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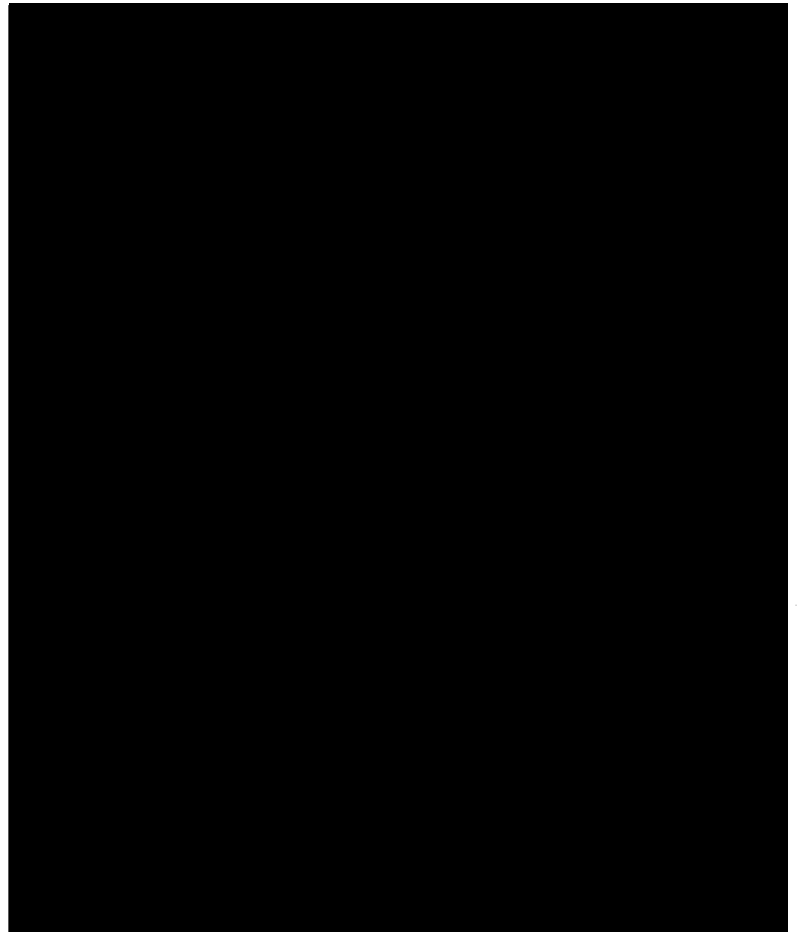
THE RHETORICAL STRATEGIES OF PREGNANCY SUPPORT CENTERS  
INCLUDING THE VISUAL RHETORIC OF FETAL ULTRASOUND TECHNOLOGY

by

Raymond Kyle Jones

A Dissertation  
Submitted to the Graduate Studies Office  
of The University of Southern Mississippi  
in Partial Fulfillment of the Requirements  
for the Degree of Doctor of Philosophy

Approved:



May 2008

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THE RHETORICAL STRATEGIES OF PREGNANCY SUPPORT CENTERS  
INCLUDING THE VISUAL RHETORIC OF FETAL ULTRASOUND TECHNOLOGY

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Abstract of a Dissertation  
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May 2008

## ABSTRACT

### THE RHETORICAL STRATEGIES OF PREGNANCY SUPPORT CENTERS INCLUDING THE VISUAL RHETORIC OF FETAL ULTRASOUND TECHNOLOGY

by

Raymond Kyle Jones

May 2008

This study examined the rhetorical strategies, including verbal and visual rhetoric, of pregnancy support centers that provide clients with fetal ultrasounds to persuade those who may be considering abortion as a means of resolving their unplanned pregnancy to carry to term. Qualitative data were gathered from 12 interviews of directors and ultrasound personnel from 7 states as well as from television advertisements and printed material. Eighteen research questions investigating the rhetorical transactions between centers and clients were answered. Rhetorical analyses were performed on the verbal and visual messages used in client interactions.

The grounded theory approach of inquiry resulted in the discovery of 10 major themes. First, centers offer holistic Christian ministry to clients. Second, centers provide professional health services. Third, a quest for uncertainty reduction and information brings clients to the centers. Fourth, centers maintain safe supportive environments. Fifth, personnel are trained to demonstrate sensitivity in sharing information. Sixth, staff exercise care in their deliberate choice of terms. Seventh, members recognize the importance of interpersonal communication in building relationships with and mentoring clients. Eighth, centers use persuasive arguments and artifacts. Ninth, ultrasound serves

to reify the pregnancy for clients. Tenth, empowering clients to make their own decisions is a center goal.

A rhetorical critique was performed using three approaches. First, the rhetorical functions communicated by the visual artifacts were explored. Second, the individual elements of the visuals were examined for persuasive potential. Third, the possibility that the visual of the ultrasound image fills the eye of the beholder with a single dominant meaning was considered. The conclusion is that the apparent persuasive success of the ultrasound can be partially explained by the client's recognition of baby schema characteristics present in the fetus, recognition of the fetal heartbeat, and recognition of the beating heart as a symbol of life. The persuasive potential of the fetal position and fetal movement were also discussed. The role of storytelling was examined. The possibility of client self-persuasion was also evaluated.

## DEDICATION

With humble gratitude for gifts and lives that have made this work possible, this dissertation is dedicated first to the glory of God and to the fame of Jesus Christ. Then this document is dedicated to those people whose choices, encouragement, sponsorship, and inspiration have facilitated the accomplishment of this goal.

This dissertation is dedicated to my birth mother who chose to give birth to me, to give life to me, and to place me for adoption. It is dedicated next to my adoptive parents, Wayne and Shirley Jones (as well as my step-mother, Leta), and sister, Connie, who received me as a gift and taught me the meaning of unconditional love. Moreover, this dissertation is dedicated to my African-American second grade teacher's aide, Miss Jefferson, who held me on her lap, helped me with my schoolwork, and inspired me saying, "You are going to be a doctor when you grow up." It is also dedicated to John Lulich, Jr., my friend and employer for more than twenty-years who constantly encouraged me and equipped me with many of the resources necessary to complete this work.

This dissertation is also dedicated to my precious wife, Lisa, who has patiently borne with my lifelong love for learning and my pursuit of higher education throughout the majority of our married years and our two sons, Jared and Jason, who have understood the necessary sacrifice of personal time for this to become a reality. Finally, this work is dedicated to the staff and volunteers of the pregnancy support centers throughout this country and around the world who provide unconditional love and support on a daily basis for women and their families facing unplanned pregnancies.

## ACKNOWLEDGMENTS

The contributions of numerous individuals made this work possible. The efforts of all are sincerely appreciated. The ones mentioned by name are only representative of the many anonymous ones who helped make my educational dreams come true.

I would like to offer special thanks to my mentor and friend, Dr. John Meyer, who graciously consented to serve as the dissertation director and who has the unique ability to offer meaningful constructive criticism and words of encouragement all at the same time. I especially appreciate the seeds of interest in visual rhetoric that Dr. Keith Erickson sowed in his rhetoric classes and the enriching rhetorical insights that Dr. Susan Mallon Ross offered. Moreover, I am grateful for the solid foundation of communication theory in general and persuasive theory in particular that Dr. Lawrence Hosman laid for me as student of persuasion. I also appreciate the constructive comments and positive feedback that Dr. Charles Tardy provided throughout my sojourn in the Department of Speech Communication where he is the chairman. A word of thanks is in order also for Mary Jo McKay who helped me with logistical details on numerous occasions.

Moreover, I would like to express my sincere gratitude to the anonymous national organization, the individual pregnancy support centers, the center directors, and the ultrasound examiners who graciously consented to work with me and help me gather the data for this rhetorical analysis. Without their cooperation, this project would not have been possible.

Finally, how very grateful I am for Lisa, my loving wife of more than 25 years, who unselfishly served as my proofreader, and for Jason, my son, who gladly served as my courier by transporting my books and papers between home and the university.



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## CHAPTER I

### INTRODUCTION

Since Aristotle, one primary focus of communication scholars has been persuasion (Aristotle, trans. 1954; O’Keefe, 2002; O’Keefe & Shepherd, 1989; Petty & Cacioppo, 1986). The process of persuasion entails many factors. Communicators will synthesize all they know to maximize their effectiveness in the given situation. For example, consider the public speaker. When addressing crowds, the speaker not only uses symbols and messages, but he or she also uses nonverbal behavior to communicate. Furthermore, the rhetor may also employ visual devices to supplement the verbal. The public speaker may be a politician seeking to influence a diverse crowd or a preacher seeking to persuade a congregation. The astute speaker, politician or preacher, will be keenly aware of the communication context and will analyze the audience. Moreover, the communication process may entail political, religious, legal, health, and other concerns. In daily life, communication is a complex phenomenon.

The social issue of abortion provides a context that pulls together multiple communication foci. Many communicators are involved with this issue, including presidents (Reagan, 1984). Health professionals, legal professionals, politicians, and religious leaders all weigh in on this matter. Moreover, ordinary people are also engaged in the debate surrounding this issue. Indeed, according to Hart (1997), “...the persuader is willing to treat the perceptions of *ordinary people* [emphasis in original] as the acid test of demonstratedness” (p. 9). Scientists are ordinarily concerned about such issues as empirical verifiability, expert judgments, and replication. By contrast, “...the persuader’s truth is often fifty-one percent truth: the majority judgment of ordinary citizens” (Hart,

1997, p. 9). Many of these ordinary people have been participants in the abortion controversy either as advocates for their position or as audience members for these advocates.

The pro-choice and pro-life advocates and movements have had several decades to develop and refine their respective rhetorical strategies since the *Roe v. Wade* decision that legalized abortions nationally. Numerous arguments for and against abortion have been set forth, but still the public remains deeply and firmly divided on the issue. Earlier in the evolution of these arguments, Condit (1984) concluded that they had only resulted in an apparent stalemate. However, in the years since Condit's conclusion, the pro-life community has begun using not only verbal but also visual argumentation in its debate with the pro-choice community. Is it possible that the widespread use of visual rhetoric might change the tide of public sentiment? Do visual pictures carry more power than verbal prose? Has this visually saturated contemporary culture become more responsive to ocular stimuli than aural? Olasky (2006), expressing his disappointment with some misleading NBC video footage and the anchorman's defense of it, opined that, "He and others knew very well that in a video medium evocative footage is worth more than a thousand words" (p. 48). Do pictures really possess more persuasive power than words? At least some in the pro-life community are convinced that visual rhetoric is extremely effective in changing minds regarding abortion.

An examination of the opposing pro-choice and pro-life movements' strategies is well beyond the purview of the project at hand. Even an examination of the pro-life community's rhetoric is beyond the scope of this paper as well. However, given the topic at hand, a brief overview of the pro-life strategies is in order.

Broadly speaking, pro-life activists have sought to effect change through political action, public opinion, and individual decision. First, on state and national levels, pro-life advocates have tried to have judges and legislators deemed sympathetic to the pro-life position appointed and elected. The goal here has been to change public policy and thereby reduce the number of abortions. This is basically a vertical top-down approach.

Second, the pro-life movement has sought not only to change public policy but also to change public opinion. Numerous rhetorical strategies have been used in attempts to reach this goal. The traditional verbal methods of public address, sermons, books and brochures have been put to use. The movement has even been successful at having state issued car tags containing a pro-life message such as “Choose Life” made available to the general public. However, the pro-life community has not only resorted to verbal but also visual rhetoric in efforts to change public opinion. Documentaries such as *The Silent Scream* (Mehaffy, 2000) have been aired in efforts to turn the tide of public sentiment against abortion on demand. This video combined verbal and visual rhetoric in an effort to change attitudes. While some have resorted to film as a medium for communicating, others have resorted to fields of white crosses. Abortion memorials have sprung up across the country. Typically, these fields of neatly arranged white crosses are presented with some sort of prominent sign identifying the site as a pro-life message. Other visual rhetorical artifacts that the pro-life community has employed include small scale-sized plastic fetus dolls and lapel pins that are replicas of a pair of fetal feet. These artifacts have been designed in apparent efforts to help the viewer identify the fetus as human and as possessing personhood. All of these efforts to change public opinion are basically lateral in nature. They are neither top-down nor bottom-up, but are instead horizontal

efforts. They are not top-down inasmuch as they are not designed by government officials in efforts to sway the masses, and they are not bottom-up inasmuch as they are not engineered by people on the grassroots level to influence officials. Rather, they are intended to influence the designers' peers in society. That is to say, these car tags, documentaries, memorials and so forth are not so much geared toward changing the minds of government leaders as toward changing the attitudes of the public at large.

Third, while the pro-life community has endeavored to affect public policy and public opinion regarding abortion, it has also sought to reach the individual(s) who are arguably most directly impacted by having or not having an abortion—the woman facing an unplanned or crisis pregnancy. This approach is geared toward changing an individual's mind—neither public policy nor public opinion. It is a bottom-up approach. The visual rhetorical strategies used in this situation are the focus of this study.

In the decades following the legalization of abortion, pro-life advocates have opened numerous crisis pregnancy or pregnancy resource centers. These centers are staffed by paid people and volunteers who seek to influence women facing unplanned pregnancies to carry the pregnancy to term rather than terminating the pregnancy. The interpersonal relationships, brochures, and pamphlets all seek to convey concern for the woman and her fetus. Many of these centers offer fetal ultrasounds to their clients in attempts to persuade the client of the humanity and personhood of the fetus. The pro-life community seems confident that women who are considering abortion are likely to change their mind if they see such an ultrasound.

Indeed, as demonstrated later in this paper, ultrasound images have become commonplace in popular American culture. Movies, advertisements, documentaries, and

experiences with pregnancies have familiarized the American public with fetal images. There are even entrepreneurs around the country who are retailing ultrasound videos and photographs of fetuses. Inasmuch as home videos and photo albums containing images of children are usually the pride and joy of families, these fetal photographs and videos are arguably ascribing to the unborn the same attributes of humanity and personhood as the children.

In summary, the pro-life community has developed numerous rhetorical strategies that include the use of visual rhetorical artifacts such as fetal dolls, lapel pins symbolizing fetal feet, abortion memorials, and ultrasound imagery. These instruments of visual rhetoric provide interesting artifacts for rhetorical criticism. However, there has been little scholarly examination of these visual rhetorical strategies. Although there has been qualitative research regarding rhetoric, as well as social scientific research regarding attitudes and persuasion, given the nature of the abortion issue there has been relatively little research regarding persuasion in the context of the abortion debate. This is especially true regarding research on the possibility of changing the attitude of someone who faces the decision of whether to abort when facing an unplanned pregnancy. Even more specifically, there is a need for an investigation as to whether and how images are persuasive.

The purpose of this section is first to review and critique selected representative research on rhetoric and persuasion, especially in the context of the abortion issue, with the goal of generating research questions. An outline of the need for further research based on the literature review and suggested research will follow. Finally, the proposed

method of data collection and analysis for the purpose of answering the generated research questions is set forth.



## CHAPTER II

### LITERATURE REVIEW

Historically, as far back as Aristotle, rhetoric has been defined as the discovery of all available means of persuasion (Foss, Foss, & Trapp, 2002). Primary rhetoric dealt with oral presentations, and secondary rhetoric with other forms such as art and architecture (Kennedy, 1999). “Rhetoricians have traditionally focused their attention on the power of the *word* as it is enacted in public contexts,” (Lucaites & Hariman, 2001, p. 37). Traditionally, rhetoric has been viewed as an art of discourse. “It is an art because its principles and teachings are directed to two general ends or functions: the making or producing of utterances and the understanding and appraising of them,” wrote Wallace (1971, p. 3). Although Wallace limited the scope of rhetoric to the speech and language that people use while endeavoring to communicate, others would broaden the range of rhetoric considerably.

#### Visual Rhetoric

One area of interest in contemporary rhetorical studies is visual rhetoric. Some rhetoricians today are shifting the focus from the word. The visual, rather than the verbal or textual, has become the subject of some contemporary rhetoricians’ concern. “Visual rhetoric refers to a large body of visual and material practices, from architecture to cartography and from interior design to public memorials (e.g. see Blair; Foss; Twigg; MacDonald; Mirzeoff; Stafford),” according to Lucaites and Hariman, (2001, p. 37). This expansion of the purview of rhetoric can be traced largely to a project of the Speech Communication Association—The National Developmental Project on Rhetoric.

*The National Developmental Project on Rhetoric*

The National Developmental Project on Rhetoric conducted two major meetings in 1970. The first meeting was known as the Wingspread Conference and the second meeting was known as the National Conference on Rhetoric. Growing out of the latter was The Report of the Committee on the Advancement and Refinement of Rhetorical Criticism. This report suggested a shift in the emphases of rhetorical criticism. Sloan, Gregg, Nilsen, Rein, Simons, Stelzner and Zacharias (1971) wrote in their report:

We shall no longer assume that the subject of rhetorical criticism is only discourse or that any critic studying discourse is *ipso facto* a rhetorical critic. The critic becomes rhetorical to the extent that he studies his subject in terms of its suasive potential or persuasive effect. So identified, rhetorical criticism may be applied to any human act, process, product, or artifact which, in the critic's view, may formulate, sustain, or modify attention, perceptions, attitudes, or behavior.

(p. 220)

Sloan et al. also indicated that attempts should be made to enlarge the range of rhetorical criticism to include the non-discursive as well the discursive and the non-verbal as well as the verbal. "Rhetorical criticism must broaden its scope to examine the full range of rhetorical transactions; that is, informal conversations, group settings, public settings, mass media messages, picketing, sloganeering, chanting, singing, marching, gesturing, ritual, institutional and cultural symbols, cross cultural transactions and so forth" (Sloan et al., 1971, p. 225).

The Report of the Committee on the Nature of Rhetorical Invention was another report that grew out of this convention. Scott, Andrews, Martin, McNally, Nelson, Osborn, Smith and Zyskind (1971) reported:

From his interactions with others, man finds that his ability to share symbols gives him the power to meet his rhetorical needs with rhetorical materials. Because of compelling social realities man's consciousness of his rhetorical environment is expanding. The technological revolution in media and in traditional forms of persuasion have [*sic*] significantly extended man's inventive needs and potentialities. These changes are critical to his ability to share and perceive symbols. (p. 228)

Other scholars echoed the call for expanding the realm of rhetorical criticism.

Turner (1998) wrote, "...I envision that rhetorical analysts will consistently examine visual as well as verbal dimensions of the rhetorical process" (p. 332). Noting that communication is saturated by visual messages, Turner observed that, "...rhetorical scholars cannot live by language alone" (p. 332). An analysis of the plethora of rhetorical forms constituting messages can yield important contributions to our body of knowledge (Turner, 1998).

The reports that came out of the National Project on Rhetoric, along with the scholarly work of others, suggested an expansion of the scope of rhetorical criticism and this suggestion has been slowly realized in the decades that followed the project as scholars grappled with new subject matter for and new methods of performing such criticism. Peterson (2001) wrote that recently, "...the balance of power has shifted between words and images," and that, "...the proliferation of visual stimuli in

communication environments calls for theories and critical work that demonstrate and explain how visuals persuade” (p. 20).

### *Visual Rhetorical Criticism*

As Hart (1997) pointed out, “because the study of visual persuasion is new, we do not yet have a standard way of discussing it” (p. 180). Although the traditional Aristotelian or neo-Aristotelian approach was popular and useful for analyzing such forms of communication as speeches, some alternative approach is needed for the analyses of visual forms. Some scholars have proposed new perspectives and suggested new rhetorical schemas for such analyses (Foss, 1994; Peterson, 2001).

While such disciplines as art history, psychology, and semiotics have made contributions to our understanding of visual imagery, these disciplines have not typically focused on the effects of such images on audiences (Foss, Foss, & Trapp, 1991). In the discipline of art, attribution is a primary focus. In the discipline of psychology, the process by which people acquire and process visual information is perhaps the primary concern. Even in the area of semiotics that deals with how signs generate meaning, the focus seems to stop short of addressing the issue of how the interpretation of the visual images becomes persuasive (Foss, Foss, & Trapp, 1991). This area is primarily the domain of the discipline of rhetorical criticism. Hence, as Foss, Foss, & Trapp (1991) observed, “The recognition that we live in a visual age has led some rhetorical scholars to the study of visual imagery from a rhetorical perspective” (p. 333).

Rhetorical scholars have used two basic approaches in their analyses of visual material. First, they have recognized that visual images are artifacts that can be used in elucidating, explaining and illustrating rhetorical constructs developed from the study of

discursive rhetoric (Foss, Foss, & Trapp, 1991). In such instances, these visual artifacts are presumed to have the same basic characteristics as discursive symbols. “A second approach to the study of visual imagery from a rhetorical perspective is the investigation of the rhetorical features of visual images themselves” (Foss, Foss, & Trapp, 1991, p. 334). With the recognition that visual images are rich with their own rhetorical features, scholars have suggested schemata for their analyses.

Foss (1994) offered one such rhetorical schema for the evaluation of visual imagery. Foss’s (1994) goal was explicitly stated. “My purpose is to apply a rhetorical perspective to the issue of evaluation of visual imagery in order to offer an alternative schema of evaluation to those developed in aesthetics” (Foss, 1994, p. 214). In the schema proposed by Foss (1994), the judgments regarding a visual image are made in terms of the image’s function. There are basically three processes entailed in reaching such judgments. First, the function communicated by the image is identified. Second, the degree to which the function of the image is communicated is assessed. Third, there is an evaluation of the legitimacy of the function itself.

Foss (1994) went to great lengths to distinguish the function of the visual from the purpose, noting:

I propose that judgments of quality about visual imagery be made in terms of the function of an image. I have chosen the term *function*, rather than *purpose*, because *purpose* involves an effect that is intended or desired, and I do not wish to suggest that the criterion for the judgment of an image is the intention of the image’s creator. The schema I propose is clearly in opposition to the intentionalist view, which suggests that a creator’s intentions are relevant to or

determine the correct interpretation of a work, a view based in the critic's "desire to meet the work on its own ground, to understand the artist's motivations before judging" the work (Sirridge, 1978, p. 40). A primary argument in support of the intentionalist view is that what "distinguishes art as human creation is precisely the presence of intentions, goals, or purposes to be achieved...Why define art as a product of human endeavor if we are not interested in what the human beings who created it were endeavoring to do" (Feagin, 1982, pp. 65-66)? (p. 215)

While rejection of the intentionalist view may prove acceptable when evaluating art from a purely aesthetic perspective, the position of this paper is that such a rejection of the intentionalist view potentially restricts Foss's (1994) schema from serving as a schema for rhetorical analysis. There is widespread debate among communication scholars regarding the concept of intentionality. As Foss, Foss, and Trapp (2002) pointed out, although rhetoric often involves the deliberate and conscious choice of symbols for communicative purposes, actions not consciously attended to by rhetors can be interpreted symbolically. They illustrated this by noting that if, on the one hand, the United States deployed an aircraft off the coast of a Central American nation to warn its government against a particular course of action, the United States has performed a rhetorical action. On the other hand, if a U.S. reconnaissance plane pilot accidentally strays over the air space of North Korea, the North Koreans could interpret the action symbolically even when the rhetor (pilot) intended nothing. Notwithstanding their illustrations, within context of intentional persuasion, Foss's (1994) schema seems ill suited for evaluating a visual rhetorical artifact.

Beyond the issue of intentionality, Peterson (2001) suggested Foss's schema has other limitations. "In particular, Foss's schema gives undue precedence to visual images, supports circularity, divorces function from aesthetics, and reflects modernist assumptions that may work against important critical projects" (Peterson, 2001, p. 21). For Peterson (2001), a consequence of focusing on the image, rather than starting with the elements of the image, may be that critiques of visual rhetoric may be more open to "accusations of interpretative license" and weak critical accountability than other qualitative methods of critical analysis" (p. 22). Furthermore, according to Peterson (2001), in Foss's schema, the images are not only determined but also evaluated by the critic, and this can tempt "self-fulfilling critical prophecy" (p. 22). Moreover, Peterson noted that, "Foss's schema severs rhetorical function too neatly from aesthetics" (p. 22). For Peterson (2001), there is an overlap between the two realms of rhetoric and aesthetics akin to that of poetics and rhetoric.

Peterson (2001) elaborated in greater detail Foss's schema within the context of modernist assumptions noting that Foss's approach is particularly useful for modern analysis since it maintains a clean distinction between function and aesthetics. According to Peterson (2001), modern analyses rely on the assumptions that visuals or images are organic wholes and that these images and/or their designers "...have more or less identifiable, real, and socially sharable purposes" (p. 23). However, not all visuals conform to such assumptions, and therefore, Foss's schema may not be so well suited for their analyses.

Peterson (2001) used the example of Superman to illustrate the alleged weakness in Foss's scheme. The person on the street may say, "It's a bird! ...It's a plane! ...It's

Superman!” Similarly, the critics may begin their analysis by trying to identify an image. Once the image is identified, the label assigned to the visual comes with its own baggage just like Superman. By definition, Superman is expected to leap tall buildings and stop runaway locomotives. Failure is not a possibility. Peterson (2001) noted:

Impenetrable and larger-than-life, Superman is pre-determined. His qualities of personal power expose the limitations of reading visual images rather than visual elements. By looking at Superman, we find Superman, and criticism becomes circular and flat. In the identification of visual images, whether they be “Superman” or “family picnic” or “Sunday drive” or “baseball player” or “woman,” we have already, at least partially, determined what it is that we have found, while we foreclose various other conceptual and critical possibilities. (p. 23)

Given the weaknesses that Peterson (2001) found with Foss’s schema, an alternative one for evaluating visual rhetoric was proposed. Basically, Peterson’s (2001) schema begins with the visual elements or building blocks that constitute the visual image. According to Peterson (2001), “Starting the critical process with visual elements and not larger complexes at least potentially expands and democratizes critical discussion” (p. 25). So shifting the starting point for critical analysis from the whole to the component parts would help alleviate the problem of circularity and would also facilitate taking advantage of existing and useful “vocabularies of the visual” (Peterson, 2001, p. 25). Such an approach, according to Peterson (2001), would enable “assessments of suasive potential” (p. 25).



Although Peterson's (2001) schema does make room for creativity and expand the scope of material available for critical analysis, this approach may potentially complicate, or even obfuscate, analyses of meaning. What was originally a single visual, rich with its own intrinsic meaning, is suddenly deconstructed into multiple components without any necessary coherency. In this sense, Peterson's (2001) schema is a postmodern approach, and as such, it rejects "...the totalizing idea of reason for the multiple reality of reasons (Lyotard, 1984)" (p. 26). Both Peterson's (2001) and Foss's (1994) approaches empower the critic to determine the function of the visual and disenfranchise the designer by diverting attention away from the intentions of the creator. Such a shift may lead to attributions not at all intended by the designer or rhetor. In such cases, where meaning is not shared between the producer and consumer of rhetoric, the presence of communication is debatable.

Hart (1997) explored this matter and raised several questions. "But how do pictures persuade? And why are some more powerful than others? Do visuals follow the same rules guiding verbal rhetoric? Does language inevitably 'frame' visuals, making them meaningless until captioned by an enterprising persuader?" (p. 188). The modernist painter, Picasso, did not think so. "I don't want there to be three or four thousand possibilities of interpreting my canvass...I want there to be only one," said Picasso (Worth, 1981, p. 172). Picasso elaborated:

Otherwise a painting is just an old grab bag for everyone to reach into and *pull out what he himself has put in* [emphasis in original]. I want my paintings to be able to defend themselves, to resist the invader, just as though there were razor blades on all the surfaces so no one could touch them without cutting his hands. A

painting isn't a market basket or a woman's handbag, full of combs, hairpins, lipstick, old love letters and keys to the garage. (Worth, 1981, p. 172)

Hart (1997) pointed out that Picasso's position was certainly debatable. There are certain pictures, although rare, that impose a single meaning on the viewer. However, most visuals, according to Hart (1997), are rich with multiple meanings. Hart (1997) illustrated by pointing out that a picture of a drought-stricken Biafran child could represent several things such as, "(1) the luck of the geographical draw, (2) the divine will of an inscrutable God, (3) the evils of agrarian communism, or (4) the moral bankruptcy of an uncaring West" (p. 189). Moreover, Hart (1997) pointed out, the same picture could be found in medical textbooks, anthropology textbooks, United Nations brochures on political realignment, and even in the hand of a dying Biafran father. Because of the potentially polysemous nature of visuals, critics must not only ask what the picture means but how the picture means.

However, in this process of inquiry, care must be taken not to overreach or over-complicate what began as a single visual, albeit one with multiple components. Indeed, graphic designers recognize the power of images to communicate themes. One graphic designer said that the easiest themes to portray with images are those with an "immediate association with something tangible. Whether cliché or not, most people have a visual to associate with those areas" (Willerton, 2005, p. 10). Moreover, "these insights have been borne out in the work of psychologist Allan Paivio, who has studied extensively the interactions of words and images" (Willerton, 2005, p. 10). "This emphasis on using tangible elements associated with a theme echoes the rhetorical tropes of synecdoche and metonymy," noted Willerton (2005, p. 10). According to Berger (2000), metonymy is a

term that deals with “communicating by association” (p. 41). People tend to make sense of things by associating them with other things about which more is known. Since Rolls Royce automobiles are expensive, people tend to associate them with wealth (Berger, 2000). Other examples of metonymy include using crown to stand for royalty, mitre to connote bishop, White House for a U.S. presidential administration, etc. (Willerton, 2005). According to Berger (2000), synecdoche is a subcategory of metonymy in which a part is used to stand for the whole. For example, the term, “brick-and-mortar,” may be used to describe traditional stores as over against electronic stores (Willerton, 2005).

Obviously, metonymy and synecdoche are very similar. Some rhetoricians, like the eighteenth century preacher George Campbell, have even questioned whether they should be distinguished (Willerton, 2005). Regardless of the classification system used, metonyms, like metaphors, are commonly used figures of speech, and are frequently found in poetry, literature, advertisements, and other genres in the media (Berger, 2000). The reason that visual metonyms are used is simple. “Metonymy is one of the most commonly used techniques used by advertisers because it builds on information that audiences already have and thus is very economical,” noted Berger (2000, p. 63). The simplicity and economy of the visual metonym make it an excellent choice for generating shared meaning. “Advertisers almost constantly use visual metonymy in attempts to get consumers to associate products and services with certain concepts,” wrote Willerton (2005, p. 12). To illustrate, Willerton (2005) noted that a visual thesaurus, used by graphic designers, contains several small images used to signify various themes. The thesaurus represented the theme, “lovable,” by means of a traditional heart shape, a candy box shaped like a heart, a silhouette of two people holding hands, and etc.

However, advertisements are not the only venue where visuals are used to represent thematic content. Teachers as well as marketing agents have recognized the power of visual images to communicate.

### *Pedagogy*

Michel (2001) argued, “Discussing visual rhetorics is equivalent to arguing for multiple rhetorics” (p. 180). Michel (2001) contended that it is time for a change:

A visual rhetoric operates in the classroom as an alternative to a rhetorical tradition that privileges writing over visual media. As our culture is becoming increasingly saturated by visual imagery through media such as movies, MTV, the Internet, and television, it seems only appropriate, therefore, that we as instructors engage students with textual forms that they mediate in their everyday lives. The objective here, however, is not to displace one form of rhetoric with another. It is to incorporate multiple rhetorics that more adequately represent the many ways legitimate knowledge is debated and institutionalized through invisible logics. (pp. 180-181)

The logic of this premise can be expanded. The basic argument that teachers should employ commonly used mediums in educating their students can be extended to say that rhetoricians should do likewise in persuading their audiences.

Other scholars interested in pedagogy have offered arguments similar to those of Michel (2001) and Kress (1999) who argued strongly regarding the role of visuals in pedagogy. “On the one hand, I suggest that the visual is becoming prominent in the landscape of public communication, and that this cannot be ignored by school-curricula. On the other hand, I suggest that our present theories of language and meaning are simply

inadequate and inappropriate for the task which English will need to perform,” says Kress (1999, p. 67). Kress (1999) not only contended that the visual is becoming more prominent, but also said that “...written language is being displaced from its hitherto unchallenged central position in the semiotic landscape, and that the visual is taking over many functions of written language” (p. 68). To demonstrate this point, Kress (1999) pointed out that there has been an increase in the amount of images and color and a decrease in text in many contemporary Western newspapers. “Where before there was the single, central mountain-range of written language, now another alpine system is being thrust up by forces of a complex kind: in part, social, political, technological, and, as yet less recognized, by economic forces as well” (Kress, 1999, p. 69). Salinas (2002) affirmed that, “...images are no longer subordinate to verbal texts in our communicative practices and in our larger cultural realm, but that images are integral to all forms of writing (broadly conceived), and primary to how we read and communicate, especially via Web writing” (p. 166). Kress (1999), however, did acknowledge that there are some tasks that are best accomplished by writing, and there are some that are best done by using images. Sometimes a combination of the two is most appropriate.

Perhaps one of the reasons that visuals are becoming more prominent is the advance in technology, especially Internet technology, that is image intensive. Salinas (2002) argued that our culture has an affinity for image intensive communication. Another potential reason for the prominence of visuals is their superiority in memory recall. Paintings and photographs are generally remembered better than their names. “The picture superiority effect in explicit memory is one of the most robust phenomena in psychology,” wrote Kinjo and Snodgrass (2000, p. 145). This picture superiority effect

in recall makes the use of visuals attractive to people seeking to move or persuade an audience.

Visuals have other salient features such as their relative ease of comprehension and capacity to elicit emotional responses that make them helpful as well. Visuals have the power to transcend language barriers. In a culture that is increasingly fragmented by different languages and cultures, visual rhetoric has a particularly strong appeal. “Visual arguments are useful for their ease of comprehension and their emotional impact on the viewer...,” wrote Shelley (1996, Introduction section). The trite adage that “a picture paints a thousand words” comes to mind here. Blair (1996) noted, “A single visual image can probably be more powerful than a single verbal assertion” (Introduction section). Moreover, regarding the emotional impact of visuals, Lucaites and Hariman (2001) affirmed, “From Plato to Neal Postman (Plato; Jay; Postman), Western philosophers and social critics alike have expressed a deep and abiding fear of the threat that visual practices pose to the public’s deliberative capacity for rational decision-making” (p. 38). Hariman and Lucaites (2002) also stated, “Like the art of rhetoric generally, visual media have been thought to be either irrelevant or dangerous with respect to democratic deliberation and the public use of reason” (p. 364). If, as these writers observed, visuals have been considered dangerous and threatening, then visuals must possess rhetorical power.

### *Social Movements*

Indeed, visual rhetoric, especially images of babies, children, and youth, who have been victimized by violent acts, are emotively powerful. The upcoming discussion will consider three cases of the use of visual rhetoric. Visual rhetoric played a prominent

role in the Civil Rights Movement of the 1960s, and visual rhetoric was a crucial part of the antiwar protests that accompanied the Vietnam conflict. Moreover, today, antiabortion activists are actively using visual rhetoric in their campaign to end abortion on demand in the United States. There are similarities and differences among these three cases. The similarities include the fact that the visuals discussed all involve youth, children, or babies. Another similarity is that they were all victims of violence. Regarding differences, one picture is of a boy, one of a girl, and the last group is of aborted babies. The boy died, the girl lived, and presumably, all of the babies perished.

First, consider the critical function that visual rhetoric performed in the Civil Rights Movement. One famous photograph played an especially vital role. The picture of the open casket containing the mutilated body of young Emmett Till (Cozzens, 1997; Hudson-Weems, 1998) figured prominently in mobilizing activists for social reform. Emmett Till was a fourteen-year old African-American boy who lived in Chicago. He visited his relatives in Money, Mississippi, in 1955. While visiting, Emmett entered a store, bought some candy, and left. As he was leaving, he said “Bye Baby” to Carolyn Bryant, the wife of the store’s owner. A few days later, two white men called on the cabin where Emmett was staying. The men took Emmett. Three days later, his body was found in the Tallahatchie River. The corpse was hardly recognizable. Mose Wright, Emmett’s uncle, could identify the body only by the initialed ring Emmett was wearing. One eye had been gouged out, and the head had been crushed. There was also a bullet in the head. Mamie Bradley, Emmett’s mother, requested that the body be shipped back to Chicago. After inspecting the body to confirm it was her son’s, she insisted on an open casket service so that “all the world [could] see what they did to my son” (Cozzens, ¶ 17).

Over the course of four days, several thousand people saw the body of Emmett. More importantly, however, others who may never have heard of the case saw pictures of the body that appeared in *Jet* magazine. Emmett came to be known as the “Sacrificial Lamb” and one of the major catalysts of the Civil Rights Movement (Hudson-Weems, 1998, p. 179).

Secondly, consider the Vietnam conflict that also provided powerful examples of visual rhetoric. Images of large numbers of flag draped caskets returning from the war zone and disfigured soldiers returning home came to represent the Vietnam era. Mitchell (1994) wrote, “Vietnam was, above all, represented as a war about the human body” (p. 401). From among all of the photographs of that period, however, emerges one very prominent one—the picture of a naked young Vietnamese girl with her flesh aflame from napalm (Belz, 2003; Lucaites & Hariman, 2001; Mitchell, 1994). The photograph quickly became influential visual rhetoric in the antiwar movement. According to Belz (2003), this picture was as influential “...as any other single factor in turning American public opinion against the war in southeast Asia” (p. 3). Hariman and Lucaites (2003) identified the picture of the burned and fleeing Vietnamese girl as an iconic photograph. Writing about such iconic photographs, Hariman and Lucaites (2003) observed, “They are believed to provide definitive representations of political crises and to motivate public action on behalf of democratic values” (p. 38). The photograph of the Vietnamese girl activated the public conscience because it embodied, among other things, pain, betrayal, and trauma.

Thirdly, consider the more recent rhetoric of Gregg Cunningham, head of the Center for Bio-ethical Reform, who has taken to the road with pictures of his own. The



Center for Bio-ethical Reform (CBR) is an activist organization opposed to abortion (Belz, 2003; Cunningham, 2001a). Mr. Cunningham displays grisly billboard-size pictures of aborted babies on the sides of large trucks and drives the trucks on the freeway system of Los Angeles and next to high schools in his area. He also tows flying billboards behind planes over crowded beaches (Belz, 2003). Moreover, he has developed a billboard display that he carries to university campuses around the country, and this is known as the Genocide Awareness Project (Belz, 2003; Cunningham, 2001b). Cunningham (2001b) wrote, "We know that the images we display are not pleasant. They represent injustice of such magnitude that words alone cannot adequately convey their evil" (The Genocide Awareness Project section). Belz (2003) countered, however, that the grisly pictures "...do little to make me think of human life. They remind me more of common roadkill" (p. 3). Regarding the effects of some of the more grisly rhetorical artifacts of the abortion controversy, Railsback (1984) commented on the sentiment of Americans saying, "They feel that they have heard all the arguments, have seen all the ghastly pictures, and have been offered no happy answers" (p. 410). Notwithstanding the potential of certain pictures, visuals are potentially influential.

According to Blair (1996), one factor that makes visual messages so influential is not any argumentative function they may perform. Instead, visual messages can be very influential because of the unconscious identifications they invoke in the viewer. In the case of the African-American youth, viewers of the same race may be made to think, "Oh my! That could have been me! That could have been my child!" Similarly, immigrants might have the same thoughts invoked in them upon viewing the picture of the Vietnamese girl. For a generation that has come of age after the *Roe v. Wade* decision

that legalized abortion, viewers of the pictures of aborted babies may also think, “That could have been me.” This could be called a feeling of vulnerability. Lucaites and Hariman (2001) discussed the power of visuals to invoke feelings of vulnerability. They also discussed the feelings of obligation that such pictures can produce in the viewer.

Lucaites and Hariman (2001) affirmed in their discussion of iconic photographs that an “individuated aggregate is a trope whereby the population as a whole is represented solely by specific individuals” (p. 38). The audience may sense its obligation to respond to the plight of the person(s) pictured. Such actions can evoke pity and persuade one to act. Lucaites and Hariman (2001) say that such pictures can “...illustrate how people must be portrayed to be deemed worthy of redemption from practices of destruction accompanying the social order” (p. 41). The African-American represented all African-Americans who were worthy of redemption from the destruction that was occurring. The Vietnamese girl represented the Vietnamese people who were worthy of redemption from the destruction they were experiencing then. The aborted babies represent the unborn people who are worthy of redemption from the destruction of abortion.

In the case of the boy and the girl, the individual singularly represented the locus of value. However, according to Lucaites and Hariman (2001), the locus of power is found in the collective of society. Visual rhetoric becomes the tool for activating that collective power through changing public opinion. The ability of visual rhetoric to activate this collective power makes such visuals a vital part of social movements. This power, possessed by visual rhetoric, is likely to increase as popular culture becomes more

and more visually oriented. The visual then is an efficacious tool not only for the pedagogue but also for the persuader.

Hariman and Lucaites (2003) observed that a salient feature of the photograph of the Vietnamese girl is her nudity. The girl's nakedness seems to take on new significance. Even hardened soldiers are averse to killing someone who is out of uniform. Her nakedness conveys vulnerability that seems to cry out for assistance. Her lack of clothing, not to mention her injuries, puts the observer in "an elemental moral situation" according to Hariman and Lucaites (2003). Obligation is foisted upon the observer.

Besides being victims of violence, the characters featured in these three cases share another feature. They are all young. Could the age of the subjects in the photographs impact the power of the visual rhetoric? Research indicates that possibility. Zebrowitz (1998) has researched the responses of people to babies and reported on findings from different countries. This researcher noted that behavior exhibited toward babies is noticeably different than that shown toward adults. The researcher noticed this phenomenon while traveling in China. People smiled at a couple with a baby and also stared shamelessly even though such behavior was a violation of cultural rules. A study in Germany also revealed that people who passed by a mother and her baby were much more likely to smile than they were to smile at the mother only. Some cultures, like the Masai of Africa and the Aboriginals of Australia, take advantage of this to hold aggressors at bay. Geriatric patients have ceased belligerent behavior and become quiet when told they would wake the baby dolls. Moreover, people of all ages tend to respond more favorably to infants.

Zebrowitz (1998) offered some explanation for why people respond so favorably to babies by discussing key stimuli that may elicit favorable responses. These include: skin color, hair color, body size, and head shape. Cartoonists have capitalized on this tendency of people to respond favorably to features that are characteristically babyish. Zebrowitz (1998) provided a figure that illustrates the redesign of Mickey Mouse over a period of time and calls it “The neotenization of Mickey Mouse” (p. 79). The evolution of Mickey included changes in the relative size of Mickey’s head and eyes, and his limbs became shorter and chubbier in relation to the rest of his body. This was done by Disney to gain Mickey a wider acceptance. Blair (1996) also pointed out that photographs of young animals such as puppies and kittens and pictures of children evoke tenderheartedness. Considerable research has focused on neural responses caused by viewing faces. For example, viewing a photograph of one’s own child versus that of another familiar child activates regions of the brain that mediate emotional responses. Moreover, these activations may indicate the strong attachment, protectiveness, and empathy that are characteristic of normal maternal attachment (Leibenluft, Gobbin, Harrison, & Haxby, 2004). So could it be that the youthful characteristics of Emmett Till and the Vietnamese girl helped to make the photographs more powerful than similar photograph of adults would have?

Regarding the pictures of aborted babies, as already noted, Belz (2003) stated that the pictures reminded him more of “roadkill” than humanity. Could the bloody and dismembered babies fail to evoke as much pity as the picture of the fleeing Vietnamese girl because they lack coherence or completeness? Belz (2003) contended, “Real emotional involvement comes not with an overly explicit portrayal of death-but with a

nuanced portrayal instead of the delicate balance between death and life” (p. 3). He says regarding the burned Vietnamese girl, “When the photographer snapped that picture, there were almost certainly plenty of dead bodies lying around. But what memorably captured the hearts of onlookers around the world was the reality of a young woman teetering between life and death. And that subtlety changed the course of a war” (p. 3). This explanation would account for the efficacy of the girl’s photograph, but not the boy’s.

The emotional component of the girl’s picture is noteworthy. Hariman and Lucaites (2002) defined iconic photographs as “photographic images produced in print, electronic, or digital media that are widely recognized, are understood to be representations of historically significant events, activate strong emotional response, and are reproduced across a range of media, genres, or topics” (p. 366). In addition to citing the picture of the Vietnamese girl, they also included the picture taken during the Great Depression of the migrant mother with her children and the picture of John-John Kennedy saluting the passing caisson of his deceased father. They referred to such iconic photographs as performances. “Performances traffic in bodies, and they call forth emotional responses precisely because they place the expressive body in a public space...The photograph’s focus on bodily expression not only displays emotions but also places the viewer in an affective relationship with the people in the picture” wrote Hariman and Lucaites (2002, p. 367).

Thus far, the potential of rhetoric to influence people has been discussed in terms of identification, recognition of babyish or youthful features, and emotion. Another issue should be addressed. The efficacy of visual images can be enhanced and the message

made more salient by how the images are arranged with relation to each other. Shelley (1996) discussed the “March of Progress.” This visual rhetoric depicted the theoretical evolution of man from other life forms. The picture shows man evolving from left to right with modern man on the far right as the finished work. Each figure, from left to right, has better posture and a larger brain. Each one is looking straight ahead except modern man who is looking slightly to one side. This picture argues for the theory of the evolution of man. Others have also employed this visual rhetorical approach. The traveling exhibit of Cunningham (2001a) juxtaposes three photographs on one of the displays. The first frame includes holocaust victims whose emaciated dead bodies are portrayed with a swastika and the Star of David in the upper right hand corner. The second frame includes a photograph of a dead African-American hanging by a rope from a tree. The third frame includes the arms and hands of a ten-week old baby (first trimester) that have been severed from the body and are now touching a dime to provide a reference for sizing purposes. The positioning of these pictures makes a powerful rhetorical argument. The visual presentation argues that aborted babies are victims of violence in the same way that Jews were victims of the holocaust and African-Americans were victims of racial violence. Cunningham’s exhibit also adds text to the display. Therefore, it ceases to be a purely visual rhetoric. Instead, it becomes a hybrid of visual and verbal/textual. The added text does seem to add weight to the argument. Across the top of the exhibit in bold uppercase letters is the phrase “THE CHANGING FACE OF CHOICE” (Cunningham, 2001b, Why Abortion is Genocide section). The holocaust frame has “RELIGIOUS CHOICE” beneath it. The hanged African-American has “RACIAL CHOICE” under it. The frame with the dismembered baby’s arms has

“REPRODUCTIVE CHOICE” beneath it along with “First Trimester (10 Weeks)” above it.

The inclusion of text, along with the visual image, can serve to clarify the premises and the conclusions. Blair (1996) observed that pure visuals could fail to clearly depict these. On the one hand, by using hybrid combinations of visual and textual symbols, the argument could be made more poignant. On the other hand, however, to almost anyone looking at the three frames, the argument is clear even without the inclusion of text. That the Jew, the African-American, and the aborted fetus (in the minds of pro-life advocates) are all humans who have suffered violently and wrongfully is the conclusion that observers would reach. The context of the latter half of the twentieth century and the early part of the twenty-first century enable the observer to reach such a conclusion without any further textual embellishment.

#### Fetal Ultrasound and Cyborg Technology

Not all of the visual rhetoric of the pro-life movement has been ghastly. The pro-life community has used other forms of visual rhetoric that are less grisly and perhaps more effective in the campaign to reduce or end abortion. One type of visual rhetoric has emerged as a favorite device for pro-life advocates seeking to persuade abortion-minded women facing unplanned or crisis pregnancies not to abort their fetuses—fetal ultrasound images. Computers used in the process generate two-, three-, or four-dimensional representations of the fetus on screens where the technicians and the parent(s) can see them. Inasmuch as these representations are a combination of computer and human, some have called them cyborgs. Indeed, several authors have discussed the rhetorical nature of fetal ultrasound technology and the implications of such technology for women’s rights

issues by means of the term cyborg (Mehaffy, 2000; Mitchell & Georges, 1998). These cyborgs are among the latest of human-computer hybrids to appear on the technological landscape.

The love affair between humans and machines has evolved for centuries. As the amount of knowledge generated in the cold war era and space age increased exponentially, so did humans' affinity for technological innovations. There has been a growing cultural fascination with the interplay between people and their gadgets. Hollywood has fueled this fascination. Television programs such as "The Six Million Dollar Man" and "The Bionic Woman" featured main characters who were hybrid combinations of machines and people. Box office hits such as "Star Wars" featured a villain turned hero, Darth Vader, whose existence depended on the machine components of his person. His son, Luke Skywalker, followed suit when his natural hand was replaced with an artificial one that was a machine. Numerous other human-machine hybrid characters have captured the fascination of our popular culture. People have grown accustomed to seeing these human-machine characters on screen, and seemingly have no reluctance acknowledging them as fully human.

These characters are known as cyborgs. "Cyborgs are symbiotic fusions of organic life and technological systems" (Dumit & Davis-Floyd, 1998, p. 1). The term cyborg is derived from the word cybernetics that Webster defines as "the science of communication and control theory that is concerned esp. with the comparative study of automatic control systems (as the nervous system and brain and mechanical-electrical communication systems)" (Webster's, 1980, p. 280). Dumit and Davis-Floyd said, "We are immersed in cyborgs; they saturate our language, our media, our technology, and our



ways of being, posing questions we cannot answer about the exact location of the fine line between ‘mutilating’ a natural process in a negative and destructive way and ‘improving’ or ‘enhancing’ it” (p. 1).

The impact of cybernetics has extended into areas such as sexual reproduction, childbirth, and childrearing. Although there are several ways that fetuses can be converted into cyborgs through technology, ultrasound is the most common. Mitchell and Georges (1998) said:

Like all cyborgs, the cyborg fetus arises through the coupling of human and machine. As part of the “mechanics” of this coupling, a transducer is pressed onto and rolled over the woman’s belly. If the ultrasound is done during the first twelve weeks of pregnancy, the transducer, phallic-shaped and sheathed with a condom, may be inserted into her vagina. Guided by the sonographer’s hand, high-energy sound waves are projected from the transducer into her womb, and the reflection of these waves produced an image of the uterus, placenta and moving fetus on a television-like screen. (p. 107)

Moreover, Mehaffy (2000) observed, “Sonographic fetuses qualify as virtual bodies since their production results not from processes involving a photographic or cinematic lens, but instead from the visual displacement of sound waves onto a screen” (p. 180).

Mehaffy further explained, “A ‘cybernetic organism’ (Haraway), the sonographic fetus straddles the conventional boundary between an organic body and a digital text. It is in Haraway’s terms, a ‘hybrid,’ occupying the space of virtuality” (p. 181). These cyborg fetuses, cybernetic organisms, and virtual bodies are the products of modern military and medical technology, and they are at the center of great controversy.

Ultrasound technology began to evolve during World War II. Sound Navigation and Ranging, also known as sonar, was used to detect objects by means of sound waves sent out and reflected back. The British used this technology to seek out German U-boats (Popp & Thomsen, 1978). The medical community later began to apply this technology in the 1950's at the University of Colorado. Dr. Ian Donald and others at the University of Glasgow also studied abdominal masses by means of pulsed ultrasound. Obstetric ultrasound, introduced in the late 1950's, has historically served a number of diagnostic purposes such as confirmation of early pregnancy, vaginal bleeding in early pregnancy, gestational age and assessment of fetal size, fetal malformation, multiple pregnancies and so forth (Woo, 2006).

The medical community is divided over the use of fetal ultrasound. In 1984, the National Institutes of Health (NIH) formulated a consensus statement regarding the indications for, the limitations on, and the use of ultrasound in obstetrics. The consensus statement read in part, "...it is the consensus of the panel that ultrasound examination in pregnancy should be performed for a specific medical indication..." (Sauerbrei, Nguyen, & Nolan, 1987, p. 1). Over the years, however, as ultrasound technology became more commonly used, pregnant women in the United States have begun wanting ultrasounds performed even when they may not help their health providers. "Between 60% and 70% of pregnant women in the United States will have a sonogram at some point during pregnancy, at a cost of more than \$1 billion to the health care system," wrote Stephens, Montefalcon, and Lane (2000, p. 601). Apparently, some women not only want it, but they also demand it. They are willing to personally pay more than \$700 for it (Stephens, Montefalcon, & Lane, 2000).

There are many reasons that pregnant women want ultrasounds. Morgan (2000) pointed out that the experience of pregnancy and childbirth is frequently steeped in uncertainty regarding the date of the baby's arrival, the baby's health, and the baby's appearance. "Prenatal surveillance techniques attempt to allay uncertainty by providing additional information to prospective parents prior to birth (Morgan, p. 358). The research of Stephens, Montefalcon, and Lane (2000) reinforced the idea that pregnant women and their partners utilize ultrasound to reduce uncertainty. Their research revealed that 33% of the participants in their study wanted ultrasound to determine the sex of the fetus, 27% to determine the health of the fetus, 9% to determine the growth of the fetus, 9% for reassurance, and 8% to rule out abnormalities.

Ultrasound then has the potential of reducing uncertainty aroused by pregnancy. The unknowns (fetal sex, health, size and abnormality) mentioned above are only some of the concerns. A woman facing an unplanned or crisis pregnancy may be uncertain as to the humanity or personhood of the fetus since there is widespread debate regarding these issues. The unknowns surrounding pregnancy sometimes create a situation of uncertainty. Moreover, as Hodson and Sorrentino (2003) observed, "under certain conditions of uncertainty, people have the opportunity to learn new information about the self and the environment or to be confused or perplexed" (p. 294). Whatever the root causes of uncertainty may be, a certain level of discomfort is likely to arise. "Feelings of uncertainty produce a state of emotional or cognitive arousal (a desire to achieve certainty) in many but not all cases," observed Heath and Bryant (2000, p. 154). Individuals do not always want to know bad news that brings negative consequences. However, according to Berger and Calabrese (1975), uncertainty tends to information

seeking behavior. So, as the research of Stephens, Montefalcon, and Lane (2000) suggested, pregnant women use ultrasound to resolve uncertainty. Moreover, Heath and Bryant (2000) have argued that the processes of uncertainty reduction and attitude formation are similar. Heath and Bryant (2000) said:

As is demonstrated herein, people work to form useful attitudes that can lead them to make rewarding decisions and avoid unrewarding ones. In that regard, they want to reduce their uncertainty about which attitudes are most likely to result in favorable choices. If that is true, then we can argue that the processes of forming attitudes are parallel to and supportive of those devoted to obtaining information to reduce uncertainty. (p. 174)

Therefore, as women seek information to reduce uncertainty over their pregnancies, their existing attitudes toward their pregnancies may be either reinforced or reshaped. This suggests that ultrasound may serve as a persuasive tool.

Of course, the ultrasounds that women want do not transpire in a vacuum. Most women do not administer an ultrasound to themselves. Various professionals ranging from physicians to photographers are in the business of administering ultrasound. The procedure once recommended by the NIH only for certain health indications is now being performed for the purpose of providing the family with movies or pictures of the child in the womb before it is even born.

Enterprising entrepreneurs have begun offering such services to pregnant women. For example, one organization's web site boasts being home to the state of Washington's first 3-dimensional and 4-dimensional ultrasound imaging services (Baby Pictures). The company's website explains that the founder wanted to offer a venue where families

could be brought into the ultrasound room with the pregnant women. The founder also wanted to provide families more opportunities to view their baby via ultrasound than most insurance companies were willing to fund. The site promotes a 3-dimensional/4-dimensional ultrasound package that sells for \$185.00 and includes the following: “a VHS video tape, an assortment of black & white still photographs, a CD containing numerous color images, and sex determination” (Baby Pictures).

Fetal picture taking has served to integrate ultrasonography into the familiar language of images. Petchesky (1987) wrote the following:

Women’s responses to fetal picture taking may have another side [as over against the predictability of a “quality” baby] as well, rooted in their traditional role in the production of family photographs. If photographs accommodate “aesthetic consumerism,” becoming instruments of appropriation and possession, this is nowhere truer than within family life—particularly middle-class family life. Family albums originated to chronicle the continuity of Victorian bourgeois kin networks. The advent of home movies in the 1940s and 1950s paralleled the move to suburbs and backyard barbecues. Similarly, the presentation of a sonogram photo to the dying grandfather, even before his grandchild’s birth, is a 1980s way of affirming patriarchal lineage. In other words, far from the intrusion of an alien, and alienating, technology, it may be that ultrasonography is becoming enmeshed in a familiar language of “private” images. (p. 283)

Indeed, in a speech on the floor of the U.S. Senate opposing the nomination of Dr. Joycelyn Elders as Surgeon General of the United States, Senator John McCain pointed out that the nominee had, “... called on those who oppose abortion to ‘end their love

affair with the fetus” (McCain, 1993). From the perspective of the Surgeon General nominee, the public, at least the pro-life public, had a “love affair with the fetus.” The public presence of fetal ultrasound images, whether generated by physicians, crisis pregnancy centers, or enterprising entrepreneurs, is acquainting and/or familiarizing the public with the appearance of fetuses.

Regardless of whether the ultrasound is performed for medical indications or for entrepreneurial purposes, the person performing the procedure is in a position of rhetorical power. The ultrasound images are rhetorical artifacts. Moreover, these artifacts are likely to appear in the public square more and more as the number of nonprofit and for-profit organizations that work with fetal imagery increases.

#### *Rhetorical Power*

“Because it borders on so many worlds, the realm of rhetoric is powerful,” wrote Hart (1997, 11). Technology is also a powerful force for shaping culture. Reproductive technology, especially fetal ultrasound technology, is located at the center of great controversy as the social debate surrounding abortion rages. The pro-choice and the pro-life movements recognize the rhetorical power of fetal ultrasound. Commercial interests and Hollywood do also. Legislators have even come to realize the potential of such technology to shape society. For example, a bill was introduced in the Mississippi legislature that would have required a woman seeking an abortion be offered a chance to view a sonogram of her fetus (Campo-Flores, 2006).

Lay, Gurak, Gravon, and Myntti (2000) noted that physicians involved in providing care to women during pregnancy and childbirth enjoy “linguistic capital” (p. 10). “Therefore, childbirth, as Treichler proposes, is not a simple label for a real event

but instead is rhetorically determined; the word *childbirth* ‘inscribes’ the event, ‘makes the event intelligible to us,’ and influences public policy (132)” (Lay, et al., p. 10). Indeed, the entire process of pregnancy and childbirth, thanks to the tool of ultrasound, provides opportunity for caregivers to engage in the rhetorical construction of reality. The cyborg fetuses are particularly available to the rhetor who wishes to use them for various reasons. Dumit and Davis-Floyd (1998) observed, “Like the toys labeled “transformers,” cyborg babies are malleable, fluid, available for socialization into the latest technomania” (p. 9). These toy transformers are hand held figures that children can reshape into multiple configurations depending on their whims. They typically can be made to appear to be more or less human and/or more or less machine. Similarly, ultrasound images in the hands of social constructionists have been made to appear less than human on the one hand and human on the other. The visuals can be reconstructed verbally. Worrying over the power of rhetors to reshape or redefine the fetus for causes not necessarily concerned with the mother’s rights, Mehaffy (2000) opined,

However, despite the promise of these reconfigured bodies, modes of reproduction, and accompanying relocated spectator positions, their transformative potential reaches its limit in recent popular media representations of virtual fetuses. It is not that Haraway is wrong when she argues that the cyborg extends and complicates the spatial map of the body. Rather, she’s too right: The (post)mechanical body of, especially, the virtual fetus, is highly vulnerable to verbal overwriting, according to its author’s design; the same technologies, that is, which empower an invisible fetus (may) also limit and recontain the authority and agency of the female body empowered in other cyberspaces. (p. 190)

The ultrasound visual images of the unborn can be shaped rhetorically by verbal symbols. Mehaffy also commented, “As T. Hugh Crawford’s analysis of recent Digisonics brochure ads suggest, the performative immediacy of biomedical sonography insists on the viewer’s acknowledgement of the human body as a constructed, and interpreted, text” (p. 181).

In an analysis of a video titled, “Ultrasound: A Window to the Womb,” Boucher (2004, p. 8) argued that the traditional fetal ultrasound images appearing on the video “...do not ‘speak’ their meaning of their own accord.” Instead, the narrator’s explanations are necessary in order to help the viewing audience understand the images being shown. Boucher (2004) argued:

The shifting, blurry, and shadowy images of ultrasound cannot bear the burden of proof of the ontological status of the embryo or fetus. Moreover, when the video is examined closely, it becomes evident that it is a complex combination of ultrasound images, photographic images, verbal argument, written text, and emotional appeal which are mobilized to “prove” that life begins at conception. In other words, the “window” of ultrasound is constructed through multiple layers of explanation, using these various elements of visual image and verbal argument, *not* the imaging technology itself. (p. 8)

Boucher’s (2004) view is that the images cannot speak for themselves but must be accompanied by further rhetoric.

The research of Georges and Mitchell (2000) further underscored how pregnancy and childbirth are subject to rhetorical construction. Their work focused on reading material or pregnancy guides available to pregnant women in Canada (North America)



and in Greece. The two North American guides are *Nine Months for Life* and *What to Expect When You're Expecting*. The *Nine Months* publication emphasized fetal subjectivity and individuality through images, but the *What to Expect* guide emphasized maternal responsibility. Both rhetorically construct pregnancy. These constructions are shaped by culture. "For example, each image is greatly magnified so that from the first month, the fetus of potentially ambiguous personhood appears to be the size of a five- or six-month fetus, presumably of uncontested personhood," wrote Georges and Mitchell (2000, p. 187). The photographs prominently display elements of personhood and individuality such as fetal faces, hands, feet, and genitals. Some of the images seem to show the fetus engaged in sucking its thumb. According to Georges and Mitchell, the rhetorical strategy here is to depict the fetus as a distinct individual. Not only do the images support the individuality of the fetus, but the language of the guide does also. "In short, word choice and visual practice simultaneously construct a powerful message for pregnant women: what lies inside their wombs is not a mass of undifferentiated tissue or a fetus of incipient personhood but an appealing, sentient, and vulnerable baby" (Georges & Mitchell, p. 189).

*Birth is Love* is the Grecian guide that Georges and Mitchell (2000) examined. This book appears similar to the North American guides at first glance. However, this guide does not highlight fetal subjectivity. The terms, fetus and baby, are both used, but fetus is used far more frequently. Moreover, wrote Georges and Mitchell (2000), "The accompanying captions either negate, or simply do not highlight, the personhood and humanness of the fetus" (p. 197). Rather, the focus is on physiological development.

In both North America and Greece, pregnant women are encouraged to substitute their own interpretations of their pregnancies with those of the experts. Such rhetoric could be construed as empowering the physician while simultaneously disenfranchising the pregnant woman. There are other agents involved in this rhetorical drama besides the doctor and the mother. Besides the extended family, there is at least the father and the fetus. What about the empowerment or disenfranchisement of them?

Technology is seldom neutral. Reproductive technology is no exception. The advances in reproductive technology raise multiple questions about rights, power, access, and knowledge. Lay, Gurak, Gravon, and Myntti (2000) remarked:

Societies must ask who has access to reproductive technologies, how women and their physicians can use these technologies to promote health and human values, what potential for abuse these technologies bring, and how these technologies affect knowledge production and the distribution of power. (p. 12)

The following discussion will examine the way that two different groups, the feminists and the pro-lifers, view the fetal ultrasound technology. The reader should be aware that these two groups are not totally distinct.

The term feminist has been variously defined. Some would say that an individual believing in equal work for equal pay is a feminist and others would say that anyone supporting suffrage for women is a feminist. Not all feminists are pro-choice or supporters of abortion. There are people who identify themselves as pro-life feminists.

In the context of this paper's discussion, the term feminist will be used generally to identify those who are concerned that women's rights not be usurped by others. This seems to be the gist of the concerns of those, or at least one of them, cited in this

discussion. Saetnam (2000) cited three experts in discussing women's narratives of pregnancy, ultrasound and self. Saetnam (2000) reported, "According to a feminist general practitioner, routine ultrasound is an imposition on women, usurping their own self-knowledge and subjugating them to unnecessary medical control" (p. 331). The feminist general practitioner expert is then quoted by Saetnam (2000):

*Expert 2:* This brings us back to the question of informed consent, and also to the issues that concern me from the feminist research perspective—things like: Do we empower women to take charge and trust their own resources? Are they to feel the baby kick inside them and experience that as something positive in itself? Or do we teach them that it isn't relevant, that they have to see it on a screen for it to be real? (p. 332)

Therefore, the term feminist will be used in a general sense to designate those who are concerned that others not usurp the woman's prerogatives with regard to her pregnancy.

So the upcoming discussion will focus first on the feminists' concerns over the rhetorical power of ultrasound technology and secondly on the pro-life movement's utilization of this modern cybernetic rhetoric.

### *Feminist Concerns Regarding Ultrasound Technology*

As with most social movements or people groups, there is not a singular voice in the feminist community on this subject. Some say that ultrasound technology empowers women to make better and more informed decisions, but others lament that such technology imposes on women and subjugates them unnecessarily to medical control (Saetnam, 2000). While there is no unified voice on the matter, there are issues of common concern. These include the marginalization of the pregnant woman, the

competition between the woman and her professional health provider, the participation of the woman's partner in the pregnancy experience, and the commodification of the fetus.

*Marginalization of the Pregnant Woman*

There is anecdotal testimony that after the birth of a child, the child becomes the focus of everyone's attention while the mother recovers from the experience in relative solitude. According to some feminist writers, the reproductive literature and technology may have a similar effect even before the birth of the child occurs. Georges and Mitchell (2000), writing about the *Nine Months for Life* pregnancy guide widely used in Canada, indicated that the book does not include a single image of a woman. Nilsson, the photographer whose images are used, totally erases the women's bodies from the images he creates. The fetuses appear against an opaque and dark background. The other guide, *What to Expect When You're Expecting*, does not really erase the woman. Instead, the woman is diminished to a fetal environment or a transparent fetal container. Georges and Mitchell (2000) said:

In this guide, descriptions of each month of pregnancy begin with a drawing of a headless, armless woman, her breast bared and her transparent torso containing only vagina, rectum, bladder, uterus, and fetus. The caption reads, "What You May Look Like." (p. 189)

With such rhetorical treatment of the woman's body, there is little wonder that a feminist critic would worry about being marginalized by reproductive rhetoric. To the critic, the headless body connotes images of mindlessness and irrationality on the part of the pregnant woman. Forasmuch as hands and arms are instruments of power and action, the armless torso speaks of a lack of power or disenfranchisement. The bared breasts betray

a sense of vulnerability. The transparent torso suggests that her privacy has been violated and that her secret space has been penetrated.

According to the feminist perspective, such a rhetorical construction, or rather deconstruction, of the pregnant person is what Dumit and Davis-Floyd (1998), citing Reynolds, called the “One-Two Punch of Technocracy” (p. 9). The first step is to render a natural process ineffective through technology, and the second step is to replace the natural process with another technological process. For example, salmon spawning could be interrupted by the construction of a dam. This would be the first punch. Then to solve the problem created by the dam, the salmon could be removed and helped to spawn with the aid of machines. This would be the second punch. Similarly, the pregnant woman’s natural state is first deconstructed, and then reconstructed with the “One-Two Punch of Technocracy.” Artificial machines supplant, or at least supplement, what has been a natural process for millennia—childbirth. Mehaffy (2000) felt that publications and/or ads similar to the one described above that entail the displacement of either a maternal body or voice or both, result in an “accompanying devaluation of maternal authority and agency” (p. 183). Typically, the maternal authority is decreased and the professional authority is increased. Some feminists fear that fetal ultrasound does likewise. This can result in competition between the woman and her physician or health provider.

#### *Competition Between the Woman and the Health Provider*

Exacerbating this marginalization is the contest that some feminists believe exists between the woman and her health care provider. This was suggested earlier when the fact that women may want ultrasounds performed for reasons other than those that a physician would use to justify the exam. As an aside, there is not only competition

between the patient and physician, there is also competing views within the medical profession. Kvande (2000) noted that in Norway's press, epidemiologists presented statistics demonstrating that ultrasound exams for all pregnant women were expensive and did not produce any medical benefits. However, obstetricians presented their own data showing how such exams saved babies' lives. Moreover, in the press treatment of these issues, the women were not the focus. They appeared alongside the doctors and medical professionals. This introduces one of the issues in the ultrasound debate.

“One of the themes in the ultrasound debate has been whether ultrasound is a source of increased knowledge about the fetus—both for medical personnel and for the expectant parents—or merely a means of moving the ownership of knowledge from lay to expert hands,” wrote Saetnam (2000, p. 338). This potential shift in the balance of power leads to some conflict between the professionals and the patients. Many times the ultrasounds lead to revised due dates that conflict with the due dates calculated by the women. There are indications that women feel vindicated and triumphant when the baby is born on or nearer to their projected date rather than on or near the professional's date (Saetnam, 2000).

Mitchell and Georges (1998) also reported on the feelings of some women in response to the ultrasound exam. Some women were surprised to see the fetus move on the screen when they had not yet felt it move inside of them. “Seeing this movement prior to bodily quickening reinforces women's acceptance that ultrasound provides authoritative and distinctive information, but for some women it is unsettling,” noted Mitchell and Georges (1998, p. 110). After such events, there are some women who seek

to lay claim to the fetus by asserting the importance of their own body's awareness of the fetal movement and age. Mitchell and Georges (1998) observed:

But contests over knowledge about the fetus are usually won by the cyborg, spoken for by the "expert" sonographer. For example, estimates of fetal age based upon ultrasound measurements nearly always take precedence in physicians' reports over the estimates given by women. Sidelined into what some physicians call an "unreliable source" or a "poor substitute" for the ultrasound-generated knowledge, women are left trying to relocate the fetus in their own bodies, looking back and forth between the image on screen and their own abdomens. (p. 110)

Whereas the professionals conducting the ultrasound point out the numerous possibilities for seeing the fetus, such as fetal pathologies, sex, and behavioral patterns, the women undergoing the ultrasound may find other meaning. Some even experience a "technological quickening" weeks before a physical quickening occurs in their own bodies. Such a physical quickening occurs when the mother feels the fetus move in her womb (Mitchell & Georges, 1998). There will be more discussion of the significance of this technological quickening later.

While some women resent the competition they sometimes find themselves in with their health care provider (physicians, technicians, midwives, and etc.), many women are looking for greater participation and support from their husbands, boyfriends, or partners. Fetal ultrasound may provide a means for fostering such participation.

### *Participation of the Partner*

Ultrasound technology can give the expectant father the same or similar access to information about the fetus as the mother enjoys. Without the benefit of such ultrasounds, the fathers and other family members are dependent upon the mothers' narratives for information about the pregnancy. The mother's body is the one experiencing the changes. She is the one who feels the unborn infant move. In the past, the father could lay his hand on the abdomen of the mother to experience the sensation of fetal movement, but that was basically the extent of his personal knowledge of the unborn. The advent of ultrasound enables the father and the mother to experience scenes of the unborn infant simultaneously. Some view this as an advantage, but others see it as a disadvantage (Saetnam, 2000).

On the one hand, those who see it as a disadvantage worry that such technology could result in a power shift from the woman to the man. After all, pregnancy is arguably one area where the woman maintains the power advantage. She controls how much information is disclosed regarding the development of the fetus within her and the changes in her own body. Involving the male could jeopardize this control.

On the other hand, those who see it as an advantage appreciate the opportunity that ultrasound offers to engage the partner's interest in the pregnancy (Mitchell & Georges, 1998). Ultrasound scans have the potential to stimulate the partner's interest in the unborn child, and they have the capacity for testing his commitment to the relationship. Mitchell and Georges (1998) reported one woman's testimony:

I want him to know that this is a baby. It's not going to go away. He just can't get it yet. I guess it's a physical thing. Men don't have all the changes in their



body...The ultrasound changes that. It's like a slap in the face for him! Now he's got to get serious about us and this baby (Vicky, twenty-five, medical receptionist). (p. 115)

So ultrasound makes paternal involvement more possible.

While some women see ultrasound as a means for involving the fathers for the father's sake, other women see ultrasound as a means for involving the father more for the sake of the mothers themselves. For some, pregnancy can be a lonely experience. Therefore, technology such as ultrasound scans can foster more participation in the pregnancy and reduce the loneliness of the pregnancy experience for the woman.

Saetnam (2000) records one woman's feelings on this issue:

I think it's really fine, the way it is now, that you can have along with you...the father. Because...

[Me: Was he with you also that first time (a clinical examination due to acute pains in the second month of pregnancy)]?

No. Then I was alone. And I felt a little...because this pregnancy wasn't planned. And I've felt that I've been very much alone, to put it that way. I don't feel that he has completely understood what I'm going through. Or also, I've felt that He's been cheated of some of what I'm going through. So in that sense I think it's really fine that he got to come along now and see the same as me, so that we have something more in common to talk about. And so that we think of it as a baby already now, and not first after it's born. (p. 349)

This woman's statements provide an interesting example of how the ultrasound technology can be used to construct relationships. The ultrasound made it possible for

the partner to share in the same visual knowledge as she, and therefore, the ultrasound could potentially lead to a reduction of her loneliness. Moreover, the ultrasound also opened the way for the couple to begin thinking of the fetus as a child, a family member, sooner rather than later (Saetnam, 2000).

*Commodification and Reification of the Fetus*

Hollywood has recognized the potential that ultrasound has to cause people to identify the unborn as a person and as a family member as well. Mehaffy (2000) examined the ways that sonographic fetal images have been displayed in television programming and advertisements. Writing from a feminist perspective concerned with preserving women's rights, Mehaffy (2000) introduced her article:

I will argue, first, that these ads commodify and reify a fetus as the means for nostalgically recentering a traditionally patriarchal family configuration and white, heterosexual consumer identity; and, secondly, that the ads' treatment of the facilitating female body in this schema, however inadvertently, strips away maternal agency, effectively colluding with contemporary anti-choice abortion politics. (p. 178)

Mehaffy (2000) went on to point out that the fetus has truly gone public. Fetal ultrasound technology has enabled large viewing audiences to participate in the maternal bonding that some women experience. Some media representations "...typically transform a fuzzy, wriggling sonographic fetus into a cinematic 'baby,' the new unifying center of white middle-class U.S. families," wrote Mehaffy (2000, p. 179). Other media representations, focusing on a disembodied sonographic fetus, do more to attribute autonomous personhood to the unborn fetuses.

Mehaffy (2000) discussed several ads featuring fetal images. One ad for Prudential Insurance, contains a bare protuberant belly being manipulated by white-sleeved hands, and this image is followed by a fetal heart monitor and sonogram image. According to Mehaffy (2000), this ad equated the fetus with a living baby through a teleological association. The anonymous technician, medical technologies, and the insurance company are helping to care for the baby before the birth. Similarly, a Proctor & Gamble Pampers Ultra-Dry Thin ad emphasizes the mother's reliance on the diapers. The ad opens with a fetal sonogram, and a picture of a one-year-old toddler follows. Therefore, this ad also draws a teleological relation between the fetus and a child. An ad by AT & T used the fetus as a galvanizing feature for a heterosexual family. While the father is away, he and the pregnant mother are talking on the telephone. The mother puts the telephone receiver to her belly. The father speaks to the fetus: "How's our kicker?...Hey, big boy, you wanta come out to play?" (Mehaffy, 2000, p. 187). The mother responds, "Sam! He kicked!" The mother goes on to describe the sonographic fetus's resemblance to his father.

Advertisements such as these become powerful rhetorical devices not only for selling goods and services, but also for shaping social reality. "The 'public' presentation of the fetus has become ubiquitous; its disembodied form, now propped up by medical authority and technological rationality, permeates mass culture" (Petchesky, 1987, p. 281). Whereas advertisers have used these sonographic or ultrasound images to sell products, the pro-life movement has been using these images to save the unborn fetuses.

### *Pro-Life Utilization of Ultrasound Technology*

The visual imagery of fetal ultrasound offers the pro-life movement a particularly powerful form of rhetoric. The persuasive power of fetal ultrasound images has been used in documentary style videos, in obstetric clinics, and in crisis pregnancy centers around the country. Research indicates that images of fetal cyborgs facilitate maternal bonding, produce quickening (the mother's real awareness of the baby within her body), and help establish the personhood of the developing fetus. Moreover, crisis pregnancy centers are using this particular form of cybernetic rhetoric to influence abortion-minded women not to have abortions.

#### *Videos*

Since the 1980s, the pro-life movement has been using fetal ultrasound technology to produce documentaries, videos, and television ads aimed at persuading audiences that abortion is wrong and the fetus is actually a baby. Mehaffy (2000) wrote:

*The Silent Scream* (1985), for example, plays on spectators' guilt by postulating that a fuzzy, unidentifiable black and white sonogram image is a "living unborn child" who "sense[s]" in the abortion process "aggression in its sanctuary."

Responsively, according to the *The Silent Scream's* narrator, the fetus then attempts to "escape," and, finally, "rears back its head" in a resistant "silent scream." (p. 181)

Branham (1991) noted that the National Right to Life organization distributed both *The Silent Scream* and *Eclipse of Reason*, another pro-life video, to all members of the U.S. Congress, Supreme Court, and many state legislatures. Hartouni (1997) observed, "Pivotal, however, in giving the 'still life' real life, its 'own' story, was the 1984 release

of *The Silent Scream*, a video production that invited the American public to witness an abortion from the ‘victim’s’ point of view” (p. 35). According to Branham (1991), these videos played important roles in the right-to-life movement’s appeals to both the public and the movement’s own members.

Feminists have challenged the presentation of the fetus in such videos however. For example, Petchesky (1987) opined:

The most disturbing thing about how people receive *The Silent Scream*, and indeed all the dominant fetal imagery, is their apparent acceptance of the image itself as an accurate representation of a real fetus. The curled-up profile, with its enlarged head and finlike arms, suspended in its balloon of amniotic fluid, is by now so familiar that not even most feminists question its authenticity (as opposed to its relevance). I went back to trace the earliest appearance of these photos in popular literature and found it in the June 1962 issue of *Look*, along with *Life*, the major mass-circulating “picture magazine” of the period. (p. 268)

Later, in the 1990’s, additional and different types of pro-life videos began to emerge. The Arthur B. DeMoss Foundation launched a television ad campaign known as “Life. What a Beautiful Choice” (Mehaffy, 2000). This campaign that began airing in 1994, solicits the audiences’ identification with the fetus through both visual and vocal strategies. Mehaffy (2000) described an ad from this series:

One ad from this set of representations features a split screen, picturing on the left a three- or four-month-old infant on its back, squirming in a crib, on the right a wriggling black and white sonogram image. The masculine overvoice intones,

The baby on the left has a beating heart. So does the baby [the sonographic fetus] on the right. The baby on the left has arms, legs, fingers, and toes. So does the baby on the right. The baby on the left can turn and kick and jump. So can the baby on the right. The baby on the left has just been born. The baby on the right would very much like to be. Life. What a beautiful choice. (p. 182)

There was a later, similar set of ads produced by the DeMoss Foundation. This second set of ads was designed to appeal to a more modern form of conservative family values (Mehaffy, 2000). The birth and adoptive families appearing in these ads made the decision to choose life rather than abortion. Mehaffy (2000) wrote, “Taken together, the fetal sonogram-centered ads and the “family values” ads allow the subjective “baby” to take what appears to be his organic place within a nuclear, heterosexual family formation: with father, mother, and siblings” (p. 183).

As Mehaffy (2000) pointed out, these ads were intended to evoke a sense of identification on the part of the viewer with the fetus. This pro-life strategy has been used in such mass appeals as described above and in individual instances with pregnant women.

### *Bonding and Quickening*

Mitchell and Georges (1998) observed that a central element in this reproductive discourse is the notion of maternal bonding. Bonding refers to the mother’s emotional attachment to the fetus or unborn child. “Both feminist and traditional scholars in science, medicine, and culture studies note that the technological development of obstetrical sonography in the 1960’s has enabled a strong maternal bond with the fetus,

especially for women with histories of ‘pregnancy loss or child loss’ (Petchesky 75-78),” wrote Mehaffy (2000, p. 179). “The idea of using ultrasound to modify a woman’s sentiments and behavior toward the fetus first appeared in clinical journals during the early 1980’s,” wrote Mitchell and Georges (1998, p. 112). This bonding soon enjoyed the status of being a psychosocial benefit. Consequently, the concept of bonding with the cyborg fetus became a new area of ultrasound research. Fetal images apparently stimulated positive feelings toward the unborn. Also, the reaction of women to images of the cyborg fetus could be used as a gauge of their commitment to the fetus. “The power of the cyborg fetus to stimulate a woman’s ‘natural’ mothering response is now also assumed to reduce her anxiety and improve her compliance with such things as medical advice, regular dental care, and avoiding cigarettes and alcohol (Reading et al. 1982),” wrote Mitchell and Georges (1998, p. 113). Similarly, Lumley (1990) reported that ultrasound scans may improve maternal-fetal attachment and that these scans may result in improvements in the mother’s health behaviors. Regarding maternal-fetal bonding, George Leopold, of the Department of Radiology, University of California San Diego Medical Center, said, “Ultrasound pictures are so good that even the patient can identify the baby’s profile, arms, legs, and so on. At the right point the pregnancy becomes ‘real’ for most mothers. The result is that they take better care of themselves—and their babies” (“Keeping Informed With Fetal Ultrasound”, 1996). Timor-Tritsch and Platt (2002) reported that the bonding effect is becoming more apparent as 3D ultrasound is used. Similarly, Baba (2004) reported that the newer more realistic images of normal fetuses may serve to facilitate parental-fetal bonding. Older research of pregnant women’s attitudes toward the fetus reveal that fetal attachment scores show a significant

linear increase over the life of the pregnancy but show no relationship between those scores and ultrasound feedback (Reading & Cox, 1984). Perhaps the older ultrasound (2D) technology was not as lifelike as the newer 3D images, and therefore, did not result in fetal attachment or bonding.

The potential for this cybernetic rhetoric to facilitate bonding does not operate independently from cultural constraints, however. For example, the way that North American women and the way that Greek women view the cyborg fetus are different. The reproductive rhetoric is also different. The discourse on bonding is common in North American texts used to educate pregnant women. However, the discussion of bonding is absent from the *Birth Is Love* booklet used in Greece (Georges & Mitchell, 2000).

Quickening is another concept connected with fetal ultrasound images. The term quickening refers to "...the onset of that stage of pregnancy when one can feel the baby move..." (Saetnam, 2000, p. 339). Traditionally, quickening occurred when the pregnant woman felt the fetus move within her. In this modern age of cyborgs, however, the quickening may come sooner rather than later through the medium of technology. "So convincing is this cyborg fetus that millions of women in North America may experience a 'technological quickening' several weeks before they sense fetal movement in their own bodies (Duden 1992)," wrote Mitchell and Georges (1998, p. 106). These quickenings are beginning to transcend cultural boundaries.

Fetal ultrasounds seem to carry more authority for those women who have not yet experienced quickening. Saetnam (2000) provided a testimony:



It was a great moment actually. Because I didn't identify with being pregnant before. I haven't any...The only thing I can see is that I've put on some weight on my behind, but that's nothing to do with the fetus in a way. So now I'm finally sure there's something in there, and seen the heartbeat, and seen it move. So it was sort of...well, I had something of a revelation. I'd been looking forward to it, to the ultrasound, since the pregnancy felt so distant even though I was so far along. I haven't begun to feel it move, you see. So therefore I was quite excited. This has to do with the impression that you're not really pregnant even if you have all the other symptoms. So I was having trouble identifying with it.

[Me: But now you feel pregnant?]

Yes, now so! Now I have proof! (p. 340)

For those who had experienced quickening already, prior to the ultrasound, their own awareness of their bodies and the fetuses within them was more salient than the ultrasound. These women viewed their own personal quickening as a more important milestone than the ultrasound (Saetnam, 2000). Interestingly, sometimes these two events, quickening and the first ultrasound exam, coincide. Before the advent of ultrasound, maternal-fetal bonding typically occurred after the fifteenth week of pregnancy, but with ultrasounds, bonding is possible within the first thirteen weeks reported (Stricherz, 2003).

### *Personhood*

The bonding and the quickening experiences, along with other elements in the fetal ultrasound images, provide the pro-life movement with a powerful rhetorical device for establishing the personhood of the fetus. While there are many in the pro-life

movement who consciously construct the fetal cyborg image in such a way so as to establish the fetus's personhood (Mehaffy, 2000), there are some health care providers who evidently do so unconsciously as a natural response to what the ultrasound image reveals. Sochurek (1988) provided an ultrasound image with the following explanation:

A picture made with ultrasound in the sixth month of pregnancy shows the face of a healthy fetus with mouth open in a yawn. "By this point the fetus does just about everything it will do after birth," said Dr. Christopher Merritt of New Orleans, who obtained the image. "It yawns, blinks, and even sucks it [sic] thumb." Sonography lets us share these sneak previews... (p. 58)

According to Mitchell and Georges (1998), such descriptions of physical parts and bodily actions pass through a cultural filter. Typically, the parts that are the most appealing and assuring to women are selected. Mitchell and Georges (1998) noted:

Fetal movement seen during ultrasound may be referred to as "the baby moving"; often is described as a particular kind of movement—an activity. Thus, the fetus is described as "playing," "swimming," "dancing," "partying," and "waving." (p. 108)

Sometimes fetal movement that makes conducting the ultrasound difficult is construed as evidence that the fetus is shy or modest. Also, if the image is obtained easily, the technician may suggest that this is evidence that the fetus is being very good or very cooperative (Mitchell & Georges, 1998). Such verbal attributions or voiceover constructions as these serve to establish the personhood of the fetus, and therefore, serve to protect the fetus from the likelihood of being aborted. Isaacson (1996) discussed the

collapsing of the boundaries between infant and fetus and the writing of the history of the fetus-infant in medical texts, stating,

New medical technology enables us to see the embryo and fetus as historical subjects in their own right by making fetal “behavior” available for observation in the fetus’ “natural” environment. Sonography allows physicians to be ethnographers of this terra incognita with its previously invisible inhabitants in the same way anthropologists rushed to interrogate strange tribes in newly discovered lands. (p. 460)

Ultrasound technicians, both those in regular obstetric clinics and those in crisis pregnancy centers, are in positions to influence the way the parents view the fetus.

Mitchell and Georges (1998) observed:

The compelling nature of this cyborg is especially evident when sonographers see an image which they particularly like. Their posture, facial expression, and voice change as they lean closer to the screen, often tilting their heads and smiling. Sonographers may even touch, stroke, and “tickle” the onscreen image, particularly the fetal feet, and create a voice so the fetus may “speak” to the expectant couple and communicate “its” feelings.” Expectant couples watch, delighted, as sonographers may wave to the image and speak to it, giving instructions and words of encouragement or reprimand, as in “Hold still, baby” and “Smile for the camera!” At these moments, sonographers and expectant couples closely resemble people admiring a baby in someone’s arms. (pp. 109-110)

Morgan (2000) commented, “In the United States, ultrasound has become a tool in the reification of the fetal subject” (p. 364). Ultrasound has become a test that can provide objective proof of fetal personhood (Morgan, 2000). This proof of personhood is one of the most powerful arguments that the pro-life movement can make in this rhetorical contest. “The stakes of these battles are high since the winners will be able to affect a woman’s right to abortion and control the management of pregnancies in both the public and medical spheres,” wrote Isaacson (1996, p. 461). Indeed, if the pro-life movement can demonstrate culturally and socially that the fetus is a true person, then perhaps most other arguments would pale into insignificance. While organizations such as the DeMoss Foundation have taken the mass communication approach through television ads, crisis pregnancy centers are taking the interpersonal communication approach.

#### *Crisis Pregnancy Centers*

For years, the pro-choice movement argued that if the pro-life movement would take steps to offer real and tangible help to women facing unplanned or crisis pregnancies, there would be less need for the pro-choice movement. After all, empowering women to make their own choices on the basis of dependable and adequate information is the ostensible basis for the pro-choice movement. In response to this challenge, the pro-life movement began to open crisis pregnancy centers (CPCs). These centers are typically operated by nonprofit organizations that derive their support from charitable donations from the communities where they reside. The typical CPC offers confidential pregnancy testing, counseling services, and assorted other services such as referrals to other providers in the area. Such services are usually offered free of charge

(Banerjee, 2005). These centers are purportedly interested in the welfare of the women who seek their assistance and in the welfare of the unborn children.

The pro-life community has come to believe that sonograms provide powerful and persuasive tools in the campaign against abortion (Banerjee, 2005). The Southern Baptist Convention launched a program known as the Psalm 139 Project with the purpose of buying ultrasound machines and making them available to CPCs that need them. Focus on the Family, another Christian organization, budgeted \$4.2 million in 2005 to provide ultrasound equipment and training to CPCs (Banerjee, 2005).

Recently, many of these CPCs have begun to use ultrasound technology in providing their clients with the care and information they need to make well informed decisions according to Keroack, Ensor, Johnson, and Gaudreault (2002). According to this same study, even though ultrasound visualization is known to impact pregnant women's decisions regarding their own prenatal health concerns, the impact of ultrasound technology in unplanned pregnancies was largely anecdotal. Therefore, an investigation was conducted to quantify the effect that direct fetal visualization through ultrasound technology had on women facing unplanned pregnancies.

The study conducted by Keroack, Ensor, Johnson, and Gaudreault (2002) included women with positive urine pregnancy tests and did not consider women who intended to complete their pregnancies. The women were selected from among the clients of CPCs who were seen during different time periods in order to compare the results before and after the availability ultrasound at the CPCs. Some of the clients were lost to contact. The results were separated into two groups, A and B. Clients who had

been lost to contact were included in Group A, but they were excluded from Group B.

Keroack, Ensor, Johnson, and Gaudreault reported:

Our present data suggests that the utilization of Ultrasonography (that can be viewed by the patient) has a significant impact on women's choices in unplanned pregnancy. When all clients were considered, the U/S group-A had a 45% rate of choosing to carry to term compared to a 20.7% rate in the Non-U/S group-A.

When the clients that were lost to contact were eliminated this difference was equally significant 63.5% vs. 33.7% (U/S-B vs. Non U/S-B). In both arms, the use of Ultrasound nearly doubled the rate of women choosing to continue pregnancy. The ability to visually bond to their pregnancy seemed to have a significant impact on our clients. (p. 10)

These findings suggest that ultrasound produced such a significant effect on the process of making a decision that a majority of women who may have otherwise had abortions chose against their initial leanings. Keroack, Ensor, Johnson, and Gaudreault (2002) wrote, "The fact that 75.4% of the Abortion Vulnerable women (with known outcomes) that were allowed to view ultrasounds in their unplanned pregnancies *chose not to abort* presents an intriguing challenge to the concept of 'Pro-Choice'" (p. 12).

Maher, Parton, and Buzzetta (2003) have also studied crisis pregnancy centers for Focus on the Family, a pro-life Christian organization led by Dr. James Dobson. Their study included a random sample of 1,026 CPCs. In the end, qualified data were collected from 334 pregnancy centers from across the United States including all fifty states and Washington, DC. The findings revealed that 30% of the CPCs use ultrasound technology. The average number of clients seen each year is 750 to 900. Approximately

20% (median) or 28% (average) of the clients who test positive for pregnancy are abortion-minded. The results indicated that an average of 70% to 90% (median) of the abortion-minded clients who were exposed to ultrasound intervention changed their minds and decided against abortion.

Stricherz (2003) wrote about one example of such a changed mind. A woman named Stephanie Monegro was already a mother of a three-year-old boy and was two months pregnant. She entered a crisis pregnancy center where she was given a sonogram. Stricherz (2003) reported:

“[Marzulla] asked why I would want to kill my baby,” Monegro told CHRISTIANITY TODAY. “She said I would always regret it. [Then] I saw my first sonogram of the baby, and I burst into tears. I thought: Why would I want to kill something that’s living?” (p. 21)

Thomas Glessner, the president of the National Institute for Family and Life Advocates (NIFLA) is convinced that the proliferation of ultrasound machines among CPCs will lead to a reduced abortion rate in the country. Glessner stated, “All I know is that [if] a woman hears a heartbeat, she chooses life” (Stricherz, 2003, p. 22).

Interviews conducted by some in the media suggest similar findings among women facing crisis pregnancies who are exposed to ultrasound images of their fetuses. The beating heart is apparently a very powerful rhetorical symbol. One woman stated that at the moment she saw the beating heart, she knew she would not go through with the planned abortion. According to her, “The beating heart is the very essence of life itself” (Vincent, 2005, p. 35). “The sonogram showed me that if I had an abortion, I would’ve been murdering my child.” Another woman reported a similar experience. “When I had

the sonogram and heard the heartbeat—and for me a heartbeat symbolizes life—after that there was no way I could do it,’ Ms. Brown said recently as she revisited the clinic and watched her daughter, Elora, now 9 months old, play at her feet” (Banerjee, 2005, p. 1). Still another woman and her partner noted the impact their fetus’s ultrasound image had on them even though the woman had thought that the exam would have no effect on her. Vincent (2005) quoted the woman:

You could see that it was real and growing and alive!...I could picture what that little circle was going to become. I could see my baby when I was four months pregnant, then eight months pregnant. I thought, ‘That thing everyone wants to call “tissue” will eventually turn into a baby that I can hold and who will look like me.’ I had never thought about that before. (p. 36)

Yet another woman had a similar experience. For her, the fetus became an “actual person” when she saw the fingers, toes, and etc. “When I saw it, I was pretty much in tears. I didn’t know that at [12 weeks] it was a full baby. Seeing it on the screen, realizing it was an actual person with fingers, toes, everything, I couldn’t do it...I knew I would be killing a human being” (Vincent, 2005, p. 37). The heartbeats, movements, and various discernible physical features such as fingers, toes, and etc. seem to convince pregnant women and their partners that the fetus is human and possesses personhood.

#### Critique

Although much is known about rhetoric and abortion, there is a great need for more research. There are several reasons that warrant further scholarly work in this area. First of all, there is a gap in the available knowledge regarding persuasion and abortion. Further research in this particular area could lead to significant contributions of



knowledge in the discipline of communication. Second, further work could also produce information helpful to various service agencies and groups who are seeking to provide real relief to people who are facing crisis pregnancies. Third, although there have been scholarly analyses of the rhetoric surrounding the abortion issue and there have been some empirical investigations of persuasive messages in this area, there has been little work focusing exclusively on the rhetorical approach of pregnancy centers that serve women facing unplanned pregnancies. This inquiry will provide such an approach. Finally, this project will enhance our understanding of the way that visuals persuade.

First of all, there is a gap in the available knowledge regarding rhetoric and abortion. Given the divisive nature of the issue of abortion and the way that the abortion issue has polarized the population of the United States, one would expect much more research than has been done. While there is a plethora of articles on the subject of rhetoric and/or persuasion, there are relatively few articles that discuss persuasion in the context of the abortion issue—especially persuasion of pregnant women who are abortion-minded. The paucity of scholarly research on persuasion and abortion cries out for further investigation.

On the one hand, much of the research related to attitudes toward abortion has been conducted using participants who are not actually facing the dilemma of whether to have an abortion in order to end an unplanned or crisis pregnancy (Breckler & Wiggins, 1991; Cohen, Aronson & Steele, 2000; Eagly, Kulesa, Brannon, Shaw & Hutson-Comeaux, 2000). On the other hand, there are some quantitative studies that consider the efficacy of using fetal ultrasound technology in attempts to persuade women against abortion (Keroack, Ensor, Johnson, & Gandreault, 2002; Maher, Parton, & Buzzetta,

2003). There is a great difference between a pro-choice undergraduate student participating voluntarily in a controlled experiment and a pro-choice person who is facing a real pregnancy and contemplating having a real abortion. Given the lack of available research regarding persuasive strategies intended to produce a change of attitude regarding abortion among abortion-minded people who are actually facing the possibility of an abortion, there is a need for research in this area.

Moreover, even though Keroack, Ensor, Johnson, and Gandreault (2002) and Maher, Parton, and Buzzetta (2003) discussed the effect of fetal ultrasound on abortion-minded women visiting crisis pregnancy centers, they made no effort to explain what elements of the ultrasound were most responsible for the apparent change of attitude in the woman. Therefore further qualitative research may illuminate the components of the ultrasound experience that were most salient in the minds of the clients and that may have contributed to an attitude change.

The work of Katz (1960) indicated that the attitudes that individuals hold serve different functions. There is a strong likelihood that the functions of attitudes held by people in different situations (e.g. a student participating voluntarily in an experiment versus a person facing a real unplanned crisis pregnancy) will be different. The function of one may be value expressive and the function of the other may be utilitarian. This possibility alone presents grounds for further research in this area. Moreover, an investigation into those factors that might lead a pro-choice or abortion-minded person to change his or her mind would move the discussion out of the theoretical realm into the practical realm.

Secondly, expanded research on the topic of persuasion and abortion could yield valuable information for those organizations trying to help people who are facing crisis pregnancies and are contemplating abortion. Besides filling the gap in knowledge, the results of this inquiry could possibly identify features of the pregnancy centers' messages (especially ultrasound), environment, communicators, and clients related to a person's choice not to abort. This information would be helpful to society at large, and ultimately, potentially very helpful in the end to those who are facing such a major decision. Since the Supreme Court's decision legalizing abortion, there has been a growing number of abortion clinics and a growing number of centers around the country devoted to helping women and men who face unplanned pregnancies by offering alternatives to abortion. Information regarding successful persuasive messages could help these centers as they seek to serve their clients.

Moreover, if this information is used and abortion-minded people decide not to abort, it is possible that this decision will result in less emotional stress and fewer mental health problems for them later. Many times people who have an abortion experience a phenomenon known as post-abortion stress (Congleton & Calhoun, 1993). A records-based study on the mental health of California women revealed that the rate of mental health care for the abortion group was 17% higher than for the birth group (Coleman, Reardon, Rue, & Cogle, 2002). Similarly, another report revealed that, "subsequent psychiatric admissions are more common among low-income women who have an induced abortion than among those who carry a pregnancy to term, both in the short and longer term" (Reardon, Cogle, Rue, Shuping, Coleman, & Ney, 2003, p. 1253). One study conducted on data from Finland even found that, "...compared with the risk of

death the year after a live birth or still birth, the crude risk of a pregnancy-associated death is twice as high after a spontaneous abortion and three times as high after an induced abortion" (Gissler, Berg, Bouvier-Colle, & Buekens, 2004, p. 454). Potential post-abortion effects may be found in the families of post-abortive women as well. Coleman, Reardon, and Cogle (2002) reported that, among five- to nine-year old children, more behavioral problems were revealed for the children of women with a history of abortion. Therefore, this research could indirectly result in a decrease of stress among women and even improved childcare in the home. Such a potential residual benefit of this research is worth noting. So while this project is a work of rhetorical criticism and not a discussion on the morality of abortion per se, the findings may prove beneficial to humanity at large. As members of communities, all learned people, including researchers, ought to seek to improve their communities and institutions. As Deetz (1982) observed, "...for the rightful value of all knowledge is the improvement of human existence" (p. 139).

### Research Questions

For pro-life advocates, reducing the number of abortions equates with saving human lives and improving the quality of lives for the women. The pro-life community is convinced that ultrasound is a powerful persuasive tool for changing attitudes regarding abortion. This research explored that possibility by investigating the rhetorical transactions of pregnancy centers.

Ultimately, this project analyzed the visual rhetorical artifact of the fetal ultrasound. While neither Foss's (1994) nor Peterson's (2001) schema is particularly well suited for this purpose, questions that Hart (1997) raised proved fruitful. While Hart

(1997) did not go so far as to offer a formal schema for visual analysis, he did raise several noteworthy questions. “1. Does the visual image carry ideological force? That is, does it grow out of a systematically articulated belief system?” (Hart, 1997, p. 189). “2. What condensations can be found in the visual image? Does the image act as a synecdoche for a particular set of ideas?” (Hart, 1997, p. 191). According to Hart (1997), “A captivating visual is captivating in two senses: (1) it ‘contains’ an idea or ideology, eliminating its extraneous or complicating aspects to make it more compelling; (2) it reduces the interpretations an audience can make, filling their eyes with a single, dominant meaning” (p. 192). Moreover, Hart (1997) posited that there are five basic moves involved in every rhetorical task:

- (1) the speaker tries to exert change by using language rather than non-symbolic forces (like guns or torture);
- (2) the speaker must come to be regarded as a helper rather than an exploiter;
- (3) the speaker must convince the listener that new choices need to be made;
- (4) the speaker must narrow the listener’s options for making these choices, even though
- (5) the speaker may become subtle by not specifying the details of the policies advocated. (p. 7)

Hart’s (1997) rubric provided the framework for the rhetorical analysis to be performed.

In summary, the purpose of this investigation was to research the crisis pregnancy centers’ rhetorical strategy of using fetal ultrasound technology to influence clients’ attitudes toward abortion. Pursuant to this goal, multiple research questions were addressed. These questions can be sorted roughly into four main categories: messages, contexts, center personnel, and clients. These categories provide a convenient means of organizing the discussion, but they are obviously not totally distinct.

Several questions regarding messages presented by pregnancy centers were addressed. RQ1: Besides the ultrasounds, what other media or messages are put forth by the centers? RQ2: Does the ultrasound seem to make an impression on the client and anyone who may be accompanying them? RQ3: What do ultrasound examiners typically say and do during the exam? RQ4: What intentions do the centers have in mind when providing ultrasound exams?

Several questions regarding the context in which the ultrasound exams are offered were explored as well. RQ5: How are clients who arrive at the centers processed? RQ6: How are the centers decorated?

Several questions pertaining to the center personnel were investigated too. RQ7: How many people are usually on hand when clients arrive? RQ8: How many different people will one client see during the initial visit? RQ9: How are the various personnel dressed, that is to say, are they dressed in casual clothes, business attire, or more like doctors and nurses at a clinic? RQ10: What are the demographic characteristics (gender, ethnicity, age, and etc.) of the personnel? RQ11: What are the goals of the centers? RQ12: What are the goals of the ultrasound examiners?

Finally, several questions related to the clients themselves were also in order. RQ13: Do clients usually come alone, or does someone accompany them? If someone usually accompanies them, who is it generally? RQ14: How are clients offered the opportunity for an ultrasound? RQ15: How do clients approach the ultrasound experience? RQ16: What do clients see and hear during the ultrasound exam? RQ17: How do clients and those with them generally respond to the ultrasound? RQ18: What do the clients typically say during the exam?

These questions were at the core of the matter under investigation. The answers to these questions were sought from the data collected during the course of this structured inquiry. The methodology for collecting, analyzing and critiquing the data is described in detail in the upcoming section.

## CHAPTER III

### METHOD

A research methodology that uses rhetorical criticism may lead to the discovery of new insights, the formulation of new theories, or the support of previously held theories. Historically, the scholarly intellectual community has been divided into two groups with literary intellectuals such as rhetorical critics in one and social scientists in the other. “Among humanists and scientists interested in rhetorical communication, the perceived goal relationship is most often one of independence, sometimes one of contradiction, and hardly ever one of equivalence,” wrote Brockriede (1971, p. 130). Nevertheless, both the critic and the scientist share the same basic common function of setting forth the best argument they can for the conclusions they reach. Moreover, Brockriede noted:

If rhetoric represents the symbolic interaction of ideas and people in a situation, then it occupies essentially the same territory as the interest of theorists of human communication. But do they have the same goals? Some people distinguish the two by saying that the critic wants to understand, interpret, and perhaps evaluate the individual transaction, whereas the scientist wants to develop general communication theory. This distinction can be accepted only if it is interpreted as meaning that the probable primary focus of the one may differ from the probable primary focus of the other. It should not be taken to mean that the critic has no use for theory or that the scientist has no use for the individual transaction. (p. 132)

So the critic and scientist share the same methods of argument and the goal of understanding. They also share the potential of discovering the inadequacies of existing



explanations and, therefore, the potential of developing revised or new theories.

Furthermore, Brockriede (1971) observed, “Critical techniques can also be blended with empirical techniques in the context of validation.” On the one hand, discovery may lead to conceptual models, and on the other, validation may lead to conclusions of generalizability.

Ordinarily, validation of or support for explanations has been sought through the means of laboratory experiments. However, experimenters have recognized the problem of artificiality. “At any rate,” Brockriede (1971) pointed out, “for whatever reasons, even the most expertly constructed experimental situation has at least the faint aura of artificiality” (p. 136).

Brockriede (1971) summed up the research potential of a blended research approach that includes the humanistic and scientific approaches:

A critic’s contribution could be to test the explanatory and predictive power of a theory in the real world of historical and contemporary rhetorical transactions.

This enterprise, which John Waite Bowers calls “predicting backwards,” must involve such fundamental techniques of experimental research as operational definitions, sampling procedures, reliable measuring instruments, and the like. He must also select historical and contemporary situations so they approximate the theoretical model he is investigating. He must conceive a rigorous design that puts himself in genuine jeopardy; he must give himself every reasonable chance of proving himself wrong. (pp. 136-137)

While this blended approach, combining quantitative and qualitative methodologies, has tremendous potential for refinement and development of theories, there are problems with

applying this approach to the problem at hand—the use of ultrasound as a rhetorical strategy by pregnancy centers. Given the intimate and sensitive nature of the subject matter (pregnancy, abortion, and etc.), collection of data (quantitative and qualitative) from the clients who visit such centers is problematic at best if not outright impossible because of client confidentiality concerns.

Notwithstanding the inability of this project to utilize the fundamental methods of experimental research, Brockriede's (1971) notion that the critic can “test the explanatory and predictive power of a theory in the real world of historical and contemporary rhetorical transactions” remained helpful here. The popularly held notion of the pro-life community that exposure to fetal ultrasound images changes the minds of abortion-minded women was investigated by examining the “rhetorical transactions” that transpire at pregnancy centers primarily by means of qualitative interviews.

Interviews are fundamental and widely used research techniques because they enable researchers to obtain information that cannot be gained by mere observation (Berger, 2000). Asking participants questions enables the researcher to discover the participants' attitudes, ideas, motivations, opinions, thoughts, and etc. Moreover, interviews can usually be recorded and/or written records of interviews can be made.

Furthermore, Creswell (2003) pointed out several characteristics of such qualitative research methods as interviews and rhetorical criticism that make them attractive to researchers. Such methods are interactive and humanistic. The qualitative approach is usually emergent instead of tightly prefigured and this provides opportunity for new and unanticipated insights to emerge. This approach is fundamentally interpretive. The qualitative approach is for the most part a holistic one. “This explains

why qualitative research studies appear as broad, panoramic views rather than micro-analyses,” wrote Creswell (2003, p. 182). Such a qualitative research model entails multifaceted and complex reasoning that may not be available in quantitative models.

The Institutional Review Board (IRB) of the The University of Southern Mississippi approved the research project before the work was done (see Appendix A). Moreover, the sensitive nature of the abortion topic necessarily constrained the research methodology and the types of data collected. Basically, two types of data were gathered and analyzed.

First, interviews of center directors and center personnel responsible for conducting the ultrasound examinations were conducted. Centers from as broad a range of states and localities as possible were used. Collecting qualitative interview data from one region only may have led to a skewed analysis of the situation. For example, the South is commonly known as “The Bible Belt.” Therefore, data from the South only may be viewed with some incredulity, whereas data gathered from multiple states and/or regions should enhance the generalizability of any findings. Moreover, interviews with center directors yielded information helpful in understanding the overall rhetorical strategy of the centers, and interviews with the people actually performing the ultrasound exams produced information helpful in understanding the role that ultrasound plays in the overall rhetorical strategy.

Second, media produced, generated, or otherwise made available to the general public by crisis pregnancy centers were collected and analyzed. These sources included television advertisements, brochures, college recruitment materials and information packets used in solicitation of support from local area pastors and churches. While the

ultrasound technology, not these other media, is the main focus of this research project, the ultrasound rhetoric does not exist in a vacuum. Therefore, a cursory examination of the various media circulated by these centers helped to provide the context for a more informed discussion of the role that ultrasound plays as a part of an overall rhetorical strategy. This examination took the shape of a rhetorical critique.

The gathered qualitative data were analyzed using the grounded theory approach that was first introduced by Glaser and Straus (1967). Straus and Corbin (1990) explained grounded theory as follows:

A **grounded theory** is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore, data collection, analysis, and theory stand in reciprocal relationship with each other. One does not begin with a theory and then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge. (p. 23)

In this case, the qualitative data collected by means of open-ended interview questions were analyzed in an effort to identify emerging phenomenon and concepts, and the categories to which they belong. Strauss and Corbin (1990) recommended this approach.

In keeping with ethical guidelines for social science research outlined by Babbie (2004), all participants were volunteers. The anonymity of all collected data was guaranteed. The guidelines of the IRB were followed. The research design endeavored to ensure that no harm came to the participants. This latter point is particularly salient

given the controversial nature of the abortion topic and the strong emotions that the topic elicits from people.

### *Participants*

While the pro-choice movement has opened abortion clinics around the country, the pro-life movement has opened facilities commonly known as crisis pregnancy centers or pregnancy support centers. These centers usually offer a variety of services to their clients at no charge. These services include confidential pregnancy testing, counseling, referrals to various medical and social service agencies in the area, and, more and more frequently, fetal ultrasound exams.

These centers are ordinarily staffed by a director, a team of trained counselors, and, where ultrasound services are offered, either doctors, nurses, or certified technicians who administer ultrasound exams. These staff members typically provide their services to their clients free of charge. Usually, the clients are women who think that they may be facing a crisis pregnancy. That is to say, women who think they are facing an unplanned pregnancy visit these pregnancy support centers seeking assistance. Occasionally, a boyfriend, husband, mother, or some other family member or friend may accompany the woman.

There are a number of non-profit organizations around the country that operate these kinds of centers. Over the years, the researcher has developed a relationship of trust with one of these organizations. Consequently, the national organization agreed to permit individual centers affiliated with the national organization to participate in this research project. This consent was offered on the condition that the identity of the national organization remain confidential. Participation by the individual centers was

purely voluntary, and was left to their discretion. The researcher assured the national organization that not only would the identities of the national organization and the participating centers remain confidential, but that even the names of the states where they are located would remain confidential also.

In summary, the national office of the participating organization first provided written consent for individual member centers to participate in this research at their discretion. A list of centers that provide ultrasound services was made available to the researcher. (While there are numerous pregnancy support centers around the country, not all of them provide ultrasound as a service.) Then, a purposive sample of 22 centers located in 16 different states was chosen from the centers on the list. The sample was chosen in such a way so as to collect data from as many different geographical regions and/or states as possible. Eight centers located in seven different states agreed to participate. These seven states were located in the Northeast, the South, the Midwest, and the West. This wide-ranging geographical distribution of participating centers reduced the possibility of certain idiosyncratic regional outcomes. Ultimately, 12 people from among the directors and ultrasound examiners who volunteered to participate were interviewed. Seven of the participants were center directors. Four were ultrasound examiners. One was both the director and the ultrasound examiner. Two interviewees were males and ten were females. Two participants, one male and one female, identified themselves as physicians, and some of the others either identified themselves or were identified by others as nurses.

### *Procedure*

The data were collected from the centers' directors and ultrasound technicians who volunteered to participate. Interviews, along with surveys and observations, have been proven to be effective tools for conducting descriptive research. Furthermore, some researchers prefer interviews when probing for answers to potentially embarrassing or sensitive data, such as this research topic, because interviews provide the researcher the opportunity to build a rapport with the participant and allay their anxiety (Tucker, Weaver, & Berryman-Fink, 1981). In this case, the relationship of trust between the parent organization and the researcher helped to open the door of opportunity for these interviews to be conducted. Moreover, telephone interviews have the additional advantages of cost savings and time savings when compared to personal face-to-face interviews (Neutens & Rubinson, 2002), and telephone interviews were conducted to gather the primary data. When permitted, the interviews were tape-recorded and the recordings transcribed after the interview. When tape-recording was not permitted, written notes were kept and transcribed afterwards. In the end, ten interviews were tape-recorded, and two were not.

### *Materials*

The structured interviews of directors and ultrasound personnel (see Appendix B) were conducted using interview questions based on general guidelines suggested by social science and health researchers. Researchers have long realized that leading questions can lead to biased answers (Berger, 2000; Foddy, 1993; Tucker, Weaver, Berryman-Fink, 1981). Therefore, an effort was made to avoid these. Moreover, ambiguous wording, double-barreled items, biased items and terms, socially desirable

responses, and the use of negatives were also avoided (Babbie, 2004; Tucker, Weaver, Berryman-Fink, 1981). Furthermore, while interview questions could have been close-ended to facilitate easier coding of the responses, open-ended questions were used to get at the “what” and the “how” of the centers’ daily operations. Kvale (1996) suggested that researchers use questions such that, “The aim is to elicit spontaneous descriptions from the subjects rather than to get their own, more or less speculative explanations of why something took place” (p. 131).

The researcher personally conducted each of the interviews according to guidelines suggested by social science and health researchers. According to Tucker, Weaver, Berryman-Fink (1981), for interviews to be most successful, the interviewer must be somewhat similar to the respondent because this creates a comfortable climate of trust and identification. Since the researcher had established and maintained relationships with this organization that operates pregnancy centers, such a climate existed for the interviews. Moreover, while the interviews were structured, the participants were given the opportunity to define terms that were used, amplify their responses, and provide examples (Berger, 2000). The use of follow-up questions and the use of “uh-huh” and other phatic communication were used to elicit more information when deemed appropriate (Berger, 2000; Kvale, 1996). The researcher endeavored to demonstrate the criteria of an effective interviewer specified by Kvale (1996) including: knowledgeable, structured, clear, gentle, sensitive, open, steering, critical, remembering, and interpreting. Such an approach with open-ended questions helped elicit sufficient data for analysis. The longest interview yielded a transcript of 26 pages and 11,843 words. The shortest interview manuscript of 7 pages and 2,372 words was produced from one of the



interviews that was not tape-recorded. The participants' responses provided much data for analysis.

### *Analyses*

Following the data collection phase, the gathered information was analyzed from a grounded theory approach in an effort to generate categories through constant comparison methods. The data yielded a total of ten major themes and several sub-themes, and answers to the research questions raised earlier were found among the data. These results will be discussed in greater detail in the upcoming chapter.

## CHAPTER IV

### RESULTS

Analysis of the data collected from interviews resulted in the discovery of ten broad themes and multiple sub-themes. These themes and sub-themes are reported in Table 1, and will be discussed in detail in this chapter. Gender specific pseudonyms will be used when quoting from the interviews. Interview data supporting the existence of these themes will be presented first, and then data from printed material will also be discussed. Finally, the answers to the research questions that emerged will be presented.

The discovery of the ten broad themes resulted from multiple cycles of reading and coding the interview manuscripts. The manuscripts were read and salient themes were recorded. Then, the manuscripts were examined again in light of the themes that had first emerged. This reiterative process resulted in a large list of concepts or themes. This list was then reviewed and reorganized. The reorganization resulted in an outlined list containing major and minor themes. Further reflection on the themes resulted in the list being reorganized once more. Ultimately, ten broad themes were identified. Approximately 44 subordinate themes were categorized under each of the ten broad headings. Finally, another level of subordinate themes was added. In the end, the concepts that frequently occurred or that were considered particularly significant were incorporated into Table 1. The major themes are not necessarily mutually exclusive. There is some overlap among them. However, this taxonomy facilitates an organized discussion of the research findings.

Broadly speaking, the first stated overarching goal of the centers is to provide free holistic (physical, emotional, and spiritual) Christian ministry to women facing

unplanned pregnancies, to their unborn children, and to the significant others in their lives. This ethic informs and shapes all that the centers do. Second, because they view human beings as divine creations worthy of respect and care, the centers endeavor to provide professional health care including pregnancy testing and limited ultrasound. Third, because of the availability of these medical resources, clients come seeking information about their pregnancies. Fourth, when clients arrive at the center, they find a safe supportive environment that is devoid of judgmental attitudes and high-pressure tactics. Fifth, because the centers ultimately want to influence the client not to abort her pregnancy, they are sensitive with regard to the nature of the information they pass along to the client and sensitive with regard to the manner in which the information is shared. Sixth and closely related to the sensitivity in sharing is the strategic and deliberate choice of terms employed by the centers. Seventh, as a part of the overall strategy of holistic ministry, the centers give much attention to cultivating personal relationships with their clients by means of interpersonal communication. Eighth, because the centers want to persuade the client to carry her pregnancy through to term, the centers utilize persuasive arguments and artifacts. Ninth, the staff members hope that such visual artifacts as ultrasound images and fetal models will help make the pregnancy real to the client and, especially, help the client to bond or connect with the fetus. Tenth, the centers aspire not only to inform but also to enable and empower the client to make informed choices that she can live with in the future.

These major themes, as well as the supporting sub-themes, appear in Table 1. The major themes appear in the first column. Secondary supportive themes appear in the second column. Finally, another level of supportive themes appears in the third column.

For example, the second major theme that emerged was professional health care. Unsurprisingly, professionalism is a major component of such care, and therefore, professionalism appears in the second column as a supporting component of professional health care. Concepts supporting the sub-theme of professionalism appear in the third column. These include quality, credibility, integrity, and consistency. Either each of these terms appeared in the interview manuscripts or each was alluded to in the manuscripts. For example, at least one respondent directly referred to the “high quality care” the center offers. Others participants noted the professional credentials that are displayed to demonstrate to the clients that the staff members are professionals. The professional certifications communicate speaker credibility, and therefore, credibility appears as a supportive theme.

Table 1

*Themes and Sub-Themes Emerging from Interview Data*

Themes	Subthemes Level 1	Subthemes Level 2
1. Holistic Christian ministry to woman, her unborn, & significant others	Christian orientation Ministry to physical Ministry to emotional Ministry to spiritual Free Significant others Perinatal hospice	Benevolence/charity (see safe supportive environment) Gospel presentation Prayer Male Grief
2. Professional health service	Pregnancy testing Limited ultrasound Prenatal care Professionalism Public relations Advertisements	Quality Credibility Integrity Consistency
3. Uncertainty reduction & information seeking	Uncertainty reduction Information seeking Education	

Table 1 (continued).

*Themes and Sub-Themes Emerging from Interview Data*

Themes	Subthemes Level 1	Subthemes Level 2
4. Safe supportive environment	Home-like atmosphere	Furnishings Music
	Emotional support	Concern & compassion Non-judgmental responses Unconditional love
	No pressure/non-threatening	
	Privacy	Privacy panels
	Proxemics	Easy exit
5. Sensitivity in sharing	Tactful approach	
	No grisly pictures	
	Fetal models	
	Gatekeepers (no overwhelming data)	
	Storytelling	Clients Caregivers
6. Deliberate choice of terms	Termination vs abortion	
	Baby vs fetus	
	Advocates vs counselors	

Table 1 (continued).

*Themes and Sub-Themes Emerging from Interview Data*

Themes	Subthemes Level 1	Subthemes Level 2
7. Interpersonal communication	Relationships & mentoring Engagement in U/S experience "Games" Communication accomodation Cues	
8. Persuasive arguments & artifacts	Verbal arguments Powerful images  Verbal overwriting of visuals Heartbeat	U/S exam, monitors & etc. Black & white photos taken home Family photo album Retention of experience Elicitation of other's help  Visual Audible

Table 1 (continued).

*Themes and Sub-Themes Emerging from Interview Data*


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Themes	Subthemes Level 1	Subthemes Level 2
9. Reification of pregnancy	Reality of pregnancy Humanity of fetus/child Bonding/connecting "Second Crisis"	
10. Empowering & enabling client	Client dignity Client ability	Power to decide Instinct to protect Instinct to provide



## Interviews

The first dominant theme that emerged was one of holistic Christian ministry to the client, her partner and her unborn. The participating centers all maintain a Christian orientation and are concerned not only for the woman who presents at the center but also for her male partner. The centers endeavor to minister to the physical, emotional, and spiritual needs of the clients and their significant others. The services provided are all free of charge.

### *1. Holistic Christian Ministry*

The Christian nature of each center was mentioned during almost all of the interviews. For example, when discussing the art visible to visitors at her center, Kayla stated, “They know that we’re a Christian agency at the very beginning.” Irene explained that the mission of the center includes, among other things, “...to share the gospel of Jesus Christ in word and deed...” Charissa also indicated that one of her agency’s goals relevant to the clients was “...to reach them for Christ.” Zoe indicated that the staff at her center has always “...wanted to have an opportunity to speak to women about the hope that could be found in Christ in a moment that was a crisis to them.” She further elucidated her center’s approach when she spoke of the clients’ attitudes, “They, they feel like they find a compassionate, serving agency in the community that consistently cares about them and offers them high quality care, professional care, uh, and as they begin to trust us, and then we really do have an opportunity both in word and deed to share the love of Christ.” Cara expressed her view of her center as an “embassy for Christ.” Bethany reiterated, “...our mission statement is that we are a sanctity of human life ministry that impacts and transforms lives with the love of Christ.” While some

participants shared that their clients know from the beginning that the center is a Christian place, others suggested that they are less overt in the manifestation of their Christian position. For example, Charissa explained that there is nothing at her center that “shouts Christianity” to her clients.

Reflected in the Christian orientation, whether explicit or implicit in manifestation, was also the desire to meet the needs of the whole person who comes to the center. Anna outlined this approach when delineating her center’s goals. “Well, uh, our goals are obviously to help women that are in need, uh, both physically, spiritually, mentally, emotionally.” Christopher’s reply was similar. “Well, you know, our main goal is to reach as many young women, men, and families facing unplanned pregnancy in our area [as possible] because we have a goal of meeting their physical, emotional, and spiritual needs.”

The provision of material items or the ministry to the physical needs by the centers apparently serves as an effective means of attracting clients. Bethany illustrated, “...a lot of them [clients] also come for material resources—things for their babies: diapers, formula, clothes, uh, maternity clothes.” Ruth mentioned the “material assistance” that is offered to visitors as well. Kayla remarked, “...we noticed that there were many many patients coming in needing material assistance.” She went on to explain that these clients were provided with the necessary materials and supplies.

The centers are not only interested in meeting the physical needs but also the spiritual needs of their clients. The two main approaches used to do so were a presentation of the gospel and prayer. Irene described the typical approach:

If we have opportunity during the conversation, we share, uh, ask her about her faith, and does she believe in God. Where is she at there? Sometimes we have the opportunity to share the gospel. Sometimes we plant seeds of hope for the future. Sometimes, probably most of the time, we have the opportunity to pray for the client. She will usually receive that well. Once in a while, we have the awesome privilege of leading someone to a personal relationship with the Lord.

Indeed, Luke affirmed that the number one goal of his center was to “introduce nonbelievers to the gospel of Jesus Christ.” According to Agatha, enlarged opportunity to present the gospel was behind the introduction of each additional service at the center she serves. These services included the following: sexually transmitted disease (STD) clinic, parenting classes, fatherhood initiatives, ultrasound exams, post-abortion recovery ministry, and etc.

The centers also employ prayer in their efforts to meet the spiritual needs of their clients. Kayla disclosed that she approaches the matter of prayer carefully by asking the client at the end the session if she may pray with her. Then, if the client consents, the two have prayer. Luke and Ruth also observed that sometimes the counselors pray with the clients. Cara suggested that praying together with the client provides a means of closing the distance between the counselor and client. She explained that center personnel strive to remain professional but remain caring at the same time. “We’re not sterile and we’re not distant from people, you know,” said Cara. “I pray with people, and we’ll do that.”

So the pregnancy centers seek to meet the physical and spiritual needs of their clientele, but they also want to address the emotional needs of their clients. This concept will be expanded in an upcoming discussion on a safe supportive environment. However,

one concept or sub-theme that deserves elaboration at this juncture is the role the centers do or could play in assuaging the grief of their clients. While none of the centers participating in this research project provide abortion services or referral for abortion services, nonetheless clients who are planning to have abortions do visit these centers. Moreover, according to Charissa, some of the clients who are planning to terminate their pregnancies request ultrasound pictures of their unborn. Charissa reported that clients planning to abort have told her that they wanted pictures so they could “say good-bye to their baby.” From this nurse’s perspective, the clients were already mourning the loss of their baby. In other instances, ultrasound imagery may not assuage grief but arouse sadness instead. That is one reason, according to Charissa, that counselors are present during the ultrasound exam. There are occasions when post-abortive women will experience extreme emotions while viewing the ultrasound images of their current pregnancy. This is especially true if the abortion was relatively recent.

Another participant, Angela, raised the possibility that the ultrasound capability of these pregnancy support centers could be used to perform a type of peri-natal hospice service. Sometimes, pregnant women receive adverse diagnoses, that is, they learn that their baby is not going to survive. In such cases, there is at least one physician who is calling on these pregnancy centers to use their ultrasound abilities to provide the only pictures of the woman’s child that she will ever have of the baby alive.

In summary, these centers endeavor to offer holistic Christian ministry to the woman, her partner, and her unborn while they seek to meet the physical, spiritual and emotional needs that exist. These services and materials provided are offered free of

charge to the clients. Apparently the free nature of these provisions serves to build goodwill among the clients and to attract clients to the centers.

Christopher explained that the center was able to offer the first five months of prenatal care for clients at no cost because of the volunteer services of receptionists, counselors, lab technicians, nurses and physicians. He also pointed out that college students usually do not have much money and their lack of money makes the free services of the pregnancy centers more attractive. When asked why clients visit the center where she works, Anna candidly replied that probably the number one factor in the client's decision to visit is that the goods and services are free. Luke commented that some visitors come seeking benevolence, and they will receive material assistance only once every three months if they are simply walk-ins. Many centers, like the one where Anna works, offer programs where clients receive coupons that can be earned by attending certain sessions and then be later redeemed for various material items.

So the centers provide limited material assistance, according to the needs of the client, without charge. Some of the centers have procedures in place that enable clients to earn coupons by participation in certain programs, and these coupons can be redeemed later for material items. However, the basic service that these centers offer is the free pregnancy test. These tests are related to the well being of the women, and therefore they fall under the category of health services.

## *2. Professional Health Services*

The second major theme that surfaced when the data were analyzed is that of professional health services. Sub-themes in this category included not only pregnancy

tests, but also included limited ultrasound exams and pre-natal care. Closely related concepts that also emerged were professionalism, public relations and advertisements.

As noted earlier, one of the primary reasons for a woman's first visit to a pregnancy center is the availability of a free pregnancy test. Christopher and Charissa both pointed to free pregnancy testing as one reason for client visits. Indeed, according to Kayla, one of the primary goals is to provide pregnancy testing. Many of the centers noted that while the center offers the tests at no charge, the client actually self-administers the test. According to Bethany, many of the women who come are already aware that they are pregnant, and they are only seeking verification. Bethany and Luke explained that clients often come for the sole purpose of pregnancy verification so they can use the pregnancy verification offered by the center to obtain Medicaid.

Another professional health service that these centers offer is limited ultrasound. Like the pregnancy tests, the ultrasound exams are offered without charge. However, they are offered on a discretionary basis. Kayla explained that clients are told that there are some criteria they must meet in order to be eligible for an ultrasound. Moreover, Ruth pointed out that clients sign consent forms that explain the limited nature of the ultrasound exam. The client is informed that the ultrasound exam is not a diagnostic exam. Bethany made a similar observation. "...I always tell the clients beforehand that this is a limited ultrasound—that we're not going to look for any fetal anomalies or problems with the mom."

Yet another sort of professional health service offered by some of the participating centers is pre-natal care. Cara, who works at a center not providing pre-natal care, observed that one goal in providing the ultrasound was to provide some

starting point for pre-natal care. Irene's testimony affirmed Cara's that ultrasound is helpful in moving clients toward pre-natal care. Agatha also commented that one unexpected consequence of the introduction of ultrasound technology was the increased interest in pre-natal care. She explained:

What I think surprised us was the added interest in pre-natal care, in pre-natal vitamins, in having a nurse to talk to. I mean, that was another huge thing is there's some element of having that professional, medical person, uh, that just is, is very positive in, in the way that they approach their pregnancy.

Kayla described her center's efforts to help those with positive pregnancy test outcomes make the transition into pre-natal care. Clients are encouraged to enter the pre-natal care program that is available rather than delay doing so until they have told the significant others in their lives about their pregnancy. The pre-natal care for such clients is available for up to five months. After that time, depending on the situation, clients are referred to a private physician or to the health department.

In short, pregnancy tests, limited ultrasound exams, and pre-natal care all contribute to the community's perception of the centers as professional health service centers. Anna summed it up when she said, "...we want to be professional." She indicated the desire to maintain a professional demeanor. The interview data revealed that the centers work to foster and perpetuate this perception by focusing on quality, credibility, integrity, and consistency.

Agatha's remarks, when speaking of clients, reflect this intent. She said:

They, they feel like they find a compassionate, serving agency in the community that consistently cares about them and offers them high quality care, professional

care, uh, and as they begin to trust us, and then we really do have an opportunity both in word and deed to share the love of Christ.

While none of the interviewees mentioned speaker credibility explicitly, the concept of such credibility did emerge. For example, Angela described the “good connection” that sometimes takes place between counselor and client and how that good connection leaves the client with the perception that the center personnel care about the client. She said, as a result of the center’s efforts, “...the client knows that we have their best interest at heart. We’re not self-serving. We honor her.” The data suggest that the free goods and services contribute to this perceived credibility. One interviewee, a Christian physician, noted that she had her medical credentials, including the medical license, displayed on the wall in her office. The dress of the center personnel is also planned to contribute to credibility with the audience. Some centers use badges with personnel names on them. When asked about their dress code, answers varied by center, but most described their attire as business or business casual. Sometimes the physicians and nurses wore lab coats or medical scrubs, but at other times they did not. So benevolence and official licensure documents seemed to be means of bolstering perceived credibility.

Integrity emerged as primary concern. According to Luke, his center receives calls from some who think it is an abortion clinic. In those cases, Luke stated emphatically, “Staff do not lie or mislead clients.” Again, when discussing ultrasound exams, the same physician reiterated, “There is no deception during the ultrasound.” In discussing the use of ultrasound, Angela responded similarly. She explained that, “...we would offer an ultrasound just to confirm a uterine pregnancy, not as a trick, not as, you



know, a ploy, but there are so many early pregnancies that miscarry, that you know, we want, we want to confirm that she's truly pregnant..." Ruth pointed out that their center's promise to their clients is displayed in the lobby, and that this promise entails treating their clients with integrity. Anna emphasized truthfulness when asked how she was trained to interact with clients. She responded:

...[W]e just tell them the truth. We give them facts. We give them information and tell the truth. Uh, you know, I do share with them, if they want to hear of my experience. And most people do. And I try to be as honest and open as I can be with that, you know. I try to stick to facts. This is my experience, not anybody else's. But I want to let you know what I went through. And, uh, you know, be aware of this. We stick to the facts. We stick to medical information that we know and [that] has been researched. And we remain professional, but yet we remain caring too.

So integrity in client relationships was seen as an important concern.

Consistency was also. Agatha noted that her center wanted to be seen by the community as an agency that "...consistently cares about them." She further explained when asked about policies the following:

We love policy, not just for the sake of it, but it helps us to provide consistent service. And no matter which volunteers are serving, you're going to have a similar experience because we've all been trained in one manner of providing those services. So we've got like a vision of what we want the client's experience to be. We have it written down. We train on it.

So these centers seek to maintain the perception that they are professional health agencies by offering selected health services and by maintaining high standards while doing so. Furthermore, the data revealed that these centers engage in public relations and in advertisements.

Christopher reported that the introduction of ultrasound technology at their center had a very positive impact on the community's perception of the center. According to him, "It has raised the level of professionalism, I think, especially in the eyes of the community and in the eyes of the donors." So the ultrasound actually had an effect on public relations. While the impact of ultrasound may have been unanticipated, participating centers do actively engage in public relations campaigns. For example, Kayla explained that her center works to raise community awareness of their agency by leaving brochures at various agencies and offices around town and by making presentations at civic clubs and churches in the area. When speaking of conducting public relations outreach at churches, Irene mentioned the role that ultrasound technology plays in those venues. She explained:

I think, you know, ...you can use ultrasound as a tool to encourage people to understand fetal development. It's a positive thing. And so in church presentations, sometimes we have used ultrasound pictures, uh, to, or in speaking to groups of women.

Zoe also mentioned having booths at various church mission fairs and of inviting church groups to come do tours of the center's facilities. Such public relations is important to the life of these centers because they are funded primarily by donations from the public.

Besides targeting likely donors through public relations, these centers also engage in advertising. Taken collectively, respondents provided a plethora of ways they advertise their services. Some of the material that is used for advertisement purposes will be discussed in a subsequent section. Although not every center utilizes each of these approaches, each one is widely used. A few of the centers seem to be particularly aggressive in their marketing efforts. Kayla observed that, “[we advertise using] almost everything that’s out there...television, radio, ...billboards...yellow pages...web page...” Centers have blurbs in church bulletins. They have trailers that run in local movie theaters. Some have ads on benches at local shopping areas. Centers that are near universities and colleges run ads in the school publications. They also visit the campuses at certain times and distribute “goodie bags” with information on the center. Christopher noted that the center where he works has a “fairly healthy advertising budget.”

Consequently, they are able to run about 200 ads per month on the six or seven local cable television channels. They also place ads in the campus newspapers of the local university and in sorority recruitment handbooks. Many pointed out the sign displayed on the street as a source of advertising their presence. Some centers have websites also. A few of the centers also run ads on the local radio stations that are popular with teenagers and people in their twenties. Irene observed that their radio ads are run on secular stations as opposed to Christian stations because they have found that young people listen to those stations more. Some also run ads on the local cable television stations.

Many respondents identified the telephone book as a major source of client visits. Only word of mouth seemed to result in more client visits than the telephone book.

Interviewees consistently and overwhelmingly identified word of mouth as the leading source for establishing new client contacts. When asked about the importance of word of mouth, Angela exclaimed, “I, I would say that word of mouth is huge. Referrals are huge.” Charissa affirmed this, noting that word of mouth has a high success rate at reaching new clients because “...girls return and bring their friends.” This is, of course, one of the goals of these centers. To facilitate this, some of the centers have implemented client satisfaction surveys to solicit direct feedback from their clients, and this feedback is then used to fine-tune the centers’ approach. Moreover, Irene elaborated on the additional success at contacting new clients because of the ultrasound. When asked about word of mouth, she replied:

I’d say that statistically our number one referral source is still word of mouth.

Uh, but we have seen over the last two years approximately, and I, and I, I’m not sure if this is totally accurate, but I would say conservatively about a 35% increase in abortion-vulnerable clients. And we credit that with the advertising as well as the fact that we now have ultrasound, and we’re able to uh, you know, confirm a pregnancy through ultrasound.

The participating centers have made earnest attempts to advertise their presence through multiple means. The efforts of the centers have not been in vain. The success of the outreach efforts is demonstrated by the continuing arrival of new clients.

### *3. Information Seeking and Uncertainty Reduction*

Several motivational forces, including the quest for information, bring clients to these pregnancy support centers. Christopher, whose center is approaching the twenty-

fifth anniversary of its formation, expressed that clients come looking for information.

He said:

So we've been here a long time. And I think that, uh, they've seen our ads, if they've seen our brochures, if they've talked to us on campus, I think that, uh, and they have either come themselves or they've told someone else about us. I think they know that they can, uh, get the information that they need in a place that's not judgmental and, uh, be able to come to their own conclusion, their own decisions.

The clients come seeking a wide range of information. They have different goals in mind when they visit the center and when they request or consent to having an ultrasound.

Clients want to confirm their pregnancy and some want to verify their due dates.

According to Zoe, some who have experienced miscarriages want to confirm fetal viability—to make sure their baby is OK. Some of the clients, those with multiple sexual partners, want to learn how far long they are in their pregnancy so they can determine who the father is. This information will be used by the client as she makes her decision regarding carrying the pregnancy to term or terminating the pregnancy.

The information that clients receive from the centers seems to help reduce uncertainty. In some instances, confusion is dispelled. Irene commented on this aspect of why client come to the centers:

Well, I think they come first of all because they're in a tough situation. They think they might be pregnant and, or they know they're pregnant. And they're confused and looking for some information that will help them make a decision.

Some of the clients, most of whom are facing unplanned pregnancies, are confused by the crisis situation they face. The information that the centers offer, especially the ultrasound exam, is able to clarify some things for them. Ann elaborated on this function of ultrasound technology:

I think it's really, I think it's extremely important because, uh, you know, women really don't know if they're in an unplanned pregnancy if, you know, they're not thinking clearly, you know, they're in a crisis. And even if they're uninformed, you know, as I was, you don't really think of it maybe as a baby or just, you know, cells or tissue. Uh, so they can see by the ultrasound that you know the baby's heart is beating at 21 days. ...Uh, we just had a woman yesterday, you know, she was uncertain what to do with her pregnancy. And she said, "Well, this kind of makes it really real for me to see that on the screen. And that kind of changed my decision."

So clients are seeking information, and sometimes the information they find leads to the reduction of uncertainty. The centers are aware of this potential and the participants indicated that education is a big part of what they do.

Charissa elaborated on the educational focus of the centers' efforts. She said, "Ultrasound is used as a means of education." According to her, ultrasound images are used to demonstrate to the client that the pregnancy is "truly a life" and that the thing in the womb is a "viable human being." Charissa also went on to say that ultrasound is used to demonstrate that to terminate the pregnancy is to terminate a life. When interviewees spoke of education, they sometimes meant also that they provide information to their clients regarding all their options. Angela explained that centers want to reach women

before they make a decision regarding their pregnancy in order that the women may make informed decisions. Angela explained that ultrasound is an educational tool that helps them in the process of “demystifying any myths” pertaining to early pregnancies that have been fostered by one’s cultural heritage or upbringing. Zoe also views ultrasound as a great pedagogical tool. She said of ultrasound, “...one of the things that I love about it, is it’s a fabulous teaching tool for the nurse and for the client advocate who may be with her client...”

In short, the data reveal that clients seek out the services of these centers for a number of reasons, and one of the main reasons is to gather information. The clients use this information to help them make decisions. The center personnel see themselves as educators and use the tools they have to inform the clients. However, the data also suggest that clients seek out the centers’ services not only for information but also for the emotional support they reportedly find there. The centers want to create a climate that clients view as safe and supportive.

#### *4. Safe Supportive Environment*

Center personnel manifested great awareness of several elements that contribute to a safe supportive environment. One major element that emerged during the interviews was the desire of the centers to foster a climate of emotional support for women and those in their lives facing unplanned pregnancies. Agatha noted that this emotional support seems to be one reason that clients come. She pointed out that even though clients can purchase pregnancy tests over the counter at various stores, they seem to be looking for more—for emotional support. She said:

It does amaze me how the number of women that come for pregnancy tests and the number that have already taken home tests. Uh, I think it's for support in something unexpected, and, and a place where they can talk to people that they're not really connected with.

Most of the staff apparently realize this and expressed a desire to demonstrate concern and compassion, to respond in non-judgmental ways, and to show unconditional love to those whom they serve.

Christopher believed that the center he directs maintains a "pleasant atmosphere." He said, "We have a staff that ...is warm and caring." Clients affirmed this by the good feedback they provided by means of the anonymous feedback sheets that some of them complete. Luke responded in a similar fashion. When asked about the goals of the center where he works, he said that providing follow up after client visits and letting clients know that people cared about them was one of the top three goals. Angela focused on compassion in her response. When asked why clients seek their services, she said:

They're seeking our services because, we hear everything from, "I could have done my own pregnancy test but I didn't want to be alone" to, uh, "My friends said that you would really help." That this was a compassionate place, to needing it free. It just depends.

Bethany echoed the concern for compassion saying, "We just try to be very sensitive and compassionate." Cara described the client experience saying:

They come and they will find out that they're cared for in a unique way that maybe they haven't encountered elsewhere. And I think that's another reason why people come. They've heard about, they've heard how people are treated. I



mean for that kind of thing. Basically they feel like they've been treated with respect and kindness.

When describing the atmosphere of compassion the centers seek to maintain, Angela contrasted the ministry of the centers with those offered by secular establishments. From her perspective, many who offer services to women with unplanned pregnancies have neither the time nor the experience to provide care that is as attractive to the women as the care offered by these pregnancy support centers. She said, "That's where ultrasound and the service that we provide was, uh, was attractive to them, to have somebody to care for the patients in an unbiased form." So compassionate client care is very important, and so are non-judgmental responses.

"We don't want to be judgmental," stated Anna. Kayla explained that early in the life of her center, the community seemed to hold a rather narrow view of the center. They were seen as the "pro-life" only group. Today, however, the mentality has shifted. People who work at the center understand that they are not to engage in character judging. Christopher reiterated this stance toward clients. He noted, "I think they know that they can, uh, get the information that they need in a place that's not judgmental and, uh, be able to come to their own conclusion, their own decisions." Irene also mentioned the non-judgmental stance of the centers. She said:

We, we want to be a good representation of Christ in the world. Uh, we want our clients to know that we truly do care about them. Uh, that we're not judging them. We love them. And that's the environment we work hard to have in our centers. And I think it works because, of all of our exit interviews, I would say 98% of our exit interviews are very, very complimentary.

The love that Irene mentioned is another theme that surface repeatedly.

Showing unconditional love to the clients emerged as another theme. When describing the way clients are treated, Kayla said, “We love them and support them.... We shower them with love and attention and who doesn’t want that?” Ruth observed that their counselor training emphasizes three questions:

And one is that does she know that we love her and care for her? Does she know that God loves her and cares for her? And does she know the truth about abortion and the truth about her options?

Anna affirmed that she thought her center enjoyed a reputation that included being known for a loving and caring atmosphere. Luke emphasized that this love is not only demonstrated in action but that it is also verbalized on occasion. He noted that sometimes, when the client is strongly considering abortion, the examiner might make statements like, “If you choose to have an abortion, God does not want you to do this, but God gave you a will.... If you have an abortion, God still loves you and we still love you and you are welcome back at the center.”

The centers focus on maintaining a climate of emotional support that includes compassion, non-judgmental responses, and love. Many of them also seek to create a home-like atmosphere. The desire to simulate a home-like atmosphere is balanced against a desire to maintain a tone of professionalism. The interviews revealed a good degree of intentionality on this subject. Participants mentioned such things as lighting, furnishings, and music.

Bethany noted that, while fluorescent lighting was used throughout rest of the center, the counseling rooms had incandescent lamps. This was done to “...make it a

little warmer, a little more homey.” Zoe remarked that clients often comment on how pretty her office is. She has decorated it with pictures of oceans, contemporary sofas and cushions, and various other articles that give the office a home-like aura. According to her, the effect of these furnishings is to create a relaxing and calming environment. Agatha’s description of the counseling rooms was similar. She observed that each one is “designed to look exactly like a sitting room or a den in your home.” To accomplish this, they are furnished with couches, love seats, chairs, TVs, bookcases, and lamps instead of overhead lighting. Luke described his center as “very warm” with a “warm atmosphere.” Christopher’s description of his facility likened it to “somebody’s large living room.” He noted that it included plants. Christopher also mentioned that music is played at the center—the kind of music that young people are accustomed to hearing. The tunes are mostly popular Christian music, but as he noted, “it’s not anything that just jumps right out at them.” Only one other respondent mentioned music. Cara said that her center played music sometimes, but she suggested that music was played infrequently. In summary, the centers endeavor to produce a home-like atmosphere where clients feel safe—one that is non-threatening.

The appearance of the facility and presentation of the staff are such that a person in crisis does not feel like they are being pushed according to Charissa. Irene explained that, based on her experience, many of the clients have several other people telling them what to do, and their clients are seeking out a place where they can escape this pressure. In describing this, Irene said:

I think that, and they’re seeking, uh, a safe place to go. Uh, everybody’s probably telling them what to do if they’ve told people like their boyfriend or their parents.

Everyone is, uh, giving them advice and suggestions. And so they may be looking for, uh, an environment where people will give them good information to be able to make a decision without the pressure of others telling them what to do. And often times clients will tell us that they like to come to our centers and they refer others to us because we're so nice. That's what they say. "You know, you guys are really nice. It's comfortable here. We feel like a person and not like a number. You treat us well." So, one client will refer another client or, uh, a friend to the center.

Later in the interview, when discussing ultrasound exams, Irene reiterated her position. She remarked, "We believe that a woman has a right to make her own decision. We don't push our uh our agenda on them. We don't have an agenda." Kayla responded similarly, noting that, when offering ultrasound exams, no pressure is exerted on the client to have the exam.

The desire to foster a non-threatening atmosphere surfaced again during the interview with Cara. She explained the care that is taken in seating a client:

And we're careful about the seating in that the client has the ability to exit freely should she wish to at any time. You know, there's no, like, blocking of, you know what I mean? Like where the chairs are placed and so on so people can exit and don't feel claustrophobic there.

Center personnel revealed the attention that they give to the matter of privacy.

Privacy, in one form or another, surfaced in several interviews as a matter of concern. Ruth made the observation that the street where her facility is located is very busy and there are many walkers. Therefore, there is an entrance in the rear of the

building. Clients can park in the rear and enter the back door. This provides a more private experience. Ruth also mentioned that their facility contains a smaller inner lobby, separate from the main lobby, where clients can wait with greater privacy. This area is used to contain overflow from the main lobby and when some client just needs more privacy or is emotionally upset. Ruth also referred to the availability of printed material on a private basis. She said:

Um, in our bathroom where the clients use for the pregnancy test, we have a table that has some, um, brochures about, um, like domestic violence, salvation brochures, and then also post-abortion brochures for someone who may want to privately get that information.

Cara mentioned that clients at her center could change before and after an ultrasound exam in a private bathroom. Kayla pointed out that her center followed HIPPA regulations, privacy and confidentiality guidelines. According to Ruth, the privacy that a woman experiences at the center, the confidentiality she finds, and the caring listening ear of a volunteer, contribute to her willingness to return to the center. Charissa's responses corroborated Ruth's. She explained that the center trains personnel to maintain a neutral posture and to sustain a welcoming atmosphere. This approach will facilitate an environment where "the client will be comfortable, will share her feelings, and will want to return."

##### *5. Sensitivity in Sharing*

Another theme, similar to that of a safe and supportive environment that appeared in the data, was sensitivity in sharing. The respondents represented themselves as showing sensitivity in the way they present themselves to the public and to their clients.

Christopher indicated that the centers do not want the client's encounter to be an "intimidating experience." Similarly, Irene expressed concern for or a desire to be sensitive to the background of audience members when presentations are being made at church or to women's groups. She noted that there are millions of post-abortive women across the country. Sometimes those women are audience members when the centers are invited to various forums to speak. Often, these presentations will include ultrasound imagery. According to Irene, these images can have very positive effects upon the audience, but sometimes, the same images can be difficult for post-abortive women to see. She explained the need for understanding:

And so, showing ultrasound pictures can also be hard for some people. So we always have to try to keep that in mind and be very sensitive to the fact when you're showing ultrasound pictures, there may be people in the audience who are post-abortive who didn't understand fetal development.

So caution is used both in and out of the center when doing presentations.

Inside the center, participants indicated in various ways that steps are taken to ensure that the clients do not feel like they are at church. Even though the centers are unapologetically Christian in their orientation, they exercise care to avoid being confrontational. Zoe said, "We have somewhat of a Christian influence but it is not blatant." She also explained that the center wants clients to know what they are doing, to be responsible in their choices, and to understand that their choices have consequences. However, the desire to realize these goals is balanced with a desire to avoid sounding "preachy." She said, "...we never really are preachy about, you know, being, being anti-abortion, but of course, we would like people to chose life over that." Agatha's interview

agreed. She observed that, when clients enter, the center does not want them to “feel like they’ve entered an old church basement with pictures of Jesus.” On the other hand, Kayla described her center as “overtly Christian” and said that clients knew from the beginning the center was a Christian ministry.

The respondents also indicated that they do not usually display parenting magazines or baby pictures in areas frequented by clients. Agatha shed light on this theme by saying, “...when a girl comes in and she’s sixteen, and the last thing she wants to be is pregnant, and she’s hoping she’s not, we don’t want her inundated with magazines, parent magazines.” Christopher candidly commented that there is some disagreement, not really sharp disagreement, regarding the appropriateness of baby pictures in pregnancy centers. However, most of the centers reported not displaying baby pictures in their facilities. For example, Charissa said that there are no pictures of babies at her center. Anna agreed in her feedback saying that her center did not hang pictures of babies in the section where clients were present because, “We want to be sensitive.” Bethany’s response was similar.

Not only do the centers avoid displaying baby pictures, they also avoid exhibiting grisly or gory pictures, videos and etc. Kayla commented, “We do not use any graphic videos.... We don’t feel it’s necessary to show graphic videos of abortions...” Luke expressed the same sentiment. In his opinion, graphic pictures turn people off. Therefore, his center does not use what he labeled “strong arm tactics” and does not use pictures of aborted fetuses. From Angela’s perspective, the use of grisly pictures is unnecessary, especially given the availability of ultrasound imagery. She clarified:

And because we don't use abortion pictures or videos, uh, we don't have to because of the ultrasound that shows exactly what is happening to that very woman. Not just a picture of somebody else's pregnancy, but here's your very own, here's your very own pregnancy. Here's what is happening right inside of you.

Angela corroborated this sentiment when she opined:

I think that, and this is a personal thing, I think that contrary to showing graphic pictures of aborted fetuses, I think showing the miraculous forming life is mind blowing. And, and I see the powerful effect that that has as women see this life that is now inside theirs. Uh, so I think the, the miracle of this life being created is, it has a phenomenal effect.

So the participants deemed ghastly pictures counterproductive and unnecessary. Even when explaining or illustrating abortions, Cara pointed out, graphic images are not used. She also stated that permission is always sought from the client before sharing information about what happens during an abortion.

In summary, the centers' personnel endeavor to show sensitivity by being tactful in their approach and by avoiding grisly visual materials. However, some of the centers, not all, do utilize fetal models when processing clients. According to Luke, whose ultrasound examination room does have a photograph of a ten week sized baby reaching up and out from the womb and grasping the finger of a surgeon performing fetal surgery, he does use fetal models. In the exam room, there are models to scale of size and weight of unborns for ten, twelve, sixteen and twenty weeks of gestation. If the clients ask about the models, they are given the opportunity to handle the models and to ask questions



about them. Agatha explained that the ultrasound examiner would use these fetal models to supplement the ultrasound exam because not everything can be seen on the ultrasound. Anna employs these models as well.

Whether a particular center reported the use of fetal models, they all reported their effort to remain sensitive to the client. Sensitivity was mentioned regarding a number of scenarios including that of storytelling. Stories by clients, stories by caregivers or center personnel, and stories in advertisements emerged as themes during the interviews.

Continuing the theme of sensitivity in the context of storytelling, Cara noted that her center had devised a method that would preclude the possibility of nurses interrupting the meeting between the counselor and the client. After the pregnancy test is administered, the nurse will discreetly place the test results in a little cassette in a bag and hang it on the door of the counseling room where the counselor and the client are meeting. The counselor will hear this and know the results are available. This method means that the nurse will not interrupt the counseling session that is underway. According to Cara, this system was worked out to avoid interrupting when the client might be in the middle of telling a tearful personal story. So this center shows sensitivity to the storyteller by avoiding interruption of the storytelling.

Furthermore, Angela discussed the significance of client stories and of showing sensitivity during such self-disclosures. Angela described the ways that examiners respond to their clients during the ultrasound exams. She said, “We want to respond appropriately according to the client...or according to her story...” She also pointed out how important it was for the women clients to understand that the women counselors wanted to enter their stories with them. “But, uh, we want women to know that women

will listen to a woman, you know, enter their story with them. And help them in a really hard place.”

Sometimes, based on the data, one way that the counselor or caregiver enters the story with the client is by sharing her own personal story. Anna discussed the way that she shares her own personal story, her testimony. As a post-abortive woman herself, Anna feels like she is in a position to offer first hand knowledge about the abortion experience. When this is disclosed to clients, her story sometimes serves to break down walls or barriers to effective communication. Anna suggested that the revelation that the counselor is post-abortive may help induce the client to be more honest about her own past and may help the client to understand that the people at the center do not want to be judgmental. Once more, however, the counselor is sensitive to the client, and she will only tell her story with the client’s permission. Sometimes the story shared by the caregiver may be related to the caregiver’s own unplanned pregnancy or sometimes the story may be her Christian testimony. Also, the caregiver’s testimony may be used outside of the center as a means of soliciting or recruiting other staff or volunteers for the center according to Zoe.

Storytelling is not only used by clients and counselors within the context of the center, but it is also used in advertising conducted by some of the centers. Angela reported that her center produces a weekly radio program that features the stories of their clients. Each day, a two-minute segment of the personal story is aired. By the last day of the week, the entire story is told. So sensitivity and sensitivity as it relates to storytelling play important roles at these centers.

Another theme emerged that reflects sensitivity in sharing—the role of counselors as gatekeepers of information. Charissa acknowledged that, during ultrasounds, if there are multiple fetuses (e.g. twins, triplets, and etc.), the nurse does not typically point this out to the client. From Charissa’s perspective, “If the client is overwhelmed at the idea of having a single baby, she would ‘freak out’ over two.” So in this sense, the nurse controls the information that is disclosed to the client. Furthermore, as Agatha pointed out, the limited ultrasounds they perform are not intended to detect anomalies. Therefore, if the ultrasound reveals anomalies, that is, if the examiner sees something out of the ordinary that could indicate a problem, the examiner is trained to communicate this delicately to the client and to refer her to some other medical professional. The examiner does not elaborate in such cases.

The staff’s revealed awareness of these types of issues and their planned responses also manifested the intentional nature of the center’s communication. Respondents provided illustrations of this. For example, Irene made the following observations about the center’s strategies:

Of course our target client is the woman who is considering abortion. And so over the years, every decision we make is made with the, uh, intention of drawing abortion-vulnerable women into the center so we can give them good information and they can make an informed decision and know that there’s support out there if they choose to carry. Uh, and our number of abortion-vulnerable women has continued to increase.

Whereas the foregoing illustration underscores intentionality regarding the target audience, the following one underscores the intentionality regarding the décor of the

center. When asked to describe the layout and décor at the center, Angela responded, “Oh, sure! Sure, that’s, uh, it’s very intentional.” She went on to explain that there is lovely upbeat art on display. She remarked further, “We want to show women as strong.” According to her, the décor of the center was chosen with that goal in view. Furthermore, Agatha noted that the position of the center she serves is that increased male participation, namely the father of the child, in the process is a good thing. “And so,” she said, “we are particularly pursuing increasing the presence of the father in our ultrasound. That’s an intentional goal, uh, that we’re going to be working on in the next two years.”

In a similar vein, Anna stated, “You know I’m very careful on my words.” So several of the interviewees noted their careful communicative strategies—including their choice of terms.

#### *6. Deliberate Choice of Terms*

The data revealed that center personnel are, for the most part, careful with the labels they assign to themselves, to the unborn being carried in the womb, and to the procedures for ending pregnancies. There are choices made between the terms counselor or client advocate, baby or fetus, and abortion or pregnancy termination.

At the center directed by Christopher, the term advocate, rather than counselor, is applied to those who service the clients. From Christopher’s perspective, when a person mentions that he or she is meeting with a counselor, he said, “You immediately have that red flag stuff.” Clients may be thinking, even if they do not express it verbally, “Why do you think I need a counselor?” “And so,” Christopher went on to explain, “we’re using the word client advocate because that’s what people do--walk beside them.” While

Agatha and Zoe did not offer an explanation of their use of the term advocate, they used it throughout their respective interviews indicating a clear preference for that term over the term of counselor. Actually, neither one ever used the term counselor at all. This further underscored that advocate is their favored label.

Participants also variously labeled the developing life in the womb. Respondents used both terms, baby and fetus, in their responses. Kayla indicated that she ordinarily uses the term fetus when she is engaged in conversations replete with medical terminology. However, she suggested that she otherwise uses the term, baby. Zoe commented that she probably used the term baby more often with clients than the term fetus. She felt like the clients related to baby better than to fetus. When asked if she favored one of the terms over the other, Cara responded, “Yeah, usually we’ll just say baby because that’s what people are used to.” She went on to say, “You know, when you see someone in your office, you’re not going to say, ‘How’s your fetus doing?’” Cara later discussed the semantic dilemma that center workers face as they seek to evoke excitement in the pregnant woman while at the same time respecting the woman’s autonomy. She discussed this tension as follows:

It’s a fine line that you walk. It’s a very fine line that you walk because you always kind of try to be respectful about boundaries and about manipulating people’s emotions. You don’t want to do that. We can’t tell people what to do, but you also don’t want to miss an opportunity to kind of celebrate the life that’s there. So you certainly [are] kind of looking for words to say that. And also there’s nonverbal communication. I mean there’s, you know, smiles.

Ruth shared her sentiments on this situation as follows:

The one thing like the doctor does not do is, she doesn't say baby in every sentence. You know, which might feel like, you know that might be hard for a woman if she's just not quite sure what she wants to do and that may feel like we're trying to drop that word in. But it's certainly used. So we don't shy away from it at all because it is a baby. Yet at the same time we try to be sensitive to the client so that, uh, we're, you know, treading lightly so that she sees the truth, hears the truth, and, uh, knows the truth yet at the same time it's not overpowering to her.

So the data revealed tensions that exist in the choice of terms used in reference to the contents of the womb.

The data also indicated that some centers shy away from the term abortion and favor the term pregnancy termination instead. For example, during the interview of Christopher, he mentioned pregnancy termination. The interviewer followed up by asking about the phrase—pregnancy termination. Christopher replied that abortion has negative connotations associated with it, but pregnancy termination means the same thing. Yet, pregnancy termination does not connote the same harshness as abortion does. He also went on to explain that certain words in certain social circles have very negative connotations and therefore, turn people off. Consequently, people at the center try to come up with terms that open opportunities to share rather than close them. Personnel reported that they make every effort to engage the clients and those who accompany them in interpersonal conversation.

## *7. Interpersonal Communication*

The personal interaction between clients and center personnel emerged as one of the most salient themes among the data. Respondents discussed the way they seek to tailor their responses to the feedback they receive from clients and the way they pay attention to various verbal and nonverbal cues provided by the clients. Some also described the ways they seek to engage the clients in greater participation in the communication experience, and how verbal “games” are sometimes played during interaction. Finally, the interviewees elaborated on the significance of the relationships they establish with those who seek their services and the role of mentoring.

The respondents appeared to be keenly sensitive to the feedback offered by clients. They pointed out that they seek to accommodate the client’s circumstances, mood, and etc. For example, Cara explained that when clients seem particularly nervous about the ultrasound experience, she always spells out everything and asks specifically for the client’s permission before showing her some feature of the ultrasound exam. However, if the client seems more comfortable and relaxed about the exam, she infers that the client is willing to see the various images the exam will provide. Angela provided a description of the way personnel seek to adjust their responses to the client’s communication during the ultrasound exam. She said:

We want to, we want, we want to follow the cadence always of the client. So we don’t have a set, we don’t have a set response, or a set, uh, when she says, you say, you know, talk track for anything we do. We want to respond appropriately according to the client, emotion is being displayed, or according to her story, like just so hard, and uh, but we’re always, I mean it’s always with compassion. And

so whatever, whatever is appropriate. And our nurse is really good. She's really good.

Angela went on to explain that even when the client is not excited about the pregnancy, the center personnel usually are. She discussed the way their desire to respond in an accommodating way is challenged in such circumstances. She noted this tension as follows:

And sometimes there's a room full of people and everybody's excited. Then we can be excited too, and not that we're not excited when she's sad. We can say, we can still keep a, you know, a demeanor that says this is, you know, here's, here's the baby's heart, uh, a heartbeat. We can show that on the screen with the, there's a graph that can, that can be shown. Yeah, so whatever's appropriate. That's how we want to respond.

Bethany's description of the ultrasound experience was similar. She said:

Uh, we just try to be very sensitive and compassionate. If they're excited then, uh, myself or the lay counselor in the room, we're there to rejoice with them over the baby. And, uh, rejoice at what they're seeing. If they're undecided, if they're sad, crying, we just try to be very sensitive to that.

Kayla commented on her responses to the client by saying, "I take their cue."

Ruth noted the attention paid to nonverbal cues. She observed that if there was any look on the client's face or anything that may concern the examiner, the examiner would pause and say, "Are you O.K.? Do you have any questions? How are you feeling about this? And that kind of thing."



The counselors and examiners not only pay attention to the cues they detect during the ultrasound exam, but they also attend cues throughout their interactions with the clients. Charissa explained, “During the interview, the counselor looks for and listens for cues to determine what other types of services the client may need.” Perhaps the client is need of counseling regarding drugs. Sometimes the client may need housing. Sometimes there is a domestic abuse situation. The counselors are trained to look for signs that may indicate additional needs.

So the personnel at the centers pay attention to the verbal and nonverbal cues of their clients. Sometimes, the personnel take extra steps in efforts to engage the clients or those who are with them in the communication experience.

Charissa explained the way this done during the ultrasound. If the client has a companion, the nurse may give the companion a long pointer to use in pointing out to the client the features of the ultrasound identified by the nurse. This engages the companion and the client more in the experience. For example, Irene explained:

[She] hands them, a, uh, a pointer stick and she'll show them on the machine a certain thing, like this is the heartbeat, and then she'll have them point to it with the pointer on the TV that's up on the wall. And so she kind of engages them and gets them involved...

Sometimes a sort of verbal game is played, according to Charissa, and this also engages the client in more interaction. She explained what she meant. Under the laws of the state where her center operates, only a medical doctor can confirm a pregnancy. So, if the doctor at the center has confirmed the pregnancy, then the ultrasound examiner will refer to the thing in the womb as a baby. However, if the doctor has not confirmed the

pregnancy, then the examiner will refer to the thing as something like “a solid white structure.” This sets up somewhat of an awkward conversation about what is going on in the womb, especially with the visible heartbeat and bodily motion. In these cases, the verbal exchange between client and examiner or counselor is more like a game. This game of sorts tends to result in more self-disclosure on the part of the client, and this helps the personnel better evaluate the dynamics of her situation. Moreover, according to Charissa, this interaction helps facilitate the development of a personal relationship with the client. This relationship is something the counselors, nurses and so forth really want.

The center personnel aspire to establish a personal rapport with their clients. Angela spoke of the importance of establishing a “good connection” with the clients. Kayla noted that one of the goals of the center she serves is to get teen mothers involved in a mentoring program. Luke also noted that his center wants to provide follow up services that include spiritual training, mentoring and education.

In their efforts to build these relationships, according to some respondents, centers have gone to great pains to make their facilities friendlier both to men and women. Ann explained that her center had recently redecorated to make the center more “gender friendly.” She elaborated, saying, “...we wanted to make it more friendly to men too...” She said, “So I think we definitely have, uh, tried to move along with times and make all of the clients feel welcome.” Christopher noted that even though he has limited contact with clients, he nonetheless endeavors to give the clients a smile and be as welcoming as he can. The respondents noted a desire to create a climate that is warm and welcome. They seek to do this through the décor at the center and through their interpersonal dialogue with the clients. In the process of interacting with the clients, the people at the

center employ persuasive arguments and artifacts in efforts to convince the client with the unplanned pregnancy to carry the pregnancy to term.

#### *8. Persuasive Arguments and Artifacts*

Luke, more than the other respondents, seemed to be the most willing to discuss the use of verbal arguments with the clients who are planning to terminate their pregnancies. He noted that in such cases, he might say something like the following:

This is a creature of God, a gift of God. You don't want to destroy this baby do you? ...If you choose to have an abortion, God does not want you to do this, but God gave you a will.... If you have an abortion, God still loves you and we still love you and you are welcome back at the center.

At least one of the centers reported exposing clients to persuasive arguments that they themselves did not author. One of the ministries that these centers offers is a ministry to post-abortive women. At one of the participating centers, clients are given the opportunity to write their aborted babies a letter. These letters by post-abortive women are posted on one of the walls at the center. Clients who are contemplating abortion are given the opportunity to read these letters if they so choose. These letters, therefore, have at least the persuasive potential of changing the client's mind regarding her plans to abort.

Overwhelmingly, the interview data suggest, however, that centers rely more on the relationships they build with their clients and the images they show their clients than they do on persuasive verbal arguments. The data suggested that the images seem to help the clients reach their own conclusion not to abort.

Ultrasound exams produce images that are, in the mind of the participants, powerful. Christopher explained:

We provide the ultrasound exams because we know and of course now having used it since 1997, over ten years now. We know it's a great tool revealing to the client that it's a little life inside them. And, uh, we know that it is a tool of changing minds. And, uh, we never put any pressure on any client, but we've seen the ultrasound be the powerful tool for changing minds to life. And, uh, that's one of the things that we pray for every day from 8:45 to 9:00 that minds will be changed to life. The ultrasound is a great tool for that. We see it over and over again every month.

Christopher elaborated further on the power of ultrasound to change minds. He said:

Well, uh, I guess without seeing an ultrasound, you know that old saying "Out of sight, out of mind"? If they're trying hard not to think about it, they're just thinking about what's convenient to them, uh, and all, if any reasons why their peers or their parents or their boyfriends have told them they can't have their baby. You know, they have all that to weigh. Yet, when they come here and they consent to an ultrasound, they actually see a living being within them. And I just think that just tilts the scales. They, it's almost like, some of them, it's almost like the first time they've realized that it's not a blob, and it's not tissue. It's a baby. I think, uh, they finally understand that, you know, something very, very valuable. And, you know, 80 to 85% of them don't want to do away with that.

Irene agreed, saying, "Ultrasound is a powerful tool." Angela's responses affirmed this. She noted:

Uh, you know ultrasound is, uh, a very important program for us. Meaning we, we would like to uh, have every abortion-minded woman... have an ultrasound. We have a twenty-four hour...nurse manager. And we also have of course, a medical director who comes in as well as a couple of other doctors that do ultrasounds for us. And the results are dramatic. It's between 80, 85%, 90% of women actually change, change their mind when they see an ultrasound.

Agatha discussed the effect ultrasounds tend to have on couples. She pointed out:

Uh, our center, I think, feels very strongly that this picture of the unique baby of this woman and this man, if seen by them, uh, will have a positive effect on their choice for life for this baby. And so that belief has been confirmed as we've seen [it] repeated with couple after couple. Uh, one of the things that I love about it is it's a fabulous teaching tool for the nurse and for the client advocate who may be with her client in there.

Agatha elaborated further on this when she said:

I think that, and this is a personal thing, I think that contrary to showing graphic pictures of aborted fetuses, I think showing the miraculous forming life is mind blowing. And, and I see the powerful effect that that has as women see this life that is now inside theirs. Uh, so I think the, the miracle of this life being created is, it has a phenomenal effect.

Ruth experience bears this out as well. According to her:

Um, I think that for women seeing the ultrasound, seeing the heartbeat, in a lot of women's minds, uh, once the heartbeat is there, they have determined that there's a baby. So I think seeing that, I think seeing the movement, seeing how much the

baby is formed, uh, very early in a pregnancy, I think that that has a huge impact on women. Uh, just the truth of, it's one thing to see a brochure of fetal development of the pictures, and then it's another whole thing to actually see it on a screen, and it's your body and your fetal development. So I think that's very key.

Again, Anna answered similarly saying:

So ultrasound just is trying to let them see into their womb with that. Wow, you know, this thing is really living, not just a clump of cells or tissue. It's, you know, a life with need, when it was conceived. So we just try to make them more aware of that, you know.

So the interviewees were confident in the ability of ultrasound imagery to change the minds of women who were considering abortion. Therefore, they offer ultrasound exams to clients who, in their judgment, may abort.

Furthermore, recognizing the potential of these images, the centers endeavor to send the clients home with their own copies of the images. These images can then be used to start or supplement a family photo album, to increase retention of the photos and/or their messages in the mind of the clients, and to elicit the support of significant others in the lives of the clients.

Irene made reference to starting a family photo album with the ultrasound pictures when she commented on the efficacy of ultrasound. She explained:

Well, ultrasound is a powerful tool. And we don't have 3-D or 4-D ultrasound, but uh people see ultrasound all the time now. On TV, people bring pictures of, ultrasound pictures and start a photo album for their children. One of the

questions I heard [a coworker] ask a client recently was, “Would you like some pictures to start an album?” And this particular girl was very abortion-minded and she said, “No.” Uh, but most of the time, they say, “Yes,” and they get excited. And we have a little frame that we put the picture in and they take it with them.

Charissa reported that, in the mind of the nurse at her clinic, these black and white images that are sent home with the client help influence the client. However, as Charissa observed, that was not true in every case. Luke mentioned that the clients are usually excited to receive the black and white photos to take home. Zoe pointed out, “So that [black and white photo] gives you a presence in the home long after the exam.”

Realizing this, the ultrasound examiner may go to extra lengths to capture some special image on the screen in order to be able to send it home with the parent(s). Cara alluded to this when asked to contrast her experience performing ultrasounds both inside and outside of the center. She responded:

Um, one big difference is time. You have, you’re not under the gun to crank through something. You actually have time to expand on things. You have time to try to capture a special image of the baby—maybe the profile. You know that’s a thing I didn’t mention. I’ll spend time after getting the basics, you know, heartbeat, measurements. I will try to catch, like a, picture of the baby’s hand or a little bit of the baby’s face or something to print out for the parents to be able to take with them and remember it. You have the time to do that. And really I think they get so much more out of it, because you know as a doctor I’ve always been able to talk to my patient. So my experience is going to be different from a

nurse... So for me, the biggest difference is time. I have the time to really interact with the patient and not just kind of get my job done.

Zoe also commented about the role these take home pictures play. According to her, they help make the pregnancy real to significant others. She commented on the importance of getting pictures “so they can take them home and show them to people, you know, which, which makes it real in their minds and real in the minds of people who are around them as well.” Angela explained the way some clients use the images from the ultrasounds to elicit the support of these significant others. When asked why clients want ultrasounds, Angela noted:

Uh, they, uh, we’ve talked about for dating as well as they just, they just, uh, really they want to confirm a uterine pregnancy. They want to really see what it’s all about. They want to show their boyfriend. They want to show their parents. Often in abortion-vulnerable women, [the] woman wants to carry but wants her boyfriend in on the ultrasound or her parents uh, to help, to help her.

That’s an interesting combination too.

So the interview data suggest that these pictures can be used for use in family albums, to increase retention of the information and/or experience at the center, and to elicit the help or support of others.

However, these images or photographs seem to rarely stand on their own. That is, the examiners do not simply perform an exam and remain silent throughout the process. As indicated earlier, they are frequently engaged in conversation with the client and with those accompanying her. So there is some verbal overwriting taking place both in the exam itself and even on the photographs that are sent home.



Zoe acknowledged that she is usually quite excited during ultrasound exams, and that her excitement is evident to client. She remarked:

Yeah. Generally there's a positive reaction. Um, you know, sometimes they're surprised that they can see as much as they can or they'll make a comment like that. Or, you know, they're surprised that they can see little arm and legs, but, uh, you know, we had one baby that was maybe 11 weeks and we got just an incredible face shot. I mean, it was almost like a 3-D picture and, you know, I mean, I'm pretty much of kind of a cheerleader and, and an enthusiastic person, and so I probably, you know, really encourage that too for them to do that kind of, you know, to look at the miraculousness and [how] cool everything looks and what they're able to see and so forth. So that's probably a little bit from me, but I think for the most part they uh, when they're seeing their own baby in there, I think it's pretty amazing for them.

Cara also acknowledged that she would not just offer a dispassionate exam. As discussed earlier, the examiners endeavor to adjust their communicative behavior to the clients'. However, as Cara pointed out, the examiners will say things during the ultrasound in attempts to offer the client a different perspective. She discussed this as follows:

You know, again, it really depends on the clients. We're very sensitive. All of us are very sensitive, so if I have somebody who's told me they want an abortion. They do want the ultrasound. We go through it. I'm going to be, you know, I'm going to say, "O.K. This is your baby. Uh, here's your measurements." And in a subdued tone I might say, "Oh, look, look your baby's moving right now. Do you see that?" Uh, whereas if it's somebody who is vulnerable because she's single

and doesn't have a job but she's happy to be pregnant, with her I'm going to be more likely to say, you know, if there's something like the baby's..., "Oh, look the baby's waving at you. This is such a cute time to do an ultrasound. The baby looks like a little teddy bear." You know, I'll say things just what I'm thinking at the time. You know, that I, about the joy of looking at this life.

Sometimes those accompanying the client, such as the father, may engage in verbal overwriting themselves. For instance, Ruth reported that fathers would often say things like, "Look at him moving. He's going to be bad like his daddy. He's going to be a football player."

Bethany commented that she would sometimes write messages on the ultrasound pictures that clients take home. She noted:

Uh, and then I usually take, depending on what I see, if they're early or late, one, maybe two pictures for the client. At times they'll ask me, "Can I have a picture for the dad or for my mom?" And so I'll take or print however many they want—two or three of one image, so they can have one to give to someone else. Uh, sometimes if they want me to, I'll put a comment on there that says, "Hi, Daddy" or something like that, or "Hi Grandma" if they want me to. If it's early, a lot of times I'll label [it, saying] "This is the baby." "This is the yoke sac," for example, so they'll know what they're seeing. And those would be for the ones that they hand out.

So the images that the ultrasound experience generates are used in communicating with clients both inside and outside of the center. Based on the interview data, one of the most meaningful elements of the ultrasound experience is the heartbeat.

Several interviewees commented on the significance of the heartbeat as seen and/or heard during the ultrasounds. Irene provided an example to illustrate this. She remembered one client's experience this way:

...this other director said, ...“What cha got there?” You know, and the girl said, “It’s a picture of my ultrasound.” And uh, the center director said, “Well, tell me what’s there. Tell me what you’re seeing.” And she said, “That’s the baby’s heartbeat right there.” And she looked up at her and she said, “I didn’t know it had a heartbeat. I didn’t know it had a heartbeat.” And she probably said that two or three times. And they had been pretty sure that they were going to have an abortion. But the fact that they learned that their baby had a heartbeat and the stage of fetal development that their baby was in did cause them to change their mind. And they carried their baby to term. And they were very grateful, you know, came back. But it was new information and, uh, they had to process that new information.

Ruth remarked that, “Sometimes the heartbeat is the same for a woman that it is an actual living baby.”

In addition to being able to see the heartbeat, at some centers, an audio of the heartbeat is also available. The interviews revealed that there is some controversy over the safety of using the necessary equipment to generate audio of the heartbeat—especially in the first trimester. In centers equipped with the machinery and possessing the willingness to do so, audio of the heartbeat is made available to the clients. In such cases, Luke reported that clients usually would be in awe. Some will say, “Awe. Listen

to that. That is my baby's heartbeat." Sometimes those who are contemplating abortion will cry. Those who have made up their minds to abort usually do not cry.

The data revealed that, whether accompanied by audio or not, the beating heart is a significant factor in the minds of the clients. The heartbeat tends to reify or make the pregnancy real. When asked about the role of ultrasound at her center, Zoe responded:

Well, basically just to visualize that there is actually a living human being present. And I think that helps with, uh, helps the mother to bond with her own baby. And uh, you know it's one thing to talk about, about your baby, but to see it on the screen and see it wiggling around, and see a little heartbeat, I mean, that just makes it more real. And uh, I think sometimes that helps it to soak in that it really is a little, a little being there and little a little human and a little baby there. And uh, so, I just see that's it's a very positive, uh, you know, life affirming type thing for, um for, the clients.

When asked the same question, Anna answered in a similar fashion, saying:

I think it's really, I think it's extremely important because uh, you know, women really don't know if they're in an unplanned pregnancy if, you know, they're not thinking clearly, you know, they're in a crisis. And even if they're uninformed, you know, as I was, you don't really think of it maybe as a baby or just, you know, cells or tissue. Uh, so they can see by the ultrasound that you know the baby's heart is beating at 21 days. And there's also a bond there too when that happens. Uh, we just had a woman yesterday, you know, she was uncertain what to do with her pregnancy. And she said, "Well, this kind of makes it really real for me to see that on the screen. And that kind of changed my decision...." You

know, but it definitely brings it, uh, it brings it home. It makes it a reality, and that it's really here. So it's a very important part of the ministry.

She continued to elaborate in response to another question, saying:

For that reality of, if a woman can, in a kind of a window to the womb if you will, if they see that, then maybe they can process that and realize, "Wow it's just not, you know, a blob of tissue. Wow the heart is beating." It has to be at 21 days. And you know, and then we will review with them all that's taking place—like at six weeks and seven weeks, what's developing, what's happening. And most people are astounded. Like, I had no idea. You know, that's what happens, you know, and, "[I] didn't really think it was anything until I was, like, 20 weeks along or something like that." So, it just, uh, it brings more of a reality to them that the baby is, you know, alive from conception.

So the ultrasound experience tends to make the pregnancy more real to the clients.

### *9. Reification of the Pregnancy*

For some clients, as indicated in the quotations above, being confronted with new data regarding their pregnancy leads to a "second crisis." Discovering they are pregnant, when the pregnancy was not planned, is the first crisis, and discovering new data relevant to that pregnancy constitutes the second. The information that centers share with their clients has the potential of challenging the clients' previously held ideas. Irene pointed this out when she observed:

And interestingly, what will sometimes happen is, you know, if they've come in and they've made up their mind that they're going to have an abortion, then they have an ultrasound, sometimes it can uh create for them a kind of second crisis.

Because now they've seen the baby's heart beat and so now they have a new set of information. And, uh, they have to kind of process that.

Whether the experience of learning new information turns out to be a second crisis, for many, the new information does make the pregnancy a reality.

Interviewees provided illustrations of this. For example, when asked why her center provides ultrasound, Kayla responded:

Uh, primarily because it's a great opportunity and a window to the womb if you will. Uh, it's a great opportunity for them to see uh, the life, for them to behold. So, uh, when the baby pops up on the screen, they can see, have a visual. This is your baby. Because a lot of times early on in pregnancy, don't really feel like you're pregnant. Doesn't seem real. And so we give them something visual to see. I've heard many of the girls say, "Wow. Now it's real." So it gives them an opportunity to actually see that there is life inside their body.

When asked how ultrasounds may influence women, Charissa answered that ultrasounds may help influence women to "carry to term," and that they serve as a "reality check."

Bethany elaborated on the influence of ultrasound on women, saying:

I think it strongly influences them, because a lot of them have been told that it's just a blob of tissue—especially the early ultrasound, you know, six or seven weeks. For them it could be very eye opening for them. "Oh, it has a heartbeat?" They can be really surprised to see that. Uh, I think it influences them with education--just lots of education about what's really going on with their baby. Uh, and then I think I already also implied earlier that sometimes the ultrasound images will allow them to connect with their baby. At this point all they are is

nauseated... They, they don't feel movement. They haven't seen their baby. They're not getting the pregnant belly or things like that. So it allows them to connect to the fact that there is a baby. This is what's going on and I will be a mom. I am a mom.

Bethany's remarks introduce another sub-theme—the connecting or bonding between the mother and the baby. Other respondents mentioned this also. Irene, for example, discussed this subject. She commented:

Well, I know that our number of women who, uh, have chosen to carry has increased significantly since we added ultrasound. So it definitely educates people, gives them an opportunity to bond with their baby, and, uh, helps them realize that if they choose abortion, uh, that is a life that they're taking. And so I think it's, uh, I think it's been a powerful tool and is a powerful tool to help women and men choose life.

Zoe identified three influences that, in her experience, ultrasound has on women. First, ultrasound makes the pregnancy more real. Second, the images help them visualize their own baby. Third, the ultrasound helps them with the bonding process.

While the ultrasound may facilitate bonding between the mother and her baby, at least one interviewee suggested that ultrasound sometimes has a similar effect upon the father. Agatha shared a story to illustrate this. She discussed her center's goal of increasing the participation of males, typically the fathers, in the ultrasound experience. However, whether the males participate or not, the centers like to have the clients do an ultrasound so "that bonding with that unborn baby can start now," regardless of what becomes of the relationship between the client and the male in her life. Agatha went on

to explain that bonding does frequently occur between mother and baby, and that women are fairly verbal about it. However, something similar to bonding or bonding itself, in the mind of Agatha, sometimes take place with fathers as well. To illustrate, she related the account of a Hispanic man who accompanied his pregnant girlfriend to the center. In her words, he was “very angry” and “not a nice person.” He wanted her to abort, but his girlfriend did not want to abort. An argument took place between the man and the woman at the center. They left, and the staff thought the client would probably abort. However, months later, a gentleman came to the front counter and asked to see the “old lady that was a nurse.” The staff laughed and told him, “Oh we don’t have any old ladies who work here.” He said, “Well, she’s the nurse.” When the nurse came out, the man held up the baby. He said, “I want you to see my pride and joy.” He introduced the nurse to his baby daughter. The gentleman was the angry man who had wanted his girlfriend to abort. Agatha explained that the man had participated in the ultrasound and that experience had impacted his thinking. This led to a change of mind.

So the data revealed that ultrasound imagery might influence both women and men. In the story above, the ultrasound technology might have facilitated the woman getting her way—keeping the baby. This leads to the final major theme that emerged from the interview data.

#### *10. Empowering the Client*

The pregnancy support centers reported that they are interested in maintaining the dignity of the client and enabling the client to reach her own decisions. From the décor to the technology, the centers aspire to preserve the dignity of their clients. Angela discussed the role of art as it relates to the women. She said:



So, uh, our décor is very upbeat. Uh, as you get off the elevator, there are, uh, we have, we have art. We also, uh, received art from a donor that's very lovely upbeat art. We want to show women as strong. We have no baby pictures out. We have no family pictures out. Uh, we don't put crosses out. Uh, somebody would, we want a woman to feel very honored when she steps off our elevator. We want her to know that this is a different place and it's a place of strength. And uh, that's, with the art that we have, it's very upbeat.

According to Angela, even providing the clients with the Request for Services Form so the clients can spell their own names, supply their own information, and etc. is intentionally designed to maintain the dignity of the clients. The clients are greeted in such a way that precludes the necessity of them having to say, "Oh, I'm here for a pregnancy test." Instead, the form they complete enables the staff to respond appropriately.

The centers reported the desire to enable the client to reach her own decisions by equipping her with the information necessary to make an informed choice and by providing the emotional support necessary to follow through on her decision. They reported that they want to empower women to decide for themselves. Christopher said, "I think they know that they can, uh, get the information that they need in a place that's not judgmental and uh, be able to come to their own conclusion, their own decisions." When asked about the role that ultrasound technology played at her center, Irene answered, "Well we view it as a tool to complement counseling. Uh, it's not something that has replaced our counseling. It's really just an additional tool to help a woman make a well-informed decision." Angela explained the influence of ultrasound by saying, "...

ultrasounds empower women with the courage and hope that they need to just make that strong, hard decision. If somehow, even though nothing else around them changes, it gives them strength to continue forward.”

Along with empowering women to make their own decisions, centers want to appeal to what they perceive to be basic instincts. Respondents alluded to the parental instincts of protecting and providing for their own. For example, when asked about the influence of ultrasound on women, Christopher responded:

Well, uh, I think, you know, I just think within us there's, there's that mystery of life. It's a recognition, you know, when they see that ultrasound image, that there is a life there, and I think...that in itself influences them to choose life. I think they have almost, in a moment, they have a sense of compassion. You know, a resistance to do anything harmful to that new life within them. And, I, I just think it's a great influence.

Angela offered a vivid description of the process she has witnessed in her clients. She said:

And if we didn't have the firm conviction that God created every woman with a heart to nurture and protect her own children, now that, that's, that's our belief. That's our conviction. That's our, that's what we know. That's what we live. So we don't have to trick anybody. All we have to do is listen, be available, show exactly what's going on, and what happens is the courage that God built women with, you know, when, when those layers are finally unwrapped and, and all the, uh, fighting and defending is put aside, then a woman can say, “This is my, this is my child. And I, nothing has changed. My circumstances haven't changed.

Nothing's changed. But I'm going forward with this pregnancy." That happens all the time.

Bethany also commented on the protective response that ultrasound, in her opinions, tends to elicit.

Agatha described how some males, fathers, seem to have the desire to provide for their baby aroused in them through the ministry of the center. She noted that her center encourages the father's participation in the parenting program. Their participation entitles them to vouchers that they can redeem for baby supplies. She elaborated:

And so of course that's what Mom's going to do, but it's really kind of cool to see mid-month, when a dad comes in to get diapers, or formula, and he's got his vouchers that he earned because he came and took the classes. And he's doing something to provide for this child. And, you know, for a dad to come to 9 weeks of parenting and budgeting and the guy is maybe fifteen and full of tattoos and earrings, that he's skateboarded and doesn't even drive a car. That's quite a big deal.

In short, the respondents indicated that the services they offer to clients and the significant others of these clients are intended, at least in part, to activate what they perceive to be maternal and paternal instincts to protect and to provide for their offspring.

The foregoing themes and sub-themes surfaced during the course of the interviews. During these interviews, the researcher requested that participants provide some examples of other materials that the centers use in their communication with their communities and clients. The participants obliged by sending various samples of printed materials and programming.

## Other Materials

Although the focus of this study has been the rhetorical use of ultrasound technology, a consideration of some of the other media utilized by these centers is in order. This section provides relatively brief descriptions of some of these media and how the themes that emerged during the interviews are revealed in these media. The upcoming section is neither a rhetorical nor a content analysis but simply a discussion of the media. In broad terms, the media fall into three categories. First, materials that are distributed on university campuses will be examined. Second, material distributed among pastors and churches will be reviewed. Third, advertisements that run on local cable television will be examined. Fourth, the statement of promise of one of the centers and the promise that the participating organization makes will be considered.

### *University Campuses*

While there were multiple centers located near colleges or universities, one center supplied examples of grab bags that they distribute on these campuses one day each month throughout the year. The reported purposes of these items are to acquaint the students with the ministries of the pregnancy support center and to acquaint the student body with the name of the center. Four samples of these grab bags were provided. Each bag is made of a clear cellophane material and tied shut at the top with colored ribbons. Each bag focuses on a particular theme such as abortion, date rape, STDs, and exercise and stress.

Moreover, each bag contains the business card of the center. The cards contain the data normally contained on business cards such as the name, address, telephone number, email address, and web address. The name of the center clearly reflects that the

organization is geared toward women. The following statement appears on the cards: “Providing educational information about pregnancy, fetal development, STD’s, healthy relationships, and related concerns.” This single statement reflects many of the themes previously discussed. The statement suggests a holistic ministry (not overtly Christian) to the woman, those with whom she may be in a relationship, and her unborn. The statement also suggests the availability of professional health services. The business card was found in all of the bags, but otherwise, each bag was unique.

The first bag contained a bright yellow postcard-sized card containing the basic contact information for the center. The card contains a statement saying, “...seeks to serve our patients with the utmost care and integrity...” This statement reflects the themes of quality and integrity. The card also contained a section labeled, “What our clients are saying about us...” One of the quotes said, “I liked being helped by friendly and non-judgmental people.” This suggested the themes of an emotionally supportive environment of compassion and non-judgmental responses. One quote said, “They made me feel comfortable instead of embarrassed.” This revealed the themes of a safe supportive environment and client dignity. Another quote said, “I really appreciate the concern the nurse and counselor shared with me.” This reflected the theme of professional medical care since reference was made to a nurse.

The flipside of the card provided a list of services provided by the center. The free and confidential pregnancy testing revealed the theme of benevolence and free services. The limited ultrasound and prenatal care revealed the themes of professional health care. The education on all pregnancy options and sexually transmitted diseases (STDs) revealed the information-seeking theme. Finally, the emotional support from

“Trained, Volunteer Client Advocates” revealed the themes of professionalism, inasmuch as the volunteers are trained, and the theme of careful label choice, inasmuch as the counselors are referred to as client advocates.

The bag also contained a bookmark with a poem titled, “I Will Soar.” The poem mentions self-respect, celebration of life, guarded emotions, protected health and commitment. The poem closes with the line, “I will pursue my dreams without bound or limit...I will soar.” This poem manifests the themes of empowering and enabling the client.

The grab bag also contained a small pamphlet titled, “Before You Decide.” It is labeled on the cover as “an abortion education resource.” The first few pages offer questions. One says, “Should I be concerned about having an abortion.” The answer mentions potential “significant physical, emotional, and spiritual consequences.” Another says, “What can I do about people pressuring me?” The answer asks the person to remember that they, as an individual, will have to live with the consequences of the choices they make. Another says, “Can I have a baby and still live my life?” The answer points out that many women have faced the same situation and still found resources “to make positive choices and realize their dreams.” The booklet moves on to provide a brief glossary of pregnancy related terms and their definitions. The next section of the booklet steps the reader through the first day, nine weeks, 13 weeks, 16 weeks, and 22 weeks of the pregnancy. This is done with color photographs for the nine, 13, 16, and 22 weeks fetus. At nine weeks, the caption says, “At this age the baby’s heart has been beating for one month.” At 16 weeks, the caption says, “At this age the baby reacts to loud noises.” At 22 weeks, the caption says, “At this age the baby’s eyelashes can be seen.” The

photograph reveals the facial hair of the unborn. The next section offers a description of various abortion procedures, and the immediate risks of abortion. This is followed by a discussion of the debate over the link between abortion and breast cancer, the effects of abortion on future pregnancies, the emotional impact and the spiritual consequences. The booklet contains a chart enumerating symptoms of post-abortion stress (PAS). The list includes the following: guilt, anger, anxiety, depression, suicidal thoughts, anniversary grief, flashback of abortion, sexual dysfunction, relationship problems, eating disorders, alcohol and drug abuse, and psychological reactions. The closing pages discuss parenting and adoption. The text says, “But **real empowerment** comes when you find the resources and inner strength to make your **best choice** [emphasis in original].”

This pamphlet resonated with many of the themes under review. The information provided offers the client a brief education on pregnancy and abortion, but it does so in a sensitive way without grisly pictures or gory details. The booklet employs persuasive material that is both verbal and visual. Finally, it closes with theme of client empowerment.

The second grab bag also contained the previously described business card. This bag also included a tri-fold pamphlet discussing ten things people can do to protect themselves against date rape. The cover says, “You have the right to say no,” and “Stay in charge.” These statements reflect the themes of empowering women and enabling women. Another purple slip contained true and false statements about date rape with the answers on the flipside. The bag contained a postcard-sized brightly colored slip with the center’s identifying information and information about the center’s STD services as well. Again, the services are promised as free reflecting the benevolence theme. A

bookmark-sized card explaining that the more sexual partners one has, the greater the risk of becoming infected with an STD. Also, a business card-sized card containing the statement, “The secret of contentment is the realization that life is a gift, not a right.” This seems to reflect the overarching pro-life stance of the centers. Finally, the bag contained a small packet of Sweetheart candies.

The third bag contained the business card, but it also contained a business card-sized item with the statement, “You can achieve anything if you have the will to become the best that you can be.” This type of positive remark supports the theme of empowering women. This packet also contained a bookmark demonstrating numerically how increasing the number of one’s sexual partners increases one’s risk of becoming infected with an STD. Also, a bright orange postcard-sized article promised free and confidential testing for a number of STDs. A bag of M & M candies was also included.

The fourth bag contained the business card and the same card promising free and confidential pregnancy testing that was described under the discussion on the first bag. The bag included a tri-fold pamphlet discussing the role of exercise in promoting good health, and especially, in reducing stress. This reflects the themes of concern for the person’s physical and emotional health. Moreover, the bag included a stick of lip balm and an emery board for filing one’s nails.

#### *Churches and Pastors*

One of the centers provided an example of a packet that is used for circulation among churches and pastors. A professionally prepared folder designed to contain 8 ½” X 11” papers contains numerous articles. The jacket has the center’s name as well as the



words, “hope, self-worth, Jesus, purity, and value.” The phrase, “Options in Times of Indecision” also appeared across the front along with “Programs and Services.” The words and phrases on the jacket front represent several of the themes under review. The mention of Jesus points out the Christian ministry approach. The word hope represents the theme of emotional support. Self-worth and value reflect the theme of client dignity. The phrase, “Options in Indecision,” typifies the themes of uncertainty reduction, information seeking and education.

The packet contains numerous articles including a cover letter promising high professional and humanitarian standards. The mention of these standards underscores the themes of professionalism and benevolence. The promise to serve with the utmost “care and integrity” points to the themes of integrity. The letter explicitly mentions the physical, emotional, and spiritual needs of clients—all themes under review. The letter moves on to speak of educational materials that are used with great sensitivity. These words reflect the themes of education and sensitivity in sharing. The theme of credibility emerged when the letter cited the more than 4,900 total patient visits it had received in the previous year. The theme of benevolence surfaced as the letter explained that these clients were all served at no cost to them. The various ministries of the center were enumerated and included, in part, free confidential pregnancy testing, limited ultrasound, and emotional support from volunteers. Again, the themes of benevolence, holistic ministry, professional health service, and the safe supportive environment surfaced.

The folder also contained a sample newsletter of the center. This particular featured the upcoming “Walk for Life.” Such fundraising activities underscore the benevolent nature of the center. The newsletter discussed how families could open their

homes to play host to women dealing with difficult situations. Such an approach reflects the commitment to meeting the physical, emotional and spiritual needs of clients. The newsletter also contained a section highlighting local businesses that supports the center's cradle club program. The back page contained the list of the board members, the list of commemorative gifts, and a table of statistics. The center had seen almost 1,000 clients through April of that year and administered 239 pregnancy tests.

The packet included a glossy tri-fold brochure that discussed how people could serve as volunteers. The article provided a list of the available services and a list of the areas that volunteers could fill. The "Commitment to Care" section promised to treat clients with kindness and compassion and this points to the sub-theme of emotional support. This section also promised to offer "accurate information about pregnancy, fetal development, lifestyle and related concerns." Information seeking and education are reflected in this pledge. The statement, "All of our advertising and communications are truthful, honest and accurately describe the services we offer," reflect the theme of integrity. The pamphlet also noted that, "The Bible is filled with exhortations for us to put actions to our words—feet to our faith." This was followed by an explanation of how the center provides volunteers the opportunity to do this. This shows the Christian nature of the ministry. Another quotation links the ultrasound ministry to a biblical passage. "Through ultrasound, [center's name] clients can see clearly the truth of Psalm 139:13, 'For you created my inmost being; you knit me together in my mother's womb.'" Such statements reveal the theme of limited ultrasound.

One of themes that emerged in the interviews was the centers' care not only for the clients (usually female) but also for the clients' partners. This theme surfaced in one

of the articles included in the packet circulated among pastors and churches. A “Daddy Pack” was enclosed. The National Fatherhood Initiative prepared this professionally produced packet that contains information on how one can be a “great dad.” It also contained steps one could take to prepare the home for the arrival of the new baby. The “Daddy Pack” also contained an interactive compact disc (CD). The CD jacket promised the user to, “help you become the best father that you can be.” This positive statement represents the client empowerment theme.

The center also placed a “Need a Speaker?” card in the jacket. Basically, this card offers to provide speakers whose presentations can be custom designed to meet the particular needs of the occasion that led to their invitation. Suggested topics for invited speakers to address include: abstinence, lifestyle issues, post-abortion counseling, prenatal care, parenting/discipline, healthy images (self-esteem), sexually transmitted diseases, and the medical aspect of pregnancy termination. The last suggested topic points out the careful semantic choices that the centers are making with reference to abortion.

The jacket also contained information on four broad areas: medical services, parenting services, sexual integrity, and support services. Each category was represented by leaflets and cards themed accordingly. For example, the medical services mentioned the limited ultrasound and prenatal care offered by the center. The parenting section contained information about the cradle club. The cradle club is a program that rewards showing up for appointments and attendance/participation in educational programs by handing out “caring cash” that can be redeemed for such things as baby clothes, baby food, bibs, and etc. This program reflects the theme of providing for one’s own. The

sexual integrity section contains suggestions for activities that couples could enjoy other than having sex. The support services features a flier that discusses recovery counseling for those grieving a past abortion. The featured program is called, GRACE. GRACE is an acronym for “God’s Redemption And Compassion are Everlasting.” The pamphlet promises that, “The goal of our facilitators is to provide a safe and comfortable environment for our support group”—one of the major themes that emerged from the interviews.

### *Advertisements*

Some of the centers run television ads on the local cable channels in their area. Video footage of four of these ads was obtained. Each one conveys a different message.

The first ad has three brief segments. In the first segment, a young African-American woman with her toddler child in her lap is seated on a sofa. She says, “I was scared and didn’t know what to do but [center name] was with me every step of the way.” In the second segment, a young Asian-American couple, along with their small child, is featured. They explain that they were first-time parents without resources. However, the parenting classes and clothes closet of [center name] helped them. The third segment contains a male Caucasian-American, identified by text on screen text as a medical doctor, seated in an armchair. He appears and sounds inviting. The doctor explains that [center name] offers free pregnancy testing, ultrasound exams, pre-natal care, and STD testing. The ad ends with the name and contact information for the center. Music was played throughout the ad.

Familiar themes emerging from segment one include uncertainty reduction and emotional support. Themes surfacing in the second section include education,

benevolence, and the instinct or desire to provide. Finally, the doctor's invitation included references to things associated with professional health care such as ultrasound exams, pregnancy tests, and STD tests.

The second TV ad reviewed focused exclusively on STDs. There are both text and spoken words. The ad reports, "Did you know that 1,000,000 teen pregnancies are diagnosed each year?" The ad goes on to explain that one out of three sexually active people is estimated to have contracted a STD by age 24 and that 50% to 80% do not know it. Then the ad promises the viewer that they can find help and introduces the contact information for the center. The video says that the center offers free STD testing as well as information on sexual integrity and healthy relationship. Themes emerging from this ad include the professional health service and education.

The third and fourth ads are very similar. The third one features a young white woman pushing a little girl in a swing. Both are smiling. Then the text, "What if..." appears. There is more footage of the woman and little girl in the swing smiling. Then the text says, "The life you loved most." There is more footage of the woman and girl. Then the text says, "Was never given the chance." Then footage of the woman pushing the swing without the little girl appears. Then the text says, "To be a life at all." Then the young woman appears sadly by the empty swing.

The fourth ad opens with the text, "Did you ever wish..." The young white blonde is sitting alone on playground equipment. Next, the text says, "You had made a different choice?" Then the young woman appears sad and reflective leaning against a tree on the playground. This scene is followed by the text, "There's hope..." Then the woman appears again on the playground equipment lightly caressing it. The text,

“There’s healing.” Again the woman appears leaning against the tree. The center name and contact data appear. Music is played throughout both.

The pro-life tone of these two ads is unmistakable. However, the argument for choosing life does not even include the term abortion or pregnancy termination. There are no grisly pictures. This reflects the sensitivity in sharing theme and the persuasive argument power of words and images. Another theme that seems to emerge from these ads is that of emotional support for those who have experienced abortion.

### *Statement of Promise*

One of the rhetorical artifacts that was mentioned in the interviews was something known as “Our Promise to You.” The promise includes a statement that the center is “affiliated with an international organization of pro-life pregnancy centers.” Reference is made to the Christian nature of the ministry, and the fact that it is committed to serving women as well as their families and partners. The familiar themes of these phrases are self-evident. The document makes a total of ten promises.

The first promise includes “providing a warm and safe environment to everyone”—the familiar theme of a safe supportive environment. The second promise reflects the benevolent nature of the ministry inasmuch as services are offered without charge. The kindness and compassion promised in the third statement speak to the emotional support offered at centers. The fourth line promises that, “your story will be listened to with respect and courtesy, and without judgment...” The themes of storytelling and client dignity surface here, and so does the theme of non-judgmental responses. The fifth statement asserts that clients have the right to withhold information. The sixth promises information about pregnancy and underscores the themes of

information seeking and education. The seventh guarantees the client the right to refuse any information that is unwanted, and this harks back to the theme of client dignity and empowerment. The eighth promise entails honest and open answers that reflect the theme of integrity. The ninth promise assures the client that she or he will be directed to other resources as appropriate, and this reflects a professional health care approach. Finally, the tenth promise pledges ongoing support, and this returns to the theme of an emotional support.

### Research Question Answers

The previously discussed themes surfaced from interview transcripts and the various other media obtained from the centers. Moreover, these same sources also provided answers to the majority of the research questions that were raised earlier. Much of this same data has already been discussed in greater detail, but is presented briefly here again in answer to these questions. The answers varied from center to center depending on the geographical location, budget, and etc. of each facility. The research questions can be roughly divided into four, albeit not totally discrete, main categories: messages, contexts, center personnel, and clients.

#### *Messages*

RQ1: Besides the ultrasounds, what other media or messages are put forth by the centers?

According to Christopher, his center has a “fairly healthy advertising budget.” Therefore, their ministry is able to advertise in a rich assortment of venues including the following: seven local cable television channels, the campus newspaper and the sorority recruitment handbooks at the local university, the year books and sports program of six

high schools in the area, the telephone book and the yellow pages. Kayla also observed that they advertise by means of billboards, radio programs, and the Internet. Her center, like many, leaves brochures on display at local area businesses. Irene pointed out that her center advertises at the local theater. Cara also noted that her center runs ads in the local theaters that audiences view before the movies begin. Many of the centers publish monthly newsletters also. However, Angela candidly observed that her operation did not use newsletters “because resources tell us that nobody reads newsletters anyway...” The messages of these centers are clearly communicated using a multi-media approach that targets young people—especially young women.

RQ2: Does the ultrasound seem to make an impression on the client and anyone who may be accompanying them?

The ultrasound exams, with some exceptions, typically have a significant impact on the ones viewing them as revealed in the section elaborating on the interview data. Christopher quantified this by saying that 80% to 85% of clients considered to be abortion-vulnerable or abortion-minded who experienced the ultrasound opted to carry their pregnancies to term rather than to terminate them. Center personnel commonly use the term abortion-vulnerable to describe clients who are being pressured either by people or circumstances to have an abortion. They also use the term abortion-minded to describe the client who has plainly stated that she plans to have an abortion. The consensus among the participants is that the ultrasound is a very effective means of persuading clients that the fetus is a human being with a beating heart that should be given the opportunity to survive. However, ultrasound is not 100% effective. Not everyone who experiences the ultrasound carries the pregnancy to term.



RQ3: What do ultrasound examiners typically say and do during the exam?

The exams are performed in a room equipped with the ultrasound machine and a monitor. Clients and anyone accompanying them are given the opportunity to view the monitor if they wish. Occasionally, the client will decline. Charissa remembered one client, a rape victim, who turned away her face. Ordinarily, however, the client watches the screen during the exam. As mentioned earlier, at least one of the examiners sometimes gives the one accompanying the client a pointer and asks him or her to point to the screen to help identify various features of the exam. The respondents indicated that they are careful to call the client's attention to the fact the ultrasound being conducted is a limited ultrasound and is not intended to point out fetal abnormalities, and etc.

During the course of the exam, depending on how far advanced the pregnancy is and what is visible on the screen, the professional may point out features such as the gestational sac, the yoke sac, and the amniotic sac. These visuals are accompanied sometimes by explanations of their respective functions. Bethany said, "If I see the baby, I will point out the baby's heartbeat."

Beyond the medical features of the exam, most of the respondents noted that their examiners endeavor to respond in ways appropriate to the client's demeanor. When the client is excited, so are they. When the client is sad, the examiner will adopt a more subdued tone.

RQ4: What intentions do the centers have in mind when providing ultrasound exams?

Participants answered interview questions related to this issue differently. However, the essence of their responses included the desire to educate the woman so she

could make an informed decision. Irene observed that over her years of service, she has met many post-abortive women and men, and they will often say things like, “I wish I had known.” So from her perspective, the ultrasound is a matter of informed choice.

Christopher summed up the intentions of the centers when he said:

We provide the ultrasound exams because we know, and of course now, having used it since 1997, over ten years now, we know it’s a great tool revealing to the client that it’s a little life inside them. And, uh, we know that it is a tool of changing minds. And, uh, we never put any pressure on any client, but we’ve seen the ultrasound be the powerful tool for changing minds to life.

Charissa’s response was similar. She noted:

Ultrasound exams are used so that the client can see that the pregnancy is “truly a life” and that it is a viable human being. The center also uses ultrasound to demonstrate that to terminate the pregnancy is to terminate a life. We show them the truth. Ultrasound is used as a mean of education.

The centers, therefore, expressed a desire to use ultrasound to educate their clients regarding their pregnancies, fetal development, and so forth. However, the centers not only intend to educate the clients but they also intend to persuade the clients that the pregnancies should be carried to term rather than aborted.

### *Contexts*

RQ5: How are clients who arrive at the centers processed?

The standard operating procedure for processing clients varies from center to center. However, Agatha’s response provided a rather in-depth account. She explained:

... a client would enter. Uh, they would approach a reception window where uh a kind person would greet them. And they would make their wishes known—why they were visiting, and then they would be asked, they'd be handed a, uh, flip chart. And they would be asked to, uh, read our limitations of services and our HIPPA compliance paperwork, and then fill out an intake form. Uh, we would ask them, uh, have they, was this their first visit to the center. If it was, then all of that info would be completely new to them. If it was not, they still signed the limitation of services and the HIPPA compliance at every visit. Uh, but, then we take their name and go to the back and have their chart pulled. And so, when they've filled out the little intake form for that day, on it they would, you know, mark down what was their reason for coming. Uh, when they finished that, they bring it back up to the receptionist, and she would take that. She would attach that to the file if they already have a client file. And take it to the client advocate office, and an advocate would be there uh to reach the file, read up a little bit about the client that they're going to meet, pray a moment for that girl and their time together, and then she would go to the door. The advocate would open the door and introduce herself and invite the young woman to come back and the two of them would then walk into a counseling room—uh, a small, uh, kind of living room like setting that I told you about. We would ask the young woman if she had brought a friend, that we would spend a little bit of time with her alone, and then she could certainly invite her friend back. Uh, you know, after we got the preliminary information. And then once she's in the counseling room, we have uh, talking points which guide the advocate and we've worded it so, you know,

she can have these, this guidance, and then just check the answers. Uh, when the whole visit is over, she's been instructed on how to do the pregnancy test, uh she's seen, uh, and done her self-diagnosis, they've counseled about all the options, uh, then the advocate asks if she would be so kind as to fill out an evaluation on the service. And the young woman does that and then returns it to the front desk person. And then we make an appointment for an ultrasound, an appointment for a follow up next visit with an advocate, if, if it's determined that they would like uh, some additional services that we provide. Then all of those appointments are made at that time. Then that client advocate, after the client leaves, she would take her file folder back into her office and she would sit down and she would take, write her client notes. And anytime there's a phone call, notes are taken on every communication, every contact with the client that we have is recorded. By recorded I mean, you know, notes taken on it. So that, if I come in in two weeks after having been out, and Mary Jo is a client, and Mary Jo's been in three times in two weeks, I can go pull Mary Jo's file and in five minutes be caught up with Mary Jo's story, even if the advocate that she saw while I was gone is not there today. And that's what we want—to make sure anytime anybody calls, we want a record of that. Because when I go to the files and look at the files, I want to make sure that we're current on any communication that she's had with the center.

This step-by-step account is fairly representative. However, for clients who may be deemed abortion-minded or vulnerable, the centers typically encourage the client to undergo an ultrasound during her first visit rather than rescheduling for a later time.

Basically, clients are welcomed upon arrival and asked to complete paperwork indicating what their needs are. Afterwards, client advocates welcome the clients into more private areas of the facility where they become better acquainted. Once the advocate and the client have become somewhat familiar with another, anyone accompanying the client is welcomed into the counseling area also. The client then takes a pregnancy test. The test results and the client's history and/or perceived attitude toward abortion largely determine the course of action to follow. Pregnant clients who are considered abortion-minded or abortion-vulnerable are encouraged to have ultrasounds performed. If the exam cannot be performed right away, the clients are scheduled, if they wish, for the earliest possible time. The staff and volunteers at the center endeavor to build ongoing personal relationships with the clients, and encourage the clients to remain in contact and to come again.

RQ6: How are the centers decorated?

The décor of the centers varied widely. As indicated previously, the facilities are decorated in such a way so as to communicate a safe supportive environment. Overtly religious emblems and so forth are usually absent, and the same is true with babies and family pictures. Ruth pointed out that the organization's promise to the client is displayed in the lobby. Irene observed that they desire to create a neutral comfortable environment. Descriptions for the décor ranged from that similar to a doctor's office to those found in the setting of a home.

#### *Center Personnel*

RQ7: How many people are usually on hand when clients arrive?

The centers are usually staffed with receptionists, client advocates, ultrasound examiners, and administrative personnel. The number of people in the waiting room varies greatly. However, it would not be uncommon for a client to discover a waiting room with other clients, their children, and their boyfriends or some other family members.

RQ8: How many different people will one client see during the initial visit?

Minimally, clients would normally see the receptionist, the client advocate or counselor, and the ultrasound examiner. Other personnel such as the center director may be encountered by chance in the hallways and etc.

RQ9: How are the various personnel dressed, that is to say, are they dressed in casual clothes, business attire, or more like doctors and nurses at a clinic?

The dress of center personnel varies from site to site. The most common response to questions about a dress code was that personnel were expected to dress in business casual. Cara suggested that the staff dresses in ways similar to their peers. The attire would be modest. People are expected not to wear mid-riffs, clothes revealing straps, or that are otherwise revealing. Angela suggested that many of the women who visit their center have had difficulty with their own sexuality and in their personal relationships. Therefore, she implied, they do not need to be confronted by people dressed immodestly. Therefore, they do not allow shorts or clothing showing cleavage. However, neither do they require suits and heels. The doctors and nurses may wear lab coats or surgical scrubs. However, even when scrubs are worn, they are typically some sort of softer color or are decorated with frogs or something that is child friendly.

RQ10: What are the demographic characteristics (gender, ethnicity, age, and etc.) of the personnel?

The demographic characteristics of the center personnel vary greatly. Among those interviewed were two men and ten women. While they were not asked about ethnicity, the researcher inferred they were Caucasian from their voices. At least two of the participants were medical doctors. One of the doctors had retired from private practice, but was too young for retirement outright. All of the ultrasound examiners were reportedly trained to perform the exams, and some of them referred to themselves or were referred to by others at the center as nurses. The ages ranged from young to senior adults. Agatha reported that the average age of staff at her center had become much younger over the past two to three years, and she viewed this as a positive development since their clients are mostly younger women.

RQ11: What are the goals of the centers?

The center reported similar goals even though the actual descriptions varied slightly by facility. Christopher reported:

Well, you know, our main goal is to reach as many young women, men, and families facing unplanned pregnancy in our area because we have a goal of meeting their physical, emotional, and spiritual needs. We provide many services to, to meet those needs or try to meet those needs. But we want to, uh, see as many of those that we can. We obviously operate in a college town, in a college community. There's a university of 24,000 students, and, uh, we feel like that our, our work is cut out for us. It's a challenge to reach all those. But that's our goal – to reach as many of those that we can. And to uh, uh, you know, uphold

the, the truth, the sanctity of life, and also the benefits of sexual abstinence before marriage.

Irene expressed the goals her center as follows:

Well, we have a four- fold mission. Uh, it is to promote the sanctity of all human life and help women choose alternatives to abortion, to share the gospel of Jesus Christ in word and deed, to promote pre-marital sexual abstinence, and to help individuals find healing from a past abortion.

Angela pointed out that her center's goals are to reach abortion-vulnerable women before they make any decision and to help them make informed decisions about their pregnancy through ultrasound. She also indicated that they seek to demystify the myths that some clients have regarding their pregnancies and to help clients know what all of their options are.

In summary, the pregnancy support centers want to provide a Christian witness in the community that includes meeting some of the healthcare needs (STD testing, pregnancy testing, crisis counseling, ultrasound exams, pre-natal care, post-abortion recovery counseling, and etc.) of the community members. They desire to present the gospel of Jesus Christ with clients in hopes that the clients will become Christians. They hope to influence their clients to carry their pregnancies to term rather than to abort.

RQ12: What are the goals of the ultrasound examiners?

Those performing ultrasounds generally responded that they seek to provide clients with information that will help them make informed decisions. Angela's response was typical. She noted:



Our center provides ultrasound exams because we want to give women all the information they need before they make any decision, and, and we see ultrasound as such an important part of making an informed decision. So they can see exactly what, what is the state of their own body. If it's a uterine pregnancy, if their, uh, they might be having trouble, they might be, taking women to the emergency room from here because they're miscarrying. Uh, just maybe they're, they think they're pregnant, but they're not. So [our goal is] to help them with information. Because whatever decision they make, their life will change, and they're the only ones that will live with the decision they make.

Ruth offered a similar explanation, but her reply provided some additional insight. Her center provides a service that some women in her area may not otherwise be able to receive for some while. She explained:

Well, we do [ultrasounds] for the reasons of, you know, confirming the pregnancy, uh, making sure it's viable, finding how far along she is. But we believe that, also that, the truth of what is happening in her body for that woman who's just not sure, not really sure what the option that she wants to pursue [is], that if she sees the life and she sees the heartbeat [she will not abort]. Sometimes the heartbeat is the same for a woman that it is an actual living baby. Now let me say this that in ... our medical assistant is in a crisis situation, and so women who find out that they're pregnant and do not have insurance or are unable to get insurance through the state because of their status, they really don't have a whole lot of options here ..., and so we also do ultrasounds, uh I would say, it's some of our clients, the ones who are not necessarily considering abortion as an option,

but, uh, may not see a doctor until well into her pregnancy. And so we're able to kind of do that first ultrasound again confirming and making sure it's viable and finding how far along she is, uh, is what really what we're looking for. But it also helps her with a little piece of mind because she's not able to see a doctor right away. So it's kind of a two-fold right now.

So ultrasounds are performed to provide the client with information that will help them make informed decisions and with peace of mind. In some instances, the centers' free services, including ultrasound, are used to fill a void left by the public health care system.

### *Clients*

RQ13: Do clients usually come alone, or does someone accompany them? If someone usually accompanies them, who is it generally?

Clients sometimes arrive at the center alone. On other occasions, they may bring their children, their boyfriends, their husbands, their parent(s), their siblings, or their friends. Usually, if a male accompanies the client, he is believed to be the father of the child. Sometimes, however, the client's father or brother will join her at the center.

RQ14: How are clients offered the opportunity for an ultrasound?

Sometimes the clients ask when they call or arrive about the availability of ultrasound. Most respondents indicated, however, that center personnel mention the possibility of the ultrasound first. While the normal procedure varies slightly, the norm is that clients self-administer a pregnancy test. The results of this test and the information gathered during the intake time largely determine the course of action. Clients who are pregnant and considered to be abortion-vulnerable or abortion-minded are introduced to the possibility of having an ultrasound. Ruth explained that staff may say something like,

“Do you know that we have this? And can I tell you what it is and see if it’s a good fit for you?” Sometimes the ultrasounds are scheduled three to four weeks in advance, but the centers prefer to do them as soon as possible. Agatha noted that when she walks the client to the scheduler, she would discreetly identify the client who is considering abortion as a client who needs a “red appointment.” In such a case, the scheduler would try to set up an appointment with 24 hours.

RQ15: How do clients approach the ultrasound experience?

According to the majority of the respondents, clients overwhelmingly respond positively to the offer of an ultrasound exam. There are instances, however, when the clients decline. Usually, those who decline are the ones who are planning to terminate the pregnancy. Sometimes, however, even those planning to terminate want the ultrasound for the purposes of dating the pregnancy or to have pictures of the child. Each situation is unique. Luke noted that the abortion-minded clients, those planning to abort, typically decline, but abortion-vulnerable, those considering abortion because of pressure being applied by circumstances or people, are usually anxious to have the ultrasound.

RQ16: What do clients see and hear during the ultrasound exam?

During the ultrasound, the clients who want to watch can view the ultrasound on a monitor positioned within their line of sight. They see what the examiner sees. Cara offered a good summary of what the client would experience during an ultrasound performed by her. She explained:

Well, I always start with an abdominal scan. I tell that to everyone the way I was trained. And say we’re not going to see a whole lot from this angle. And you know you’re six, seven or eight weeks and I just get me a starting point. Um, but

if I can see, you know, so I'll be explaining to you as we go along. Let me know if you have any questions... Once we start to see images within the uterus, I will just identify landmarks for them. This is your uterus. This is black area is fluid. In this case it's amniotic fluid. And here's the sac. This is the sac the baby is growing in. Where you see that whitish kind of lima bean, that's your baby. ... Afterwards I have a model I can show you actually what it looks like.... And, uh, then if the baby's larger we can see limbs. I'll point out arms and legs, the baby's head, the baby's heart. If she's over ten weeks I will use the Doppler heartbeat where you can hear the heartbeat.... I'll explain to them, you know, this little repeating pattern that represents the baby's heart...actually contracting over and over again. And here I can give you the rate and...and how fast the baby's heart is.... We have the peer counselor there too, and that's nice because she can kind of watch. I've got my eyes in two places. I'm looking at the screen and at the patient. She can just have her eyes on the patient and the patient's partner and see how they're reacting, uh, for later conversations or at that moment. Uh, we've had an inexperienced sonographer [at one] point, inexperienced in a sense of she really wasn't, she really hadn't learned how to do life affirming sonography. She was just trained through a regular program, and so she would have these long gaps of silence and, uh, you know we were coaching her. So the counselor would pick up on that... She would sort of fill in the gap with something to help the person not wonder what's going on. I think that's a frustration that patients have with ultrasounds is that techs are not permitted to say anything and it's very different when you come to a pregnancy center.

Basically, the clients are given the opportunity to view a monitor that displays for them the same thing the examiner is seeing. The examiner points out various features such as the uterus, the amniotic fluid, and the fetus or baby. The visual elements of the fetus are largely determined by the stage of the pregnancy. The fetal anatomy will be more developed if there has been more time lapsed since conception. Whenever possible, the sonographers try to point out the baby's face, arms, legs, and so forth. The heartbeat is a special area of focus. There is some controversy regarding the use of audio equipment that enables clients and examiners to hear the fetal heartbeat. Some centers do have the capability of playing audio of the heartbeat, but all of the centers' ultrasound equipment can display the heartbeat. The heartbeat usually appears as a white flicker on the screen. The examiners generally endeavor to tailor their verbal and nonverbal communication with the client, as well as what they point out on the screen, according to the information they have learned from the client. The personnel reportedly tend to walk a fine line between respecting the clients' viewpoint and their own desire to see the client carry the pregnancy to term.

RQ17: How do clients and those with them generally respond to the ultrasound?

As indicated earlier, the responses of clients and those accompanying them vary.

Cara answered this question by saying:

Well you get the gamut. You have people who are totally poker faced, and you can hardly discern any emotion at all. And then you have people who burst into tears. You get the people who go, "That's my baby!" And they just see a little heartbeat, you know. It's a whole [range] of reactions.

Cara went to explain that the reaction of men, if they are present, also varies. However, men are typically less expressive than women. On the one hand some are silent and appear almost as though they are in shock, but on the other hand, some are smiling and pointing. Ruth noted the silence of men, but pointed out that men will sometimes identify with what they are seeing. She said:

He'll say, uh, "Look at him moving. He's going to be bad like his daddy." Or "He's going to be a football player." Or you know some kind of sport thing that men identify with easily. Uh, there's always though a, usually, I would say, there's usually a, uh, about a pride in this man that this is his child. Occasionally just like with the women, we will get men who come in and are very silent and you really can't read them. You're not really sure what they're thinking.

So client responses run the gamut from being expressionless to being very animated. Some appear to be distant and detached while others appear to be very engaged and participatory.

RQ18: What do the clients typically say during the exam?

Client responses to the ultrasound depend largely on their circumstances. Some clients seem to have favorable responses. Zoe observed the following:

Well, usually they seem to be pretty excited. You know, and uh, I think it, it kind of, sometimes it kind of hits them and, and, uh, they just kind of sit and stare at things, and I mean, I've had patients cry just because they're happy, you know. That, that uh, with what they see, and uh, they, you know, sometimes they'll giggle when they see, see different things or seems like the baby's moving around. A lot times they think that's kind of funny so they just giggle about that.

And, uh, but usually they're pretty impressed, I guess is the word, you know, by what they're seeing, and uh, you know, I, I will make a comment about just, you know, just the miraculousness of the whole thing.

However, as Agatha noted, there are other less positive responses as well. She said:

I think a lot of times their responses to the ultrasound are sort of, uh, parallel to their feelings about the pregnancy. Uh, if, if you've got a person who is horrified at the thought that she's pregnant, uh, whose mother or father or boyfriend or husband or whatever is pressuring her, the confirmation that this viable pregnancy is terrifying even though it may motivate her that she's going to carry, it's still, reality has checked in. So I think sometimes, uh, I've seen girls where they hoped that they weren't pregnant, uh, when they found out that they were, they just cried because they didn't want to be pregnant, but they loved this baby already. That's shocking to them. Uh, sometimes a girl will get her, have her, ultrasound, and the nurse will talk to her about, well, now, you know, "What do you think your boyfriend is going to think about this?" "Oh, he's going to be sooo excited." We just wanted to have a baby, and, uh, she leaves high as a kite and, you know, we've talked to her about, uh, now when you talk to you're the father of the baby, if he does have questions, uh, and you want to bring him in, do that. And then she'll come back in a week and he's left her high and dry. So it just, uh a lot of their response depends on what else is going on inside them besides just this pregnancy. Uh, and that I think is the, you know, when I go to talk in the community, I'll always say, "For most of us, pregnancy is good news. But in this world it isn't typically good news."

In summary, client responses vary widely. Some appear emotionless while others are expressive. Some are happy and some are sad. The client responses seem to reflect their feelings about the pregnancy. Some are surprised by the revelation of the heartbeat and by the level of development they can see on screen.

### Summary of Results

Transcripts of the interviews, along with other types of media including printed materials and advertisement videos, provided sufficient qualitative data for analysis using the grounded theory approach. These data also provided answers to the research questions raised earlier.

Grounded theory analysis led to the emergence of ten major and broad themes. The centers endeavor to provide a holistic Christian ministry to their clients and to the significant others, including the unborn, in the lives of those clients. Maintaining a professional health care approach is important. The services offered by the center, especially the pregnancy tests and ultrasounds, help to reduce uncertainty in the clients and to educate them regarding their pregnancies. These pregnancy support centers seek to maintain safe, secure and supportive environments where clients will feel free to express themselves without fear of being judged or condemned. Center personnel typically demonstrate great sensitivity toward their clients in their relationships with them, and toward their audiences when are engaged in public relation efforts in the community. The staff and volunteers make careful and deliberate choices with regard to the labels they assign to themselves (client advocates versus counselors) and to the act of ending the pregnancy (pregnancy termination versus abortion). While ultrasound technology is important in the overall ministry, these organizations recognize the



significant role of cultivating interpersonal relationships with their clients. Persuasive arguments, both verbal and visual, are employed by the centers in attempts to get clients to carry their pregnancy to term rather than to abort. One of the most persuasive strategies involves the ultrasound exam because giving the client the opportunity to see what is happening inside of her with the fetus tends to make the pregnancy and the humanity of the fetus real to the client and/or to those accompanying her. The centers aspire to empower women by educating them about their pregnancies and informing them of their options.

By and large, the rhetorical strategies of these centers appear to be successful. The multimedia approach targeting high school and college-aged women has reportedly worked. However, the preponderance of responses suggests that word of mouth, the testimony of satisfied clients, remains the most effective means of reaching new clients. While not every pregnant client decides to carry the pregnancy to term, the respondents in this study reported that 80% to 85% of pregnant clients who are either abortion-minded or abortion-vulnerable decide to carry their pregnancies through to term once they experience an ultrasound. However, the ultrasound is only one element of the overall strategy. The supportive personal relationships are very important in helping the centers carry out their mission.

## CHAPTER V

## DISCUSSION

The rhetorical strategies of these pregnancy support centers include numerous elements such as spoken verbal arguments and printed verbal arguments. Visual rhetorical elements such as décor, fetal models, ultrasound imagery, television advertisements, and etc. are used as well. There is no shortage of material for critical rhetorical analyses. Moreover, the primary emphasis of this project is visual rhetoric. Ultimately, while this project is a work of rhetorical criticism, the approach will largely be an endeavor to see the visuals through the eyes of the clients. So while there are as many possible interpretations as there are rhetorical critics, the interpretations discussed in the following sections will primarily, albeit not exclusively, be those that, based on the interview data, seem most compatible with the clients' view of the images. This utilitarian approach may preclude multiple meaningful interpretations that perhaps can be explored by other critics. However, the parameters for this project must be drawn somewhere, and this seems to be a logical and suitable place.

Among the available schemas for performing rhetorical analyses are Foss's (1994) schema, Peterson's (2001) proposed alternative to Foss's schema, and Hart's (1997) questions regarding visual communication as well as Hart's (1997) five rhetorical moves. These three approaches will guide the critical analyses of various features of the pregnancy support centers' rhetoric that is to follow. After analyses of the centers' rhetoric by means of these three approaches, a brief evaluation of the findings in light of the literature review will be offered, and concluding remarks will follow.

### Foss's Schema

Foss's (1994) schema for the evaluation of visual imagery entails three processes. First, there is the identification of the function(s) communicated by the image. Second, there is the assessment of the degree to which the dimensions of the image support the function. Third, there is the evaluation of the legitimacy of the function. Foss (1994) distinguished between function and purpose. In this schema, function is not what the creator intended but "rather the action the image communicates" (Foss, 1994, p. 216). Foss (1994, p. 215) stated unequivocally, "The schema I propose is clearly in opposition to the intentionalist view..."

Foss's (1994) stated opposition to the intentionalist view could potentially serve to limit the usefulness of this approach. The researcher's position is that any rhetorical criticism ought by sheer definition to at least incorporate some element of intentionality. If Aristotle defined rhetoric as the discovery of all available means of persuasion (Foss, Foss, & Trapp, 2002) and if one is to accept Aristotle's definition, then rhetorical criticism should include a consideration of the rhetor's intent. Notwithstanding Foss's opposition to the intentionalist view, Foss's (1994) basic schema remains somewhat useful. This is especially true in those instances when the acknowledged intent of the rhetoric's designers and the apparent function the rhetoric serves are synonymous. This is the case, in some instances, regarding the rhetorical use of ultrasound.

The anti-intentionalist view of Foss (1994) has other implications as well. According to Foss (1994, p. 215), "...the anti-intentionalist stance, which undergirds my proposed schema, suggests that a work, once done, stands independent of its production, and the intentions of the artists or creators are irrelevant to critics' responses to their

works.” In this discussion of ultrasound imagery, this statement seems to be true in some instances and false at others as will be demonstrated.

The schema of Foss (1994) provides the framework for some of the discussion regarding the visual rhetoric of both the ultrasound exam, the ultrasound pictures, and the décor of the centers. In each instance, the function is identified. The visual elements supporting or failing to support the function are presented. Then, the function is evaluated.

### *Ultrasound as Visual Rhetoric*

The pregnancy centers use ultrasound as a means of educating and persuading clients. Ultrasound, then, helps the centers reach their goal of providing professional health care to their clients. Clients possess differing goals when they consent to or request an ultrasound. Some clients want the ultrasound exam because the exam will provide information regarding the size of the fetus that will enable them to more perfectly date their pregnancy. Dating their pregnancy more accurately will, in turn, enable them to identify the male who impregnated them. This piece of data is key in the minds of some women as they ponder preserving or terminating their pregnancies. Some clients want the ultrasound exam because they want the photographs that the ultrasound exam will yield even though they plan to terminate the pregnancy. In the mind of the interviewee, such clients are already grieving their loss and the photographs will help them cope psychologically and emotionally with the loss of the pregnancy or child. Some clients want the ultrasound out of curiosity and to learn what is transpiring in their bodies. Foss’s (1994) schema may be applied to the rhetorical use of ultrasound in each of these scenarios.

First, some clients, typically those with multiple sexual partners, have the ultrasound exam so they can determine the identity of the father by dating the pregnancy. In such an event, the function of the ultrasound becomes a purely utilitarian one. Knowing the identity of the father helps the client decide whether to abort or to keep the pregnancy. The measurement data obtained during the exam, coupled together with the client's knowledge of her menstrual cycle history, enable the client to make an informed choice. Heath and Bryant (2000, p. 174) pointed out that, "...we can argue that the processes of forming attitudes are parallel to and supportive of those devoted to obtaining information to reduce uncertainty." So regarding the assessment of the identified function, this numerical metric information obtained from the ultrasound is substantive data that the client processes in reaching a decision. In such a case, the intent of the center to persuade the woman to keep the pregnancy may or may not be achieved. The center's assistance in helping the woman determine the father may facilitate her choice to abort or may facilitate her choice to carry to term. Clearly, the primary intent of the center is to convince the woman to keep the pregnancy. So if the client chooses to abort, then the fundamental purpose, the rhetor's goal, of the visual rhetoric is frustrated. This lends credence to Foss's (1994) argument that the creator's purpose and the critic's or consumer's function should be divorced from one another. However, the research participants were plain upon the point that they wanted to empower women to make informed choices. So whatever choice the woman makes, the centers will have reached this goal by informing her prior to her making a decision. The legitimacy of the educational or informative function of the ultrasound photograph then stands.

Secondly, one interviewee reported that a pregnant woman requested pictures of her ultrasound, even though she planned to abort, because she wanted to say goodbye to her baby. In this instance, the function of the ultrasound photograph appeared to have been to facilitate the grieving process for the pregnant woman who planned to terminate. The photograph would become a means of obtaining closure on her experience of loss. Such a scenario reinforces Foss's (1994) argument that the purpose of the visual's author should not be used to constrain the functions attributed to an artifact by the critic. Yet, upon further reflection, even though the grief processing function apparently served by the photograph is clearly in opposition to the ultrasound photographer's design that the woman would carry the pregnancy to term, the function served by the photograph in the life of the woman is not so antonymous to the centers' goals as it may seem. This is the case because one of the major themes that emerged from the data was the centers' desire to provide holistic Christian ministry to the client and to provide a safe supportive environment where the clients' emotional needs could be met. So even though the center's goal of persuading the woman not to abort was not realized, the goal of providing emotional support was. So this function is legitimized.

Moreover, the substantive and stylistic dimensions of the picture served to meet the emotional needs of the client in helping her say goodbye to her baby. Substantively, the picture was a representation of the real baby developing within her until the pregnancy was terminated. The image was not an artist's version but an actual representation of her progeny very much like ones taken for school yearbooks, personal photographs for parents to use in showing off their children, and so forth. Stylistically, the photograph would have been a black and white image. The richness of full color

photography would have been absent. Nevertheless, the black and white nature of the image would not have detracted from the image's functionality. People have kept black and white photos of their loved ones for years. Even though color photography is available today, there are times when people prefer the black and white to the color. Therefore, the grief processing function of this visual rhetoric still stands. After all, the display of the photograph of a deceased loved one on or near the casket during funeral proceedings is commonplace when the corpse was lost or was too badly disfigured for public viewing. In this sense, as Petchesky (1987, p. 283) noted, "...it may be that ultrasonography is becoming enmeshed in a familiar language of 'private' images."

Thirdly, some women participate in the ultrasound to gather as much information about their pregnancy as they can and in order to remove uncertainty. Their goal in seeking new data relevant to their pregnancy may be purely to satisfy their curiosity, or their goal may be not only the discovery of new information but also the formation of new attitudes. The client may subconsciously want to be persuaded or may want new information that will empower her to persuade significant others in her life. Even when the clients are only seeking data out of curiosity, however, the center personnel are in a position not only to provide new data but also to shape new attitudes through the means of ultrasound. So while the client may consider the function of the ultrasound to be one of discovery, the technician typically has both the pedagogical and persuasive functions in view.

Therefore, one of the functions attributable to the rhetorical act and images of the ultrasound is then the persuasion of the client to carry the pregnancy to term. Bound up in this goal are the subordinate functions of enabling the client and/or those

accompanying her to see the fetus as a human—as a baby, equipping the client and/or her companions to recognize the baby as helpless and dependent, and finally to evoke whatever, if any, latent instincts to protect and provide that may be present in those experiencing the ultrasound.

Recognition of the fetus as human, as a baby, is a vital part of the strategy of the centers. The interview data suggests that ignorance regarding fetal development exists among several of the clients. Ultrasound technology then provides a substantive means of demonstrating the humanity of the fetus to the client. The heartbeat, the bodily movement, and various physical features such as the head and the limbs function to confirm the humanity of the fetus. Since many of these features become more distinguishable over the life of the pregnancy, the centers prefer to perform ultrasounds during the eight to twelve week-period. By this stage, the participants reported that the fetus looks like a baby—like a little person. There are arms, legs, heartbeat and etc.

Moreover, medical textbooks support the reports of participants regarding fetal development. By the twelfth week of pregnancy, the crown-rump measurement of the fetus is six to seven centimeters. The fetal bones are beginning to ossify. The fingers and toes, complete with nails, have become differentiated. There are scattered appearances of hair. The external genitalia are evident and are beginning to show signs of male or female gender. Also, of course, the head of the fetus is a prominent feature and is characterized by a somewhat bulging forehead (Cunningham et al., 1997).

The presence of these recognizable features helps the client identify the fetus as more than just a tissue mass. Indeed, images of such manifest features may go beyond the basic recognition of the fetus as human. Zebrowitz (1998) discussed the favorable



responses of people to key stimuli such as body size and head shape. Blair (1996) also pointed out the tendency of the photographs of puppies, kittens, and children to evoke tenderheartedness. More about these phenomenon will be said in upcoming sections. Therefore, these identifiable babyish physical features may function to cause the client to see the fetus not just as a baby but also as one that warrants special attention and assistance. The fetus is tiny, naked, and silent. Any one of these characteristics signifies vulnerability, and taken together, they bespeak helplessness. Such features may function to activate feelings of empathy, protectiveness and attachment. Such feelings are characteristic of normal maternal attachment (Leibenluft, Gobbini, Harrison, & Haxby, 2004). Moreover, given the fact that this being is housed in the client's very own womb, these feelings may be intensified. The images being experienced reflect a reality that is internal to the client—not external. The images represent a reality possessed by the client—not another.

Based on the interview data, a significant number of clients considered by the center personnel to be abortion-minded or abortion-vulnerable, after experiencing the ultrasound and viewing the images, decide to carry the pregnancy to term. In these instances, the intent of the center to persuade the clients to carry the pregnancy through coincides with the function performed by the ultrasound. Something about the ultrasound leads to the decision not to abort. The ultrasounds are efficacious tools in the hands of the center. More times than not, the center's goal of saving the unborn is realized. Such an outcome is consistent with the pro-life ethic of the center and the people who work there.

By facilitating the ultrasound experience for the woman and those who may be with her, regardless of the outcome, the centers are reaching their goals. From the center's perspective, if the client does not abort, then the baby's life is preserved and the woman is saved from the numerous negative phenomena associated with abortion for many post-abortive women. There are positive outcomes for the child and the mother. Moreover, even in those instances where the client chooses to abort following the ultrasound, the center's goal of educating the client so an informed decision can be made is still realized. This is significant because interviewees mentioned that many times, when counseling with post-abortive women and men, they hear statements suggesting that if such information (i.e. ultrasound images, fetal development data, and etc.) had been available to them when they were reaching their earlier decision to abort, perhaps they would not have chosen abortion.

Before moving on to discuss the décor of the centers, a consideration of one of Foss's (1994) tenets is in order, especially with respect to the act and the images of the ultrasound experience. According to Foss (1994, p. 215), "...the anti-intentionalist stance, which undergirds my proposed schema, suggests that a work, once done, stands independent of its production, and the intentions of the artists or creators are irrelevant to critics' responses to their works." The significance of such a position in the context of this discussion on ultrasound should be examined. The ultrasound is first of all a rhetorical act—a performance. The act of the ultrasound results, secondly, in the productions of images that clients carry home with them.

The researcher in this analysis finds himself in disagreement with Foss's (1994) postulate. That is to say that the suggestion that the ultrasound images retained by the

client and presumably shown to significant others in her life cannot be divorced from their production. The client herself will almost certainly associate the images she holds in her hand, stores in her photo album, or shows to someone at a later time with her experience at the center where the images were produced. Unless the images are somehow circulated outside the circle of people surrounding the client and those familiar with her circumstances, anyone who sees them will know something of the details surrounding them. So the circumstances surrounding the production of the images remain vital to understanding or critiquing the pictures. Moreover, interviewees consistently reported that they usually get positive feedback from their clients regarding their experience at the center, and that word of mouth from satisfied clients is one of the most effective means of increasing the number of new client visits. In other words, for most clients, the experience at the center was a pleasant one, and this experience usually entailed an ultrasound.

The rhetorical performance of conducting the ultrasound gives birth to the images. This performance could be considered a drama using Burke's dramatisic pentad including act, agent, agency, scene and purpose (Foss, Foss, & Trapp, 2002). The act that produced the images was the ultrasound examination. The scene or the background of the act involved the situation, in most instances, of a crisis or unplanned pregnancy. This pregnancy confronted the client with the dilemma of whether to carry the pregnancy to term or to abort it. The agent responsible for the production of the images was the ultrasound examiner. The agency of the image's creation was the ultrasound machine. Finally, the purposes of the ultrasound, as expressed by the interviewees, are to educate the client, empower the client, and persuade the client to keep the pregnancy.

The foregoing details are not irrelevant to critiquing the image. They necessarily constrain the critic's options in evaluating the images. Foss's (1994, p. 219) application of the schema to the complex image of "The NAMES Project AIDS Memorial Quilt" underscores this. According to Foss (1994) one function communicated by the quilt is love and care for people who have died from AIDS. However, this function is only a plausible one if the critic understands the origin or the production of the quilt.

"Conceived by Cleve Jones, the Quilt is a collection of panels, created by friends and family members, that commemorate individuals who have died of AIDS," says Foss (1994, p. 219). An observer of the quilt who is ignorant of the circumstances of the quilt's origin may not make such an attribution at all. However, an observer who knows those circumstances could readily reach that conclusion.

Similarly, anyone knowledgeable of the ultrasound image's origins would have their responses constrained by that knowledge. Even though ultrasound images are becoming more commonplace, not everyone has photo albums containing such images. Not everyone carries in her or his wallet a black and white photo with a small infant cradled in a sea of darkness. So the relative uniqueness of such images sets them apart from normal photographs and puts them in a separate class.

Therefore, while a critic may be free to attribute some function to the ultrasound image not at all intended by the image's creator, any attribution made without regard to the image's origin would almost certainly be incongruent with attributions made by the client. The images are created specifically for the client and those near her. Any critique that fails to entail such considerations would potentially have meaning only to the critic. However, a critique that is shaped by knowledge of the image's productions would more

likely have meaning to the designers and consumers of the images as well as to the public at large. In other words, the critic's attributions of function are much more likely to make sense to more people when they are shaped by an understanding of the rhetorical performance that produced them.

The producers of the ultrasound images are not only responsible for those images, but are also responsible for the way the centers that produced these images are decorated. Foss's (1994) schema accommodates even the critique of décor as visual rhetoric.

### *Décor as Visual Rhetoric*

Foss (1994) discussed the way that a kitchen painted a sunny yellow may function to express warmth and the way the décor of a living room may function to create a warm, comfortable, and relaxing environment. So this schema can be used to evaluate the décor of a facility.

Each of the pregnancy support centers is decorated differently. However, the interview data suggest several similarities. The centers endeavor to exude a home-like aura that will be welcoming while at the same time maintaining a medical clinic feeling that communicates professionalism and credibility. The tension between these apparently conflicting goals has apparently been resolved through strategic furnishings at the centers.

Most of the centers are decorated in such a way so as to create a home-like atmosphere. The centers are generally equipped with incandescent lighting in the form of lamps on tables in the conference and waiting rooms. This softer lighting is more akin to that found in homes. Furniture typically includes sofas, loveseats, rocking chairs and etc. Landscape or pastoral paintings, pictures or photographs adorn the walls. Attention to

such details has apparently helped the centers succeed in their quest to create an atmosphere where clients feel comfortable and relaxed. They “feel at home.” In such a relaxed atmosphere, the client is perhaps less likely to have her cognitive defenses up. Since she is enveloped in a home-like aura, she feels less threatened. Moreover, while there are men on staff at some of the centers, the majority of the center personnel who interact with clients are women. Since the caregivers and the clients usually share the same gender, this feeling of security, or at least the feeling of not being threatened, is reinforced. The interlocutors usually have gender in common.

While the centers seek to maintain a comfortable home-like environment, they also seek to communicate an air of professionalism. In some of the offices, the medical doctors or nurses have their diplomas or other similar professional certificates on display as well. The display of such professional credentials would certainly remind clients or visitors that the staff members at the clinic are professionals in their fields and licensed when necessary and appropriate. The display of such credentials would give the clients the feeling that they are at a facility much like the one operated by their family or general practitioner. Moreover, the display of fetal models, along with charts showing fetal development and etc., helps exude a clinic like aura. At least one of the centers has on display in the lobby their promise to their clients. This promise is very similar to a patient’s bill of rights. Furthermore, the process whereby new clients are greeted and processed is itself similar to what happens at the local doctor’s office inasmuch as clients are greeted by a receptionist, asked to complete forms, called back into more private areas, and etc. All of these factors work together to leave the client with the impression that the center is a professional facility staffed by qualified people who know what they

are doing and who are qualified providers of information. In other words, these elements bolster the credibility of the people at the center in the mind of the clients and visitors.

While considering the visual elements that are present at the centers has been helpful in evaluating their rhetorical strategies, reflecting upon the visual elements that are absent may be equally illuminating. Conspicuously absent from most centers are baby or family pictures and Christian icons. Also, some of the centers are decorated with colors that are gender neutral.

The majority of centers do not have pictures of babies or families displayed in areas frequented by clients. This helps the centers in their quest to create a client friendly environment where the woman feels empowered—not threatened. Pictures of babies plastered everywhere would communicate the center’s mission is baby-centered rather than woman-centered, and this would be counterproductive to the centers’ mission. The centers do not display pictures of families for similar reasons. One interviewee remarked, “...in our crisis pregnancy offices we’re not going to have pictures of oooney, gooey, mothers with their precious family and the intact dad” because that is not a reflection of the lives of the majority of clients. So while the centers do aspire to save the lives of babies by preventing abortion and while the centers do endeavor to include the males in the lives of their clients, they are careful to maintain the image of caring primarily for the woman’s physical, emotional and spiritual needs. Pictures of babies may induce feelings of guilt in the mind of the client who is considering abortion, and pictures of intact families with fathers, mothers and children may induce similar feelings of shortcomings. The centers do not want to arouse such negative feelings because they

prefer to give the woman the feeling that she is in control and that the choice she makes should be her own.

Notwithstanding the aversion of the majority of centers included in this study to displaying baby pictures, some participants observed that baby pictures are displayed in some areas of the facilities not usually frequented by the client. One respondent noted that there are a few baby pictures on display in areas where guests and donors who are given tours can see them. So again the centers appear to be handling the tension that exists between the competing expectations of donors who support the ministry of center because of the pro-life ethic and the clients who face unplanned or crisis pregnancies.

Moreover, one interviewee acknowledged that in the ultrasound room where he conducts exams, there is a baby picture on display. The picture shows a 10-week old sized baby (identified as a baby—not a fetus by interviewee) reaching and grasping the finger of the surgeon who is performing an operation on the baby in the womb. However, the only visible part of the baby is the outreached hand clutching the surgeon's finger. This respondent, like most of the others, noted that the pictures on display are non-threatening by design.

Not only do the centers avoid displaying baby pictures, but they also eschew showing pictures of aborted fetuses as well. From their perspective, the graphic nature of such pictures makes them counter-productive to the centers' goals. The blood and gore would probably evoke feelings of aversion and repulsion, and the centers would rather evoke feelings of attachment and instincts of protection.

Similarly, the centers do not display many, if any, overtly religious icons or images even though they are Christian in their orientation. While there are some



paintings and photographs with captions that could be considered inspirational, the centers are more or less void of religious imagery. Respondents noted that they are not ashamed of their Christianity, but they do not want the clients to feel like the staff is preaching to them. Their preferred approach is to “preach the gospel” through their actions rather than through their icons.

In a somewhat similar fashion, at least one of the centers has been redecorated to be more gender neutral by means of neutral colors (browns and oranges versus pinks and purples) so as to create an environment where men would feel as welcome as women. Here again, the center’s awareness of the impact of visuals is reflected in the choices regarding décor. While wanting to empower women and help them feel welcome, the centers do not want men to feel unwelcome or unwanted in the process. On the contrary, the centers want men to feel included and to be as much a part of the process as the client and the male desire.

So, as already suggested, the décor of the centers serves at least two functions. On the one hand, the furnishings serve to communicate an air of professionalism, and on the other hand, the interior decorations serve to foster a warm and welcome home-like atmosphere. These functions are in keeping with the themes that emerged from the interview data. The former fosters the atmosphere of a professional health care service provider and the latter fosters the atmosphere of a safe supportive environment.

The interviewees’ responses suggested that they receive frequent positive comments on the way the centers are decorated. Perhaps client expectations are violated in a positive way and this positive violation helps the centers in their persuasion of clients. If the clients come expecting a brightly lighted sterile environment akin to a

surgery suite and find softer lighting and furnishing similar to those at home, this would result in a positive violation. However, if the surroundings are so attention grabbing as to warrant compliments from visitors, perhaps the centers have been a bit too overt in their efforts to create the home-like environment. At any rate, apparently the majority of the clients find the décor pleasant, and this serves the rhetorical goals of the centers.

In summary, Foss's (1994) schema has proven helpful in evaluating the ultrasound images and the center décor. The ultrasound images can be viewed as fulfilling multiple functions including helping the client date the pregnancy, facilitating the closure of the grieving process for the infant the client plans to abort, and providing the client with additional information regarding her body and the pregnancy. The center décor can be viewed as accomplishing at least two functions also—creating a professional health care setting where clients can receive excellent care and fostering a home-like atmosphere where clients feel comfortable.

Whereas Foss's (1994) schema has proven helpful, according to Peterson (2001), perhaps a better approach to visual rhetorical criticism involves beginning with the individual visual elements that constitute the artifact rather than focusing on the artifact as a single entity. Therefore, having employed Foss's (1994) schema, Peterson's (2001) will now be utilized in critiquing the visual rhetoric of pregnancy support centers.

#### Peterson's Alternative to Foss's Schema

“Starting the critical process with visual elements and not larger complexes at least potentially expands and democratizes critical discussion,” affirmed Peterson (2001, p. 25). Beginning with the building blocks, the visual elements, should enable the critic to not only make aesthetic judgments, but also assess the suasive potential of an image.

Peterson (2001) postulated that this approach would facilitate a critical discussion of the way the elements shape perception and persuade viewers. Therefore, this approach should really help get to the crux of the issue—the way the rhetoric of pregnancy support centers, especially ultrasound, persuades clients who may be considering abortion to carry the pregnancy to term. Unlike Foss's (1994) schema, Peterson's (2001) approach makes room for the intentionalist view.

The individual elements of the ultrasound experience that were examined can be broadly categorized as technology and imagery. Although this taxonomy is somewhat artificial, these categories are helpful in framing the critical analyses of the respective components. The individual elements belonging to the technology class include the monitor used in displaying the ultrasound images to the client and those accompanying her, the ultrasound machine that uses waves of sound to produce images of light, and the probe or transponder that actually gathers the data that will be converted to images. The individual elements comprising the class of imagery include the simplicity of the image, the fetal body parts, the fetal movement, the fetal heartbeat, and the verbal overwriting of the image. The last element, the verbal overwriting performed by the ultrasound technician, is obviously not visual only but verbal also. Nevertheless, when it occurs, even though it is not visual imagery per se, this overwriting is very much a part of the overall experience and cannot be divorced from any meaningful discussion of the event.

### *Technology*

The first piece of technology to be considered, arguably the most prominent, is the monitor. Most of the interview respondents referred to the screens on which the clients and they see the images as monitors. Some referred to the item as a screen, a TV

screen, or even a TV monitor. Usually, the ultrasound technician views the images on a smaller monitor and the client sees the images on a larger monitor located where they can see it from where they are lying during the exam. At least one of the centers utilizes a 42" flat screen television for displaying the images to the client.

The word choice made when referring to the element of the ultrasound experience that literally lets the client see what is happening in her body, monitor, is significant. Respondents favored the term monitor when referring to what the clients see. Monitor is both a noun and a verb. The connotative meaning of monitor suggests that one is engaging in surveillance as opposed to amusement or entertainment. The display permits the client to observe in real time the activity transpiring in her body. She is not watching animated or choreographed video footage. She is watching something that is peculiarly her own. She is viewing her body, her pregnancy, and the fruit (fetus) of her womb. While what she is seeing is similar to what millions of others have seen or may see, what she is seeing at that instance in time is uniquely her own. The image may be captured and reproduced like a photograph for later circulation among friends and family members, but in that moment of time, the image is all her own. The point is that this visual image is not cinematic. The video is not news coverage of some other person's story, but it is actual footage of her own personal story—one never before seen by anyone else. She is watching it unfurl before her very eyes. The images she sees are not the product of an artist using a canvas and brush. They are not even the product of a movie director using a camera and props. They are images produced by means of technology.

Moreover, whether the technician and/or the client refer to the display as a monitor, screen, or TV screen, the perspective and perception remain the same. People

have grown accustomed to being monitored wherever they go and accustomed to viewing the actions of others on screen. Television screens and computer screens are ubiquitous across North America. Internet communication among individuals today frequently includes the use of web-cams that enable people to look at each other, though separated by miles of distance, while seated in the privacy of their own homes. Banks, convenience stores, school facilities, and even traffic intersections, just to mention a few, are all venues where the behaviors of real individuals are monitored by others. Therefore, for a client, given the opportunity to monitor the activity of the fetus developing in her womb, to consider the fetus as an individual would be no stretch of the imagination at all. From her position on the exam table, she is able to monitor what is happening inside her womb in much the same way a principal can monitor what is happening in the classroom or the fast-food clerk can monitor the customer at the drive-thru ordering station.

The client is almost certainly not cognizant of such connections, but that only serves to reinforce how powerful they are. The point is the monitor becomes what some have called a window to the womb. At least three interview respondents referred to it as such, and there is a video by the same name (Boucher, 2004). Again, when a person looks through a window, they see what is actually on the other side. Similarly, the client's gaze at the display permits her to see what is really on the inside. She is seeing with her eyes the contents of her womb. She is not hearing it described in such abstract terms as a blob. She is experiencing her pregnancy visually, and in some cases, audibly.

There is some control, however, exercised by the ultrasound technician. First of all, the limited ultrasound is offered at the discretion of the center personnel. So this window to the womb may not be opened for every client. Second, the centers prefer to

wait until the pregnancy has advanced sufficiently to the stage that certain elements are more visible or more pronounced—usually the twelfth week. Third, the technicians typically endeavor to conduct the ultrasound in such a way so as to accentuate elements of the fetus such as the face. So, given these considerations, one could argue that the event is somewhat orchestrated or choreographed. Nevertheless, the subject of the ultrasound, the fetus, cannot be manipulated. Either the heart is beating or not. Either the body is moving or not. Either the face is turned so that is visible or not. Either the thumb is being sucked or it is not. So ultimately, there is a limit to the manipulation that the technician can employ. Moreover, the client can see, feel, and hear everything the examiner is doing. The ultrasound exam is a sensory experience.

Behind the image on the screen, there is a machine at work. However, the client's attention is not focused on the machine producing the image any more than the motorist commuting home is focused on the engine under the hood producing the motion. The motorist has implicit trust in the machine. Similarly, the client has been conditioned to trust machinery. Medical equipment is but one example. From the simple stethoscope that can be used to listen to one's own or another's heartbeat to heart monitors that enable people to monitor their own or another's heartbeat, people are accustomed to depending on machines to learn more about what is happening inside of their own bodies. This trust is so implicit that some may argue that including the machine as an element of visual rhetoric is out of place. However, while the machine is not the focus, it is a part of the experience, and may actually serve to reinforce the client's confidence both in the center as a professional health care provider and in the images being viewed as authentic

representations of her own innermost reality. This symbiosis of technology and humanity was discussed earlier in the section on cyborgs.

Yet other important elements of the ultrasound experience are the vaginal probe, when used, and the transponder. While some centers may utilize a vaginal probe to conduct the ultrasound, the transponder seems to be the preferred device. Whether the probe is used internally or the transponder is used externally, the client's body is exposed to a device that will enable the client and the technician to see, and in some cases hear, what is happening inside the client's body.

Unlike the ultrasound machine that is for the most part out of sight, the probe or the transponder is making contact with client's body. The client is able to sense the device being used. While the sensory perception of the device could prove to be a distraction to the client from what is appearing on the screen, the sensory stimuli induced by the device may actually serve to make the make the experience more real. Once more, this is not unlike the stethoscope the doctor or nurse uses when monitoring blood pressure or heart activity. The stethoscope, the vaginal probe and the transponder are vehicles that gather and carry information from inside the client's body to the client or to someone else. The tactile stimuli is akin to the traditional experience of having one's pulse taken by someone placing gentle pressure on the underside of the wrist in order to be able to feel the pulse of blood through the body. The point is that the literal point of contact with the client's body opens a channel of communication. Contact is made and information begins to flow.

Moreover, even though some technicians and doctors, especially males, apparently shy away from using vaginal probes for different reasons, the probes are used

on occasion. Male examiners apparently use them less frequently. The probes emit heat, and there is some controversy regarding their use. Whenever the vaginal probes are used, they enter into perhaps the most private space of the woman—a space usually only entered on very intimate occasions. This space is typically shared only with those whom the client trusts. Davis (1973) referred to the individual who enjoyed such a privilege as a “trusted intimate.”

Opening up this very private portion of one’s self becomes a means of very intimate self-disclosure—of revealing private or secret information. “Men, but more especially women, may go to great lengths to keep everyone but their intimates from becoming informed of their sexual sector,” wrote Davis (1973, p. 108). “They may feel that the most important sort of secret knowledge others can acquire from them is ‘carnal knowledge.’” In the case of a vaginal ultrasound exam, the “knowledge” or information being shared relates primarily to the pregnancy. Ordinarily, sharing this private space involves self-disclosure on a very intimate level. Unlike the client’s face and hands, this part of the client is not routinely exposed to others. However, like the face and the hands, this feature is a means of self-disclosure—of communication. The information obtained from the privilege of penetrating this very private space is truly personal and intimate. The client’s permission to use the vaginal probe for the means of gathering information about her pregnancy is akin to the client’s permission for her partner to enter her private world to learn more about her personally. In both cases, a self-disclosure of the most intimate variety is made.

On the surface, the information being gained by this privileged access to the woman’s body seems to pertain to the fetus or the baby in the womb. The focus is on the



woman's womb and the contents of the woman's womb. Measurements are obtained. Features are observed. Images are viewed and reproduced. The ultrasound introduces the woman to information that may be entirely new to her or at least to information that she had never before considered.

However, the ultrasound experience may do more than introduce the woman to information regarding her pregnancy. The ultrasound not only has the potential of bringing out into the light the inner workings of the womb, but it also has the potential of bringing out into the light of the woman's consciousness suppressed or hidden inner feelings. The interview data suggest that this is the case. Angela made comments indicating the role of the center and the role of the ultrasound in particular in helping women access their inner feelings. She said:

All we have to do is listen, be available, show [by means of ultrasound and other visual] exactly what's going on, and what happens is the courage that God built women with, you know, when, when those layers are finally unwrapped and, and all the uh, fighting and defending is put aside, then a woman can say, "This is my, this is my child. And I, nothing has changed. My circumstances haven't changed. Nothing's changed. But I'm going forward with this pregnancy." That happens all the time.

So Angela's testimony suggest that the ultrasound becomes not only a means of learning more about the fetus or baby in the womb but also of learning more about one's self. The technology facilitates self-disclosure to one's self in such instances. The monitor becomes a mirror in which the client can see things about herself that were previously unknown to her. The transponder or the probe serves to penetrate not only the unseen

areas of the woman's body but also of her psyche. She learns information about her pregnancy and she learns information about her person.

The vaginal probe, a part of the machine, actually enters the privacy of the woman's body and sends data back outside of the body for the consumption of the examiner and the client. So, in one sense, while both the transponder used on the woman's abdomen and the probe used in the woman's vagina are both gathering data very similar in nature, the probe is gathering from the inside. The point is not to minimize the client's confidence in the ultrasound done by means of the transponder. Using the transponder on the abdomen to gather information about the pregnancy is very similar to placing one's hand on the abdomen to feel the baby move when such bodily movement becomes detectable later in the pregnancy. Both the hand that feels and the transponder that "sees" with sound waves are means of gathering information about the pregnancy. The point is rather to emphasize the private internal nature of the data gathered by means of the probe.

Regardless of the particular device used, the probe or transponder, the machine, and the monitor are all used in conjunction to create or rather to re-create images for those viewing. Center personnel use these images as rhetoric, and the individual elements comprising these images are worthy of critical consideration.

### *Imagery*

The visuals emerging from the ultrasound experience possess several elements that can be evaluated rhetorically. One of these elements is the simplicity of overall image. Other features worth noting are the fetal body parts, the fetal movement, the fetal

position and the heartbeat. Finally, verbal overwriting, when present, is another component that deserves some attention.

The striking simplicity of the ultrasound images is a salient feature of this rhetorical artifact. While one of the centers participating in this research project uses 3D ultrasound technology capable of producing color images or photographs, the majority of the centers use traditional ultrasound equipment that produces black and white images. Therefore, with the one exception, the images clients take home with them are black and white, and even the center with the more sophisticated machinery often uses black and white images also. Whether the image is color or black and white, however, the image is raw and unadorned. The client sees the naked reality of what is transpiring in her womb when she sees the naked fetus. Unlike the subjects in grade school pictures or high school senior portraits, the fetus does not have the advantage of dressing up for the snapshot. There are no clothes and no makeup to put on. There is no brushing or combing of hair. The sonographer, unlike the photographer, does not have the advantage of giving verbal instructions for a better pose or the advantage of being able to position the subject for the photograph. The image produced by the ultrasound is a simple reflection or representation of what is in the womb.

The utter simplicity of the image serves to make it all the more credible. The image viewed on the monitor during the exam is created in a real-time environment. The client knows that the examiner does not have the benefit of dressing up the image by means of editing software. The footage being watched is actual—not the product of animation. So theoretically, the client should put more trust in what she is seeing.

Another element of the ultrasound images worth noting is the fetal anatomy. Of course, the stage of the fetus' physical development is a function of the time since conception. The further along the pregnancy is, the more distinguishable the various body parts will be until such time as they are fully developed. Generally speaking, the interview data suggests that clients are amazed that they can distinguish as many of the physical features of their babies as they can. One respondent noted, "...they're surprised that they can see little arms and legs." The client's ability to make out these features of the ultrasound image helps them establish the humanity of their fetus. Rather than seeing a tissue blob with nondescript features, they usually see a baby with arms and legs.

Sometimes these arms and legs are in motion. Clients, especially those planning to carry to term, will frequently exclaim, "It's looking at me" or "It's sucking its thumb" or "Look at it jump." The data suggest that clients contemplating abortion are less verbal than their counterparts who plan to carry to term. However, the clients considering abortion may be thinking these same thoughts but not expressing them because the data they are receiving via the ultrasound is conflicting with their planned course of action. Whatever the client's attitude toward abortion as a means of resolving the pregnancy, the fetal movement visible on the screen suggests that the thing in the womb is alive. While inanimate things do move when acted upon by outside forces, the normal person seeing human arms, legs and heads moving would conclude that the person is alive. Moreover, those not considering abortion will frequently make statements personalizing the baby, the baby's physical features, or the movement. They may say, "Oh, look! My baby's jumping around just like Daddy." Or they may say, "Those legs look like Daddy's." Or, "He's going to be a football player." Again, while those the centers consider abortion-

mindful or abortion-vulnerable may not say such things, that they may be thinking them is entirely plausible. The point is that movement suggests vim, vigor and vitality. In other words, seeing the fetus move helps persuade the client that the fetus is alive. The fetus has arms like she does. The fetus has legs like she does. The fetus turns its head like she does. The fetus sucks its thumb like babies do. Perhaps the fetus is a baby—not a blob!

Another visual element of the ultrasound worth noting is the fetal position. While none of the respondents suggested that the fetal position might offer an explanation as to why clients seem to be affected by the ultrasounds, the posture of the fetus deserves comment. Growing and developing as it does in the cramped quarters of the woman's womb, the characteristic position of the fetus is a curved one. In this position, the head and the legs and arm are bent and drawn toward the chest, and the head is bowed forward. The phrase, fetal position, is a relatively common one that people use to describe someone assuming the described posture. In Webster's definition, the explanation includes a note that this position is assumed by people in some forms of psychic regression. Here again, not only from the days in utero but also from one's earliest childhood days, people are conditioned to assume just such a posture when threatened with physical harm. For example, during drills or actual tornado alarms, students have historically been told to hunker down, face walls, and bury their faces between their legs—a posture very similar to the fetal position. Such a posture minimizes the area of the body exposed to flying debris or whatever danger may be lurking nearby.

The point of this little excursion back into elementary school days is simply that individuals will often assume the fetal position when danger threatens either because of

their instincts or because they have been instructed to do so. When one person sees another person in such a position, the observer intuitively senses that something is wrong. Perhaps the person in the fetal position is being threatened by dangers that exist only in her or his mind or perhaps the person is being threatened by dangers that exist in the environment and are yet undetected by the observer. Or, as in the case of the fetus in the womb of the woman who be thinking about terminating the pregnancy, the posture is the normal one maintained for the most part on a daily basis. Nevertheless, the client considering abortion is aware of her personal plans that entail terminating the pregnancy and knows that the fetus is truly in danger of being terminated.

The significance of this is that the fetal position, characteristic of individuals who feel threatened, may evoke feelings of sympathy or urges to protect. Such feelings or urges may operate below the client's level of consciousness. She might not even be aware of the psychological forces at work within her. Nevertheless, the fetal position of the fetus within her may offer additional insights as to why the ultrasounds tend to touch the hearts of the clients who have them.

Even though fetal position did not emerge as salient feature of the ultrasound interviews and while fetal movement did emerge as an important element in the overall ultrasound experience and visual, the heartbeat emerged as perhaps the most salient. Zoe remarked, "I think the client gets the biggest buzz out of hearing and seeing the heartbeat." Depending on the available equipment and philosophy of each center, the client may either hear and see the heartbeat when one is present or they may only see the heartbeat. There is some controversy regarding the use of Doppler technology for producing audio of the heartbeat, and therefore some centers only use it for a few seconds

to give the client the opportunity to hear the heartbeat, and some centers do not use it all. Whether the client sees and hears or only sees the heartbeat, this element seems to be particularly significant to the client. On the ultrasound, the heartbeat shows up as a bright flicker of light.

If moving arms and legs connote vitality, then a beating heart certainly connotes life. The significance of the beating heart repeatedly emerged as a salient element of the ultrasound experience and image. For many clients, seeing and/or hearing the fetal heartbeat is a pivotal factor in deciding whether to abort. The interview data seem to suggest that the heartbeat is a metonym for life itself.

By definition, metonymy involves communicating by association. People make sense of the things they know little about by making connections between them and the things they know more about (Berger, 2000). When clients face unplanned or crisis pregnancies, they frequently are confused about what is happening inside of them. There is a good deal of uncertainty regarding their pregnancies, fetal development, and etc. Moreover, significant others in their lives may be offering them conflicting pieces of advice on what they should do regarding their pregnancies. When these clients see and/or hear the heartbeat of the fetus within their womb, they are most likely to associate the fetal heartbeat with life. Tissue masses do not have beating hearts. Blobs do not have beating hearts. People have beating hearts. Animals have beating hearts. Living things have beating hearts.

This conclusion is no stretch of the imagination at all. The beating heart is synonymous with life. In the minds of most people, when the heart has stopped beating, especially for any length of time, the person is dead. Similarly, when the heart starts

beating the human is alive. Therefore, when clients comprehend that the fetus developing in their womb has its own distinct heartbeat, they are led to conclude that the fetus is alive.

The heartbeat is a ubiquitous symbol of life, and therefore the beating heart is a suitable metonym for life. For practically all people, hearing one's own or another person's heartbeat has been a common experience. Television medical dramas reinforce this notion by including clips that show cardiac monitors. The telltale image of the electro-cardiogram is very familiar to most. Life is present as long as the heartbeat, as recorded by the continual etching of the machine, continues. When the steady audible thump-thump thump-thump ceases and the line on the machine goes flat, the heart has stopped beating and the patient has died.

In the same fashion, when the client hears the thump-thump of the fetal heartbeat where centers make it available and sees the bright light flicker denoting the heartbeat on the screen, the patient concludes that life is present. In the same manner that the tangible traditional red heart-shaped valentine evokes an association with the intangible notion of love, the tangible (detectable by the senses of sight and/or hearing) beating heart evokes an association with the concept of life. Once this association has been established in the client's mind, then all of the things associated with life enter the picture. If the beating heart is a metonym for life, then taking action that will stop the beating heart amounts to taking life.

Aside from the overall simplicity of the images, the anatomical features such as arms, legs, and faces, the fetal movement and the fetal heartbeat, one other feature should be mentioned before concluding this section on the application of Peterson's (2001)



schema. At least one respondent reported that they sometimes place inscriptions on the ultrasound pictures if clients request them to do so. Upon request, the examiner will produce more than one picture for the client to carry home. Sometimes the client wants one for the father of the baby, or sometimes the client wants one for her mother. If the clients want the examiner to, the technician will write something like “Hi, Daddy” or “Hi, Grandma” across the picture. This verbal inscription has the potential of increasing the effectiveness of the image as a persuasive article. The client and the examiner are giving voice to the unborn baby. They are speaking for the one who cannot speak for herself or himself. Such a salutation seeks to establish a relationship between the unborn and the person receiving the picture—either the father or the grandmother. While the picture may have been somewhat impersonal, the salutation written across the bottom personalizes the image and seeks to establish a link, a connection, between the unborn baby and some individual other than the mother. The salutation signifies a potential relationship at least inasmuch as, if the pregnancy is carried to term and the baby is born, then the relationship will come to fruition.

In summary, the individual elements of the ultrasound visuals, not just the overall images, do possess what Peterson (2001) labeled as “suasory potential.” Any one of them has the capacity to influence the attitudes of those viewing them. When taken together, they have the potential to, as Hart (1997) mused, fill the eye of the beholder with a singular principal meaning.

#### Hart’s Questions and Five Basic Rhetorical Moves

Hart (1997), like Foss (1994) and Peterson (2001), has contributed to the scholarly discussion of visual rhetoric. While he did not offer a formal schema for visual

analysis, he did offer comments and raise questions regarding the characteristics of an arresting visual. Moreover, while not referring explicitly to visual rhetoric, he also suggested that there are five basic rhetorical moves associated with any rhetorical task, and by extension, these same moves could be used to discuss visual rhetoric. The fetal ultrasound images that have been discussed using Foss's (1994) and Peterson's (2001) schemas will now be examined under the lenses of Hart's (1997) contributions.

### *Two Questions*

According to Hart (1997), "A captivating visual is captivating in two senses: (1) it 'contains' an idea or ideology, eliminating its extraneous or complicating aspects to make it more compelling; (2) it reduces the interpretations an audience can make, filling their eyes with a single, dominant meaning" (p. 192). Congruent with these comments, he also raised two questions. First, "Does the visual image carry ideological force? That is, does it grow out of a systematically articulated belief system?" (Hart, 1997, p. 189). Second, "What condensations can be found in the visual image? Does the image serve as a synecdoche for a particular set of ideas?" (Hart, 1997, p. 191).

The interview data seem to support the available research data that, after a pregnant woman, a client considered by the pregnancy support center to be abortion-vulnerable or abortion-minded, views ultrasound images of her fetus, she is more likely to carry the pregnancy through to birth than to abort. The testimony of the participating center directors and ultrasound examiners bears this out. Therefore, there is something about these ultrasound images of one's pregnancy that usually leads to a change of attitude and action regarding abortion. This implies that these ultrasound images are indeed captivating—at least to the target audience, the pregnant woman. Perhaps other

audiences would not find them so, but the centers do not generate these images primarily for other audiences. The ultrasound images are provided to the client. The client may then share them with significant others including the father of the baby, the client's mother and etc. Therefore the following analysis will be offered in light of the primary consumer of these visual rhetorical artifacts—the client, perhaps the man who impregnated her, and possibly her mother. While other audiences may view these same images, this discussion will primarily critique the images in light of the target audience's likely disposition toward them.

Limiting the discussion to a consideration of the target audience's likely responses brings up the matter of context once more. Foss (1994) insisted that a visual rhetorical work should stand independently from its production. Peterson (2001), however, agreed that visual elements might be evaluated in light of their context. Analyzing the potential impact of ultrasound images on the rather narrow target audience necessarily entails a consideration of the context.

Basically, the context of these images is as follows. A woman thinks or knows that she is pregnant, and this pregnancy is not planned. Therefore, the pregnancy could be construed as a crisis pregnancy. Any number of possibilities make this so. The woman may have been the victim of rape or of incest. The woman may have had a sexual relationship with one or multiple partners. The woman may be married and have had an affair with some other man. The woman may be married with several children already in her family. Whatever the circumstances that led to her becoming pregnant, carrying the pregnancy through to birth will almost certainly be a burden to her. The pregnancy will affect her body, her health, her financial situation, her relationships with

those close to her, and her educational and/or career plans. Given these concerns, the woman visits the pregnancy support center for help and information. The woman or significant others in her life may be in favor of aborting the pregnancy. Once she visits the center, she is given the opportunity and consents to have an ultrasound exam. The exam results in visual images of her body, her pregnancy, and her fetus. The images may reveal information that is new to her. The woman is provided with pictures of her fetus to take home with her and with pictures to give to others if she so desires. She and anyone to whom she gives the pictures will have a basic knowledge of the foregoing details. The way they view the images will almost certainly be affected by this intimate knowledge they have of the woman's situation. The context is important, therefore, for a consideration of the woman's likely response.

Furthermore, the rhetor in this case is the pregnancy support center. These centers, certainly the ones participating in this study, all subscribe to a pro-life view, and they seek to dissuade women from having abortions. They aspire to offer alternatives to abortion. Pursuant to this goal, they provide holistic Christian ministry to the woman, her unborn and significant others in her life, and they provide professional health services, including pregnancy testing and limited ultrasound. Therefore, the fetal ultrasound image grows out of a clearly articulated system of beliefs.

Moreover, the fetal images carry ideological force. One of the reasons for the production of the image was to convince the client to carry to term instead of aborting. Furthermore, in most instances following the ultrasound, the client elects to see the pregnancy through to birth, but there are some exceptions. The centers are mostly successful in their use of these images. As previously noted, they do not use graphic and

gory pictures of abortion procedures or aborted fetuses. They refrain from such fear tactics, and instead rely on the ultrasound image and the other services and care they offer the client.

As indicated earlier, the image she sees is relatively simple and unadorned. The pictures of the naked fetus bare the naked reality of the individuated person taking shape in the womb. The “extraneous or complicating aspects” that Hart (1997, p. 192) mentioned are missing. This evidently contributes to the picture’s compelling nature. The client is not viewing someone else’s pregnancy but her own. She is not looking at pictures of someone else’s baby but her own. She is not seeing what might happen if she has an abortion but she is seeing what is happening then and there in her womb. She is not seeing blood and dismembered body parts, but she is seeing tiny limbs, a small (perhaps moving) intact body, and a beating heart.

The ultrasound pictures present to the client visual arguments akin to the systematically articulated beliefs of the pro-life movement and the pregnancy support centers. Moreover, these arguments literally emerge from within the client. By baring her private parts, either for the abdominal transponder or vaginal probe, the woman is giving the technician permission to peer into her innermost being—both physically and psychologically. The technology permeates the woman’s torso and womb to reveal the inner workings of her womb. In one sense, the data that emerge from within the client are totally new. No one has ever seen exactly what she is seeing at that moment—not even her. She may be startled to learn that the fetus is as developed anatomically as it is or to see and/or hear the beating heart. Such a revelation may evoke a cognitive and/or emotional crisis as her planned actions to abort are challenged by the fresh data. In

another sense, the data that surface may not be new or surprising, but instead, they may confirm what she innately knew all along. That is, the knowledge gathered from the ultrasound may validate her thoughts and feelings about the person taking shape within her. These visuals may give voice to her desire not to abort.

The emergence of these images from inside the client, as opposed to the presentation of arguments from outside the client, only strengthens the pictures' persuasive potential. The images are not foreign to the client in that sense. Some external agent is not fabricating or concocting them. In the purest sense, they are not arguments for preserving the pregnancy made by some social movement, some medical professional, or some religious zealot. They are visual arguments welling up from within the client. An old saying in Proverbs 20:5 (King James Version) states that, "Counsel in the heart of man [or woman] is like deep water, but a man [or woman] of understanding will draw it out." The ultrasound technology then potentially becomes a tool that helps put the woman in touch both with her innermost feelings.

Given the reported success of the centers in using these images, there is little doubt as to their compelling nature. Besides the fact that these images emerge from within the woman's very own womb, these images are forceful precisely because they contain the important "condensations" suggested by Hart (1997, p. 191) that make them so. The overall picture of the fetus or baby inside the woman and the individual elements of the image both serve to reduce the interpretations that the audience can make. They fill the eyes of the client with the "single, dominant meaning" that, according to Hart (1997, p. 191), make the visual captivating.

The position of this paper is that the single and dominant meaning of these ultrasound images, as intended by the center and as understood by the client, is that the fetus within her womb is a baby human being. The images leave little room for any other interpretation. The image appearing on the screen and printed on the paper to be taken home serve as a visual synecdoche for the pro-life set of arguments.

At this juncture, Hart's (1997) insightfulness regarding what constitutes forceful visuals surpasses the contributions of Foss (1994) and Peterson (2001) in aiding the rhetorical critic in evaluating the persuasive potential of a visual argument. On the one hand, for Hart (1997), filling the eyes of the audience with a dominant meaning is precisely what makes the visual compelling. On the other hand, for Peterson (2001), filling the eyes of the critic with a single dominant meaning precludes the possibility of more meaningful critical insights. What Hart (1997) considers a compelling characteristic, Peterson (2001) laments as a limiting one.

As already noted, Peterson (2001) used the identification of Superman as an illustration. A rhetorical critic, like the person on the street that points toward the sky shouting, "It's a bird!...It's a plane!...It's superman!", limits the available interpretations once a positive identification of the image has been made. This is so because the person on the street already has preconceived notions regarding Superman. Superman is faster than a speeding bullet, more powerful than a locomotive, and is capable of leaping tall buildings in a single bound. Superman cannot fail. Superman is unstoppable. Superman is a super human. These features define Superman. All of these preconceived characteristics constitute what Peterson (2001) calls baggage.

However, the very thing that Peterson (2001) considers the weakness of Foss's (1994) schema is the strength of Hart's (1997) insights. More importantly, however, for the discussion at hand, the reported tendency of the client to identify the thing taking shape within her womb as a baby human being is what makes the ultrasound image so powerful. Whatever meanings a rhetorical critic or some disinterested observer may attribute to the images, the client viewing the images is likely to identify it as a baby human being. Moreover, it is not just a human baby; it is her baby. She conceived it. It has her DNA.

Once that identification has been made by the client, all of the things associated with a baby human being are instantly associated with this fetus in her womb. As Peterson (2001) rightly pointed out regarding Superman, once the positive identification has been made, various other conceptual and critical possibilities are constrained. The ultrasound image provides a picture of a baby, not an undifferentiated tissue mass or a blob, but a baby.

Foreclosure on other conceptual possibilities is made for numerous reasons. Interestingly, Peterson's (2001) work is most helpful here, because the individual elements that comprise the image serve to communicate the meaning intended by the pregnancy center and reportedly shared by the majority of clients. As pointed out in the earlier discussion using Peterson's (2001) schema, the fetal body parts, the bodily movements and the heartbeats serve to communicate that the thing inside the womb is a baby human.

While seeing these individual elements may offer the rhetorical critic numerous and multiple opportunities for analyses, seeing these elements, from the researcher's



perspective, reduces the number of possible interpretations left open to the client. That is one explanation for their efficacy. As will be discussed later, one of the moves in every rhetorical task, according to Hart (1997), is to restrict the listener's options for possible choices. Before progressing to an elaboration on those rhetorical moves, however, a consideration of why the fetal ultrasound images serve as a visual synecdoche for the pro-life complement of arguments, and by extension, how they constrain the client's choices by setting before them singular dominant meaning, is in order.

The majority of the clients who see an ultrasound of their pregnancy come to the understanding that the fetus within their womb is baby human being, and therefore, they do not terminate their pregnancy. Something about the ultrasound leads the clients to attribute that meaning to the images they see. While conclusive identification of the ultrasound elements that lead the clients to such attributions may be difficult or even impossible from the qualitative data at hand, reaching probable conclusions is not.

First, the ultrasound image identifies the fetus as a distinguishable entity or object. The object is situated in the womb of the client and is attached to the client by means of the umbilical cord, but remains distinguishable from the client. The client who is considering abortion understands that the fetus is a distinct and discreet thing that can be removed from her body by means of an abortion without removing any piece of her own body from her body. The client who undergoes an abortion is not undergoing a hysterectomy. The abortion does not remove her uterus, but the abortion does remove the fetus from her uterus instead. The client already thinks and believes that an abortion will remove something from inside of her without removing anything of her. The client, identified by the center as abortion-minded or abortion-vulnerable, has probably already

individuated herself from the fetus and vice versa. In this regard, the ultrasound only reinforces what she already knows—the thing in her womb is distinct from her and can be destroyed without destroying her.

However, this cognitive individuation that becomes visually apparent by means of the ultrasound undermines the argument that women should have unfettered rights to abortion because they should have the right to do what they want with their own bodies. They know they can destroy the fetus without destroying themselves, and now they can see that the fetus is indeed individuated from them. Not only is the fetus individuated from them, but the fetus is also an individual in her or his own right. That leads to the next major element of the ultrasound that helps the client arrive at a singular dominant meaning.

Closely related to the first visual feature is the second set—the elements that help the client identify the individual inside of them as a human being. When the pregnancy is far enough along, the client can often make out the body parts including the head and the limbs. While it is true that many creatures in the animal kingdom have distinguishable body parts such as heads and limbs, the client knows that whatever is developing inside of her is human. Dogs and cats have heads and legs, but the client instinctively knows that what she sees is not a dog or a cat. Therefore, the head and limbs she sees are human.

These discernible anatomical features contribute significantly to the client's recognition of the fetus as a human baby. Clients, like all people, are accustomed to seeing babies with all of their physical features. While clients may never have analyzed the physiological differences between adults and babies, they intuitively know them.

Babies are not only smaller than adults but they have proportionately larger heads and "...proportionately shorter and chubbier arms and legs," according to Zebrowitz (1998, p. 71). Lorenz (1971) labeled these and other infant qualities as Kindchenschema (baby-schema) and suggested that they provide meaningful stimuli (Zebrowitz, 1998, p. 71).

Zebrowitz (1998) further noted differences between adult and baby head shapes. The baby's head is relatively larger and the forehead is more vertically sloping. The baby's eyes are larger and lower. The nose and mouth are comparatively smaller and the chin is more receding. Zebrowitz (1998) said that research suggests that while these differences may be subtle, people are highly sensitive to them. "Not only can people readily discriminate a less from a more mature head shape, but also the infantile head shape stimulates caretaking impulses and inhibits aggression," wrote Zebrowitz (1998, p. 74). This is true because the babyish features connote perceptions of dependency that should warrant more caretaking. The individual with the baby face is considered less alert, less strong, and less intelligent, and the individual is perceived to be less threatening, cuter, and more lovable according to Zebrowitz (1998).

Other researchers have investigated whether younger or older infants are deemed cuter. Sanefuji, Ohgami, and Hashiya (2007) conducted two studies, one involved evaluating perceptions of adults and the other perceptions of children, regarding perceived cuteness. The outcomes of both were similar. In the first study, when evaluating human stimuli, adult participants judged the photographs of babies at the ages of three and six months to be cuter than older babies at 18 and 21 months of age. In the second study, children judged the photographs of babies at three months of age to be cuter than those at 18 months of age. These findings suggest that human adults and

children share similar preferences for baby faces around a specific period because of stronger baby schema. Sanefuji, Ohgami, and Hashiya (2007) also observed, “The present study also suggested that even young children, who have relatively less cultural experience than adults, show similar responses to baby schema and demonstrated the potency and universality of the baby schema” (p. 254). The potency and universality of the baby schema may, therefore, offer some explanation as to the persuasive nature of these ultrasound images.

However, the research of Zebrowitz (1998) raises a caveat here. Research has demonstrated that parents watching videotapes of premature or full-term infants found the premature babies less pleasant and experienced greater physical arousal in response to the premature babies. Zebrowitz (1998) did suggest that some of this arousal was attributable to the distinctive crying sound the premature babies made.

Notwithstanding this caveat and with these findings in mind, understanding why the clients recognize the fetus as a human baby and decide not to terminate the pregnancy is easier. Ultrasound images of fetuses as early as twelve weeks reveal a large head with protruding cranium as well as tiny arms and legs. The relatively large head is a key component in the client’s interpretation of the image. This large head is one of several physical features that, according to Lorenz (1971), influence the way people respond to children. Lorenz (1971) described the characteristics of small children that tend to make them adorable to adults, and went on to describe how these features can lead to abstractions of these features when relating to animals and even to dolls. Lorenz (1971) wrote:

A good subject for analysis is presented by the innate releasing mechanisms with which we respond to small children. A relatively large head, predominance of the brain capsule, large and low-lying eyes, bulging cheek region, short and thick extremities, a springy elastic consistency, and clumsy movements represent the major characters following the law of summation and combining to give a child (or a dummy such as a doll or an animal) a lovable or 'cuddly' appearance. The products of the doll industry, which are literally the results of dummy experiments carried out on a very wide basis, and also the various types animals (e.g. pug-dogs and Pekinese) which are taken over by childless women as substitute objects for their parental care drive, permit clear-cut abstraction of these characters. (p. 154)

Some of these characteristics that are prominent in the visual presentation of the fetus include the relatively large head, predominance of the brain capsule, short and thick extremities, and, where evident, clumsy movements.

Doubtlessly, the client is unconsciously applying the baby-schema described by Zebrowitz (1998) and Lorenz (1971) to the fetus in the ultrasound and concluding that the thing growing within her is a baby. The visual images conform to the patterns of the baby-schema that the client has assimilated over her lifetime.

Critics of this view may protest by pointing out that traditional ultrasound lacks the clarity of resolution necessary to facilitate such attributions by the client. However, while there are instances when these features may not be as discernible as at other times, there are numerous instances when these features are readily recognizable. Moreover, even on the occasions when the image may be somewhat vague, the general outline of the

fetus is usually apparent, and in such instances, again, the fetal head prominently appears. The vagueness or ambiguity that may be present could, ironically, actually strengthen the client's perception of the fetus as a small child by calling more attention to the overall image and profile than to the smaller features that are may be more difficult to discern.

Furthermore, many, not all, of the pregnancy centers make use of fetal models in educating the client on fetal development. These fetal models are scaled to size and weight of the actual fetuses. They are available at various stages of gestation such as 10, 12, 16 and 20 weeks. These are visible and available to the client. If she wants to, she can handle them. According to one participant, the models offer a good adjunct visual but the ultrasound remains the primary visual because of the component of motion. So, the fetal models have the potential to compensate for any lack of clarity in the ultrasound. Moreover, these fetal models are strikingly similar to baby dolls. The introduction of the client to these dolls (fetal models) may evoke nurturing instincts, activate the innate releasing mechanisms described by Lorenz (1971), or at least, elicit fond memories from the client's childhood when she played with her own baby dolls. The persuasive potential of the models when used apart from the ultrasound may be limited. However, presenting the fetal models together with the ultrasound probably provides a powerful persuasive message.

So the ultrasound images and fetal models communicate to the client that the thing within her womb is a separate and distinct entity from her. The object in the womb is individuated from the client who carries it and is recognized as an individual. Moreover, the object is recognized as a baby human by various anatomical features associated with humans—especially baby humans.

Finally, the third salient feature of the ultrasound that shapes the client's response is the fetal heartbeat. As suggested earlier, the beating heart is a metonym for life. Whereas the overall ultrasound serves as a synecdoche for the pro-life set of arguments, the heartbeat serves as a synecdoche for life itself. Whether the client only sees or both sees and hears the beating heart, the heartbeat connotes life. The presence of the heartbeat reduces the number of available interpretations open to the client. The fetus in the womb is recognized as an individual human being that is alive. But why does the heartbeat, whether visible only or visible and audible, of the fetus have such an impact on the attitude and actions of the client?

The answer to this question can probably be traced back to the time when the client was herself a fetus in the womb of her mother. Whereas fetal eyes are sensitive to light by 28 weeks and the fetus is responsive to variations in the taste of ingested substances by 28 weeks, the sense of hearing is present sooner. "The internal, middle, and external components of the ear are well developed by midpregnancy. The fetus apparently hears some sounds in utero as early as 24 to 26 weeks (Cunningham et al., 1997, p. 169).

With the sense of hearing developed by 26 weeks of gestation, the fetus has the capacity to begin learning about the world around her or him. Among the sounds that are available to the fetus is the mother's heartbeat. Maternal cardiovascular sounds have been recorded in utero in women experiencing labor after the amniotic membranes were ruptured (Moone & Fifer, 2000). The acoustical environment of the in utero fetus includes not only the maternal cardiovascular sounds, but also the respiratory and intestinal sounds as well as vocalizations of the mother (Porcaro et al., 2006). "All these

sounds are an important component of prenatal development since they provide a memory-linked foundation for later learning and behavior” (Porcaro et al., 2006, pp. S1-S2). Research regarding the effects on young infants of hearing recordings of heartbeats suggest that such sounds may lead to reduced crying time, greater weight gain, and a general soothing effect (Moone & Fifer, 2000). The sound of heartbeats acts as a reinforcer for infants (Moone & Fifer, 2000). These data are relevant to the discussion at hand because they support the idea that, since the earliest days of the fetus in the womb, the person has been reassured by the sound of heartbeats. As a fetus, the client was reassured by her own mother’s heartbeat. Now, facing the prospect of motherhood herself, the client may find her fetus’s heartbeat reassuring, or at least find the heartbeat reaffirming of the humanity and personhood of the one growing in her womb.

The salience and prominence of the sound of heartbeats only increase after birth as the child grows and learns that the beating heart is essential to life. For some children, a fun activity was listening to the heartbeat of another person by placing one’s ear on the other’s chest. Later in life, the literal sounds of a lover’s beating heart are sometimes a part of romantic embraces. People are taught to look for a pulse, the result of a beating heart, as evidence for life. Heart monitors on patients in health care facilities act like ocular magnets because they attract the attention of the visitors who hope that the telltale images of life continue to appear on the screen. And on and on it goes. The heartbeat is the quintessential symbol of life—even from the earliest days in utero. Humans are conditioned by their environment, even the environment of the womb, to find solace in the sound of the beating heart.



Therefore the heartbeat, whether perceived audibly, visibly, or both audibly and visibly, symbolizes life. The effect may be greater if the client can both hear and see the heart beating. However, in those instances where only the visible stimuli, not the audible, are available, the client will still associate the heartbeat with life. She has been conditioned to do so. This is a reality that is not lost on the pro-life movement that has managed to influence legislation to capitalize on this phenomenon. At least one state, Wisconsin, has a law that requires abortion clinics to tell women that they have the option of listening to their fetus's heartbeat before undergoing the abortion (Stevenson, Gordon, Begun, Check, & Haskins, 1999). The law also requires women to read a pamphlet depicting the fetus at various stages of development.

So the ultrasound pictures satisfy Hart's (1997) criteria for captivating visuals, and the acoustic element of the beating heart, when present, contributes even more to their captivating nature. They carry with them the ideological force of the pro-life arguments that the fetus is a separate living human being. The images succinctly communicate with little verbal explanation, except for the pointing out of the various elements such as the heartbeat that appears as a bright flicker, the fluid that appears as darkness, and etc., that the fetus is alive. The audience is left with few interpretations.

Notwithstanding the reduced number of meanings that the clients might attribute to the images, there is no guarantee that the clients will carry the pregnancy to term. Some clients terminate their pregnancies after experiencing the ultrasound. Their pregnancy terminations do not necessarily imply that they reached a different conclusion as to the meaning of the images than their counterparts who carried their pregnancies to term. It is altogether plausible to conclude that they recognized the fetus as an individual

living human baby, but they simply were not persuaded or convinced that they should not abort the fetus.

Having examined the ultrasound images using Foss's (1994) schema, Peterson's (2001) alternative approach, and Hart's (1997) characteristics of captivating images, a consideration of how these images fit into the larger context of the pregnancy centers' overall rhetorical strategy is in order. Once more, the work of Hart (1997) is beneficial in this endeavor. The upcoming section will discuss the manner in which the pregnancy centers accomplish Hart's (1997) five rhetorical moves. The framework for the discussion will consist of the five rhetorical moves. The substance of the narrative will focus on the themes and sub-themes that emerged during the course of the interviews. Examining the intersection of the rhetorical moves and the major themes should offer insights on the rhetorical strategies of the centers. The reader should note that neither the five moves nor the major emergent themes are altogether discrete concepts. There is arguably some overlap among them, and this overlapping will become apparent in the ensuing narrative excursion. For example, one of the major themes was sensitivity in sharing and sub-themes belonging to this category included: a tactful approach to communicating with others, the use of fetal models, the avoidance of the use of grisly images, and the avoidance of relaying overwhelming data to the clients. The discussion of these sub-themes logically spans at least two of the rhetorical moves: the effort to exert change by using language instead of non-symbolic forces (guns, torture, and etc.) and the subtleness of the communicator.

*Five Rhetorical Moves**Exerting Change*

First, the communicator, in this case the center staff, tries to bring about change by using language rather than non-symbolic forces. Hart (1997) clarified what he meant by “non-symbolic” forces by identifying some such forces as guns and torture. Hart’s (1997) articulation of this first basic move will be amplified and expanded to include not only language but also visual images. Doing so does no harm to Hart’s (1997) description of the first move but simply extends it to include what scholars generally acknowledge as legitimate works of rhetoric—visual images.

In their efforts to exert change, namely to convince women facing unplanned pregnancies that they should not abort their offspring, the centers exercise deliberate care in their choice of terms. Their attention to semantics surfaced in at least three areas: the label assigned to those who help the clients, the label assigned to the unborn, and the label assigned to the process of ending a pregnancy.

Many of the interview participants referred to client caregivers as client advocates rather than counselors. Different reasons were given and/or may be considered for the alternate appellation. One more negative reason has to do with the connotative meaning of the term. As one respondent pointed out, if the receptionist introduced a client to her caregiver as her counselor, the client may resent it. Going to see a counselor, at least in contemporary parlance, implies that something is wrong with the individual. Otherwise, why would one go to see a counselor? So the term counselor has certain negative connotations associated with it. Using that term, therefore, may tend to alienate the client from the beginning or at least make building a relationship or communicating with her

more problematic. The center does not want to insinuate to the client that they think something is wrong with her.

On the contrary, the center wants the client to view them positively or favorably. So the second reason, a more positive one, has to do with the way the center does want to be viewed. The center would much rather be viewed as a helper, and this is the essence of Hart's (1997) second rhetorical move. By ascribing to the person at the center the title of advocate, the center is seeking to portray itself in a more favorable light. The center staff wants the clients to perceive them as a friend, as one who can assist them through this time of crisis. This careful choice of terms is subtle and yet very significant. Some of the clients arriving at the centers have others in their lives urging or demanding that they abort the pregnancy whether the clients want to or not. A boyfriend may be threatening to break off the relationship, or a father and mother may be threatening to kick the client out of their home. Minimally, the client faces a situation that has left her in need of assistance. Therefore, labeling themselves as advocates is a wise move that communicates to the clients very subtly that people at the center will rally around them and defend their cause. After all, they are not counselors; they are client advocates. Their job is to advocate for or back the client—not the boyfriend, not the parent(s), and not the baby.

Still another reason that some of the centers refrain from labeling themselves as counselors is a legal one. Some respondents expressed concern over calling their caregivers counselors since many, if not most, of them are volunteers who do not have the professional credentials of counseling degrees or state licensure. Even though the centers mandate initial and ongoing training for their staff, apparently most of them are

neither degreed nor licensed as professional counselors. So the self-designation of client advocate avoids the potential professional liability issues as well as personal misgivings associated with seeing someone known as a counselor.

Another area of semantics attended to by center personnel has to do with the labeling of the pre-born or unborn. Center personnel use both terms, fetus and baby, to refer to that which has been conceived in the womb of the woman. This research project was not designed to conduct a content analysis for the purpose of evaluating the use of these two alternate terms. However, worthy of note is the fact that the only use of the term fetus in some of the interview manuscripts was the mention by the researcher. Unsurprisingly, the center personnel seemed to show a bias for the use of the word baby. Nevertheless, some respondents used the terms interchangeably throughout the interviews. Cara remarked on possible choice of terms, "You know, when you see someone in your office you're not going to say, 'How's your fetus doing?'" According her, the staff usually uses the term baby because that is what most people are accustomed to using.

However, as will be discussed later, the staff is not only intentional with regard to their choice of terms, but they are also intentional with regard to adapting to the client's communicative behavior. In other words, if the client refers to the pre-born as a fetus and seems to be strongly contemplating abortion, then the one interacting with the client will seek to accommodate the client's preference for terms in an effort to avoid appearing forceful or pushy.

The alternation between the two terms on the part of some reflects one of the tensions that the center feels. On the one hand, the term fetus probably sounds more

professional and more academic to the client. This helps inculcate the impression that the center offers professional health care and can be trusted as such. On the other hand, the term baby is more likely to be associated with home and family. This helps foster the feeling that the center is a welcoming and supportive environment.

Aside from the available choice of terms regarding the caregivers and the pre-born are the possible options for describing the ending of the pregnancy. Some interviewees discussed pregnancy termination while others discussed abortion. Kayla observed that the term abortion evokes negative connotations, and that the term seems harsh. This term, with its harsh connotations, has the tendency to alienate people, and that is counterproductive to the mission of the center. Therefore, even though the term pregnancy termination means the same thing, people tend to receive it better. She reported that this choice of terms is analogous to sexual integrity versus abstinence. The point is that pregnancy termination gets the meaning of ending the pregnancy across without the negative baggage associated with the term abortion.

The centers' attention to the selection of labels they use reflects their commitment to sensitivity in sharing with the clients—another of the emergent themes entailing symbolic communication. This sensitivity in processing clients emerged over and over during the interviews, and one area where it appeared was that of storytelling. Both clients and their caregivers participate in this practice.

Clients find the opportunity to tell their stories at the centers in an environment that has more or less been sanitized of judgmental attitudes. More about this safe supportive environment will follow later. At the centers, the clients find advocates who are eager to listen to them and to participate in their stories with them. Angela explained

that, "...we want women to know that women, we'll listen to a woman, you know, enter their story with them." In this sense, the centers become shelters or havens for the clients where they can express themselves. There they can unburden their souls and share their secrets—not only by permitting the ultrasound to probe their innermost physical parts but also by permitting the client advocates to probe their innermost psyches. The practice of storytelling becomes a means of self-disclosure for the client and a means of exploration for the advocates. Of course, this is all a part of the rhetorical strategy of the centers. The staff members are trained and encouraged to facilitate this process not only as a means of learning more about the client so that the center will be able to respond better to her situation but also as a means of helping the client discover for herself what she really thinks, feels, believes, or knows down deep inside. This is such an important part of the overall strategy that center personnel go to great pains to ensure that clients who are baring their souls through storytelling are not interrupted in the process. So the storytelling not only helps the advocates understand the clients better, but such narratives also help the clients understand themselves even better. In this sense, one could argue that the client is more actively involved in persuading herself than the client advocate is.

Indeed, critics questioning the persuasive efficacy of these centers' rhetorical strategies may object that the preponderance of clients presenting at these centers is predisposed to maintain rather than terminate their pregnancies. They want to be persuaded to keep the pregnancy, or minimally, they want to be reaffirmed in their decision not to terminate it. Else, why would they visit a support center rather than an abortion clinic? However, in some areas, there is easier access to pregnancy support centers than to abortion clinics because of the relatively larger number of the former and

smaller number of the latter. Moreover, notwithstanding the fact that these support centers never claim publicly or privately to provide abortion services, clients frequently call or visit these support centers thinking that the centers provide such services. Furthermore, even women who have already made the firm decision to abort will sometimes visit the centers for the purpose of obtaining a free ultrasound to help them make more informed choices regarding the type of abortion to be performed. Therefore, one cannot conclude that most of the women visiting these support centers are already inclined to keep instead of abort their pregnancies. The number of women whom the centers would consider to be abortion-minded or abortion-vulnerable varies from location to location. So at any given center, at least some of the clients are likely to be classified as abortion-minded or abortion-vulnerable. This portion of the clientele constitutes the target audience of the centers' persuasive efforts. The centers endeavor to persuade them to carry their pregnancies to term, or at the least, the centers aspire to facilitate the client's persuasion of herself.

After all, people, including the clients who visit these centers, are to some extent capable of self-persuasion according to Heath and Bryant (2000). As noted in an upcoming section, their quest for information is often what brings them into the centers. Exposure to the new information and the new influences at the centers may empower the client to achieve goals they have set for themselves. From the perspective of the centers, clients are enabled to discover how they truly feel down deep inside about their pregnancies and are empowered to decide for themselves the appropriate course of action. Therefore, this process of self-discovery may be construed as one of self-



persuasion. Several elements of the centers' rhetorical strategies potentially facilitate this process including the ultrasound experience and the practice of storytelling.

The storytelling of the client has the potential of doing more than persuading herself. At least one of the centers reported that they use the stories of clients to advertise to the public. The client shares her story with the public by means of a radio program. Every day on a Christian station, a two-minute portion of the client's story is shared. By the end of the week, the whole story has been told. Such an approach has tremendous potential persuasive power. The program does not have a preacher decrying the sin of abortion on the airwaves. The broadcast does not have a pro-life activist telling grisly tales of botched abortions. Instead, the program gives a woman, one very much like many in the listening audience, the opportunity to share her experience with an unplanned pregnancy and how the center helped her. This approach is much more likely to be appealing to the other women who might be facing a similar situation. Moreover, this approach reflects the rhetorical sensitivity on the part of the center.

The clients, however, are not the only ones engaged in the art of storytelling. When the client advocates enter the stories of the women who visit, they are sometimes given the opportunity to tell their own story. This is a natural part of getting to know someone whom you have just met. Most people who have shared something about themselves are accustomed to the other party in a conversation reciprocating by also sharing something about themselves. Therefore, a client would not feel particularly threatened whenever a client advocate told her own story. Indeed, it would almost be expected. This sets the stage for those caregivers who have faced crisis pregnancies of their own at some point in their past to tell the clients about their own experience. The

personal testimony of another woman who faced a similar situation has the potential to influence the client greatly. The client can realize that the advocate is not speaking from second-hand knowledge but from first-hand personal experience. The client cannot say, “But you don’t know how I feel,” or “You don’t know what I’m facing.” Moreover, if the advocate is post-abortive herself, she can say to the client, “You don’t know what you are facing if you have an abortion, but I do because I have.” This storytelling on the part of the advocates, of course, becomes a means for the advocate to unburden herself. The storytelling, according to the Burkian pentad, becomes a means of redemption or atonement for some act in the past that is now regretted. In this sense, the helper becomes the helped. The client becomes the caregiver. Language, more specifically storytelling, facilitates this potentially therapeutic interchange.

While storytelling may prove indirectly persuasive, the centers do sometimes employ more direct arguments when seeking to persuade them not to terminate their pregnancies. Indeed, one of the major emergent themes was persuasive arguments and artifacts. The preponderance of the participants did not report resorting to strong verbal arguments in their persuasive efforts. The majority seemed to prefer the less direct approaches of storytelling, interpersonal dialogue, ultrasound images and sounds, and so forth. However, on occasion, those processing clients do become forthright in their statements. One ultrasound examiner said that sometimes, if the client seemed to be strongly considering abortion, the examiner might say something like, “This is a creature of God—a gift of God. You don’t want to destroy this baby do you?” Or the examiner might say, “If you choose to have an abortion, God does not want you to do this, but God

gave you a will. If you have an abortion, God still loves you and we still love you and you are welcome back at the center.”

An analysis of these statements aimed at persuading the client not to terminate the pregnancy reveals that they represent a clear articulation of the ideology of the center. Monotheistic religious people operate these centers. While the reference to God is not explicitly Christian, the centers participating in this research were Christian in their worldview. The pre-born are viewed as creatures of God—not as cosmic accidents or the product of chance processes. The pre-born are not only viewed as creatures of God but as gifts from God. This appellation is particularly striking because the client contemplating abortion is challenged to view the contents of her womb not as a bane but as a blessing instead. She is confronted with an alternative interpretation of her circumstances. The pregnancy is reframed for the client rhetorically both verbally through such an oral argument and visually by the ultrasound. She may not embrace the alternative interpretation but she encounters it nonetheless. Furthermore, the client, whether she believes in any God at all, is reminded that many people in the world do believe in God. She is also confronted with the caregiver’s perception that God does not like abortion and does not want her to have an abortion. This may or may not come as a revelation to the client. On the one hand, some people, even in the Christian community, are of the view that abortion is not bad, and therefore, the client may be challenged to rethink the morality of abortion. On the other hand, such statements may only reinforce what the client already thinks, namely that God is and that God does not like abortion.

The indicated argument does not only introduce the concept of God into the discussion, but also reinforces the notion of the client’s personal responsibility. The

concept of client responsibility is predicated on the notion that even her will is a gift from God—something with which she has been divinely endowed. Now that she has a will, she is responsible to exercise it. She is culpable for the choices she makes. Implicit in the argument is that she is also accountable to God for the decisions she makes. But the argument does not paint God so much as judgmental as it does benevolent.

God is characterized as loving and welcoming. “If you have an abortion, God still loves you and we still love you and you are welcome back at the center.” Perhaps this is the most powerful part of this typical argument. This is so for a number of reasons. Many of the clients considering abortion who come to the center are under duress from their boyfriends, parents, or husbands to have an abortion. The clients are facing threats of abandonment by their lovers or threats of being driven from home by their parents if they do not abort. In effect, they are being told implicitly by such threats, “If you do not have an abortion, we will not love you anymore.” Yet, when the client comes to the center, she finds people who plainly do not want her to have an abortion, but who verbally and nonverbally communicate to her that God will still love her if she has an abortion. They will still love her if she has an abortion. She will even be welcomed back to the center if she has an abortion. Such words and actions, when compared with the threats the client faces by significant others in her life, provide a stark contrast for the client’s consideration. She may be prompted to think, “Who *really* loves me? Who *really* cares about me? Who really has *my* interest at heart?” On the one hand, she faces threats by those on the outside of the center, and on the other, she faces promises by those on the inside of the center. This unconditional love, expressed in the form of an

argument against abortion here, is also an important component in fostering a supportive environment—a theme to be addressed later.

So the people at the center endeavor to affect change by using symbolic means such as language—one of the basic moves in any rhetorical task. Sometimes this language takes the form of very overt remonstrations, but sometimes this language takes the form of very subtle arguments. This is especially true with reference to the ultrasound exam and images.

During the ultrasound exams, the clients not only see the images being generated by the machine that uses waves of sound to generate images of light, but they also hear what the examiner has to say. While the examiners, like the client advocates, endeavor to take their communication cues from the client, they are openly pro-life in their worldview and want the client to carry the pregnancy to term. They may use the term fetus on some occasions, but they also use the term baby. As the examiners, they are in a position of rhetorical power. They have the prerogative to label the pre-born as a baby. Out of deference to the client, they may choose not to, but they can and probably do, whether consciously or not, call it a baby. At this juncture, it should be noted that communication accommodation is a two way process. The examiner has been trained to let the client's mood and language set the tone for the experience. However, the client has been conditioned culturally as well to engage in communication accommodation. Therefore, the examiner's verbal overwriting of the ultrasound experience may result in the client's picking up and using the word baby instead of fetus unless the client is consciously resisting the tendency to do so.

Moreover, during the ultrasound, the examiners may ascribe descriptions or actions to the pre-born that indicate personality or personhood. For example, if the examiner is having difficulty getting a good image to appear, the examiner may say something like, "The baby is being shy." Cara noted that she may say something like, "Oh, look the baby's waving at you. This is such a cute time to do an ultrasound. The baby looks like a little teddy bear." Sometimes, the client or the male in attendance with the client will make such attributions of personhood. Bethany noted that she has heard clients say things like, "Oh, look my baby's jumping around just like Daddy" or "Those legs look like Daddy's." So the ultrasound experience occasions opportunity for a verbal overwriting by the client, those visiting with the client, and by the examiner.

Furthermore, a tangible product of the ultrasound exam is the picture or pictures that the clients are given to carry home with them. Some respondents pointed out that clients sometimes ask them to write certain expression on the pictures. The client may request the examiner to write, "Hi, Grandma" or "Hi, Daddy" on the images she carries away from the experience. That the client would ask the examiner to write the words is interesting since the client could theoretically put the words on the picture herself. Perhaps the client is afraid she will deface the picture if she does or perhaps the client thinks the words will carry more significance if the professional writes them. That the client would even request that anything be written is telling as well. If the client requests that the phrase, "Hi, Grandma" be written, perhaps the client is doing so because she knows grandma will be delighted to be included, even in this remote way, with the pregnancy and ultrasound. Or perhaps, this is the client's way of reaching out to grandma in efforts to persuade her that the pre-born is a person and ought not to be

aborted. The same is true with the father who may be addressed by, “Hi, Daddy” on the image. In any event, in these instances both during and after the ultrasound, words (symbolic forces) are used to exert change. However, quite apart from the words, there are images and sounds (sometimes) that arguably possess as much if not more persuasive potential than any of the words.

These images and sounds were explained in greater detail in the previous section discussing Hart’s (1997) criteria for a captivating visual and one that fills the eye of the beholder with a single dominant meaning. They are summarized here because they constitute key components of the communicator’s efforts to exert change through the use of symbols. Basically, center personnel believe that the ultrasounds they provide offer the client the opportunity to discover for herself what is really transpiring inside her body. The position of this researcher is that there are at least two probable explanations for the apparent power of these images to persuade clients considered to be abortion-minded or abortion-vulnerable to carry their pregnancies through to full term instead of terminating them. The first is the baby-schema proposed by Lorenz (1971) and expanded upon by Zebrowitz (1998). The relatively larger head, bulging cranium, shorter limbs and clumsy movements contribute to the client’s likelihood of unconsciously or subconsciously applying the baby-schema to the image of her fetus she sees through the medium of ultrasound. The second is the sight and/or sound of the beating heart. Humans are conditioned from their earliest days, perhaps even by gestational week 26 in the womb, to perceive the heartbeat as a reassuring sound. So when clients detect the presence of the beating heart in their fetus, they are more likely to find it difficult to terminate the pregnancy.

Doubtless, other possible explanations for the reported persuasive potential of these ultrasounds exist, and the centers utilize other visual artifacts in their rhetorical efforts as well. For example, some centers reported displaying posters of fetal development. Some centers also use fetal models that produced according to scale both in terms of weight and size. Clients who wish might not only see these, but they may also actually handle these models. Centers find them to be useful adjunct visual aids.

In summary, the pregnancy support centers seek to exert change by using symbolic means such as words, ultrasound images and/or sounds as well as fetal models. This is only the first of the five basic rhetorical move according to Hart (1997). This symbolic communication does not operate in a vacuum where feelings have been expunged though. For these symbols to achieve their full persuasive potential, the communicator must lead the audience to view him or her as a helper rather than a hurter. This is Hart's (1997) second basic move.

*Regarding the Communicator as a Helper*

Among the ten major themes that emerged from the interview data are four that reveal how the efforts of the centers could cause the clients to view them as helpers. The centers endeavor to operate top quality professional health care facilities, offer holistic Christian ministry to the client and the significant others in her life, foster a safe supportive environment, and establish ongoing interpersonal relationships with the client. Any one of these has the potential of leading the client to view the center favorably, but taken together, they form a quartet that exudes concern for the client.

In a manner similar to obstetrics clinics, these centers provide pregnancy tests and limited ultrasound services for clients. Moreover, many of them go beyond these to also



offer prenatal care for the pre-born. All of these services are provided in a setting that, in many ways, has a clinic-like atmosphere. Culturally speaking, clients are conditioned to expect their personal interests will be cared for when they enter such a facility. The medical community is expected to help people—not hurt them. This reinforces the significance of the professional health care theme in the overall rhetorical strategy of the centers. They are not being confronted by trite slogans on the street or by protesters carrying placards on the sidewalk. Rather, they are being treated by medical professionals such as doctors, nurses, and etc. in a clinic-like setting. This approach undergirds the centers' efforts of developing credibility with the community.

The interview data suggest that during the early years of some of the centers, the communities viewed them with some suspicion. However, over time, as the centers consistently provided top quality care, the communities came to respect them more highly. The introduction of ultrasound at the centers only served to reinforce in the minds of the community the perception of the centers as professional health care establishments. The high cost of obtaining and maintaining ultrasound equipment, along with the medical training required of those who conduct the exams, is apparently not lost on the communities surrounding these centers. So the ultrasound ratcheted up a level or two the respect for the centers.

However, the ultrasound technology is only a piece of the larger professional puzzle. Well-maintained buildings and beautifully decorated offices contribute to the aura of professionalism. So does the attire of the caregivers. Wearing white lab coats or medical scrubs serve as nonverbal reminders to clients that many of the center people are highly trained medical personnel. The diplomas, state licenses, and various other

certificates that appear on office walls are also tacit indications of the caregivers' credentials. Moreover, even the very language or lingo that is used during the ultrasound exam smacks of medical expertise. During the exams, phrases such as crown-to-rump measurement and amniotic fluid and yoke sack all bespeak an environment that most of the clients do not enter on a daily basis. The posters depicting fetal development that adorn the wall as well as the assorted other medical paraphernalia about the facility also help in this regard.

While the centers do labor to maintain a professional health care climate, they also strive to provide holistic Christian ministry to the client. This ministry involves caring not only for the physical needs of clients but also caring for the emotional and spiritual needs as well.

Caring for the physical needs of clients goes beyond the types of medical care that were discussed previously. These establishments do more than offer pregnancy testing, testing for sexually transmitted diseases, and limited ultrasounds. They also offer other tangible assistance to the clients who visit them. For example, by participation in learning opportunities at some facilities, clients earn coupons that they can then redeem for baby items. Indeed, the free material resources such as maternity clothes, diapers, formula, and so forth not only communicate to the client that the center cares about them by giving them these articles, but the free resources also serve as a means of inducing others to come. Word of mouth in the community about the free resources results in some additional visits.

The material items such as clothes, food and furniture are not the only things provided by the centers at no charge. All of the goods and services offered by them are

free. The pregnancy tests are free. The limited ultrasound exams are free. The counseling or training sessions are free. Everything is free. The fact that all of the goods and services offered by the centers are free communicates very clearly and resoundingly to the client that the centers really do have her best interest at heart. Where else can she go to receive such quality care at such minimal expense? Presumably, most, if not all, of the abortion clinics charge a fee for their services, but by contrast, these centers charge nothing. There is no monetary profit motive driving these centers. Nothing is charged for any of the good and services—even the medical services.

The centers do not only offer goods and services aimed at addressing the physical needs of the clients, but they also offer services meant to meet the spiritual needs of their visitors as well. While the centers are unapologetically Christian, they are not overt or brazen in their Christian presentation. If clients are open to the suggestion, client advocates will pray with them before they leave. Also, when opportunity arises, if clients are willing, the client advocates will also share the Christian gospel with them in hopes of converting them and making them into Christians. The people at the center are very discreet about praying and evangelizing, however, and are generally careful not to go any further in their efforts than the verbal and/or nonverbal communication of the client warrants.

While such religious activities as praying with or witnessing to another could potentially alienate some clients, they might also strengthen the client's perception that the center truly does have her best interests at heart. In a manner analogous to the way the medical accoutrements contribute to a perception that this is a quality professional

health care facility, the spiritual undertones of praying or evangelizing contribute to a perception that this is a place of hope and love.

This perception blends in well with another of the major themes—a safe and supportive environment. Home-like furnishings, emotional support, and a non-threatening approach characterize such an environment. They are key components of the plan to help the client view the center as friend instead of foe. The interview data suggest that the centers are aware of the tension that exists between maintaining a professional health care environment while at the same time maintaining a safe supportive atmosphere where clients feel right at home. They work to ensure that both are preserved.

Softer lighting, pastoral works of art, and living room style furniture serve to create the sensation that one is at home in her living room even though she is at a pregnancy center or clinic. In some instances, soft music is playing in the background. These features serve to create a climate where visitors will feel more at ease and where a client may expect emotional support.

The emotional support that the center provides the clients is an invaluable element of the overall strategy of the centers. The majority of the caregivers who interact with clients are women. They share their gender. In some cases, they share similar experiences of unplanned pregnancies. The client advocates are trained to demonstrate concern and compassion for the clients. But to say that they are trained overlooks a very significant point. Many, if not most, of the client advocates are volunteers. They are working at the center in the first place because they really do love and care for women facing unplanned pregnancies. Overlooking this reality would be a mistake. While the caregivers are trained initially and undergo continual training, in the majority of

instances, their care, concern and compassion are not the result of canned responses memorized at some training seminar. Their expressions of concern, verbal and nonverbal, are visceral, spontaneous, and genuine. The authenticity of their concern is almost certainly perceived by the majority of the clients. The caregivers are not in this business for the money. They are in it to help others.

Moreover, some of them, those who have faced unplanned pregnancies in their own pasts, are keenly and personally aware of the exigencies faced by their clients. When they interact with them, they can do so on an even deeper more intimate level forasmuch as they have experienced similar things. In some instances, the ones performing the ultrasounds at these centers formerly conducted abortions themselves until they underwent a religious conversion. So many of the people at the staff are able to see the situation from the view of the client facing the unplanned pregnancy, from the view of someone who has had an abortion, and/or from the view of one who has performed abortions in the past. The ability to see the situation from so many angles is invaluable and contributes to the ability to interact with clients without sounding judgmental.

Indeed, listening to clients and serving clients without sounding judgmental is an important feature of the overall strategy. Carping on the conduct that led to the unplanned pregnancy or on the consequences of abortion would almost certainly be counterproductive inasmuch as the client, like most people, would not enjoy being told all about the mistakes she had made or plans to make. Instead, the people at the centers engage the client without condescension or condemnatory rhetoric. In lieu of judgment, unconditional love is expressed—verbally, nonverbally, and materially. The self-

reported interview data suggests that the clients experience no pressure one way or the other and that they are not threatened. Recall the statement, “If you have an abortion, God still loves you and we still love you and you are welcome back at the center.”

The data suggests that even the proxemics of the pregnancy centers take into account the staff’s desire to avoid having the clients feel threatened. At least one interview participant mentioned arranging the furniture in such a way so that the client had an easy exit if she opted to leave. This arrangement would leave the client with the feeling that she was in control. She would not feel boxed or hemmed in by the place. The centers want the client to sense that they are welcomed and wanted. They want the client to feel safe and secure.

They also want to engage the client and those with her not only in the ultrasound experience but also in an ongoing relationship. During the ultrasound, the examiners will sometimes give guests accompanying the client a pointer to be used. The examiner will enlist the guest’s participation by having the guest point out certain features being discussed on the screen for the benefit of the client. This enlistment of participation serves to breakdown barriers to communication and makes both the guest and the client feel more a part of the entire experience. Such an action invites responses. The event has the potential of becoming more of a conversation than merely an examination or even a lecture. One respondent noted that, in that center’s state, by law, only the doctor could make the diagnosis of pregnancy. Therefore, for the ultrasound examiner to refer to the pre-born as a baby would be inappropriate. However, in such instances the client, any guest with the client and the examiner can all see plainly what is on the screen. So the semantic exchange between the client and the examiner becomes a sort of word game

where no one says the word baby but must instead discuss what is being seen by means of other terms and expressions. In such instances, not only are potential relational barriers dissolved to some degree by the somewhat playful interaction centered around the ultrasound screen, but the reality of the pregnancy is driven home to the client and any accompanying her.

Coming to terms with the reality of the pregnancy, and more specifically from the perspective of the centers, with the reality that there is a baby in the womb that will be destroyed if the pregnancy is terminated, is key to the success of the rhetorical strategy. The client considering abortion needs to be convinced of the need for new choices. This is the third basic rhetorical move proposed by Hart (1997).

*Convincing the Listener of the Need for New Choices*

While moving the clients, considered by the centers to be abortion-minded or abortion-vulnerable, to recognize that new or different options are available is necessary, the centers must be careful not to overreach in their efforts. Care must be exercised to avoid pushing the client too far too quickly. Otherwise, the clients' cognitive defenses may be activated making the task more difficult or even impossible. Rather than telling the client overtly and explicitly that new choices ought to be considered, the strategy of the centers entails leading the clients along a pathway of discovering for themselves the availability of alternatives. Only in cases when this approach has apparently failed, do staff members resort to the overt verbal arguments cited earlier. Based on the interview data, the preferred approach is one of enabling the client to discover what is really happening inside her body, how she truly personally feels about it, and what ought to be done afterwards.

One of the motivating forces bringing women to these centers, the desire for knowledge, helps set the stage for this process of self-discovery. Many clients come to the centers in efforts to reduce uncertainty. They are seeking information. They are facing difficult situations and need more and better information in order to determine a course of action. Some of them suspect that they are pregnant, and some have even used a home pregnancy test kit. However, they want confirmation that they are pregnant. They want the uncertainty removed. Other clients are looking for information that will help them determine the identity of the father because this information may be a significant factor in whether they terminate the pregnancy. Still others, especially those who may have miscarried in the past, are looking for information that can assure them of their baby's welfare. Some are interested in learning the sex of the baby. There are also those who receive positive pregnancy test results and have a great deal of uncertainty about what is happening with regard to their pregnancies. The interview data suggest there is widespread ignorance about pregnancy, fetal development, and so forth. Whatever the case, the centers, and especially the ultrasound exams, assist the client by removing some of the uncertainty associated with the pregnancy by educating the client.

Providing information to the clients, especially those whom the center has identified as abortion-vulnerable or abortion-minded, becomes a means of moving them to the conclusion that new choices need to be made. The introduction of new information creates for them, at least in some instances, what one respondent called a second crisis. The discovery or suspicion of an unplanned pregnancy created the first crisis, and now, the discovery of additional information results in the second. This is especially true for the clients contemplating abortion or pregnancy termination. When these clients are



shown ultrasound images of their fetuses, their plans to terminate are challenged. Once more, reducing the number of options open to the audience is the fourth basic rhetorical move outlined by Hart (1997).

*Narrowing the Listener's Options*

Theoretically, prior to exposure of the new information provided by the center, the client had several means of resolving her pregnancy. Her most basic options included terminating the pregnancy or carrying the pregnancy to term. Teleologically speaking, at least at first glance, the former would provide closure on the whole unplanned pregnancy whereas the latter would occasion the need for still more choices. Once the pregnancy culminated in the birth of the baby, the client could keep the child and rear her or him. Alternatively, the client could place the child for adoption, and once more, this decision would necessitate even more choices. The child could be placed for adoption with a family member, a friend or with a stranger.

However, exposure to additional information at the center tends to reduce the number of options available to the client. While this is not the case with every client, the preponderance of the participants affirmed that most clients whom they considered to be abortion-minded or abortion-vulnerable changed their mind and decided to carry the pregnancy to term rather than terminate it once they had seen ultrasound images of their pregnancy. So, in this regard, paradoxically, increasing the knowledge resulted in reducing the number of options available to the clients.

But how did additional information reduce the available options? The ultrasound served to reify the pregnancy. Suspecting that one is pregnant is much different from seeing one's progeny on the screen. Even if the pregnancy confirmation is unwelcome

news, it is nonetheless concrete news. Thinking or reflecting or talking about being pregnant is much different than seeing one's fetus on the monitor. The pictures concretize the reality of the pregnancy in a manner that missed menstrual periods and pregnancy tests cannot. The ultrasound opens what has been called a window of the womb and allows the client and others to see with their own eyes what is transpiring within their wombs. The ultrasound, in this sense, makes the pregnancy real to the client and significant others in her life who may be experiencing denial over the situation. The images demand attention to the situation that the client had probably rather ignore.

However, these images do more than reify the pregnancy. These images, and in some cases, sounds, move the client to recognize the humanity and/or personhood of the fetus. When asked about the role of ultrasound at their respective centers, several participants made statements indicating that such technology helped clients visualize that a living human being is present. For example, one respondent elaborated as follows:

And uh, you know it's one thing to talk about, about your baby, but to see it on the screen and see it wiggling around, and see a little heart beat, I mean, that just makes it more real. And uh, I think sometimes that helps it to soak in that it really is a little, a little being there and little a little human and a little baby there. And uh, so, I just see that's it's a very positive, uh, you know, life affirming type thing for, um, for, the clients.

So the center personnel are convinced that ultrasound is life affirming. They have reached this conclusion after hearing first-hand observation of its effects on clients and by interaction with their peers at other centers who have seen the same results.

Of course, critics would allege that exposure to these ultrasound images does not really limit or reduce the number of options open to the client. The client can still terminate the pregnancy if she desires. While it is true that the client can, and indeed sometimes does, still terminate the pregnancy, it is also true that doing so probably becomes significantly more difficult morally speaking. Prior to exposure to the ultrasound images, the client may truly have believed that her womb contained nothing more than an undifferentiated blob or tissue mass of cells. However, the ultrasound depicts not a tissue mass but a little being with a beating heart, a nodding head, budding limbs, and so forth. By extension, terminating the pregnancy would entail stopping the beating heart and destroying the body, the head, the limbs and so forth. So the position of this paper is that, while the ultrasound does not actually narrow the options in the purest sense of the meaning, ultrasound does indeed narrow the options in the practical sense. If such were not the case, why would so many clients considered to be abortion-minded or abortion-vulnerable opt to carry the pregnancy to term?

Moreover, apart from the role that ultrasound plays in the reification of the pregnancy and the recognition of the fetus as a little human being, ultrasound sometimes facilitates bonding between the client and her pre-born. This theme surfaced several times in the interview data. In those cases where ultrasound images evoke strong emotions as well as maternal instincts to protect and nurture, the client is again constrained by what she has experienced. While terminating the pregnancy is still an option, choosing that option has been made much more difficult if feelings of emotional attachment were evoked through the medium of ultrasound.

The issue of bonding introduces the affective component into the discussion of persuasion in an even greater way than the discussion of the implications of baby-schema did. According to the notion of baby-schema, people recognizing babyish features may have certain care-taking impulses aroused in them and certain aggressive impulses inhibited. However, the affective component aroused when a client experiences bonding is arguably much stronger than similar feelings aroused in an observer of someone else's baby or child. Realizing this, interview participants spoke of their desire to see the ultrasound result in bonding.

Notwithstanding the fact that the participants in this study believe that ultrasound can result in maternal bonding, there is no way to establish whether bonding is as likely to take place in the case of a client considered abortion-minded or abortion-vulnerable as it is in the case of the client who is not. In other words, while maternal bonding is a long recognized reality, it is possible that the women strongly considering abortion are not as likely to experience those feelings as their counterparts who would never entertain the idea of having an abortion. In spite of this caveat, however, the data suggest that women who view ultrasounds of their pregnancies overwhelmingly choose not to abort, and maternal bonding may be at least partly responsible.

The centers' awareness of ultrasound's efficacy at changing minds has created confidence in them that ultrasounds can largely speak for themselves. In other words, using ultrasound images and/or sounds reduces the need for increased elaboration by center personnel. The ultrasound offers an ipso facto argument against abortion that stands alone very well with little or no verbal embellishments. Verbal embellishments in the form of overwriting during the exam, inscriptions on pictures to be taken home, and

so forth may enhance the images effectiveness, but they are not as salient as the beating heart or the recognition of the human form served up by ultrasound.

The apparent efficacy of ultrasound precludes the necessity of many supplemental verbal arguments against terminating the pregnancy. Staff members at the center do not have to say as much, theoretically, because the images say things for them. In this regard, the ultrasound advocates for carrying the pregnancy to term rather than terminating it. The center does not need to tell the client that she should not have an abortion because the ultrasound has, it seems, aroused within the client, both thoughts and feelings that compel her to carry to term. So the ultrasound permits the centers to be even subtler in their efforts. According to Hart (1997), the fifth basic move in every rhetorical task is that the communicator may become subtle by not spelling out all of the particulars of the policy being promoted.

#### *Becoming Subtle*

In most every way, the centers are careful in their communication with the clients. As previously revealed, they are judicious in their phraseology. They are diligent regarding the data they disclose or withhold. They are also careful to accommodate the client's verbal and nonverbal behavior in their efforts to join the client in her story and take their place along side the client as her advocate. Ultimately, as revealed in one of the emergent major themes, they are intent on enabling and empowering the client to make the decision(s) that are most appropriate for her. Such a rhetorical strategy, one could argue, precludes the necessity for forthright or overt statements of intention. The communicative behavior and rhetorical symbols employed free the centers from the need of being explicit in their goal to stop the woman from having an abortion. Years of

experience have helped them refine their rhetorical strategy. Their approach permits them to become subtle by not specifying the details of their policy.

The phraseology of center personnel reflects their tactfulness. This point has already been enlarged upon in another section, but is worth mentioning again here because it so appropriately underscores Hart's (1997) fifth move. In their dialogue with clients, the centers will often use the phrase pregnancy termination in lieu of abortion because the former does not carry with it the negative connotations of the latter even though both refer to the same thing. The irony of this choice of phrases is that, while not using the word abortion, the centers are actually laboring to ensure that abortion is not the outcome. However, they are being subtle in their efforts by not specifying they are against it. One could say that by eliminating the term abortion rhetorically, the center is hoping to remove it phenomenologically. Eradicating abortion from the conversation, even though pregnancy termination is substituted in its place, has the potential of pushing it out of the client's mind.

Similarly, even though center personnel use both terms, fetus and baby, when referring to the contents of the client's womb, they tend to prefer using the term baby as indicated earlier. Ontologically speaking, the rhetorical use of the term baby in lieu of fetus sets the stage for the client to begin thinking of the pre-born as a baby, even her baby, rather than as a fetus. In the minds of most people, although there are exceptions, it would seem that the connotative meanings of the two terms are different. Fetus sounds academic, sterile and impersonal. Baby sounds familial, cute and cuddly. So this subtle substitution of terms has the potential of shifting the client's thoughts and feelings toward her pregnancy.

Moreover, as noted already, while those who serve the clients are sometimes referred to as counselors, at least some of the centers designate them as client advocates instead. On the one hand, going to see a counselor, in the minds of some, may imply that the client has a problem, perhaps some emotional illness, that needs addressing, on the other hand, going to see an advocate sounds more like going to see an attorney who can plead your case. The centers do not want the clients to think that the center views them as broken people in need of being repaired. That would be counterproductive to the centers' goals. Neither do the centers want the clients to view their pregnancy as an illness—some medical condition from which they need to be cured. That would also be very counterproductive. The centers do want the clients to perceive their caregivers as advocates who will help them during this crisis time and champion their cause as the need arises. They want to be perceived as helpers—not hurters, and this subtle substitution of terms contributes to that perception.

Besides being judicious in their choice of terms, the centers are also cautious in their choice of images. The respondents resoundingly rejected the notion of using grisly pictures of aborted fetuses or abortion procedures. They viewed these as counterproductive. Instead, they prefer to use ultrasound images and, in some but not all cases, fetal models. Once more, this is a tactful tactic. Using grisly pictures may evoke affective feelings of fear, shock or horror, and they may even evoke visceral feelings of nausea. At the least, using such images would put abortion and/or its aftermath on center stage rhetorically. The center does not want abortion on the center of the client's cognitive stage. So in a manner similar to using the label of pregnancy termination rather

than abortion, the centers are pushing the possibility of abortion farther away by shunning the use of abortion related pictures and using ultrasound imagery instead.

Whereas the abortion pictures would conceivably portray blood, gore, disjointed and dismembered fetal body parts, and so forth, the ultrasound images would show a unified living and moving being. Whereas there are vivid color pictures of aborted fetuses available to show clients, the ultrasound technology in widespread use makes black and white images of varying degrees of quality available for the clients to see. These black and white images are almost certainly not the same quality that abortion pictures would be. While the lack of clarity and detail could conceivably militate against the center's goal of preserving the pregnancy, the lack of detail may actually help their cause. The lack of detail in the images permits the client to fill in some of the blanks cognitively. As ultrasound technology improves and as funding becomes available, the detail and resolution of the ultrasound images used by the centers are likely to improve. Moreover, abortion pictures would show someone else's aborted fetus, but the ultrasound images the client sees are of her very own.

So the centers are careful in the words they say and in the pictures they show. However, they are also careful in the way they interact with the clients. The interview data suggest that client advocates and ultrasound examiners pay attention to the client's verbal and nonverbal behavior, especially those whom they consider to be abortion-minded or abortion-vulnerable. If the client's tone is subdued, then the examiner is not likely to behave in a bright and chipper fashion. If the client refers to the pre-born as a fetus, then the examiner will take her or his cues from the client and adopt similar phraseology. This communication accommodation permits the caregivers to meet the



clients where they are. Adopting the language facilitates building a relationship—a bridge from the heart of the caregiver to the heart of the client. The rhetorical flexibility of the personnel enables them to take the client by the hand and gently lead them out of the maelstrom of their present crisis, but if they were inflexible and adamant in their communication, the client would not be as likely to connect with them either verbally or emotionally.

Establishing these personal connections is a vital part of the overall rhetorical strategy. The centers relied on this approach before the availability of ultrasound, and they still rely on it today. Such relationships cultivate trust, and as the client comes to trust the staff member or volunteer more, she is more likely to be open to her guidance when she makes her decision regarding her pregnancy.

Ultimately, the centers endeavor to give the client information, self-confidence, and the support she needs to reach her own decision. Nowhere perhaps, is Hart's (1997) fifth move involving a subtle approach, more illuminating than here in this discussion. The participants' interview responses generally reflect the centers' belief that the client will choose not to abort if she is only given the information and the permission she needs to carry the pregnancy to term. The center personnel genuinely believe that their services enable and empower the client to reach her own decision—a decision they hope will result in the pregnancy being carried to term. But, whatever the decision may be, the center wants the client to reach it for herself. The client must make the choice; the center cannot make the choice. Nevertheless, of course, the center is engaged a full-fledged attempt to influence the client to make the choice they want her to make. They are just being careful in how they do so.

The center is enabling the client in her decision making by equipping her with information she needs to make an informed choice. Interviewees noted that many of their post abortive clients make comments suggesting that they might have made different choices if only more information had been available to them. Such feedback from post-abortive clients who are being served by the post-abortion recovery ministry of the centers fuel the passion of the personnel to provide current clients with as much information as possible so they can make informed decisions. Irene commented, “We believe that a woman has a right to make her own decision. We don’t push our, uh, our agenda on them. We don’t have an agenda. Our only desire is to help women make well-informed, well thought out decisions that they can live with.”

The comments of Irene generally reflect the points of view of the interviewees. They see themselves as facilitators and enablers. However, these particular comments do seem a little disingenuous. While it is true that the centers do want the women to make their own decisions, it is also true that the centers really do want the women to choose not to abort. The centers are in operation because they want not only to help women but also to influence women toward life-affirming decisions. In the minds of some, there may be times when these two are in opposition to one another. By guiding the women toward life-affirming decisions, they are, in the end, helping them because they see firsthand how harmful abortion has been, at least in some cases, for the women and men who have experienced them. So, as has been previously pointed out, the information that is shared, the terms that are used, the pictures that are shown, and so forth are all tailored so as to guide the client toward choosing to keep the pregnancy.

However, the rhetorical subtlety of the centers is not only evident by examining the words and images they use, but by also examining their overall approach. They not only want to enable the clients by educating them, but they also want to empower the clients by affirming the clients' dignity and ability to make the right choice.

Expressions of concern for the dignity and the prerogative of the client surfaced in one form or another across the interviews. The décor of some of the centers was chosen to foster this sense of power. Angela said of the décor, "...we want a woman to feel very honored when she steps off our elevator. We want her to know that this is a different place and it's a place of strength. And uh, that's, with the art that we have, it's very upbeat." Also according to Angela, the fact that the clients complete the intake form, spelling their own name, providing the information themselves, and etc. instead of having some staff member do it for them underscores the view of the center that the woman is capable of doing things, including making major decisions, on her own. This same tone is further reinforced by the fact the women self-administer the pregnancy test while at the center. Moreover, some of the printed material that is distributed at local colleges and universities contain messages intended to communicate to women that they are both capable and responsible. A bookmarker with a poem titled, "I Will Soar," was distributed with other materials. The marker contained a poem mentioning self-respect, celebration of life, guarded emotions, protected health and commitment. The poem closes with the line, "I will pursue my dreams without bound or limit...I will soar." This poem reinforces the concept of client empowerment. Moreover, one of the promises contained on the "Our Promise To You" poster guarantees the client that, "[her] story will be listened to with respect and courtesy, and without judgment..." So besides the

verbal and nonverbal affirmations the clients receive that reinforce their self-respect or dignity, the procedures and the furnishings of the centers also serve to bolster the clients' ability to do things on their own.

Beyond the posters with promises of respect, the protocol that calls on clients to complete their own paperwork and even self-administer their pregnancy test, and the pictures hanging on the walls, the subtle rhetorical approach is also evident in the use of ultrasound technology. Whether the ultrasound images actually elicit instincts to protect and to provide for one's offspring is potentially a matter of debate. However, the interviewees are largely convinced that they do. Moreover, their conclusions are supported from their own personal experiences with clients in the uncontrolled laboratory settings of the day-to-day operations at the centers. Quotations illustrating this can be found in the section discussing the theme of empowering the client. In summary, the participants believe that, somehow, the ultrasound images evoke basic instinctual urges to protect and/or to provide for one's own. This belief is behind their use of the ultrasound as a rhetorical tool. If the images do evoke such feelings or drives, then their use precludes the necessity of the personnel saying as much with words. They do not have to tell the client that she should feel compassion for her pre-born and spare her life. The ultrasound elicits these feelings spontaneously. Such an approach is a subtle one indeed.

So Hart's (1997) five basic moves involved in every rhetorical task have provided a useful framework for analyzing the pregnancy centers' rhetorical strategy. The centers endeavor to exert change through the use of symbolic devices including words, pictures, actions and so forth. They realize that to succeed they must convince the clients that they are there to help them. They also must convince the client that new choices must be

made, and in doing so, they must narrow the options for making those choices. Finally, throughout each of the moves, the centers are subtle in their approach by guiding the client to reach the decision not to abort without them having to tell her so explicitly.

In summary, Foss's (1994) schema for the evaluation of visual imagery, Peterson's (2001) alternative schema, and Hart's (1997) questions on what makes visual images powerful as well as Hart's (1997) five basic moves have provided insights regarding the effectiveness of the centers' rhetoric. Evaluating the function served by the visual rhetoric as suggested by Foss (1994) yielded insights as to why the images may be so powerful. Examining the individual elements of the ultrasound images, as Peterson's (2001) alternative approach warrants, provided additional insights as to how the images may persuade. Exploring possible answers to Hart's (1997) questions concerning visual images resulted in possible explanations as to the images' efficacy also. Whereas Peterson (2001) was concerned that the critic not jump to conclusions regarding the image without first deconstructing the image into its individual elements and analyzing them out of fear that such an approach would preclude meaningful criticism, Hart (1997) raised the question of whether the image filled the audience's eyes with a single dominant meaning. Both possibilities have been explored to some degree in the preceding discussion, but the conclusion is that, notwithstanding the value behind a rhetorical analysis of the respective individual elements, the ultrasound images do indeed fill the eyes of the audience, that is to say, the client, with a single dominant meaning—"this a baby, my baby." However, as Peterson (2001) affirmed, the individual elements comprising the larger picture contribute to the overall interpretation. In other words, the

individual elements of the ultrasound image collectively help contribute to the single dominant meaning of the overall image.

So the insights of Foss (1994), Peterson (2001), and Hart (1997) have all been useful in this discussion of the rhetoric of these centers, particularly the visual rhetoric. Having analyzed the interview results through the lenses of these three scholars, evaluating the results in the light of some of the other available literature is appropriate as well.

#### Evaluation of the Findings and the Available Literature

The pro-life social movement has taken advantage of the decades following the *Roe v. Wade* ruling to refine its rhetoric. Today, oral and visual materials are used in efforts to educate women on their pregnancies and in attempts to persuade women not to abort their fetuses.

Over the years, people have grown accustomed seeing human-machine characters (cyborgs) on screen and accustomed to using machines to learn more about their own bodies. Ultrasound technology has played a role in this phenomenon. The findings of this research project support the notion of Lay, Gurak, Gravon and Myntti (2000) that health care providers serving women during pregnancy enjoy positions of rhetorical power inasmuch as the symbols (words, images, models, and etc.) may shape the perceptions of their clients.

On the one hand, Mehaffy (2000) was right in asserting that the virtual fetus is very vulnerable to verbal overwriting by those in positions of rhetorical power. However, in the instances of these pregnancy centers, this rhetorical power becomes a means of preventing the termination of the actual fetus represented by the virtual fetus on

the ultrasound image. Boucher (2004), on the other hand, was wrong in arguing that, “The shifting, blurry, and shadowy images of ultrasound cannot bear the burden of proof of the ontological status of the embryo or fetus” (p. 8). From an ontological standpoint, baby schema and beating hearts offer strong warrants for recognizing the fetus as an individual human being, albeit a very small one, worthy of preservation and protection. From the perspectives of Mehaffy (2000) and Boucher (2004), the sights and sounds of the ultrasound are not able to stand on their own. They are incapable of establishing the personhood or humanity of the fetus. The findings of the study at hand, however, suggest that the visible and audible elements of the ultrasound may indeed enjoy sufficient rhetorical power on their own quite apart from any verbal overwriting by the health care provider. Admittedly, there is hardly ever one without the other. Therefore, reaching any definite conclusion upon this matter may be difficult if not impossible. Beyond dispute, however, is the notion that both the ultrasound alone and the ultrasound in conjunction with accompanying explanations possess rhetorical power.

This rhetorical power has been a cause of concern among some feminists, and the pro-life movement, recognizing this power, has sought to capitalize on this rhetorical potential in reaching their goals. The use of ultrasound by women’s health care providers has raised concerns among some feminists as noted earlier. These concerns include the marginalization of the pregnant women, competition between the woman and her health care provider, the participation of the woman’s partner in her pregnancy, and the commodification and/reification of the fetus.

Data from the project at hand suggest that the rhetorical strategies of pregnancy support centers do not marginalize the pregnant woman. According to the self-reporting

of the participants, most of whom were women, their clients, mostly women, are empowered and enabled—not marginalized. The centers are places where attention is given to the woman—not just her fetus. Rather than being pushed to the side of the drama, she is moved to center stage. She is nurtured physically, emotionally and spiritually. The technology enables her to discover more about her pregnancy and her person than she knew before. The ultrasound becomes a means of increasing her knowledge about her pregnancy, and therefore, she becomes more of an authority. The client advocates and ultrasound technicians at the centers do not supplant her position of authority, but, instead, they reinforce it by providing her the information and permission she needs to reach her own conclusions.

Moreover, based on the interview data, there does not appear to be much competition between the client and the center personnel. Whereas the literature suggested some feminists are concerned that the ultrasound becomes a means of relocating ownership of information about the pregnancy from the hands of the woman to the hands of the professional, this project's data suggest the opposite. Ultrasounds are a means of giving ownership of information about the pregnancy to the client. Furthermore, the data suggest that the relationship between the clients and the caregivers at the centers is not one of competition but collaboration. The caregivers are called client advocates, and they, according to their responses, seek to work with the client.

While the findings of this research do not support the notion of competition between the client and the caregiver, they do support the notion that ultrasound invites the participation of the client's partner. The centers reported a desire to include the male in the process as much as possible. The décor at some of the centers is designed to make



males feel welcomed. Males are given the opportunity to be present during the ultrasound exam. In some instances, they are even engaged in the experience by means of using a pointer device to call attention to certain features of the ultrasound on the screen. Similarly, respondents reported that the ultrasound exams do tend to reify the pregnancies for both the client and the male who may accompany her.

The use of ultrasound by pro-life advocates such as those who operate pregnancy support centers has been the focus of this project. Project participants reported that they believe they have seen their clients, both females and males, experience bonding with their pre-born child. This finding is in keeping with the literature (Baba, 2004; Timor-Tritsch & Platt, 2002). The concept of quickening that emerged from the literature (Mitchell & Georges, 1998) is also supported by the results of this research. Moreover, as Mitchell and Georges (1998) noted, many times sonographers will make statements during the ultrasound describing a particular movement as an activity. Such attributions were reported in the interview data, and they do apparently contribute to the client's recognition of the fetus as a human being—a little person.

Ultimately, the findings of this project are consistent with the research of Maher, Parton, and Buzzetta (2003) who reported that 70% to 90% of the abortion-minded clients who were exposed to ultrasound intervention changed their minds and decided against abortion. Moreover, these findings also are similar to the reporting of Vincent (2005, p. 35) who quoted one woman saying, "The beating heart is the very essence of life itself."

### Limitations of the Present Study and Suggestions for Further Research

While the results of this project have contributed to an understanding of the rhetorical strategies of pregnancy support centers and have also contributed to an understanding of how visuals, particularly ultrasound images, persuade, there have been some limitations. The recognized limitations basically fit into two categories: participants and procedures.

Even though the design of this project incorporated interviewing the directors of the pregnancy centers and the ultrasound technicians including doctors, nurses and highly trained professionals, all of whom have interaction with the clients and have witnessed client behaviors, the fact remains that none of these participants can report perfectly how the client actually felt and what she actually thought upon experiencing the ultrasound. They could report on verbal and nonverbal responses, but they could not report on the inner feelings and thoughts of clients. They were able to offer eyewitness accounts. However, perhaps a research design that allowed for interviewing the clients and those who accompany them would yield even richer insights as to how and why the ultrasound seems to be such an effective means of persuasion.

Moreover, the data for this study were gathered from a relatively small number of volunteer participants by means of telephone interviews. While the open-ended nature of the interview questions probably resulted in additional insights that may not have emerged if written survey instruments had been used, the possibility exists that administering and analyzing a well-designed survey completed by a large number of clients who had experienced ultrasound would help quantify these findings. Such

quantification may provide additional insights regarding the efficacy of the various elements of the ultrasound.

Notwithstanding the relatively small number of participants, respondents came from every major geographical region of the United States. This would suggest the generalizability of these findings. Moreover, the interview format allowed for more meaningful and insightful contributions from the participants. Such an approach, while guided by the researcher's questions, gave the people who know the most about the subject matter to speak to the issue. The data more or less emerged from their wellspring of experience rather than from the researcher's rather limited knowledge based on the research of scholarly work in the area.

As interesting as the findings of this study are, ample areas for future research exist. The effect of baby schema on viewers' perceptions of in utero fetuses as compared to newborns or young infants could be explored. Efforts to identify the most salient elements of baby schema could be launched. Research designed to measure the effects of seeing the fetal heartbeat, hearing the fetal heartbeat, or seeing and hearing the fetal heartbeat may yield additional insights. Furthermore, research designed to measure the persuasive effectiveness of the ultrasound images standing alone versus the same ultrasound images accompanied by verbal overwriting may provide new information in that debate.

### Conclusion

The polarizing debate over abortion is not likely to go away soon, and neither are the pregnancy support centers that have sprung up around the country. Their continued presence alone argues that their rhetorical strategies must be enjoying at least some

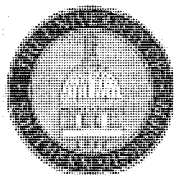
degree of success. Respect for them has apparently grown along with their numbers. These pregnancy support centers have become commonplace. In many cases, these centers are receiving either direct funding from states, indirect funding through “Choose Life” specialty license plates, or both (Vincent, 2008).

Their overall rhetorical strategy is evidently working. The abortion rate has declined in recent years, and the efforts of these centers are probably responsible in some measure for this decline. The Alan Guttmacher Institute released new research data on the 35<sup>th</sup> anniversary of the *Roe v. Wade* anniversary indicating that the 2005 abortion rate (the number of pregnancy terminations per 1,000 women ages 15-44) was at its lowest point since 1974 (Olasky, 2008). “A February 2007 study conducted for the Heritage Foundation Center for Data Analysis by University of Alabama political science professor Michael New found that the abortion rate among minors plummeted by 50 percent between 1985 and 1999, compared with the overall abortion decline of 29 percent,” wrote Vincent (2008, p. 64). While a number of factors such as laws requiring parental involvement have contributed to these declines, the efforts of these centers, more especially their use of ultrasound technology, have arguably resulted in somewhat of a cultural shift regarding attitudes toward abortion.

This shift is even apparent in the output of Hollywood. Movies like *Knocked Up*, *Bella*, *Noelle* and *Juno* have all demonstrated a greater respect for human life (Vincent, 2008). Some attribute this attitudinal shift to a changing of the guard among filmmakers but others associate the shift to ultrasound technology. According to McEveety, a pro-life individual working in Hollywood, the filmmakers in Hollywood are heavily influenced by ultrasound (Vincent, 2008).

The widespread availability of ultrasound technology seems to have affected the way that women facing unplanned pregnancies view their unborn and the way that society views the fetus as well. The silent fetus has been given a loud voice through the medium of ultrasound.

## APPENDIX A



The University of  
Southern Mississippi

*Institutional Review Board*

118 College Drive #5147  
Hattiesburg, MS 39406-0001  
Tel: 601.266.6820  
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**HUMAN SUBJECTS PROTECTION REVIEW COMMITTEE  
NOTICE OF COMMITTEE ACTION**

The project has been reviewed by The University of Southern Mississippi Human Subjects Protection Review Committee in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months. Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: **27043001**

PROJECT TITLE: **Pregnancy Support Centers' Use of Fetal Ultrasound Images as Rhetoric**

PROPOSED PROJECT DATES: **06/01/07 to 05/31/08**

PROJECT TYPE: **Dissertation or Thesis**

PRINCIPAL INVESTIGATORS: **Raymond Kyle Jones**

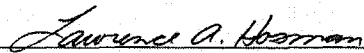
COLLEGE/DIVISION: **College of Arts and Letters**

DEPARTMENT: **Speech Communication**

FUNDING AGENCY: **N/A**

HSPRC COMMITTEE ACTION: **Exempt Approval**

PERIOD OF APPROVAL: **05/21/07 to 05/20/08**

  
\_\_\_\_\_  
Lawrence A. Hosman, Ph.D.  
HSPRC Chair

5-29-2007  
\_\_\_\_\_  
Date

## APPENDIX B

## Interview Questions for Center Directors &amp; Ultrasound Technicians

1. Are you the center director or one who performs ultrasound examinations or both?
2. How did you come to be interested in working at the pregnancy center?
3. How long have you been involved at this center or some similar center?
4. What are the goals of the pregnancy center you serve?
5. What types of media do your center and organization use to aid you in reaching your goals?
6. What role does ultrasound technology play at your center?
7. Please describe the layout and décor at your center.
8. How does your staff dress while working at the center?
9. Please describe the typical client and anyone who usually accompanies them to the center.
10. Why do clients seek the services that your center offers?
11. How do most clients learn about your center?
12. What percentage of clients visiting your center seems to be considering abortion as a means of resolving their pregnancies?
13. Please describe the normal manner in which clients are processed upon arriving for their initial visit.
14. Do clients generally introduce the possibility of an ultrasound first or do center personnel mention it first?
15. Why do clients want to have ultrasound exams?
16. Why does your center provide ultrasound exams?

17. When given the opportunity to have an ultrasound, how do clients respond to the idea?
18. How do you set up the client's experience with the ultrasound images?
19. During the ultrasound exam, what do clients hear and see?
20. How do you show your clients ultrasound images?
21. During the ultrasound exam, what do examiners usually say or show to the client?
  - A. Please explain in detail the words used to describe the ultrasound to the client.
  - B. What is pointed out to the client?
  - C. What is **not** pointed out to the client?
22. How do clients react to the various elements of the ultrasound exam?
  - A. What do clients **do (nonverbally)** in reaction to the ultrasound presentation?
  - B. What do clients **say (verbally)** in reaction to the ultrasound presentation?
23. If males are ever present during ultrasound exams,
  - A. Who are they in relation to the client?
  - B. What do the males **do (nonverbally)** in reaction to the ultrasound exam?
  - C. What do the males **say (verbally)** in reaction to the ultrasound exam?
24. Using a scale of 1 to 4 where 1 is the most noticeable and 4 is the least noticeable, please rank the client's reaction to the following features of the ultrasound:
  - a. The fetal movement?
  - b. The recognition of body parts?
  - c. The heartbeat?
  - d. Other? \_\_\_\_\_



25. How do you use ultrasound images?
26. How do you believe ultrasounds may help influence women?
27. How has the center trained you to interact with clients?
28. Are policies, procedures, or guidelines given by the center to the staff and volunteers for processing clients? If so, could the researcher obtain copies of these?
29. How many ultrasounds examinations have been performed at your center in the previous 12 months?

**30. For ultrasound technicians only:**

If you have ever performed ultrasounds in some setting other than the pregnancy center, please compare and contrast the client's ultrasound experience at the pregnancy center where you now serve with the client's ultrasound experience at locations other than pregnancy support centers such as this one.

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