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Authoritative Knowledge and Single Women's Unintentional Pregnancies, Abortions, Adoption, and Single Motherhood: Social Stigma and Structural Violence

This article explores the sources of authoritative knowledge that shaped single, white, middle-class women's unintentional pregnancies and child-bearing decisions throughout five reproductive eras. Women who terminated a pregnancy were most influenced by their own personal needs and circumstances. Birth mothers' decisions were based on external sources of knowledge, such as their mothers, social workers, and social pressures. In contrast, single mothers based their decision on instincts and their religious or moral beliefs. Reproductive policies further constrained and significantly shaped women's experiences. The social stigma associated with these forms of stratified maternity suggests that categorizing pregnant women by their marital status, or births as out-of-wedlock, reproduces the structural violence implicit to normative models of female sexuality and maternity. This mixed-method study included focus groups to determine the kinds of knowledge women considered authoritative, a mailed survey to quantify these identified sources, and one-on-one interviews to explore outcomes in depth. [authoritative knowledge, social stigma, abortion, birth mothers, single mothers, unintentional pregnancies]

We need to anthropologize the West: show how exotic its constitution of reality has been; emphasize those domains most taken for granted as universal . . . make them seem as historically peculiar as possible; show how their claims to truth are linked to social practices and have hence become effective forces in the social world.

—Paul Rabinow [1986]

At least 48 percent of women living in the United States will experience an unintentional pregnancy by midlife.¹ The lack of public awareness of the high rate of unplanned pregnancies, which are neither limited to early childbearing nor to single women, indicates the cultural censorship of an experience

shared by many women and their partners. This censorship reflects the tensions of a dominant pronatalist ideology within a culture that increasingly prizes self-determination (Blake 1974; Solinger 2001). Planned pregnancies are socially prescribed, and women expect to be able to time their pregnancies to fit their life goals and family needs at a socially accepted age and marital status. Married women avoid social stigma regarding their unplanned fertility through their legal relationship to a man, which allows them to “pass” (Goffman 1963). In contrast, single women² are particularly vulnerable to the social stigma surrounding unintentional pregnancies.³

In the United States, when marriage is not an option, single women who unintentionally conceive face three alternatives: to terminate their pregnancy, to adopt away their child, or to become a single mother. This study suggests that each of these alternatives permanently and profoundly alters a woman's life course and her reproductive history or “procreative story” (Ginsburg 1987). The meaning of the term *history* as a story or tale is derived from the Greek *historia*, for inquiry, and from *istor*, knowing, what is learned.⁴ This study further suggests that women's stories and the knowledge that single women glean from their pregnancy and child-bearing outcomes have been culturally censored. Moreover, this censorship signals the implicit structural violence⁵ (Kleinman 2000) that underlies normative models of female sexuality and fertility and the rhetoric of what it means to be a “good” and worthy woman, mother, and wife.⁶ Because reproductive policies in the United States have been ethnically bifurcated (Collins 1995; Davis 1981; Litt 2000; Solinger 1992), this study is limited to the sources of authoritative knowledge that shape single, white, middle-class women's unintentional pregnancies and their subsequent childbearing decisions.⁷

Pregnancy, Knowledge, and Power

The label “authoritative” is intended to draw attention to [the status of a body of knowledge] within a particular social group and to the work it does in maintaining the group's definition of morality and rationality. The power of authoritative knowledge is not that it is correct but that it counts.

—Brigitte Jordan [1997]

Since Jordan's groundbreaking work in the mid-1970s, studies of authoritative knowledge (AK), have clarified how social differences in power, authority, prestige, and access to resources shape birthing practices. These differences perpetuate forms of stratified reproduction “that supports and rewards the maternity of some women, while despising or outlawing the mother-work of others” (Rapp 2001:469). For example, the biomedical hierarchies of hospitals, medical clinics, and epidemiology tend to reproduce and privilege a birthing ecology dominated by technological interventions and professional and medical expertise, while occluding ethnomedical knowledge and women's embodied knowledge (Jordan 1997; Kitzinger 1997). In contrast, birthing practices that minimize social hierarchies between birth attendants and parturient woman tend to incorporate pluralistic sources of knowledge, such as maternal embodied knowledge, touch, instincts, ethnomedical knowledge, and cultural practices that privilege social affiliations (Davis-Floyd and Davis 1997; Kitzinger 1997; Sosa et al. 1980).

Studies of authoritative knowledge in childbirth have illuminated the mutable, context-dependent quality of the birthing knowledge that counts in non-biomedical settings. For example, among the San, primiparas are not expected to have the requisite knowledge to meet the cultural ideal of a silent and unassisted birth; their first birth is often assisted (Biesele 1997). Similarly, in rural Mayan communities, a midwife may yield to the knowledge of a multipara in labor, but assert her own authority over an inexperienced primipara (Jordan 1978; Sargent and Bascope 1997). Thus, differences in power and authority are not simply indices of hegemonic versus pluralistic knowledge systems, but may be determined by women's reproductive histories.

Women may also resist, negotiate, and reproduce the hegemony of biomedical birthing. For instance, Betty-Anne Daviss (1997) describes how the secular logic of an epidemiology-based program to reduce maternal-child mortality rates inadvertently increased the personal trauma to laboring Inuit women. The practice of airlifting parturient Inuit women to a distant hospital invalidated ethnomedical models and severed women from birth "as a community, social and spiritual act" (1997:441). Similarly, women of color and working-class women, who may face the triple jeopardy of ethnicity, class, and hegemonic medical models, may be more likely than white middle-class women to resist dominant biomedical models and instead draw on parallel systems of knowledge (Litt 2000; Martin 1987). In contrast, women may inadvertently reproduce the hegemony of medical models, as they ambivalently accept medical advice regardless of its actual benefits, in an attempt to hedge their bets as reflective consumers and responsible mothers (Browner and Press 1997).

The dense interplay of agency and social forces revealed in these studies underscores that women are, ineluctably, neither free agents nor passive victims. This study explores one of the historically most contested forms of conception—single women's unintentional pregnancies—and underscores the intractable tensions between individual agency and social forces, which are further shaped by shifting reproductive policies.

Five reproductive eras have profoundly shaped women's fertility-regulating options in the United States: the mid-19th century statutes that criminalized abortion and the distribution of contraceptives; the cult of motherhood as a civic duty; the subsequent cult of scientific motherhood;⁸ the post-World War II adoption mandate; and the interplay of the FDA approval of birth control pills in 1960 and the 1973 passage of *Roe v. Wade*. Each of these eras reified shifting forms of medical and scientific knowledge. In this study, I explore the sources of knowledge that count, and their moral and rational concomitants, for single women who discover they have unintentionally conceived.

Criminalizing Abortion and Contraceptives

Until the mid-19th century, the quickening, when a woman first senses fetal movement, confirmed pregnancy (Duden 1993). Abortion, which was viewed as a means to remove "obstructed" menses, was not socially sanctioned; yet abortifacients were widely available to both single and married women. With the establishment of the American Medical Association in 1848, physicians used the medical management of childbirth to separate themselves from competing models of

medical knowledge (Mohr 1978). Their purported biomedical authority encompassed all aspects of maternity, including female sexuality, morality, and the scientific determination of pregnancy and fetal personhood. By 1872, this consolidation of medical authority, paralleled by social reform movements, culminated in the Comstock Act, which prohibited the advertisement and mailed distribution of contraceptives and abortifacients. Although a lively black market for contraceptive devices and abortifacients continued to thrive (Tone 2001), by the Turn of the Century abortion had become illegal in the United States and women's fertility was more firmly under legal and medical authority.

The Cult of Maternity as Civic Duty •

The social purity movements of the early 1900s, increased birth rates among recent non-Protestant immigrants, paralleled by declining birth rates among white Anglo-Saxon Protestants, resulted in fears of "race suicide" (Berebitsky 2001; May 1995). President Theodore Roosevelt called on white middle-class and upper-class Protestant women to fulfill their civic duty and procreate. His pronatalist campaign reified maternity, typified by nurturance and self-sacrifice, as women's highest calling and civic duty (Berebitsky 2001; May 1995; Solinger 1992). As urbanization and industrialization increased the gender stratification of labor, gender ideals were further redefined (Apple 1987; Nathanson 1991). In contrast to the 18th-century colonial era, where the practice of bundling contributed to a 33 percent rate of premarital conceptions and births (Lawson and Rhode 1993; Smith and Hindus 1975),⁹ during the Progressive era feminine purity and premarital chastity became the cornerstones of maternal moral superiority (Brodie 1994; Nathanson 1991). This reification of white, middle-class maternity as a civic need resulted in the establishment of evangelical maternity homes and widows' pensions. Thus, it was socially expected that single, pregnant, middle-class white women and widows would keep and raise their own children (Berebitsky 2000; Kunzel 1993).¹⁰

The Cult of Scientific Motherhood

By the 1920s, the advent of the first-wave feminist movement, the newly formed Children's Bureau, and rising maternal-child mortality rates culminated in the 1921 Sheppard-Towner Act. This legislation allocated federal funds to promote hospital births and increase women's access to obstetric specialists. Hospitals offered the "twilight sleep," x-rays, transfusions, and sterilized equipment. Scientific experts proffered advice to mothers on the management of household germs, infant feeding, and childcare (Apple 1987; Wertz and Wertz 1977).

As the new science of eugenics garnered cultural authority, the etiology of single women's unintentional pregnancies shifted from a redeemable moral failing, to feeble-mindedness, a form of heritable intellectual inferiority. Thus, the management of maternity homes shifted from evangelical charity workers, to social workers with the scientific training necessary to deal with heritable disorders (Kunzel 1993; Solinger 1992). This new scientific approach dictated that a single mother and her child remain together in the maternity home until the child, at six months of age, could undergo an intelligence test. Within this model, social workers

were then able to scientifically match the tested child with adoptive parents (Berebitsky 2000).

The Post-World War II Adoption Mandate

From 1960–70, 27 percent of all births to married women between the ages of 15 and 29 were conceived premaritally. Yet the etiology of single, white, middle-class women's conceptions had shifted again and were now perceived as a symptom of female neurosis (Solinger 1992; Vincent 1961). In keeping with this medical model, a single pregnant woman could obtain a therapeutic abortion if she could find a physician willing to diagnose her as psychologically unsound, or if her pregnancy could be diagnosed as life threatening. However, the approval of a board of hospital physicians was necessary to obtain a therapeutic abortion and 53 percent of teaching hospitals and 40 percent of all U.S. hospitals, and, thus, their boards, required that women accept simultaneous sterilization to prevent a future unplanned pregnancy (Solinger 1998:24).

Given these constraints, the majority (85–95 percent) of single, white middle-class women, who either could not or would not procure an illegal or therapeutic abortion, were encouraged, and at times coerced, to adopt away their child (Edwards 1998; McAdoo 1992; Pannor et al. 1978; Solinger 1992, 1993).¹¹ Maternity homes became total institutions where neurotic pregnancies could be cured by separating single mothers from their children (Solinger 1992). By the 1950s, attachment theory dictated that this separation occur as soon after birth as possible, to promote an infant's ability to bond with its married adoptive parents (Berebitsky 2000).¹² After relinquishing their child, birth mothers could secretly reenter society as marriageable women and bear future legitimate children.¹³

The Oral Contraceptive Pill and Roe v. Wade

The civil rights movement, the second-wave women's movement, and the gay rights movement fitfully reconfigured the kinds of knowledge that counted regarding female sexuality, fertility, and maternity. Rising divorce rates, the increased number of women obtaining secondary education and in the work force, and women's delayed childbearing shifted normative models of the family (Petchesky 1984). In 1960, Enovid, the first FDA approved oral contraceptive, was available by medical prescription (Marks 2001), and by 1965, the Supreme Court ruling of *Griswold v. Connecticut* guaranteed married couples the right to privacy regarding contraception. Seven years later, *Eisenstadt v. Baird* extended these rights to single women and men, repealing the last of the century-long Comstock statutes.

As a result of women's access to the pill and the dual 1973 Supreme Court rulings—*Roe v. Wade* and *Doe v. Bolton*¹⁴—that legalized abortion, the number of white middle-class women adopting away their children plummeted from 85–95 percent to 3 percent. This rate has not increased since, despite the 1976 *Hyde Amendment* that prohibited the use of Medicaid funds for abortions while maintaining full federal funding for sterilization or birth expenses, thus limiting poor and young women's access to abortion (McFarlane and Meier 2001; Solinger 1993).

By 1988, religious fundamentalist antiabortion groups had reframed procreation as a religious and moral obligation to female nature while promoting the pro-life position that life begins at conception (Ginsburg 1989; Luker 1984). From 1989–1992, over 700 antiabortion rights statutes were brought before state legislators, and by 1992, only 26 percent of U.S. counties had physicians willing to provide abortion (Solinger 1993). By 1995, members of religious fundamentalist pro-life groups had murdered two employees at a women's health clinic and one physician who provided abortions. Given this cultural climate, and the shift away from the model of unintentional pregnancy as a neurotic symptom to be treated by separating single women from their children, it is not surprising that single motherhood has become single women's most frequent childbearing decision, despite recent restrictions on public support for single mothers (U.S. Department of Health and Human Services 1995).

Each reproductive era comprised shifts in the sources of knowledge that defined single women's unintentional pregnancies. In contrast to previous structural–functional analyses of single pregnancies as a form of “deviant” social behavior (Rains 1971; Vincent 1961), this study examines how white middle-class women negotiate, resist, and reproduce the scientific and biomedical authority that informs normative models of sexuality, fertility, and maternity.

Methods

This sequential, mixed-methods study ($n = 62$) evolved from an earlier pilot study that compared women's long-term outcomes of abortion versus adoption.¹⁵ In the current study, focus groups ($n = 24$) explored women's perspectives of unintentional pregnancies and childbearing decisions. These data informed the development of a mailed, self-administered questionnaire ($n = 58$). Finally, to provide a context for the survey and focus group findings, a subsample of survey respondents participated in one-on-one interviews ($n = 10$). The triangulation of data across these data caches enhanced the reliability and validity of the study's findings and reduced research bias (DeMunck and Sobo 1998; Miles and Huberman 1994).

To explore the impact of shifting reproductive policies, the study's age eligibility criteria was broad, from 22–72. To control for the impact of ethnicity on racially bifurcated reproductive policies, all participants were of Euro American descent. The sample was also limited to women currently residing in southern California, with the assumption that this highly transient population would include women whose pregnancy occurred in various regions of the United States. To provide ample time for long-term evaluations of their decision, participants were screened to ensure that their pregnancy had occurred at least seven years prior to their participation in the study.¹⁶

Focus Groups

In a pilot test group ($n = 5$) and six small focus groups ($n = 19$), I explored single women's procreation stories and key issues, such as the kinds of knowledge that they privileged during their pregnancy and in making childbearing decisions.¹⁷ To control for idiosyncratic group responses, I conducted two groups for each of

the three childbearing decisions. Groups were kept small ($n = 3-6$). This protected participants' privacy, increased the homogeneity of the groups, and created a safe place for participants to discuss sensitive life experiences (Krueger 1994; Madriz 2000).¹⁸

I moderated and audiotaped each of the two-hour sessions. I transcribed the tapes verbatim and analyzed them following standard qualitative data analysis techniques: open coding to identify core themes, axial coding to determine the range and dimensions of each theme, and selective coding to "find the story in the data" (Strauss and Corbin 1995).¹⁹

The topics relevant to AK were: (1) How do single women feel when they discover they unintentionally conceived? (2) Who do single women turn to for help and advice in dealing with their pregnancies? and (3) What most influences women's childbearing decisions during an unintentional pregnancy? The sources of authoritative knowledge identified in the group discussions informed the development of the survey items described below.

Surveys

I reviewed existing surveys and scales, none of which fit the study's focus. Therefore, I used the focus group data to generate relevant survey items. I pretested the survey in a focus group setting, which consisted of the most vocal former focus group participants. This sample enhanced the likelihood that participants would thoroughly and openly critique the survey instrument.

The revised mailed self-administered survey included two items measuring authoritative knowledge: (1) At the time of your first unplanned pregnancy, who had the most influence on you in reaching your decision? (2) How important were each of the following in making your decision about your pregnancy?²⁰ Likert scales measured the level of influence/importance of each item (i.e., from "1" [not at all] to "7" [very much]).²¹

I analyzed continuous data using the Kruskal-Wallis test.²² Categorical variables were analyzed using the chi-square test ($\alpha = .05$, two-sided). The survey participants ($n = 58$) were identified through a random sample ($n = 24$), snowball sample ($n = 6$), respondents to the focus group advertisements ($n = 23$), purposive sampling through an adoption-affected support group ($n = 4$), and a newspaper advertisement for birth mothers and single mothers ($n = 1$).²³

Interviews

A small sample of survey respondents ($n = 10$) participated in a two-hour, one-on-one, face-to-face interview with me.²⁴ The participants were purposively sampled by their positive or negative outcomes.²⁵ I interviewed four women who had had an abortion (two positive and two negative outcomes) and four women who had adopted away their child (two positive and two negative outcomes). Because the small sample of single mothers resulted in overwhelmingly positive outcomes, I only interviewed two single mothers. I transcribed the audiotaped interviews verbatim and analyzed them using the same qualitative data analysis procedures described above for the focus group data. Given my previous pilot study, and the data caches described above, only a small number of interviews

were necessary to reach theoretical saturation (Sandelowski 1995; Strauss and Corbin 1995). The interviews included topics such as what it meant to the women to discover they had unintentionally conceived, how their pregnancy and childbearing experiences impacted their sense of self and social status, and how they negotiated disclosure about their pregnancy and childbearing decisions.

Findings: Survey Demographics

The survey respondents ($n = 58$) included 26 women who terminated their pregnancy, 21 birth mothers, and 11 single mothers.²⁶ The current age of the survey respondents ranged from 27–72, with a median age of 45. Their ages at the time of their pregnancy ranged from 15–37, with a median age of 19.5.²⁷ Although this study's sample was not representative, this median age is similar to national data (Henshaw 1998). Although women's age at the time of their pregnancy was not associated with a particular childbearing decision, women living with their parents were more likely than others to adopt away their child.²⁸ The remaining demographic characteristics of the survey sample are presented in Appendix A. Although women from working-class or poor families were more likely to carry their child to term, and upper-middle-class women were more likely to terminate their pregnancy, there were no significant associations between class and childbearing decisions. Similar to national data, religion was not associated with a particular childbearing decision. Nor were there significant associations between women's childbearing decisions and a history of social vulnerability (e.g., the loss of a parent, child abuse, or rape).²⁹ Although the majority (61 percent) of the respondents' pregnancies occurred in California, their decision was not determined by their access to childbearing options (e.g., living in an urban, suburban, or rural area).

The only predictive variable was the reproductive era of their pregnancy.³⁰ Women who unintentionally conceived during the adoption mandate, before *Roe v. Wade* legalized abortion, were more likely to adopt away their child. This underscores the significance of reproductive policies and the social force of the shifting forms of knowledge that shape women's childbearing decisions (see Figure 1).

Results

When you're single and have an unplanned pregnancy you feel isolated. You feel like you've had unprotected sex, or you've had sex and your contraception failed, and now what do you do? You have to choose the decision you want to make and decide how to make it.

—Ellen [abortion 1983]

Isolation and fear were dominant themes in single-women's procreation stories. Although there is nothing inherently traumatic about becoming pregnant, single women described their unintentional conception as a traumatic event: "the world stopped," "everything was in slow motion," "I went cold," "I cried uncontrollably," or "it was as if the earth had swallowed me."³¹ The trauma women described illuminates the common core of authoritative knowledge that influenced their pregnancy and childbearing decision, a code of honor regarding women's sexuality, fertility, and maternity (Ellison 2000). That is, regardless of era of the

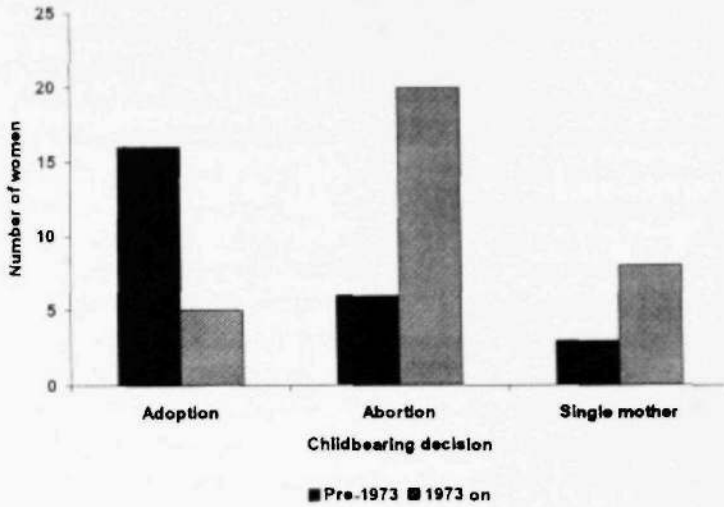


Figure 1
Women's childbearing decisions pre- and post-*Roe v. Wade*.

participants' pregnancy, an ideal of female sexual purity and honor was the most pervasive and enduring form of implicit cultural knowledge. While participants were keenly aware of the sexual double standard of their situation, each feared being stigmatized as an "easy" or "loose" woman.

My mom looked down upon girls that got pregnant very young, so I was afraid of disappointing her. It would have really hurt my dad. I would have been labeled as loose or easy. I had an abortion because I thought having a baby would ruin my life. I wasn't ready to have a baby.

—Julia [abortion 1989]

I wanted to make sure I wasn't portrayed negatively or discounted at work, that my boss wouldn't think I was less able to be successful. A man can walk away and no one knows. But as a single pregnant woman, you're wearing a scarlet A.

—Susan [single mother 1988]

Moreover, the social stigma of their pregnancy also threatened their family's social standing and, depending on the era of their pregnancies, their child. These are classic examples of what Erving Goffman (1963) described as a "courtesy" stigma, which may afflict associates of stigmatized individuals.

There must be societies that don't make single women feel this way about being pregnant, stripping them of motherhood. I don't think it's about religion; it was about being single. Nobody should be surprised that most birth mothers are white, from middle-class homes because those were the people that cared what the neighbors thought. That's what it all comes down to, shame, shaming your family.

—Bonnie [birth mother 1965]

My mother was livid. It was an affront to her. She told me I was ruining her life. My father called me a whore; I don't know what he could have said to hurt me more. It's unbelievable that this still persists, but sexually active single women are considered whores. For men it's positive, but women lose respect.

—Nancy [abortion 1987]

The women negotiated these symbols of social stigma by drawing on culturally implicit "rules for breaking rules" (Edgerton 1967, 1985). That is, to preserve their personal and their family's honor, women used the culturally implicit gender work of secrecy, to navigate normative expectations of maternity, female sexuality, and fertility. This secrecy isolated women, intensified their trauma, and limited their access to information. Further, because of the cultural censorship of stigmatized single pregnancies, the wealth of stories and knowledge of other women, even that of their own mothers or sisters, was often inaccessible. Thus, women's options and social support were circumscribed. Within these constraints, which were further constricted by the reproductive era of a single woman's pregnancy, women made their childbearing decisions.

Abortion

Women who terminated their pregnancy reported making their decision based on self-knowledge, their own needs, and circumstances. They were not ready to have a child; their partner was not the right man to have a child with; it was not the right time in their relationship to have a child. Compared to single mothers, they rated meeting their own needs and their personal goals as significant influences in their childbearing decision.³² Their decision was also significantly more influenced by meeting their own needs than it was for birth mothers.³³

The place where I got my pregnancy test was very pro-life and tried to talk me into keeping the child. I didn't even have a job. I didn't know if I was going to get a job. There was a lot of uncertainty in my life. I was moving out to California. I didn't think that was the right time in my life to have a child.

—Joni [abortion 1986]

I was very much a feminist in the 1970s and believed abortion was my right. But it was a much more difficult decision than I thought it would be. I didn't want to marry the man I was seeing and I didn't want to have a child with someone I didn't want to marry. In my gut, my feeling was that this is not the right person; this was not the right time. I didn't want to raise a child alone.

—Meredith [abortion 1988]

The reproductive era in which women's pregnancies occurred also influenced their decisions. Pre-*Roe v. Wade*, women rated meeting their own needs, not being ready to raise a child, and their personal goals highly; they also rated social expectations, avoiding family shame, and avoiding social stigma highly. In contrast to single mothers from the same era, women's decisions to terminate their pregnancy were significantly influenced by their desire to avoid social stigma, to meet their personal goals, and because they did not feel they were ready to raise a child.³⁴

However, post-*Roe v. Wade*, again, in contrast to single mothers from the same era, fear and avoiding family shame significantly influenced their decision to terminate their pregnancy.³⁵

In the focus groups and one-on-one interviews, all of the women who had terminated a pregnancy reported enduring social stigma. For example, both of the women quoted below were middle-aged, Jewish-identified but not religiously observant, middle-class professionals with a college education. Emily is divorced; Donna is married. They are pro-choice, liberal Democrats whose parents most likely share their political beliefs. Yet they have never disclosed to their parents that they had an abortion. Donna has also kept her abortion a secret from her adolescent daughter.

Years ago a group of prominent women took out an ad in the *New York Times* stating that they had had an abortion. I remember Gloria Steinem was on that list. There were lots and lots of women, trying to destigmatize abortion, but I don't want my parents to know.

—Emily [abortion 1980s]

I don't want my mother's negative judgment about me. I don't know what my mother would think of me, that her daughter had an abortion. And back then you just didn't tell your parents if you didn't have to, if you could handle it on your own, which I did. I have never told my daughter, and even though my husband thought she could know that we had an abortion before we were married and had her, I made sure that she would not be home during this interview.

—Donna [abortion 1977]

This sense of shame and secrecy was not uncommon; mothers of the study participants had often kept their own unintentional pregnancies secret from their daughters, sometimes until years after their daughter had secretly endured an unintentional single pregnancy of her own.

Adopting Away

Women who adopted away their child reported being influenced by their mothers, social workers, social expectations, and multiple threats of social stigma for themselves, their family, and their child. Birth mothers, in comparison to the other two childbearing groups, were significantly more influenced by social workers.³⁶ They also reported being more highly influenced by their mothers than women who terminated a pregnancy.³⁷ In contrast to single mothers, their decision was significantly more influenced by a desire to protect their child from shame, which reflects the era of their pregnancy.³⁸

The majority of birth mothers (76 percent) adopted away their child before 1973, during the adoption mandate. Women in this cohort reported being more highly influenced by social workers than the other childbearing groups.³⁹ In interviews and during participant observation, birth mothers often repeated the advice they had received from social workers, that it would be selfish to keep their child. In contrast to the single mothers of that era, birth mothers also reported that they

were more influenced by financial instability, avoiding family shame, avoiding social stigma, and social expectations.⁴⁰

After we hit our seventh month we weren't allowed to leave the maternity home. In the hospital they let me hold him and see him. When the caseworker showed up with the papers for me to sign, I sat with my arms defiantly crossed in front of me, saying, "I'm not signing. I'm not. I can't. No." It was my only defiant moment. The social worker leaned into me and said, "You're the most selfish person I've ever met." I said, "I love him." And she said, "No you don't. You couldn't possibly love this child." I signed.

—Bonnie [birth mother 1965]

I think you honor your parents' choice; it really doesn't matter what you feel. My parents paid for the maternity home. I didn't really have an option. I did this for them because I had made a mistake. Why should my parents have to pay for the rest of their lives with comments or sneers?

—Kathleen [birth mother 1971]

After 1973, the birth mothers in this study had not been institutionalized during their pregnancy.⁴¹ However, they still reported making decisions that were influenced by their parents and by social expectations. In contrast to women who had an abortion, birth mothers were significantly more influenced by doing what seemed best for their child and by their fathers.⁴² In comparison with single mothers, birth mothers were significantly more influenced by social workers, a desire to protect their child from shame, their mothers, and social stigma.⁴³ Birth mothers were the only group to rate what they thought was best for their child more highly than their own needs.

When my father found out I was pregnant, he said, "The only option you have is to give up this child for adoption."

—Jan [birth mother 1975]

I'm pro-choice but when I went for my abortion I found out I was six months pregnant. My mom is a pro-life counselor and when she found out, she took over and said, "We're going to get you set up for an adoption." I just went along with it because I knew that would be my ultimate role, my decision.

—Mona [birth mother 1978]

Birth mothers bear the twin stigmata of being single and pregnant and giving birth as a single woman. However, these stigmata are further compounded by adopting away their child in a strongly pronatalist society. For example, both of the birth mothers quoted below are single, middle-aged, middle-class women who have never carried another pregnancy to term. Both are professionals with advanced degrees. Neither is religious; Bonnie was raised as a Presbyterian, and Carol was raised in a nonreligious Jewish extended family. Carol's adult birth daughter searched for her and found her. Although they live in different countries, they have an ongoing relationship. In contrast, ten years ago Bonnie searched for

and found her adult birth son. He did not want to meet her; she has respected his decision.

My God, it was the 60s! Everyone was sleeping with everyone. But still there was this feeling of turning into a Jezebel, that I was different from other women who were no longer virgins. They could sleep with anyone they wanted. But if you had relinquished a child you really could, because you were in a different category. There was a blackness around it.

—Carol [birth mother 1964]

I'd like people to understand the loss involved; it's a true loss. I'd like people to take this issue a little more seriously. I don't think things have really changed that much. Women are still relinquishing because of shame.

—Bonnie [birth mother 1965]

Single Mothers

Single mothers ranked internal sources of knowledge most highly; these included instinct, religious and moral beliefs, their own needs, and doing what they felt was best for their child. Compared to the other groups, their decision to bear and raise their child was significantly less influenced by their marital status or their lack of financial security, social expectations, avoiding social stigma, or family shame.⁴⁴ In contrast to women who terminated their pregnancy, single mothers reported being significantly more influenced by what they thought was best for their child and by their religious beliefs.⁴⁵

Once I knew that abortion wasn't an option, I knew that I was going to keep the child. There was something deep inside me that said I was going to make this choice. We think experts know better and we don't even listen to that voice. Especially for women, people always tell us what we should do. My heart told me to do it, to bear and raise my child. I've wondered if it's innate, hard-wired.

—Sherry [single mother 1961]

I was nineteen and I thought I would be the best mother to my child. My child would never wonder, why didn't my mom keep me? I think the most important thing is love. You have to be kind of winging it on instinct.

—Amelia [single mother 1978]

I think the decision has to come from the person themselves. My decision was based on me, not on what everybody else was saying, not on what I saw or heard, not on social expectations. A woman knows herself. I had to stand up and do what I needed to do.

—Zoë [single mother 1989]

Before 1973, the single mothers in this study made their decision based on their own needs and what they felt was best for their child. Single mothers from 1973 on still ranked these influences highly. However, in interviews they emphasized

the importance of their family's support in their decision making, as well as the importance of their religious beliefs, and their feelings for their partner.

I thought that with the support of my family I could be fine. My friends wanted to kill me for not having an abortion. I knew right away what I had to do. But I remember that I did pray to have a miscarriage, "God, please remove this burden from me." I remember thinking this is crazy, I'm so committed to doing this, but wanted to have a miscarriage.

—June [single mother 1988]

I was crazy in love with this guy. He didn't want a child. We went to an abortion clinic twice but I had already grown attached and my heart was with the baby. I wanted to keep it. Subconsciously, I think years of being in religion did affect me; I felt it was wrong to end the pregnancy. I didn't give it much thought at the time; I was more concerned with the way I felt, but I do think religion affected my decision.

—Sabrina [single mother 1990]

Although a subsequent marriage may allow single mothers to pass ("I eventually did marry; people didn't have to know that I'd been a single mother"), they still reported enduring social stigma. Doreen, at 40, was divorced, middle class, a politically liberal nonreligious Quaker with an advanced degree and a professional career. At 31, Susan, who never married, was an upper-middle-class professional, in a field dominated by males. A pro-life Republican, she also regularly attended a Catholic church with her daughter.

I used to say I was an unwed mother, but now I never tell anybody unless I know them very, very well. They may think less of me because I never got married.

—Doreen [single mother 1978]

It's difficult with the older men I work with. I'm very professional, but when I talk about my daughter I still think that because I was unmarried and pregnant they must be thinking, she's sleeping around. No one has ever said that to me but it's in the back of my head.

—Susan [single mother 1988]

Discussion

When single women discover they have unintentionally conceived, their agency is circumscribed by "rules for breaking rules" (Edgerton 1985). For unintentional pregnancies, the implicit rule is secrecy; that silences individual as well as collective bodies (Ellison 2000; Scheper-Hughes and Lock 1986; Sheriff 2000). This secrecy reflects the gender work of veiled virtue that women assumed as they navigated the symbols of social stigma, of being "loose" or "easy" women (Edgerton 1967; Goffman 1963), while they secured the aid of others that was necessary to finalize their decision.

Deeply ingrained cultural assumptions about the categories of women who can legitimately lay claim to their sexuality, fertility, and maternity represent what was most at stake in single women's procreation stories. The cultural ideal of being

a “good” woman promotes a form of structural violence (Kleinman 2000) that constricts single women’s sexuality, fertility, and maternity. Thus, women’s pregnancy experiences and their subsequent childbearing decisions were strongly influenced by their attempts to avoid social stigma for themselves and their families. The trauma they described resulted from their fear of failing to meet culturally entrenched ideals of female sexual honor and socially accepted forms of maternity.⁴⁶ The data from this study suggest that similar to women who have struggled with a life-threatening illness or infertility, single unintentional pregnancies were not episodic events. Single women’s unintentional pregnancies and childbearing outcomes were deeply embodied experiences that irrevocably altered women’s lives (Becker 2000; Lock and Kaufert 1988). This article demonstrates that these experiences, choreographed by a culture of honor, result in a stigmatized form of sexuality, fertility, and maternity, stratified by women’s marital status.

Abortion

Women who had an abortion reported that their decision was influenced by internal forms of authoritative knowledge, such as their circumstances, their assessments of their partner, and their life goals. The majority of women who made this decision did so when they had legal access to an abortion. Their decision was guided by an ethics of care (Gilligan and Belenky 1980; Ruddick 1993) that included themselves, as well as their potential child, and their family of origin. Although most women obtained an abortion without telling their parents, this was less a reflection of their religious beliefs than the social stigma of abortion.

In contrast to Brenda Major and Richard H. Gramzow (1998), this study found that all women who had an abortion feared social judgment about their decision. In particular, and similar to other studies of abortion, women feared being judged as having made a “selfish” decision (Belenky 1978). This echoes the same ideological tensions that Faye Ginsburg (1989) and Kristin Luker (1984) identified in their studies of abortion activists. These authors found that the pro-life ideology of naturalized ascribed maternity clashed with the pro-choice ideology of maternity as a self-determined role that women may achieve or reject. The pro-life ideology of ascribed maternity that hinges on the belief that life begins at conception provides another motif to the 19th-century cults of female domesticity and motherhood as women’s duty. The authoritative knowledge of selfless maternity persists, in another authoritative guise, influencing women regardless of their position on abortion.

Birth Mothers

Birth mothers reported being strongly influenced by external sources of knowledge, such as their mothers and social workers. This finding supports previous studies of adoption (Bachrach et al. 1992; Edwards 1999; Solinger 1992). It is important to note that birth mothers’ ages at the time of their unintentional pregnancy were not different than those of women who terminated their pregnancies. It was the reproductive era of their pregnancy that most impacted their childbearing decision. The majority of birth mothers conceived during the post-World War II adoption mandate, while abortion was illegal. The sharp decline in the number of

women adopting away their child after *Roe v. Wade* (Cooksey 1990; McAdoo 1992) suggests that birth mothers were not psychologically different from other women. Their decisions were congruent with the reproductive policies of the adoption mandate and its control of illegitimacy, women's sexuality, and fertility (Nathanson 1991; Solinger 1995; Vincent 1965).

Forty-three percent of the birth mothers in this study were sequestered in total institutions during the visible stages of their pregnancy. Faced with limited childbearing options, women adopted away their child to preserve their own and their families' honor, and to do what the adoption mandate dictated as being in the best interest of their child. Similar to women who terminated their pregnancy, birth mothers reported making their decision to protect themselves, their families, and their child from social stigma. However, birth mothers were the only group that rated their child's needs above their own and excluded themselves in the ethics of care that informed their decision. This reflects the ideology of selfless maternity at the heart of the adoption mandate.

Single Mothers

Across all three data caches, single mothers stood apart from the two other childbearing groups in the kinds of knowledge that influenced their decision. They interpreted their pregnancy decisions as moral or religious obligations to themselves and their child and drew on intuition and instincts in their decision to become a single mother. They often anticipated social support from their families of origin and they were the only group that talked about being "crazy" in love with their child's father. The most intriguing aspect of this group was the paradox that their religious or moral conservatism was coupled with their resistance to normative expectations. This was particularly striking, given that the social visibility of raising children as a single mother increased their vulnerability to stigma. The internalized sources of knowledge that they drew on—"winging it on instinct," "knowing in my heart," "knowing what I had to do"—appear to have defrayed external sources of authoritative knowledge.

In the interviews, single mothers talked about the gender work of maternity as "stepping up to the plate" and "handling their mistakes," which represent active agency and self-determination. A dominant theme in their stories, of making an unselfish childbearing decision, is congruent with pronatalist sentiments and social expectations of selfless maternity. Yet in contrast to birth mothers, single mothers staunchly included their own needs in the ethics of care that influenced their decision (Belenky 1978; Ruddick 1993). These findings support Martha Ward (1995) and Diana M. Pearce's (1993) assertion that referring to young single mothers as "children having children" disempowers and infantilizes women. In addition, this study's findings suggest that dismissing single mothers as children promotes current dominant forms of scientific knowledge, while disparaging single mothers' embodied knowledge.

This study's findings are particularly provocative, given that, to date, neither demographic nor psychological factors predict single women's pregnancies or childbearing decisions (Solinger 1992; Vincent 1961).⁴⁷ This research elucidates the significance of reproductive policies and authoritative knowledge in single women's pregnancy experiences and their subsequent childbearing decisions.

A limitation of this study is that its relatively small, predominantly self-selected sample may have introduced selection bias, which limits the generalizability of its findings. Another limitation is that the study is retrospective. However, recent research on maternal recall has documented the accuracy of retrospective accounts of such a significant life experience (Tomeo et al. 1999). Another limitation is the study's purposive narrow focus, which future studies can extend across ethnicity and gender.

Conclusion

Until there was an infectious disease model in the AIDS pandemic, male sexual activity had provoked little public controversy. Communities in the United States have neither built nor filled paternity homes with single fathers to undergo moral or psychological cleansing before being returned to society as marriageable. Male illegitimate fertility has not been the focus of heated political controversy, moral recriminations, reproductive legislation, or institutionalization.

This study illustrates the extent to which single women's bodies have been the sites of extensive and extended biopolitical contestations. At the core of these contestations lie the definitions of morality and rationality (Jordan 1997) that give shape to normative models of female sexuality, fertility, and maternity. Although the authoritative knowledge forging these models has shifted across reproductive eras, the core social category that has undergirded each of these models has been a woman's legal relationship to a man. While female dependence on a father or a husband is socially legitimate, single women's independent fertility and sexuality or single mothers interdependence on her community and extended webs of social affiliation or the state are proscribed (Pearce 1993).

The social stigma study participants experienced reflects a culture of honor that anthropology has, for the most part, attributed to circum-Mediterranean societies and religious fundamentalists. This showcasing (Appardurai 1986) has obscured the similar, deeply entrenched cultural assumptions in the West (Rabinow 1986). The everyday violence explored here, as explicated in pregnant single women's isolation, shame, stigma, and the coercive practices circumscribing their childbearing decisions, is not as extreme as infibulation (Johansen 2002) or honor killings (*Los Angeles Times* 2000; *New York Times* 2002). Yet these findings suggest that the biopolitics of single women's pregnancies are similarly rationalized and given moral weight, enacted, embodied, and reproduced as authoritative facts, rather than as social artifacts.

Moreover, the cultural censorship of an experience shared by so many women reinforces an inflexible tension between cultural ideals and women's lived realities. Consequently, pregnant single women resort to the socially prescribed gender work of secrecy as they struggle to maintain their social standing as good women and mothers. Thus, women's secrecy, and the censorship of their experiences, reproduces the social order and the cultural ideology of female sexual honor. This limits social diversity and narrows social expectations about what constitutes a legitimate family. Secrecy and cultural censorship also results in the loss of valuable knowledge for future generations. This, in turn, perpetuates the structural violence and social stigma surrounding single women's sexuality, fertility, and maternity.

Notes

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1. For a discussion of how these rates were estimated, see U.S. Department of Health and Human Services 1999; see also Henshaw 1998.

2. Throughout this article, I have used the terms *single woman* rather than *unmarried woman*, and *single pregnancy* instead of *out-of-wedlock pregnancy* to avoid defining women by their legal relationships to men.

3. Two other categories of women vulnerable to the social stigma of nonnormative fertility are infertile women or women whose partners are infertile (Becker 2000; May 1995) and lesbians (Lewin 1995).

4. Merriam-Webster's Collegiate Dictionary, 10th ed. Springfield, MA: Merriam-Webster, Inc., 1993.

5. See Kleinman 2000, for analyses of the ways in which the collective and individual suffering wrought by social forces often remains socially invisible, especially when it has been normalized or routinized by historically specific social practices that codify moral and ethical norms and, hence, social hierarchies and power relations.

6. By normative fertility, I mean socially legitimated intercourse between a husband and wife.

7. Future research is needed to explore the biopolitics of unintentional pregnancies across ethnicity.

8. Whereas Solinger (1992, 2001) suggests the adoption mandate took place post-World War II, Kunzel (1993) and Berebitsky (2001) demonstrate that this race- and class-specific reproductive mandate began to gain force by the late 19th century; Solinger illustrates the impact of this mandate at its zenith, post-World War II.

9. Single males and females shared the same bed but, ostensibly, remained clothed.

10. See Garfinkel and McLanahan (1986) and Solinger (1992, 2001) for these ethnic and class-specific policies.

11. Children were redistributed from women of a socially proscribed category to women deemed legitimate mothers. For example, in Ireland single women suspected of being sexually active or who became pregnant were forcibly incarcerated in the Magdalene Laundries run by the Catholic church; their children were adopted away, many to couples in the United States. Children were also forcibly separated from indigenous women and families in Australia and the United States. These programs of forced assimilation, "child rescue," and adoption were based on religious beliefs, eugenics, and social science.

12. The post-World War II practice of closed stranger adoption was given authority by social scientists, including psychologists Henry Harlow and John Bowlby, sociologist Clark Vincent, and anthropologists Margaret Mead and Ashley Montagu.

13. The term *birth mother* refers to women who conceive and carry a child to term and then adopt away their child. Unlike surrogate mothers, who intentionally conceive and are paid for their services, birth mothers, until the recent shift toward a transnational adoption market, did not receive financial remuneration.

14. For a history of abortion legislation, see Solinger 1993 and McFarlane and Meier 2001.

15. I conducted sequential, open-ended, face-to-face life history interviews with four women who had adopted away a child as a single woman and had terminated a subsequent

pregnancy. These interviews were augmented by two years of participant observation in adoption-affected peer support groups, in three U.S. metropolitan areas.

16. Although studies suggest that the trauma of abortion is transient for most women, the trauma of adopting away appears to be most severe during the early years of women's separation from their child, hence the time-based criteria of seven years. Many birth mothers insist that the trauma is lifelong; some suffer from psychological reactions similar to post-traumatic stress disorder. This trauma may be acutely revisited during adoptee-birthparent searches and reunions.

17. The focus groups comprised women living in San Diego County. Local pregnancy counseling centers, hospitals, women's health centers, adoption agencies, and peer support groups were contacted and informed about the study. A church-based adoption agency and an adoption support group distributed a flyer for it. Advertisements were placed in ten local newspapers, with distribution across broad demographic strata.

18. Similar to peer support groups, group interviews provide participants an opportunity to share their experiences with others who share similar experiences, thus decreasing judgment. Participants tend to treat one another with interest and a sensitivity leavened by an insiders' dark humor. This study's participants often commented that they enjoyed the opportunity to participate in research on a topic that they feel is socially taboo and misunderstood. At the close of each session, some participants spontaneously shared identifying information. This suggests that just as researchers strive to protect the confidentiality of research participants, it is also important to avoid making paternalistic decisions about which research methods we deem appropriate to research sensitive topics.

19. A computerized data analysis program, QSR NUD*IST Vivo, was used to manage the study's narrative data and facilitate coding. SPSS was used to manage and analyze the quantitative data.

20. Abbreviated responses for Item 1 included: self, partner, friends, mother, father, social worker, doctor, God, laity, other. Item 2: social expectations, marital status, meeting own needs, fear, financial instability, best for child, social stigma, religious beliefs, feelings for partner, protecting family from shame, personal goals, not ready to raise a child, partner not willing to marry.

21. Cronbach's alpha for the first items was low (.53) but acceptable for an exploratory study; the internal consistency of the second scale was good (Cronbach's alpha = .72).

22. Because the data were not normally distributed and the sample sizes were small, the Kruskal Wallis Test was used in place of ANOVA. To compare the direction of differences between groups, the Mann-Whitney U test was used, followed by the Dunn Multiple Comparisons Procedure, with an alpha corrected to .0166 to control for Type I errors (Pett 1997).

23. Due to the difficulty of identifying and recruiting participants about such sensitive topics, the initial random sample study design was integrated with snowball and convenience sampling. One-third of the survey respondents had participated in a focus group; there were no statistically significant differences in AK between the two groups. Approximately one-third of the survey respondents for each childbearing decision had participated in the survey (31 percent abortion, 33 percent single mothers, 36 percent birth mothers).

24. Only two women preferred not to be interviewed in their home; one requested that I meet her at a church-affiliated office, another asked that we conduct the interview in my home. I am indebted to each of these women for their trust and their willingness to discuss such deeply personal aspects of their lives with a stranger.

25. A paper that explores women's evaluations of their childbearing decision is in preparation (see also Ellison 2000).

26. Their median age was 34, with a range from 27 to 56. At the time of their first unintentional pregnancy their median age was 19, ranging from 15 to 37. One-third had never married; 70 percent had completed some college; one-third were Presbyterian; and one-third

were Catholic. Their current combined annual household incomes ranged from \$15,000 to over \$50,000 per year.

27. Just as social stigma contributes to women underreporting the number of abortions they have had, their use of fertility treatment, and the use of donor gametes, it also appears to contribute to women underreporting the number of unintentional pregnancies they have had.

28. ($p = .057$).

29. The survey included items about verbal, physical, and sexual abuse; neglect; and the presence of alcohol or drug abuse in their household of origin. Almost half of the women in each childbearing decision reported one of these abuses as a child (abortion, 46 percent; adopting away, 62 percent; and single mothers, 64 percent) and 10 percent reported that they had experienced sexual abuse as a child. One-third reported involuntary sexual intercourse at some point in their lives (25 percent date rape, 8 percent stranger rape); 9 percent of the respondents' first unintentional pregnancies were the result of date rape (14 percent adoption, 18 percent single mothers).

30. The results of the chi-square test for k independent samples indicates a very highly statistically significant, moderate association between the era in which the unintentional pregnancy occurred and women's childbearing decision ($\chi^2 = 14.75$, $p = .001$, Cramer's $V = .504$).

31. Only one woman did not report being traumatized. She and her partner were engaged at the time of her legal abortion, eventually married, and are now raising children. This participant stated that her pregnancy, although difficult, also gave her pleasure, as it was proof of her fertility.

32. ($p = .0003$, $p = .001$).

33. ($p = .0003$).

34. ($p = .024$, $p = .026$, $p = .023$).

35. ($p = .007$, $p = .012$).

36. ($p = .0001$, $p = .0006$).

37. ($p = .0008$).

38. ($p = .0023$).

39. ($p = .005$, $p = .037$).

40. ($p = .011$, $p = .020$, $p = .033$, $p = .038$).

41. An exception to this is the recent proliferation of fundamentalist Christian maternity homes.

42. ($p = .012$, $p = .042$).

43. ($p = .013$, $p = .019$, $p = .028$, $p = .036$).

44. ($p = .0001$; $p = .0001$, $p = .0016$; $p = .0008$, $p = .0015$; $p = .0001$; $p = .0006$, $p = .0005$).

45. ($p = .0139$, $p = .0166$).

46. For two excellent analyses of Mediterranean cultures of honor, see Kertzner (1993) and Abu-Lughod 1986. Although the ideologies and practices of a culture of honor have been attributed to other cultures, and often male codes of honor, the social norms of female sexual and moral behavior in the United States reflect a similar culture of honor. This article follows Wikan's (1984) suggestion, to explicate female cultures of honor.

47. Increased parental education has been found to be associated with terminating a pregnancy (Cooksey 1990), whereas increased maternal education has been associated with a daughter becoming a birth mother (Bachrach et al. 1992). Thus, demographic predictors of this decision have been contradictory.

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Appendix A: Demographics of survey respondents.

	Abortion N = 26		Adoption N = 21		Single Mother N = 11		Total N = 58	
Class								
Upper middle class	36%	9	14%	3	18%	2	25%	14
Middle class	48%	12	43%	9	46%	5	46%	26
Working class or poor	16%	4	43%	9	36%	4	30%	17
Completed education								
High school/GED	8%	2	—	—	9%	1	5%	3
Some college	35%	9	62%	13	27%	3	43%	25
Bachelor's degree	23%	6	5%	1	36%	4	19%	11
Advanced degree	35%	9	33%	7	27%	3	33%	19
Combined income								
Over \$100,000	19%	5	19%	4	27%	3	21%	12
\$81,000–\$100,000	4%	1	14%	3	18%	2	10%	6
\$61,000–\$80,000	23%	6	14%	3	18%	2	19%	11
\$41,000–\$60,000	27%	7	24%	5	18%	2	24%	14
\$21,000–\$40,000	15%	4	5%	1	18%	2	12%	7
\$15,000–\$20,000	4%	1	14%	3	—	—	7%	4
Under \$15,000	8%	2	10%	2	—	—	7%	4
Current religion								
Protestant	16%	4	14%	3	46%	5	21%	12
Catholic	20%	5	24%	5	18%	2	21%	12
Jewish	28%	7	5%	1	—	—	14%	8
Agnostic/atheist	16%	4	29%	6	—	—	18%	10
Other	20%	5	29%	6	36%	4	26%	15