have a "normal abortion," they often lack the conditional privilege to reinterpret their experiences in this manner. Furthermore, the fact that white, middle-class communities have significantly higher access to these biosocial states concerns me. In this context, biosocial exclusion reflects and affirms a pattern of which groups have control over their reproduction and which do not.

Conclusion

Whereas most research views abortion as a standard biological event—studied from either a biomedical or social scientific perspective—in this article, I have argued that we must examine abortion through a naturecultural lens. Its physical traits and social meanings always vary in relation to each other. In other words, we cannot separate how someone conceptualizes the abortion (or their feelings of, perhaps, relief or concern) from the abortion itself. Abortions do not exist prior to or outside of their social contexts, which in the US involve high degrees of medicalization and naturalization. Furthermore, I have argued that by detaching emotions from materiality, abortion scholars and activists reinforce harmful conditions for pregnant people. We can and must destigmatize abortion, but how we define abortion also has material consequences.

For example, I show how dominant ideologies encourage participants to have "normal" and "natural" abortions. This is not necessarily a bad thing, given that no unmediated abortion exists outside of society. However, these ideologies obscure other embodied experiences, leading to underrepresentation of marginalized stories, a lack of personalized support, and stress and frustration when someone's experience deviates from their ideal abortion. In terms of this third point, "normal" and "natural" abortions are not always achievable, particularly for disadvantaged communities. But while I hope to displace these universalizing expectations, as an abortion advocate, I also want to support people in achieving

their desired biosocial state—similar to how I may critique heteronormativity but support someone's effort to build a nuclear family. People also deserve to know what a vacuum aspiration and/or a medication abortion entail, including embodied details that might contradict the logic of "normal" or "natural."

The reproductive justice movement already engages in many practices that would support people's ability to have their desired abortion experience. For example, by working to end the Hyde Amendment, which prohibits federal funds in the US from going towards abortion, activists reduce the indignities low-income people encounter in the abortion process and increase financial access to people's preferred sedation and abortion options. Similarly, many abortion funds strive to provide practical in addition to financial support for their clients. Practical support, including rides to and from the clinic, doula services, and childcare, give someone more control over their social environment, thus enabling them to create the "normal" or "natural" abortions they may desire. Finally, abortion storytelling projects such as We Testify (National Network of Abortion Funds) and the 1 in 3 Campaign (Advocates for Youth) have the power to disrupt dominant abortion discourses through the elevation of lived experience.

Studying abortion requires naturecultural tools and strategies. In this paper, I have argued that abortion storytelling can build an archive of body knowledge if we talk to people about their bodies and take their biosocial accounts seriously. To do so, we must challenge how social movements regulate abortion discourse—in ways that are at times detrimental to their own goals. For example, in *Happy Abortions*, Erica Millar argues that despite the rise of pro-choice discourse, "the idea that abortion could or should be a happy experience…is virtually unspeakable" (2017, p. 3). Researchers Lisa Martin et al. (2017) discuss the importance of *danger talk*, describing how abortion providers hesitate to share complicated emotions out of fear they will be taken out of context by anti-abortion activists. In this spirit, I propose that abortion scholars, activists, and providers also embrace *body talk*. Although people's embodied abortion experiences might be perceived as graphic and thus harmful to abortion's public image, body talk is paramount to providing pregnant people the resources to navigate their own abortions.

Further research on embodied abortions can help develop body talk practices. I encourage researchers to ask more pointedly about each stage of the abortion (rather than speaking of it in the singular). I recommend comparative studies that examine embodiment across different abortion methods and in different clinics or

geographies. Finally, we need more collaborative research with people who have had abortions to center the issues are important to them and what would have improved their experiences.

The frameworks of naturecultures (Haraway, 1992) and stratified reproduction (Colen, 1995) complement each other well. Both centralize the becoming of phenomenon (materiality and reproductive experiences) usually considered pre-given or pre-social. What do we get from thinking about these frameworks together, particularly through my concept of biosocial exclusion? First, stratified reproduction reminds us that the emergence of our naturecultural world is *deeply unequal* and occurs differently for various groups of people. For example, not all people have the ability to embody a "normal" or "natural" abortion. Some scholars even argue that universal notions of "the body" (McRuer, 2006) or humanity (Wynter, 2003) are foundational for maintaining social inequalities. Second, reading these frameworks together makes visible new sites of inequality (such as biosocial exclusions). Rejecting the biologizing of social relations (Willey, 2017), naturecultures offer the conceptual tools to see and disrupt stratification.

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Notes

[1] Given the fact that not all people who get abortions are women (including transgender men and gender-non-conforming individuals), I use the term "pregnant people" over "pregnant women" or "women," when discussing this general population (Indra, Midwives Alliance of North America, 2015). My sample contains three genderqueer participants, who do not identify as men or women.

[2] Harris et al. (2018) argue that we should use the category of abortion provider expansively to include not only the doctor who performs the abortion but other clinic works and counselors, whose labor is imperative for the abortion to actually take place.

[3] Under the guise of protecting women's health, Targeted Regulation of Abortion

Provider laws impose medically unnecessary standards (such as hospital admitting privileges) that force abortion clinics to close. For example, one Texas law—since overturned by *Whole Women's Health v. Hellerstedt*—shut down nineteen of the forty-one clinics in the state.

[4] Due to the 1976 Hyde Amendment, no federal funds in the US can go towards abortion, meaning that Medicaid does not cover abortion in thirty-four states. The average first-trimester abortion costs $470 (Jones & Koostra, 2011).

[5] We can think of abortion as something of a "ficticious unity" (Foucault, 1976, p. 154), a constructed category—such as sex—that falsely presumes the alignment of its composite parts (in the case of sex, the fact that we group together hormones, chromosomes, gonads, genitals, and secondary sex characteristics and call this "sex" is an ideological position that, like "abortion," hides variation).

[6] Ultrasounds are not universally considered mandatory practice, and have increasingly become less so with the rise of the medication abortion.

[7] Some people need to travel further or pay more for an abortion in their second trimester because they could not afford to get one earlier. This could result in the difference between a vacuum aspiration abortion and a dilation & evacuation (D&E) abortion, or being too far along to be eligible for the medication abortion and therefore needing to pursue another option.

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