Female and Fetal Personhood

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Terminology Note

A note on the terminology used in this thesis: I use the terms "women" and "female" as well as "men" and "male" to differentiate between the two genders, a very binary and outdated way to describe sex and gender. When I use the terms "women" or "female" within this document I am describing a person who can become pregnant. I personally believe in a more inclusive and less binary way to describe humans, but I write in this style to differentiate clearly between the two genders due to the issues of female and male bodies throughout our history, as well as the role of intersectionality that has led us to a place where we are today. Ideally, a less binary way of seeing humans will become the norm, and the historical issues I discuss in this research will be seen as historical failures and no longer applicable to our current society.

Reflexive Statement

I am extremely grateful to the many individuals who took the time to take this survey and share deeply personal and emotionally difficult experiences. Your honesty and openness is a gift to this research and shows the importance of giving a safe space to allow people to share. I write about historical issues and current issues pregnant bodies face, especially women of color in the U.S., not from a place of experience but from a place of research, readings, and desire to understand and be an ally. I am extremely passionate about female comradery and hopeful that the feminist movement is heading in the right direction of inclusion and acceptance of diverse experiences, opinions, and beliefs. As Audre Lorde (1979) says, "It is learning how to take our differences and make them strengths. For the master's tools will never dismantle the master's house."

Abstract

The overturning of *Roe v. Wade* in the *Dobbs v. Whole Women's Health* decision by the Supreme Court in 2022 opened the ability for states to restrict abortion as a healthcare option for female bodies. Along with this change in federal law, fetal personhood laws are beginning to increase and become more common. The purpose of this study was to gauge the general public's understanding and opinions on the topics of female bodily autonomy and fetal personhood. To do this, I developed a Qualtrics survey with open-ended and closed-ended questions along with demographic questions to gather opinions and ideas about abortion, fetal personhood, and health care rights among others. Key findings from the survey include the complexities of individual perspectives regarding definitions, labels, and personal experiences. The results show the challenge of defining broadly used terms and the issues with using labels to form assumptions. Most importantly the results align with feminist theory in terms of amplifying lived experiences and the unique perspectives from the distinct standpoint of those who have experienced pregnancy, childbirth, or both.

With the overturning of *Roe v. Wade* in the *Dobbs v. Whole Women's Health* decision in June 2022, the United States is in the midst of a massive change in healthcare options for female bodies and is facing a crisis of women's bodily autonomy. As of mid-April 2023, thirteen states have full bans on abortion; four states have partial bans; one state has a six-week ban; four states have a ban in place for 15,18, or 20 weeks; and eight states passed bans that are currently blocked by courts pending the outcome of litigation (The New York Times 2023).

Fetal personhood, which is defined as the granting of legal rights to the unborn at conception or a couple of months after, is also becoming a key debated topic within society. The concern of these potential new personhood laws is that they could criminalize some types of contraception, pregnancy termination if it threatens a woman's life, miscarriages, and abortions (Bloomberg 2022). As of April 1, 2023, two states have introduced legislation to ban abortion by establishing fetal personhood, and ten states have introduced legislation that criminalizes abortion for women or providers (Guttmacher Institute 2023). A federal personhood law entitled H.R.1011 - Life at Conception Act, which stated the right to life begins at fertilization, was introduced in 2021 in the U.S. House of Representatives, and though it did not pass, it had 166 cosponsors (Congress.gov 2021-2022)).

Politically, the United States is very divided, and the growing divisions are pushed by the media and politicians' narratives that can contrast with the general public's opinions on the topic of abortion (Pew Research Center 2022). While there are multiple well-respected surveys that have been conducted recently on the public's opinions on abortion access, such as the Pew Research Center and the Guttmacher Institute surveys, few surveys have been conducted on opinions of fetal and female personhood. This study is needed at this time in our history to give everyday people a voice to address some of these topics. The research aims to find out if and

why there are differences in opinion based on personal characteristics, if individuals have changed their opinions throughout their lives, and if they are interested in hearing other thoughts, are open to potentially forming new opinions on the topics, or both.

The research questions were: What is the public's opinion and understanding of female and fetal personhood, and has it changed over time? Do demographic and personal characteristics influence understanding and opinion on these topics? Are individuals open to others' opinions as well as potentially changing their own? I addressed these by conducting an anonymous voluntary survey, with the parameters of being a resident of the U.S., and eighteen years or older. The proposed study design of a non-probability online survey with close-ended and open-ended questions gave both statistical data as well as rich descriptions as to the public's views and opinions on these topics, as well as their backgrounds and demographic characteristics. Though this research is not representative due to the limits with a non-probability online sample, it still adds important information to the body of knowledge on society's opinions, backgrounds, empathy, and openness within a turbulent time in our country's history.

Literature Review

The term patriarchy is an ancient Greek term that literally means "the rule of the father" (O'Reilly 2010). In simple terms, patriarchy is the privileging of men in regard to the conditions of women (Feagin, Vera, & Ducey 2015). In our world today, this term stands for the social, political, and economic structures that create an inequality between those defined as men and those defined as women. This patriarchal structure is due to a set of beliefs, relationships, and values that have been embedded in our culture since ancient times (Nash 2020). This structure causes issues that will be discussed below such as female bodily autonomy, maternal mortality, obstetric gaslighting, and fetal personhood laws.

Patriarchal Structure

Reproduction from a Patriarchal Perspective

Throughout western culture's history, the female body has been viewed as "other" (Bordo 1993). Historical depictions show humanity as male and allow "man" to define "woman" in relation to himself (de Beauvoir 1949). Due to the view of humanity as male and female as "other", those identified as "woman" were never able to be fully autonomous given they were unable to define themselves (de Beauvoir 1949). The idea of woman as "other" contributes to the sexualizing of women and girls (Bordo 1993). Female identified bodies are valued and judged morally based on their sexuality and virginity (Valenti 2010). Women are seen as future mothers in the United States (Waggoner 2017), and culturally there is an understanding that reproduction only occurs in women's bodies (Almeling 2020).

Bodily Autonomy

Bodily autonomy is the "right to one's person" and is held at an extremely high value in the United States (Bordo 1993). Simply, it is the ownership and control of one's own body. Bodily autonomy is a human right and allows for integrity, privacy, and personhood (Bordo 1993), and both liberty and agency are required to exercise this right (Sedig 2016). Though bodily autonomy is a fundamental human right, it has not always been upheld the same way for different bodies. In legal and medical situations, some bodies are given conscious subject status and others are denied protection and simply seen as bodies without agency (Bordo 1993).

Traditionally, an individual's independence has been the highest priority in American bioethics (Sedig 2016). To maintain one's human right to bodily autonomy in any kind of medical procedure, the individual is given the right to informed consent, and this right affords the individual the ability to agree or not agree to any procedure that would involve their body.

Informed consent acknowledges that a human body must be treated with meaning, history, and value, and no one except the patient can determine for that body what medical risks or procedures are to happen (Bordo 1993). Informed consent came from Western medical ethics after the Nuremberg trials following the Holocaust and was codified into law in the U.S. in 1972 (Sedig 2016). Informed consent requires physicians to give individuals all the information needed along with all alternatives for the individual to make an independent decision (Sedig 2016). But informed consent is not always upheld in medical fields such as in reproductive care during pregnancy, labor, and/or delivery (Morris 2013).

Differences in the application of informed consent have been studied in past literature such as by Bordo (1993). For example, in the 1979 court case of *McFall v. Shimp*, a male individual was asked to donate bone marrow to save a family member's life (Bordo 1993). The individual refused the procedure to save his family member's life after receiving informed consent, and his decision was upheld by the court due to his rights of bodily autonomy. The ruling even compared forcing this unwanted procedure to vampirism (Bordo 1993). In a different case a pregnant woman did not want to move forward with a recommended cesarean section due to religious beliefs and was forced to do so by the court against her will. In its ruling, the court's reasoning included "not wanting to indulge in the desires of the pregnant woman at the expense of the fetus" (Bordo 1993). As Bordo argues, because there is no rational reason for the difference in treatment of informed consent in these two court decisions, we must consider that law can be influenced by culture and ideologies (Bordo 1993).

In addition, the violinist argument can also be applied. The violinist argument gives the example of a well-known violinist who has failing kidneys and needs another body to survive. The violinist's right to life outweighs the other's right to decide what happens to their body so

they are made to be a donor for the violinist against their will (Thomson 1971). This argument acknowledges that a fetus is a human life, but that does not obligate another human life to keep that life alive (Thomson 1971). The debate on keeping a life alive is where "maternal-fetal conflict" can come into play, and the law can see a pregnant individual's interests in opposition to their fetus (Roberts 1997). The idea of maternal-fetal conflict gives the government a reason to restrict autonomy of the pregnant individual (Roberts 1997). Our culture tells us that a pregnant individual is supposed to let go of her own subjectivity, to be selfless and to care for her fetus. "The essence of the pregnant woman is her biological, purely mechanical role in preserving the life of another… her claims to subjectivity…will conflict with her life-support function" (Bordo 1993).

Divisions between Women

For privilege to exist, there must be oppression for others. "Oppression eliminates or reduces human dignity and the capacity to express oneself and participate in society as effectively as those who are more privileged" (Feagin, et al 2015). Oppression has levels that vary for everyone based on gender, race, ethnicity, sexual orientation, and class (Feagin, et al 2015). One dominant and privileged group in a patriarchal society is males, although privilege will vary based on their other demographic characteristics.

Dominant groups thrive on control, and there has been a male fascination with controlling the female womb (Rapp 1999). In the 1960s and 1970s control shifted for a short time from the male-dominated physician profession to privileged female individuals due to FDA approval of the birth control pill and legalized abortion in 1973 (Waggoner 2017). These important advances were not helpful for all females, as many females were not given the ability to choose due to circumstances involving their additional oppressions within the system. For example, some

women of lower socioeconomic status were not able to afford contraceptives or abortions, and women of color, predominantly those who were on Medicaid, experienced reproductive control in the form of forced birth control, abortions, and sterilization (Taylor 2020). By the 1970s, sterilizations began to grow with 200,000 performed in 1970 to over 700,000 in 1980, and many of these were performed without informed consent on women of color with those on Medicaid tending to be targeted most aggressively (Roberts 1997).

Due to the female gender not having a common history or an exact event that led to the subordination, there is a lack of commonality and solidarity among females (de Beauvoir 1949). White women tend to align themselves with white men before they would align with women of color and tend to tie themselves to their families and their husbands and less so to each other (Lorde 1979). As de Beauvoir states "the tie that binds her to her oppressors is unlike any other". The ideology of patriarchy, which oppresses females and removes their ability to fully participate in society as successfully as their male counterparts causes the issues of aligning with males instead of other females (Feagin, et al 2015). Without the same opportunities, females are put in a role of survival, which often leaves them in a subordinate position unable to find true independence and thus, female solidarity.

The issue of finding commonality does not explain the full extent of the trouble with the female gender's solidarity. Racism and exclusion in the feminist movement are issues that continue today (Goodwin 2022). Diverse perspectives are not welcomed or supported and that has led to the failure of feminist movements within the United States (Lorde 1979, Luna 2020). Women of color, and in particular, black women, have a unique perspective and experience that continues to be overlooked much to the determinant of the movement (Luna 2020). This unique perspective is due to the intersection of predominantly race, class, and gender (Hill Collins

1990). White heterosexual feminists have followed a patriarchal, capitalist approach to the movement, which in turn has led to its demise, and females must recognize differences as the core strength of feminist movements (Lorde 1979).

Control and Impacts on Maternal Health

Maternal Mortality and Morbidity

The United States is currently grappling with extremely high and growing maternal morbidity and mortality rates (Fielding-Singh & Dmowska 2022). Maternal morbidity is when pregnancy-related complications result in serious health issues for women (Taylor 2020). Maternal mortality rates are the number of maternal deaths per 100,000 live births (CDC 2023). Though maternal mortality has continued to decrease in other countries, that is not the case in the United States. The US has the highest rate of maternal mortality among high-income countries (Fielding-Singh, et al 2022). The rate continues to climb each year with 32.9 deaths per 100,000 live births in 2021 compared with a rate of 23.8 in 2020, and 20.1 in 2019 (CDC 2023). The increases from 2020 to 2021 were significant for women in all race categories (CDC 2023) although, there is a large disparity for women of color, predominantly black women. They experience a maternal mortality rate at roughly three times that of white women (Taylor 2020). For example, in 2021, non-Hispanic white women had a rate of 26.6 per 100,000 births, while black women had a rate of 69.9 per 100,000 births (CDC 2023).

Defensive Medicine and Obstetric Gaslighting

Taking away a woman's right to choose if pregnancy is right for her body could increase pregnancy and childbirth complications. People who experience pregnancy and childbirth report a wide range of experiences and it is crucial to understand more about why people have negative outcomes and traumatic experiences. It's also important to try to understand what changes have

occurred more recently that could be factors for our increasing maternal mortality rates (CDC 2023).

The U.S. cesarean rate has increased dramatically from just over 5 percent in 1970 to 32.1 percent in 2021 (CDC 2023). The current c-section rate is more than double the maximum rate recommended by the World Health Organization of 15 percent (Morris 2013). The consolidation of healthcare systems and the increase in malpractice insurance premiums have led to this increase in c-sections, which doctors use as defensive medicine (Morris 2013). The c-section allows maternity care providers to say they did everything they could to protect the baby and avoid malpractice claims (Morris 2013). In the Listening to Mothers study, black women were more likely to be given a c-section at a rate of over 40 percent, while white women were given one at a rate of 29 percent (Taylor 2020). The rates found in the Listening to Mothers study are mostly consistent with national rates which are 36.8 percent for black women and 31.0 percent for white women (CDC 2023). The rates for maternal mortality and morbidity are about three times higher for women who had a c-section versus vaginal delivery (Taylor 2020). The overuse of c-sections has been a concern for the medical and public health community for decades (Taylor 2020), but women are often told it is safer for the baby and encouraged to have a c-section, causing women to unknowingly increase the risk to their own lives (Morris 2013).

Gaslighting is defined as a type of abuse aimed at making victims question their sanity as well as the legitimacy of their perspectives and feelings (Fielding-Singh, et al 2022). This can take form in the field of obstetrics due to stereotypes of women as irrational and emotional and medical professionals seen as rational experts (Fielding-Singh, et al 2022). Judgments of pregnant people and assumed expertise by others carry through into the pregnancy, delivery, and postpartum experience for women. A recent study using in-depth interviews between 2019 and

2020 found that between one-fourth to one-third of women who will give birth in their lifetime have reported the experience of birth as traumatic (Fielding-Singh, et al 2022). Gaslighting affects women of color more than white women due to the intersection of gender and race discrimination in the healthcare system (Pirtle & Wright 2021). As mentioned earlier, maternal mortality is decreasing globally but continues to increase in the United States and this is attributed to gaslighting in the medical field due to the medicalization of childbirth and the practice of defensive medicine by increasing c-sections (Fielding-Singh, et al 2022). Doctors are listening more to monitors than to the actual patient and doing whatever will be the least risky to the hospital and themselves versus the short- and long-term risk to the mother (Fielding-Singh, et al 2021).

Healthcare Technology and Fetus as Person

Technology Aides Personhood

Technology has changed the way we can view a fetus, with advances such as ultrasounds. When technological advances were introduced in the late twentieth century, they were seen by feminists as a power play by the male-dominated obstetrician field, but also as a positive to give women more insight into the fetus growing in their bodies and the ability to make decisions based on that knowledge (Rapp 1999). When ultrasounds became common in the late 1970s in the United States, issues arose due to ultrasound technology dissolving a female's bodily boundaries and making the fetus an independent autonomous agent (Mitchell & Georges 1998). Sonograms, which are the images produced by ultrasounds, continue to advance, and give images of younger and tinier fetuses in clearer depictions (Mitchell, et al 1998). The popularity and experience of ultrasounds and sonograms have led the way to perceive a fetus as a baby.

Ultrasounds are so powerful in connecting personhood to a fetus that lawmakers legislate mandatory viewing before having an abortion (Mitchell, et al 1998).

Describing something with action words is central to giving something the status of personhood in our culture (Martin 1991). When an egg and sperm are described as living beings with action words, it lays the foundation for the argument of life at the moment of fertilization (Martin 1991). Giving cells personalities describes them as people and can have and has had dire consequences (Martin 1991). Giving sperm and egg human characteristics translates into giving an embryo and fetus the characteristics of a child. During ultrasounds, fetal movements are labeled by the sonographer as actions like "dancing" or "playing" and personalities are given such as "shy" or "cooperative", and the parents are discouraged from saying "fetus" and encouraged to refer to the fetus as "baby" (Mitchell, et al 1998). Oddly, though the woman during an ultrasound is the actor for the device, the fetus becomes the actor, and the sonographer becomes the expert on what is happening to the woman's body (Mitchell, et al 1998).

Fetal Personhood

Recently, abortion and fetal personhood laws are being proposed across the country. For example, a new law in Arizona that was argued by the ACLU in 2022 stated that an unborn fetus has all the same rights, privileges, and immunities as all persons, and Georgia recently passed a law stating a fetus can be claimed as a dependent on tax forms (Time 2022). In terms of abortion regulation, there is recent conflicting federal rulings on the invalidation of the FDA approved abortion medication, Mifepristone in Texas and Washington (Valenti 2023). The new Texas abortion law, SB8, is an antiabortion law that bans abortion after six weeks of pregnancy with no exceptions for rape or incest and allows citizens to monitor and seek civil damages against anyone who aids or abets a person seeking an abortion (Goodwin 2022). To better understand

what six weeks of pregnancy means, consider a typical menstrual cycle. The cycle is typically every 28 days meaning that if a woman does not realize they are pregnant until a missed cycle, the realization could occur around week five of the pregnancy (Clevelandclinic.org 2023). By the time they make a doctor's appointment to confirm the pregnancy and an appointment for an abortion if that is their choice, they will likely be beyond week six of the pregnancy and thus will no longer be able to make that decision for their body according to this law. This law takes away the agency and liberty of vulnerable people and has similarities to American slavery in terms of handing the law over to citizens (Goodwin 2022). With the protection of potential life and the Supreme Court agreeing that a womb is subject to state regulation, female bodies do not have the same rights as male bodies (Goodwin 2022).

Criminalizing pregnant women is nothing new for women of color, but fetal personhood is finally getting attention from white feminists as these laws begin to take shape. The control of the reproduction of black women shifted to making reproduction a crime in the 1980s during the Reagan Administration (Roberts 1997). Those on Medicaid were targeted and drug abuse, predominantly crack use, was used as the focus which specifically targeted women of color (Roberts 1997). Unfortunately, criminalizing pregnant women was not seen as a problem in the mainstream feminist movement when it only impacted women of color (Luna 2020). Because abortion was the dominant focus for the white, middle- and upper-class feminists, a serious issue was ignored and overlooked: the prosecution of pregnant women (Goodwin 2022). The early fetal personhood rulings were mostly seen as a race issue, and that is one of the biggest mistakes of the feminist movement that we are now living with the consequences of today (Goodwin 2022).

Theoretical Framework

The theory that relates most specifically to this research is contemporary feminist theory. Contemporary feminist theory assesses the situations and experiences of women in patriarchal societies and seeks to see women as the central subjects to the research (Feagin, et al 2015). Within contemporary feminist theory, I am drawing on Standpoint theory from Dorothy Smith (1979) which is research done from the standpoint of women and moves away from object to subject status to focus on lived experiences and the diversity of those experiences (cited in Feagin et al 2015). In addition, specifically within feminist theory, women as "other" (de Beauvoir 1949; Bordo 1993), control of women's bodies, specifically reproductive bodies, and the controlling descriptions and images within our culture (Almeling 2020; Martin 1991; Roberts 1997) are used in this research. Lastly, the theory of Intersectionality from Kimberlé Crenshaw (1991) is used that points to a complex intersection that subordinated people live within that includes racism, sexism, and classism and points to the need for feminist thought to be more nuanced and inclusive (Hill Collins 1990).

Method

Study Design

The research study used a cross-sectional survey. The survey used a nonprobability sampling method beginning with a convenience sample and followed with a river sampling method by recruiting individuals across the country via different methods discussed below. The online survey aimed to understand various individual perspectives on fetal personhood and how a female's individual rights and bodily autonomy are viewed before, during, and after a pregnancy. The research was interested in understanding opinions and how they change over time, and how they differ by a variety of demographic data points such as geographical location, age, gender identity, religious background, race, ethnicity, education, political views, and socioeconomic

status (SES). I collected quantitative data within this survey, but for this research I focused on the qualitative data. Qualitative analysis was conducted from the survey responses from demographic, close-ended, and open-ended questions.

Participants

The participants were of any gender identity aged over eighteen living within the United States. The reason the sample was so inclusive is that I wanted to include individuals from every background with various beliefs to try to get a deeper understanding for the overall feelings and opinions on this topic within the country. The research goal was to include all states within my target population to make sure I captured various regional views and to ensure I gained enough participation in the survey. The only exclusion is those under eighteen years of age due to the nature of the topic. Individuals were recruited for the survey using a convenience sample by sending out emails to my and the sociology faculty's personal and professional networks asking for participation. A social media post also went out through the UIndy Sociology account, my personal accounts, and my thesis advisor's accounts. I hoped to gain participation from at least 250 respondents, but ideally, I aimed for 500 respondents across the country. After recruiting this way, I determined paid promotion was necessary to increase participation and expand reach using a river sampling method through paid ads on Facebook and Instagram targeting anyone living in the United States over eighteen years of age. After running these ads for a few weeks, I ended up with a total of 1,149 responses.

Materials/Measures

Data for this study was collected via an online survey developed in Qualtrics. The survey questionnaire was developed based on questions that arose from the literature review and recent

topics within our society and political climate. The questions were reviewed and revised with the help from thesis advisor, Elizabeth Ziff, PhD, University of Indianapolis; Sociology faculty members including Amanda Miller, PhD and Colleen Wynn, PhD; and current graduate students in the Applied Sociology program. The survey contained multiple choice, Likert scale questions, open-ended questions, and demographic questions. A hyperlink to the survey was distributed to adults in the United States via email and through social media (Facebook, Instagram, Twitter, and LinkedIn). The survey was constructed to understand participants' opinions and knowledge of fetal personhood, female bodily autonomy, and infant and maternal mortality. The survey contained a total of 40 questions with predominantly close-ended and open-ended questions ending with demographic questions (Appendix A). Questions were developed based on information found throughout the literature and are rooted in the research covering the broad topics of intersectionality, patriarchy, and changes in healthcare systems.

Data Analysis

The purpose of this study was to describe the opinions of adults across the United States in terms of fetal personhood and female personhood. Data was analyzed in Qualtrics and Dedoose. Regarding the qualitative responses, I performed an inductive analysis and used the four-stage Grounded Theory: code, concept, category, and theme (Bernard & Ryan 2010) approach. This methodology requires multiple rounds of coding, which identify and connect different themes within qualitative data. Both open coding and axial coding were used to analyze the open-ended responses. Open coding helped identify patterns within the survey respondents, while axial coding drew connections between them. I met with my thesis advisor on a regular basis to review trends and codes, identify a common code deck, identify themes, and identify areas for more

exploration. Descriptive statistics to describe responses to the closed-ended demographic questions were conducted utilizing Qualtrics.

Results

As mentioned, this survey used a nonprobability sample and is not generalizable to the entire population of the United States. This research is exploratory to understand opinions within the actual sample achieved using these methods rather than to generalize these opinions to the greater population. This sample skews female, white/Caucasian, and highly educated (Appendix B). There was however a wide range of ages and geographic locations represented in this survey. The age of respondents ranged from 18 to 88 years old with the largest number of respondents in the age range of 36 to 38 years old. Besides Alaska and Rhode Island, all states had at least one respondent. Respondents overwhelmingly provided rich details and, in some cases, lengthy responses to open-ended questions, which are explored below.

The idea of complexity in terms of human reproduction and fetal personhood is nothing new or groundbreaking. These topics are a point of contention in many cultures and have been so in the United States since its formation. This research offers data that point to a different complexity, that of the individual. The data show there are social and human components to these issues that are far more nuanced than what a chosen side on the topics can define. To examine the nuance, the open-ended responses to the following five questions were reviewed: "Do you view birth control as a form of abortion?"; "If you do think there are low birth rates in the US, what do you think is the cause?"; "When do you believe a fetus becomes a living human being?"; "Do you believe an unborn fetus is entitled to the same rights as the person carrying the fetus inside their body? Why or why not?"; and "Throughout your lifetime, have your opinions on reproductive choices changed, and if so, why?". The following themes were found that show

complexity where we may not always look for it, by how humans describe and make sense of definitions, labels, and their unique lived experiences regarding fetal and female personhood. The results show the challenge of defining broadly used terms and the issues with using labels to form assumptions. Most importantly the results align with feminist theory in terms of amplifying lived experiences and the unique perspectives from the distinct standpoint of those who have experienced pregnancy, childbirth, or both.

Definitions

Birth Control and Viability

The subjective nature of definitions in human reproduction adds to the complexity of defining terms or describing reasoning or outcomes. For example, when survey respondents were asked if they considered birth control a form of abortion, 23 individuals chose not to answer the multiple-choice question as yes or no, but rather the choice of "other" with an explanation of a gray area where they view some types of birth control as abortion while other types are not. The primary reasoning is that some are abortifacients and impact a fertilized egg. Respondent 328, a female who works in healthcare stated, "If it prevents conception, no. If it causes the uterine lining to shed an implanted fertilized egg, yes." While respondent 632, a female stay-at-home mom (SAHM) from Wisconsin noted, "It could potentially prevent a fertilized egg from implanting, which means it dies, so I can't bring myself to use it, but I don't consider it abortion." This respondent shows the conflict between their personal feelings along with their overall belief, something commonly found throughout this analysis.

Viability was extremely difficult for some to define due to a newer gray area caused by advances in neonatal intensive care units (NICUs). For example, respondents were asked when they believe a fetus becomes a living human being and could choose all that apply from multiple

options. Based on responses most respondents overall are close to an even split between viability and at birth with 44% and 38% respectively (Appendix C). Seventy-four individuals chose "other" and provided additional details as to why. For example, respondent 407, a female from Ohio working in biomedical research, chose the options of "when it is viable", "at birth", and "other" and noted the difficulty in the definition. "Defining viability is tricky because it is now possible for fetuses to survive outside of a human uterus earlier - ultimately I think regardless of my understanding of fetal personhood, a decision about terminating a pregnancy should be between the pregnant person and their doctor." Respondent 30, a female in management consulting from Indiana had a similar difficulty in defining viability. "'Viability' is complicated and when a child could survive will depend on the level of access to healthcare available in their area. I'm not sure if I know a specific week of pregnancy where a cutoff should be." Both respondents note the difficult nature of defining "viability" due to healthcare access and advances, and the difficulty defining a "cutoff" or making that decision for someone else.

Other respondents note the need for clarity in terms of defining viable and further medical care needs, such as respondent 252, a female geologist from Texas:

> Viable is an ambiguous term. With medical advancements, yes, a 23-week fetus *could* survive with extensive round-the-clock care for months. I feel viable should refer to being able to live without medical props. A 1-year-old still hooked up to machines with physical and cognitive issues isn't a miracle. It's a shame.

Respondent 74, a female teaching assistant from Missouri noted, "Viability is a gray area. When I think of viability, I mean that the fetus can survive without medical intervention." This respondent along with others consider how to define viability in terms of the need for further medical treatment and care and the difficulty with defining the difference within the broad terminology of "viable" that is consistently used in our dialogue.

Opportunity for Women - varied interpretations

When respondents were asked if they believe that we have an issue with low birth rates in the United States, of those who agreed that we do, they were asked what they think the cause of the low birth rates are. Interestingly, many cite women's opportunities with their careers, educational attainment, and individualism as the cause, but some see women's opportunities as positive, while others see these same opportunities as a negative. For example, respondent 507, a female from South Dakota not currently working, states, "All women are called to be mothers," and notes that "Birth control, female empowerment, and large PR campaigns that assure women that their careers are the secret to a happy, successful, meaningful life" as the cause for lower birth rates. Similarly, respondent 281, a female homemaker from California, notes a career as an issue but also the loss of marriage and morals. "Out of wedlock public financed abortions. Progressive values instead of biblical values thus moral decline in society, no family values, thus no marriage, career-oriented seeing no need for children." Both respondents have a common view that low birth rates are caused by people (and, as one implied, women in particular) seeing their career as a fulfilling component to their lives instead of children.

Stating women's opportunities but from a positive perspective, respondent 790, a female from Wisconsin in the field of education explains and provides an idea for how to improve population growth without enforcing childbearing:

> Women are more educated now and they can choose when to have children and how many. Raising children costs too much money. There is no longer a need to have a lot of children if a woman doesn't want to. Women should be able to be all they can aspire to be. Being forced to have children takes away from those opportunities. We should increase immigration, which will take care of population demographic issues.

Interestingly those who note the positives of additional opportunities for women, also note other factors that could impact birth rates in the US such as marriage later in life, fertility issues,

personal influences, or the state of our global economy. For example, respondent 915, a female from Illinois in the software industry explained:

> I believe the American family is no longer what it was 20+ years ago. With greater access to information, women have a better understanding of the sacrifice and cost involved in raising a child and may choose to focus on their careers or travel the world instead. Additionally, women may not want to have a child due to the direction the world is heading. Fertility issues may also play a role. Furthermore, people are getting married later in life and therefore, starting families later than in years past and having fewer children. Personal influences (family/friends suggesting not to have children, terrible childhood, etc.) may also play a role.

What some respondents define as a moral decline in society and false PR campaigns, others define as the access women now have to more accurate information, education, and career advancement. The opposite opinions display our divisions in describing the change in our society and the complexity of defining how opportunities for women impact birth rates in our country.

Varied reasons for Female Personhood Rights

Overall, most respondents of this survey believe the female body is entitled to the right of personhood over the fetus having the same or any rights. However, when giving reasoning for female personhood, the answers vary considerably. When asked if they believe an unborn fetus is entitled to the same rights as the person carrying the fetus, respondents gave various reasons as to why not, including bodily autonomy and informed consent, constitutional rights, and that the pregnant person already has a life, feelings, and connections with other living beings.

For example, respondent 1042, a female SAHM from Oregon stated, “The fetus cannot survive without the mother. The fetus doesn’t have a life or feelings. A living, breathing woman has a life, feelings, needs, people that may depend on her, etc.” Similarly, respondent 633, a female elementary school teacher from Vermont notes a personal story of a friend who had a difficult pregnancy:

> A woman carrying a baby has a huge network of people that love and need her. If the fetus had the same rights as the woman, then her life could be at risk which could negatively impact the people who depend on her. One of my friends had a life-threatening pregnancy with three young children and a husband already at home. Luckily, both her and the baby survived but if the baby had the same rights as her before birth and things went wrong, her family would have been devastated and the quality of life for her previous children would have decreased significantly.

Both respondents used the reasoning of the pregnant woman already having a life with ties to others and potentially family and other children who are attached to her.

Many use the case for informed consent and bodily autonomy as their reasoning, such as respondent 877, a female student from Texas, stating:

> No other human is given the right to use another human's body without their consent, so a fetus should not be given rights that are given to no one else. We do not even allow organs to be donated from dead people who are no longer using them to save lives if we do not have consent, so why should using a pregnant person's body be any different.

Respondent 556, a female from Indiana also expands on the contradictions in informed consent in terms of a pregnant body:

> We already don't give people the same rights when they are underage. Does a fetus mooching off the body of the pregnant person even have a right to do so? Does the concept of bodily autonomy extend to a right to use other people's bodies for your own survival? If I can't force someone to give me one of their kidneys so I can live, then a fetus can't force a pregnant person to give their bodies. Maybe we should also be asking if a fetus should be charged with manslaughter if the person who births them dies in the process. If a fetus has the same rights as a grown person, then should they not bear similar responsibility?

And respondent 984, a female attorney from Kansas notes the importance of bodily autonomy. "No. Whether or not a fetus is "a life" is irrelevant. No person can be compelled to use their body to benefit another without their consent. The right of the mother to bodily autonomy must take precedence." These respondents point to the inconsistencies found in informed consent for human bodies and when bodily autonomy is applied and taken away.

The last main argument focused on U.S. constitutional rights and what is and is not afforded to a fetus and a pregnant individual. Respondent 999, a female in the military from Texas, states:

> No. They are not legal citizens, because they haven't been born yet. They don't have a social security number and their life starts at the first breath. Simply put, a parent can't take out a life insurance policy on an unborn fetus. A parent can't ask the other parent for child support because they are not a baby. There's literally nothing offered on the table to parents legally to cover them if something should happen to a wanted baby. Simply because a fetus isn't a baby.

And respondent 15, a female from Georgia noted:

> No, constitutional rights are given to those who are explicitly "born", if we prioritize fetal rights this diminishes the autonomy of the pregnant person rendering them a vessel for reproduction and placing the pregnant person at risk of increased surveillance and reduced overall rights.

The respondents point to legal rights at birth and the inconsistencies with our country viewing a fetus as a baby but also not as a living baby in terms of available benefits and identification as a citizen of the U.S.

Labels

Demographics and Labels Do Not Determine Views

As a country, we use and rely on demographic labels, and we tend to believe a label can tell you a lot about a person without ever having an actual dialogue. This survey gave people a chance to communicate their personal beliefs and share demographic information in a private online setting. The demographic information that is used as labels in our society combined with the detailed responses shared indicate that labels and the assumptions that go along with them can be inaccurate and misleading. Respondent 166, a female from suburban Indiana working in healthcare who identified as a Republican, conservative, and Christian stated their belief in female bodily autonomy and the right to choose.

> Until the baby is born, it should not have rights that could harm the mother. The mother should have the right to have complete control and governance of her own body… Politically/religiously I used to disagree with abortion. But after I opened my eyes to the real world- how cruel it can be to women, and worked in healthcare with various socioeconomic classes, it became clear that women deserve the right to choose. I personally will forever choose life because that is my fundamental belief, but I think it's imperative every woman gets to choose for herself and not allow laws/government to choose for them.

Respondent 112, a female from suburban Pennsylvania working as an engineer who identified as an Independent, liberal, and a Catholic, believes a fetus is a person, stating:

> Yes. They are human. A doctor should work to prioritize the health of everyone involved in the pregnancy. Sometimes that is not possible. Ending a pregnancy by abortion should not be an answer, because it ends the life of the child. While some other medical procedures result in an abortion, that is not the intent of the procedure. All procedures should always be with the intent of keeping the pregnant person and child alive and healthy.

Respondent 835, a female from suburban Nevada working in education who identified as an Independent, both conservative and liberal, and a Catholic does not believe a fetus has rights and that women should have the right to choose.

> No. People have rights once born… I was once pro-life and then I experienced pregnancy and motherhood. I now believe that women should have full bodily autonomy regardless of their circumstances. Children are wonderful but they shouldn't be forced on anyone. We should have unregulated access to birth control, including sterilization, and abortion. We could also support families wanting to have children by reducing the cost of healthcare and offering more programs for children of any socioeconomic status. The middle class is often forgotten when pushing through support for children and I see countless middle-class families struggling with appropriate care.

These examples show Catholics can be pro-choice, liberals can be pro-life, and those who identify as Republican, Christian, and conservative can still believe in women's bodily autonomy and the right to choose. Inaccurate assumptions may seem obvious to some who know people are complex, but in mainstream dialogue and the media, labels are historically and still today used to oversimplify a person's complex beliefs in simplistic binaries. As exhibited here, that is simply not accurate. A person's complexity also relates to the theoretical framework of contemporary

feminist theory and intersectionality that point to the argument that you cannot assume uniformity with identity and the focus must be on diversity of lived experience.

Pro-life stance of Equal Rights label vs Fetal Rights label

Of those who responded to this survey and believe that a fetus is entitled to the same rights as the person carrying the fetus, many did not want to label their opinion of fetal rights as fetal personhood or state that a fetus's rights outweigh the female's rights. When asked if an unborn fetus is entitled to the same rights as the person carrying the fetus, respondent 983, a female from suburban Virginia states, "Both the woman carrying her child and the child have inherent dignity and both are worthy of life." Respondent 871 a male from Tennessee who retired from the military states "Yes...they are that person, essentially." Respondent 587, a female from Texas working in healthcare, states "Yes. Both are separate genetically unique individual humans that both have inherent rights and dignity by virtue of being human persons." Respondent 1029, a male from Massachusetts working in education shows clearly dislike for the term "fetus" stating "The value of each life is equal. Why do you refer to the child as an 'unborn fetus?' Is there such a thing in your mind as a 'born fetus?'" It is clear there is some discomfort with using the term "fetus" when describing any rights and typically is replaced by "child" or "baby". A few use the term "dignity" to describe a right to life for the fetus. These respondents' reason that the pregnant person and the fetus each have equal rights while sharing one body and each deserve to live.

Embracing a change of opinion, but avoiding labels

When it comes to stating how opinions have changed throughout the course of their lives, respondents predominately stated whether they became or always had been pro-choice or became or always had been pro-life. There were however respondents who indicated a change but did not

state either side or choose a label when responding to this question. There was a trend found in those who note a change in opinion regarding having children of their own with a total of 41 respondents. Sixteen of the respondents note a change in opinion of having children along with becoming more pro-choice or that they have always been pro-choice, while the other 25 do not note the change in opinion as a factor of choosing a side or label but simply state their views on having children as the reason their opinions have changed. For example, respondent 659, a female attorney from Utah, states, "Yes. My personal decisions on having kids has changed as I got older and was able to ignore societal pressure saying I had to have kids because I'm a woman." Respondent 261, a female from Florida states "It's ok to not want children when in a society that emphasizes having them after being married. Everyone has the right to choose the family (with or without kids) that's right for them." And respondent 498, a female from Washington working in adult education touched on multiple experiences in their life along with the cultural messaging issues:

> Girls in my high school got publicly humiliated and "sent away "for being pregnant. It radicalized me for life. (I was not a teen mother). I favor vigorous promotion and use of birth control, abortion, and voluntary sterilization for both genders. I feel that infancy and childhood are idealized in much the same way that marriage and weddings are. The costs of a baby to the environment, society, and the development of women are carefully shadowed by a romanticized view couched in religiosity.

Predominant themes for change in opinion on having children include becoming aware of the societal pressures and cultural messaging towards women and making decisions based on their personal judgments instead. One respondent recalls a memory from her childhood and how witnessing the mistreatment of girls in her school changed her views forever. The respondent's recollection connects with the final theme found and explored below, lived experiences.

Lived Experience

Personal choice vs choosing for others

When responding to how opinions have changed throughout their lives, a total of 34 respondents note the realization that their personal opinions should not control the available decisions for anyone else. For example, respondent 652, a female from California, states:

> Yes, when I was very young I was a rabid anti-abortionist. I felt there was never any reason for an abortion, part of that was influenced by a girl I knew who only used abortion as her birth control. When I got older and started learning more and learning about all different types of pregnancies and life situations, I came to understand that for some people abortion could be the answer they need. I don't have to like abortion, I'm never going to like it, but I learned that I have no right to force my feelings on another person no matter who that person is.

Respondent 605, a female in recruiting from Indiana, noted:

> Yes, if I had been impregnated as a teenager I likely would have considered abortion because I wouldn't have been ready to carry a fetus or be a parent. Now in my 30s, I likely wouldn't abort unless my doctor thought it necessary. But I would never try to deny someone else their bodily autonomy.

And respondent 452, a female in consulting from rural Washington, states, "No, I have my own beliefs about what is morally right for me but do not think I can make those choices for anyone else. Freedom of choice is the bedrock of our constitutional freedoms." These responses show empathy and openness for others to form their own beliefs and decisions as well as a transformation to get to this point for some.

Family trauma

One of the ways to listen and understand best is to hear from people with lived experience. Several respondents noted a personal, friend, or family member trauma in response to asking if their opinions had changed throughout their life. Respondents were asked if their opinions on any reproductive choices changed throughout their life. Respondent 253, a non-binary individual from Minnesota working in early childhood education noted their views based on their mother's experience as a teenage mother. "No. My mother was 16 when she got pregnant with me, and in my opinion it ruined her life." Respondent 871, a male retired from the

military from Tennessee stated, “Yes. We lost our daughter when she was born prematurely because we are a mixed-race couple and lower in social status at the time.” Respondent 323, a female in health communication from Washington recalled a past family trauma:

> No. I was a young adult when Roe was enacted, and I saw the tragic results of state interference with a basic human right. I never got to know my dad’s older sister, who died of a self-induced abortion before I was born.

Respondent 771, a female from New Hampshire, experienced incest and rape and had to obtain an illegal abortion as a child. “No. I was raped repeatedly by my father & impregnated at 13. Without a (not legal at the time) abortion, I would have committed suicide.” And respondent 576, a non-binary and transmasculine individual from Montana shared the following experience growing up and how the fear of pregnancy caused mental and physical health issues:

> As a very young child, I thought that if someone was pregnant and didn’t want a baby, the answer was adoption. When I was 12, there was no event that could have caused pregnancy, but I decided that if I were ever raped and got pregnant, I would starve myself so I wouldn’t have the baby. As a non-binary child with anorexia, the idea of pregnancy was utterly terrifying. It still is; I’m so grateful for my hysterectomy that makes it completely impossible…Looking back, this child was so terrified of the idea of pregnancy that they had a plan to hurt themself to stop it. They had that plan for their own peace of mind without ever even having sex or being in a position where they could get pregnant. Abortion needs to be legal and openly available, not just for those who need it, but for those who need to know that they could get medical help without having to hurt themself.

These examples are only a sampling of the deeply emotional stories shared by respondents and shows how policy, law, and access to reproductive care can affect not just the immediate individual involved but also generations to follow. It also shows how bodily autonomy and mental health are interconnected for human beings.

Empathy by experience

Lastly are those who have experienced exactly what is being heavily debated: pregnancy, childbirth, or both. Over 20% of respondents who noted they had become more pro-choice

pointed to experiencing pregnancy and childbirth as the reason why. For example, respondent 39, a female in nonprofit management from Indiana, stated:

> Yes. I was strongly anti-abortion as a young person, but my views began to moderate during and after college. Ultimately, becoming pregnant and giving birth convinced me that no woman should ever be forced to experience that against her will.

Respondent 1005, a SAHM female from Utah, noted:

> Yes, I used to be very anti-abortion until I had my own children and realized pregnancy and the complications, fears, limitations, and consequences should not be a punishment, but an active choice - it's already so hard when the pregnancies are wanted and loved and eagerly awaited.

These respondents tend to focus on their newfound empathy for other people who could become pregnant along with the difficulty of pregnancy and childbirth even when it is a wanted and anticipated pregnancy.

Some respondents focused on the importance of their children to them, such as respondent 611, a female in education from Kentucky who became more pro-life after having children, who noted, "Yes. I used to be more pro-choice. But now I'm a mother of two and am more pro-life." Respondent 23, a non-binary professor from Texas noted:

> Yes. I spent a lot of time adamantly pro-choice with little appreciation for the sanctity of creating new life. However, I recently had a baby and, while my views on abortion haven't changed at all, my understanding of how sacred the creation of life is has been greatly expanded.

Though this respondent did not become more pro-life, they did explain the experience of having a child expanded their views on the sanctity of life. Lastly, there was a respondent who connected the change in opinion to not just experiencing having children but also to the fact that she has a daughter that could be affected by these newly created laws. Respondent 153, a female dental hygienist from Indiana, stated:

> Yes. As a young adult, I believed birth control should be limited and abortion was always wrong. I have 4 children, and being pregnant and being a mom are not easy things. I no

> longer believe anyone should have those choices made for them. It is very important to me that my daughter be allowed to make her own choices.

For those who focus on their children in their responses, the responses predominantly still show empathy for others who could become pregnant and need the ability to make their own choices for their bodies, be it a stranger or a daughter.

Open to listening, but not changing

When asked if their opinions have changed throughout their life some respondents acknowledged that these topics are complex. For example, respondent 234, a female from Hawaii, stated, "I realize it's all more complicated than I realized and that the variety of opinion is greater than I understood." Respondent 966, a female from Indiana working as a school psychologist, stated, "Yes. They have broadened. It is much clearer that most issues aren't black and white." And respondent 235, a male student from Illinois, notes:

> My opinions on abortion have not really changed, but I see a connection of choice and pregnancy-related to health care services. To alleviate the difficult decision-making on abortions, I argue for the maximum of reproductive care (such as birth control) to prevent tough abortion choices. I consider sexual health a human right. I have come to better respect other opinions on reproduction as the beliefs around a fetus' personhood are moral, religious, metaphysical, and ultimately not something science can prove or disprove.

These respondents note the complexity of the topic of human reproduction and the openness to hearing other opinions. Receptiveness to other opinions as well as thoughts on opinions changing over time was asked of all respondents. The respondents to this survey noted being mostly open to hearing other viewpoints (Appendix D) but they were adamant about their formed opinions and that they will likely not be changing them much if at all (Appendix E). Only 3.6% of respondents stated they are never open to hearing other viewpoints, while the majority at 79% of respondents are typically open, stating they are either "sometimes", "usually", or "always" open to hearing other views. In terms of their opinions on any reproductive topics covered in the

survey changing in the future, 69% of respondents stated they either “somewhat disagree” or “strongly disagree” that this is likely, and a few noted some openness to this potentially happening with 29% stating “neither agree nor disagree”, or “somewhat agree”. Only 1.5% of respondents “strongly agree” that they could change their opinions in the future. These responses show many respondents are open to hearing other opinions but are mostly confident in their opinions and do not see their opinions changing in the future.

Discussion

The results of this qualitative analysis point to a few key findings. First, definitions and labels used in mainstream society and media are not as clear as one may be led to believe. There are gray areas that many respondents point to, and when it comes to topics of human reproduction, one’s personal views on reproductive choices for themselves can be the opposite of their thoughts on reproductive choices for everyone else. The theme of forming empathy for those who could become pregnant by those who have experienced pregnancy was consistent in this research, and the respondent’s personal descriptions of that unique experience point back to the literature in several ways explored below.

Defining fetal personhood

In exploring the complexity of definitions, many respondents explained that some kinds of birth control are abortifacients in their opinion, while others are not. As the literature tells us, due to living in a patriarchal structure, views on reproduction take a patriarchal perspective. One way this can take shape is through the cultural imagery of an alive and active sperm influencing the individual to view a fertilized egg as a life demonstrated in Martin (1991). Some of the respondents noted certain kinds of birth control that shed a fertilized egg are abortifacients in their opinion. The view of life beginning at fertilization has become a more vocal and supported

view by those in powerful government positions who are creating our laws, such as the House Life at Conception Act proposed in 2021.

Along with action words for sperm, as Mitchell & Georges (1998) describe, fertilization is only the beginning of the use of action words that are ultimately utilized to refer to a fetus. Due to technology advances with sonograms and ultrasounds, a fetus is viewed as a baby and described as a child within our culture. The view of fetus as person is clearly depicted by the respondents who note a fetus has an equal right to life and the discomfort in using the term "fetus" and replacing it with the word "baby" or "child" in their responses. There was also a common theme from these responses of the pregnant person and fetus having equal rights and the use of the term "inherent dignity" for both. The concept of "dignity" in this debate is often culturally coded. "Dignity" is used in the literature to describe oppression, and thus there is an interesting and one could argue trained response to counter the equal rights question. As Feagin et al. (2015) explains, oppression eliminates or reduces human dignity and the capacity to express oneself and participate in society. When respondents describe that both the "mother" and "child" have equal rights, some refer to them as separate but equal, while others refer to them as one person sharing one body. These two arguments align with the woman as "other" theory from de Beauvoir (1949) and from Bordo (1993) that a woman's body is not seen as autonomous and the difference in legal application of informed consent. As Bordo (1993) points out, the cultural imagery that women are to be selfless and should preserve the life of another is a message in our society and mainstream media that continues to be prevalent today. The selfless cultural imagery also aligns with Valenti's (2010) findings in a patriarchal society of female bodies as valued and judged based on their morality, sexuality, and virginity, all adding to the complexity of how a pregnant body is judged and viewed based on those attributes by outside perspectives.

Defining female personhood

When it comes to defining why pregnant bodies deserve personhood, the various responses in the research point to a few different reasons. Many gave the reasoning of informed consent and bodily autonomy, reasoning that has been heavily explored and communicated in past literature such as Bordo's (1993) analysis of informed consent differences by body and Thomson's (1971) violinist example argument that argues a right to life does not translate to an obligation from another for the use of their body.

The second argument reasoned that a fetus does not have the same constitutional rights as a pregnant woman. This argument points to the issues with lack of diverse perspectives in the feminist movement. As Goodwin (2022) explains, recent fetal personhood rights laws have been passed and are being proposed in states across the country. Fetal personhood laws are a relatively new issue facing white women, but the criminalization of pregnant women has been common among women of color for decades (Roberts 1997). The feminist movement was largely from a white woman's perspective and thus this issue was mostly ignored as a race issue, and the movement focused more so on abortion rights. As Luna (2020) and Goodwin (2022) point out, feminists missed the opportunity to be proactive and address the criminalization of pregnant women when this first came up and now fetal personhood legislation is starting to be addressed reactively instead. As many of my respondents allude to, fetal personhood laws are still not fully understood as an impending crisis for many who have been shielded by privilege from these laws up to this point.

The last argument noted women already having a formed life with lived experiences and connections to other humans. This argument aligns with contemporary feminist theory and the perspective of seeing women as subjects instead of objects with lives and distinct points of view.

The impact of lived experiences

As the results show, to use a label as an assumption for someone's views on human reproduction topics, is to miss the nuance and intersectionality of diverse experiences. Respondents had varying views on female personhood, female opportunities and life choices, fetal personhood, and abortion to name a few. Their demographic characteristics were not always an indicator for their views, and many respondents who held a personal view for themselves decided that view should not be held as a restriction for others.

Many respondents noted changing their opinions to be more pro-choice after experiencing pregnancy and/or childbirth for themselves. Some went into detail as to why their views changed, while others simply stated that fact. Many stated that after experiencing pregnancy, childbirth, or both, they could not, and they do not believe others should be able to mandate a pregnancy or birth to anyone else. Respondents noted "complications, fears, limitations, and consequences" of being pregnant with a planned and wanted child and described the experience of giving birth as "traumatic" or as "torture" to force someone to do against their will. The research shows there is a voiced need for bodily autonomy that only those who have experienced growing a fetus inside their body or experienced the increasingly risky procedure of childbirth can fully understand or explain based on this unique lived experience.

From the literature we know the factual data from the CDC (2023) on our country's growing maternal mortality and morbidity rates, which affect women of color and predominantly black women at three times the rate of white women. Second, the issues with defensive medicine and as Morris (2013) found, the growing number of cesarean sections that put women at a higher risk of complications. Finally, as Fielding-Singh and Dmowska (2021) point to, the gaslighting of women and predominantly women of color in the healthcare system and issues of health care

workers not listening to women's concerns during pregnancy and childbirth. All these issues combined can create a "traumatic", "complicated", "fearful" experience that the respondents address.

Limitations and Future Research

This study does have several limitations. Due to the convenience sampling a predominately white, female, liberal, highly educated audience from the Midwest was reached. Along with the convenience sample limitations, river sampling (Lehdonvirta, Oksanen, Räsänen, & Blank 2020) that utilizes Meta's algorithms, was likely biased in terms of a high percentage of the sample showing either an interest in the topic of reproduction or a connection to higher education in some way. Although common themes were found, further research should be conducted including more diversity in gender identity, ethnic and racial identity, educational levels, SES, and political affiliation. Due to the fairly homogenous nature of the sample the respondents lacked diversity such as racial diversity and thus further issues to examine within this topic such as intersectionality and structural racism in reproductive care were not explored. With a more diverse sample, I believe my participants would have had more personal experiences with traumatic births, an increase in family or friend experience with maternal and infant mortality, and additional opinions on reproductive justice with the need for full reproductive rights including not only the right to choose not to have a child, but also the right to have a child safely and raise a child in a healthy and safe environment (Luna 2020). Still, this research does show the importance of gathering qualitative research in combination with quantitative research due to the intricate complexities that each individual encompasses when it comes to this topic. Although this research shows comfort levels with sharing deeply personal experiences, this was an online, completely anonymous survey and shows people may feel most

comfortable sharing in this setting regarding these topics. Moving forward, the quantitative, generalizable research on these topics ideally will also include open-ended questions in their surveys to gain this deeper insight and, if respondents are comfortable and open to sharing in-person, follow-up interviews for further understanding.

This research shows that our patriarchal society does inform our definitions and opinions, but that lived experiences can add complexity and diversity that can alter how individuals use and understand definitions and labels. As a society we tend to default to a quick and easy label while missing the opportunity to find out how nuanced the conversation really is. The research aligns with intersectionality and contemporary feminist theory including Standpoint theory in showing the need for qualitative components in research on these topics to see each individual's point of view and gain deeper understanding. The need for in-depth research is nothing new in regard to the already well-known need for mixed-methods and qualitative research. Rather it is another example for why exploring these topics with the intent for encouraging respondents to expand and provide open-ended responses can add to our understanding of how complex and unique fetal and female personhood can be. The key takeaway from this research is that without lived experience we are left guessing and using our own perspectives to make assumptions. Instead, we should give those who have experienced what is being debated a voice. We must listen, try to understand, and value lived experiences as truths.

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Appendix

Appendix A - Link to the Survey

https://uindy.co1.qualtrics.com/jfe/preview/previewId/0c6c0b25-fdab-4ff3-8fa3-f200cbd08da7/SV_dgI4XnzqqbQnhu6?Q_CHL=preview&Q_SurveyVersionID=current

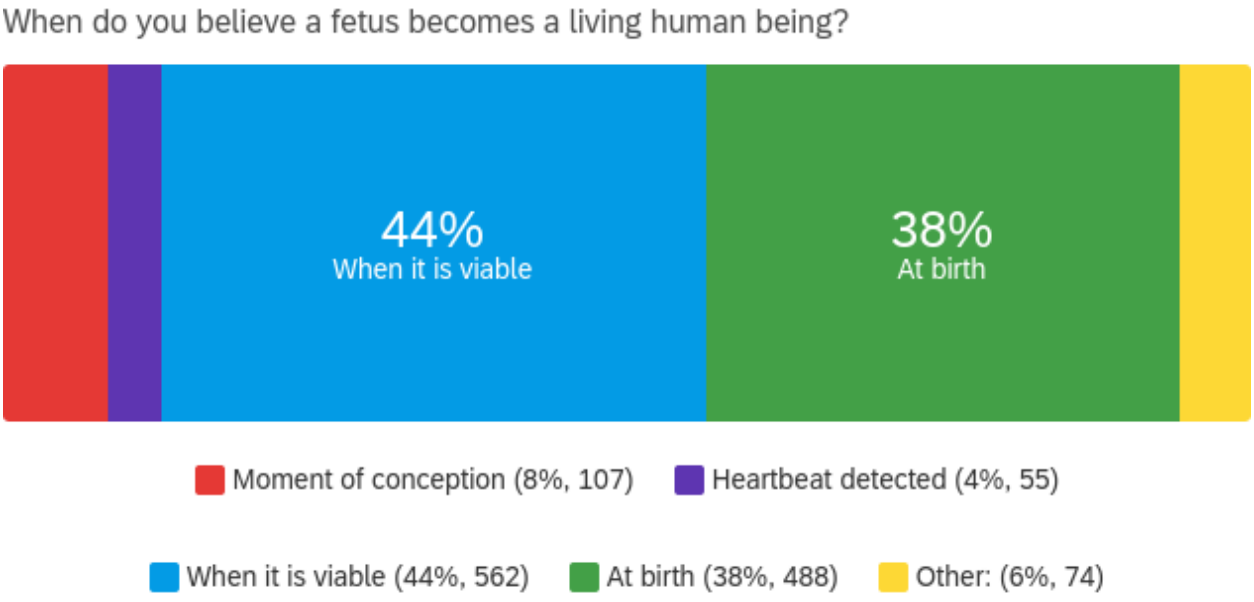
Appendix B - Table 1- Descriptive Statistics

Table 1. Participants' Demographics

Characteristic	Count (Number)	Frequency (% Total)
Gender		
Male	66	6.27
Female	937	88.98
Non-binary	33	3.13
Prefer to self-describe	10	0.95
Prefer not to say	7	0.66
Race/Ethnicity		
White or Caucasian	976	89.87
Black or African American	18	1.66
Hispanic or Latino	24	2.21
American Indian/Native American or Alaska Native	13	1.20
Asian	15	1.38
Native Hawaiian or Other Pacific Islander	1	0.09
Other	21	1.93
Prefer not to say	18	1.66
Political Views		
Extremely Conservative	5	0.48
Somewhat conservative to conservative	54	5.19
Both conservative and liberal	125	12.01
Somewhat liberal to liberal	580	55.71
Extremely liberal	277	26.61
Practice a Religion		
Yes	372	35.60
No	612	58.56
Rather not say	61	5.84
Educational Attainment		
Some high school, high school diploma or GED	8	0.76
Some college, associates or technical degree	127	12.06
Bachelor's degree	378	35.90
Graduate or professional degree	540	51.28
Residential Area Type		
Urban	326	31.08
Rural	207	19.73
Suburban	493	47.00
Other	23	2.19
Have children		
Yes	642	61.44
No	383	36.65
Other	20	1.91

Appendix C - Table 2

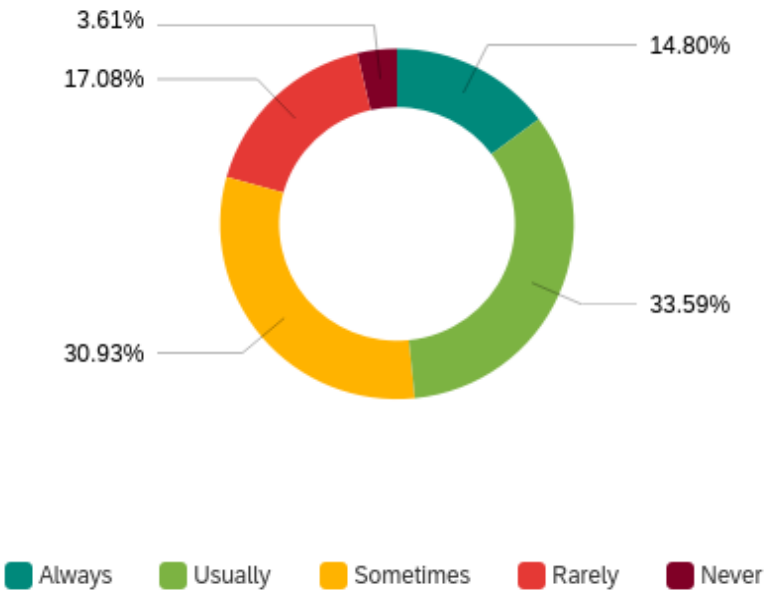
Table 2. Survey Question 18 Responses (Choose all that apply)



Appendix D - Table 3

Table 3. Survey Question 24 Responses

Do you consider yourself open to hearing other viewpoints on these topics?



Appendix E - Table 4

Table 4. Survey Question 26 Responses

Respond to the following statement: My opinions on any of these topics covered could change in the future.