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Terror at the Clinic: Remembering, Performing, and Confronting Antiabortion Terror at Independent Clinics

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Terror at the Clinic:

Remembering, Performing, and Confronting Antiabortion Terror at Independent Clinics

A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Culture and Performance

by

Amy Elizabeth Alterman-Paradiso

2023

ABSTRACT OF THE DISSERTATION

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by

Amy Elizabeth Alterman-Paradiso

Doctor of Philosophy in Culture and Performance Studies

University of California, Los Angeles, 2023

Professor David Gere, Committee Chair

"Terror at the Clinic: Remembering, Performing, and Confronting Antiabortion Terror at Independent Clinics" analyzes the obstacles, resiliencies, and support networks associated with independent abortion clinics. In the United States, more patients access abortion through independent clinics than through any other portal. With the overturning of *Roe v. Wade* and countless other barriers, independent clinics across the United States have become increasingly threatened, with many shuttering their doors. The many arms of the antiabortion movement are primarily responsible for this. For decades they have terrorized clinics—providers and patients alike— evoking fear, inflicting violence, and catalyzing abortion stigma. With the impending peril of independent abortion clinics and increased difficulty in accessing their services, understanding their challenges, strengths, and needs emerges as a top priority.

Using my ethnographic engagement with the nonprofit organization Abortion Access Front (AAF) as an entryway, my research demonstrates how the antiabortion movement terrorizes abortion clinics, providers, patients, and their communities. Drawing from feminist and performance theory, it explores the many ways clinics respond to this terror. By examining the work of AAF, I demonstrate how an arts activist nonprofit organization leverages humor to meet the needs of independent clinics and shift abortion discourses in the United States. To investigate the relationship between abortion stigma, fear, and comedy, I address the following questions: (1) How does terror characterize abortion access? (2) What is the experience of providing and accessing abortion at independent abortion clinics like, and what are the cultural implications of these experiences? (3) In addition to legislative advocacy, what are some of the ways in which activists and advocates in the public arena can confront/interrupt/mitigate the terror surrounding abortion? And, (4) more broadly, how can performance theory and practice help us better understand abortion access? Drawing from ethnographic fieldwork from over eighteen independent abortion clinics across the United States and countless AAF arts activist events and comedy shows (from June 2018- January 2020), my dissertation explores these questions in three parts. In Part One: Remembering Terror, I investigate the histories of violence at the clinic, ask how they compose the collective memory of terror, and explore the ways in which independent providers respond to them. In Part Two: Performing Terror, I address performances outside of the clinic, drawing primarily from my ethnographic experiences as a clinic escort. And in Part Three: Confronting Terror, I take a deep dive into how Abortion Access Front uses humor to confront antiabortion terror and support independent clinics. What results is a theory of terror in the clinic landscape: terror infuses everything regarding abortion access, and it needs to be understood in order to move forward and expand equitable access.

The dissertation of Amy Elizabeth Alterman-Paradiso is approved.

Anurima Banerji

Jessica Gipson

Carole Joffe

David Shorter

David Gere, Committee Chair

University of California, Los Angeles

2023

DEDICATION

This dissertation is dedicated to my mom and dad, Pamela Meeks Alterman and Paul Joseph Alterman (1947-2006), my first feminists.

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VITA

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2015 "Homage to Esther Newton: One Lesbian Researcher's Autoethnographic Journey Toward LGBTQ-Inclusive Sex Education in Atlanta, GA." Presented at QGrad: "Curing the Queer" from Pathology to Resistance, UCLA Department of LGBT Studies Graduate Conference, Los Angeles, CA.

2015 **"**Dykes on Mics: Lesbian Comics Employing the Stand-up Comedy Stage as a Site for Change." Presented at Hysterical Bodies: Disabling Normative Behavior in Contemporary Art, UCSD Department of Visual Arts Graduate Conference, San Diego, CA.

PROLOGUE

The research for this dissertation was completed before the overturning of *Roe v. Wade* in the *Dobbs v. Jackson Women's Health Organization* case. Some of the clinics I visited have closed; however, protest still occurs at clinics, and the dynamics I describe are the same, if not more virulent. In some sections, I have added abortion policy updates as of May 2023.

INTRODUCTION

Indianapolis, Indiana
July 19, 2018

We scramble out of the white van with large protest signs and bags brimming with snacks and water. My sign says "Join Lady Parts Justice" on one side and "WARNING: PISS US OFF AT YOUR OWN RISK" on the other. Kat reminds us of the "buddy system" and to turn off our location services for safety.[1] The forecast predicts another sweltering summer day in Indiana, but we can still feel the cool breeze of the morning. There are six of us, including me with a notebook and Kat with a camera. The five of them are wearing highlighter orange color t-shirts that say, "Ask me about their lies." (A latecomer to the group, I do not have the orange shirt yet, but I am wearing a standard Lady Parts Justice League shirt.) With ACLU emergency numbers scribbled in black sharpie on our arms and the strong scent of SPF wafting above us, we make a beeline for Monument Circle in downtown Indianapolis.

We hear the unmistakable and all too familiar bellow of the antis—pronounced ANT-eye- z, that is, the antiabortionists—even a few blocks away. I can hear one man speaking. He drones on and on, barely pausing in between sentences. I cannot make out exactly what he is saying, but I hear "murder," "baby," and "God" sprinkled in the unrelenting harangue. There are six of us from Lady Parts Justice League (LPJL), compared to at least fifty of them in this moment, and the hundreds of them who will attend the actual week-long event. We are there to counter the antiabortion group Operation Save America's annual "Summer of Justice" event. Amber says we are there "to give them a taste of their own medicine."

According to the leader of LPJL, Lizz Winstead, Operation Save America (OSA) terrorizes abortion providers and patients at health clinics— often uncontested. So why not confront them at their events? Lizz is the founder and director of LPJL, which would ultimately be known as "Abortion Access Front" after its name change in 2019.[2] The members of Abortion

[1] I use the real names of all public figures, staff, activists, comics, and abortion movement workers who make their affiliation with abortion work public (i.e., affiliations with abortion listed on a public website). I anonymize most abortion providers primarily by identifying the region of their clinic (e.g., a provider from a clinic in the South or Southern clinic). I have used the names of a few providers if they have passed away or meet the beforementioned criteria.

[2] The group was called Lady Parts Justice League in 2017 when I started this research. In turn, their annual tour was called the "Lady Part's Justice League Vagical Mystery Tour." Founder Lizz Winstead christened the group "Lady Parts Justice League" (LPJL) after State Representatives Lisa Brown and Barb Brynum were banned from speaking on the Michigan House floor for using the word "vagina" when arguing against a transvaginal ultrasound bill. The Speaker of the House suggested that next time Brown use a word "less offensive" like "lady parts" (Lady Parts Justice League 2017b). Incensed that politicians were offended by the word "vagina" yet felt entitled to legislate it, Lizz made a satirical move and repurposed the ridiculous phrase for her abortion non-profit. From the start, LPJL made clear the history of term clear and emphasized that the name was not meant to imply cisnormativity. On their website in 2017 they stated, "At LPJL, we advocate strongly for the reproductive health and rights of women, all genders and non-binary people. Our advocacy has one mission: Whatever your gender identity, we will fight for safe, dignified and affordable reproductive healthcare"(Lady Parts Justice League 2017b). However, the name did not resonate for many activists and made some gender non-binary and trans activists feel excluded. So, in 2019, they

Access Front (AAF) describe themselves as a pro-abortion[3] "coven of hilarious badass feminists who use humor and pop culture to expose the haters fighting against reproductive rights" (Abortion Access Front n.d.). I am with them as a feminist ethnographer interested in their unique approach of using comedy to destigmatize abortion and support abortion providers. I have joined the group for "Abortion AF: The Tour," their annual multi-city stand-up comedy show, which celebrates independent abortion providers while strengthening their local community support networks. The tour has three main components: (1) clinic service; (2) protest; (3) and comedy shows. Countering OSA is part of their protest activities and is some of their riskiest work. They are one of the only, if not *the* only, group that opposes antiabortion organizations at their own events, such as their annual "festival of hate," in the words of Winstead.

I initially did not plan to accompany the league to Indianapolis. At that point, I was primarily interested in the comedy show component of their tour. Plus, when they mentioned Indianapolis, it seemed somewhat mysterious. They peppered the previous weeks with comments like, "If we get arrested in Indianapolis," but I still did not understand what they were doing there. The longer I was with them, however, the members of AAF began to divulge more about the planned actions. Lizz explained that antiabortion group Operation Save America (OSA) was having their annual "Summer of Justice" event. The "Summer of Justice" is a weeklong gathering of OSA members from across the country. They engage in various programming, church services, public marches, and large-scale protests; they also lobby legislators. Their protest activities usually take place at the state capitol, local clinics, and even public spaces (i.e., parks, government buildings, etc.). They also expand their antiabortion activities to non-abortion related spaces they oppose such as LGBTQ centers, gay bars, mosques, and progressive churches. When I ask what we will do there, Lizz says, "Without engaging, we counter their narrative." She elucidates that we would respond to their misinformation and misogyny with t-shirts and signs and that the vibe is, "I'm not here to talk to you; I'm here to tell people the truth."

I asked my AAF colleagues if I should prepare for Indianapolis; they responded, "Yes." I was not sure what preparing myself meant, but Amber and Lizz explained,

> If you come, you have to know that you will likely get arrested. [This can happen when counter-protesting, especially in places where the police may be on the side of antis.] You need to turn off the location services on your phone. You should NEVER be alone. And stay vigilant in case antis follow you. Also, know that they bring go-pros to the protests

changed the name to Abortion Access Front to dispel confusion about the meaning of the name and to ensure that all activists felt welcome (Winstead 2019).

[3] Abortion Access Front (AAF) does not use "pro-choice" language but identifies as "abortion activists" or "pro-abortion." For both of these reasons, I avoid using choice-based language unless I am specifically referring to organizations that, unlike AAF, explicitly identify as "pro-choice." Many organizations that advocate for abortion identify as "pro-choice." Rosalind Petchesky and other reproductive justice advocates have problematized this term because it implies that some women, in fact, have a choice (Petchesky 1990). Regardless of abortion's legal status, many women do not have the choice to procure one due to many factors, including geographic location and cost. Additionally, "choice" language tends to de-emphasize abortion, perpetuating abortion silencing and stigma.

and they take pictures, so they will likely add you to their databases. And afterward, take some time for yourself because it may make you feel your work is hopeless.

Going to Indianapolis felt entirely out of my comfort zone, but after a few weeks on the road with them, I did not have any doubt about wanting to go. By this point of the tour, I was sufficiently incensed at the antis for their vitriol and perturbed at progressives for their absence. However, I also felt dedicated to AAF; we had already been through so much together. So if they would risk it, I would too. As I finished the last few sips of my motel lobby coffee, I declared confidently, "I'm in."

And a few weeks later, I am in Indianapolis, heading straight for the Operation Save America protest. As we approach, I notice the gray limestone tower that looms over the center circular plaza: the Sailor and Soldiers Monument. Surrounding the bottom of the phallic tower is a set of limestone stairs, a platform, and another set of stairs to the brick-layered ground level. Covering the ground level is a heavily trafficked roundabout, and circling the roundabout is a giant truck that says, "Jesus is the standard" along the side. Another truck creeps around the periphery bearing images of bloody "fetal" remains. Several white men in hats are posted at various positions on the sidewalks across from the plaza, handing out antiabortion fliers and attempting to engage passersby. I notice one man donning a blood-red shirt that says, "Truth sounds a lot like hate."

Below the stairs leading to the monument is a giant wooden cross about four feet wide by eight feet tall. Women circle at the bottom of the war memorial pushing baby carriages and with children in tow.[4] Another group of women hovers next to a table on the far right. The table holds a small white casket. There is a blanket rolled on top of the coffin that says, matter-of-factly, "baby," and a series of baby toys displayed in front of the casket, such as plastic keys, a teddy bear, a pair of blue baby shoes, and a pair of white baby shoes with flower designs. The items frame two plastic fetuses—one peachy white and one slightly darker. In addition, large canvas banners of antiabortion images form walls framing the cross. Giant speakers and a podium are shaded by a large black tent; it stands directly behind the cross in the center of the banners. This is their Operation Save America stage.

As we enter the plaza with our signs, all eyes dart towards us, and the speaker on the microphone changes to who I would later come to know as "Coach Dave." When he brings the microphone to his lips, he starts yelling at us, and about us. First, he shouts that none of us are "real women." He says we have all been recruited by the "homosexuals." Next, he singles out my friend Sarah by saying, "You, with the purple hair, I know you don't have a husband." When

[4] My use of the term "woman" as an individual or small-group descriptor connotes people who identify as women. I most frequently use the term when I know that the people I am describing do, indeed, identify as women. Generally, I try to default to gender inclusive language such as "patients" or "people" to acknowledge that I often do not know the respective gender identities of people and that not all people who receive abortions are women. For instance, trans men and gender-nonconforming people also use abortion services, and they often face additional barriers when accessing care. When Lizz speaks about abortion restrictions, she describes them as specifically concerning the bodies of "women and people with uteruses." When I use women in reference to public health studies, I mean people who were born with uteruses, whether they identify as women or not (as this is how their data is collected). When I refer to women in the context of the feminist movement and activism in general, I am referring to people who identify as women and people with uteruses (who may or may not identify as women).

she responds and says, “Actually, I do,” he replies, “Well, he’s not a ‘real man,’ because no man would let his wife come out here like this.” He abruptly switches strategies and says, “Who touched you and put you in all this pain? I know you have all been molested.” To my shock, he details a potential scenario he thinks must have happened to us where a PE teacher molests us. It is all hard to hear. And then he points at me and says, “It’s not too late for you, blondie!” I roll my eyes and chuckle: “Oh, if only he knew.”

Lizz and Amber initiate a few chants in response. I join them, but not loudly. Between our counter-protests yesterday and today, I feel sad, hopeless, and, quite frankly, scared. I have done so much work to accept and develop my voice as a strong feminist who values her right to pleasure, and I am beginning to feel that voice diminish into silent, seething anger. Until now, I have never confronted so many people whom I disagreed with so vehemently all at once—and most certainly not dangerous people connected to the murders of doctors and the bombings of clinics. I feel small and vulnerable in the wake of their anger, volume, size, and all they represent. I am operating in protection mode, and I do not like it. I cannot help but think that they usually do this outside of abortion clinics. How must patients feel, being accosted like this while trying to access the healthcare they desperately need? How must providers feel, enduring their charades every day? And for providers, it is not only a threat of moral attack and shutdown but of physical safety for them, their patients, and their staff. This, I think to myself, is what terror feels like.

Later that day, we trail behind the antis in their death march with the baby casket, holding signs shaped like arrows that read “misogyny,” “lies,” and “bull *poop emoji*” (Figure1). Instead of screaming back, we plan to point at them with our arrows. The arrows, combined with the shirts that say, “Ask me about their lies,” should convey to the public that Operation Save America is spreading hateful misinformation. We do not scream over them because, after all, that would be moot, but we hold our signs, and we do not waiver. As hoped, our presence prompts questions from people ambling to and from work. They ask us who they are, who we are, and what we are protesting. During this period, several passersby thank us for being here. One man says, “They’ve been here all week. It’s been horrible, and no one from the other side has come to oppose them.” I think then, even though we are small, we signal dissent for the people passing by.

Figure 1

The thick line of OSA members looks back at us in disgust. Occasionally, someone yells something about hell, demons, and being saved. I notice "Coach Dave" approaching us with a megaphone in my periphery. He asks several of us if we will go to lunch with him and "talk." We all adamantly refuse. In response to our explicit rejections, he walks alongside us, taunting us. He revisits his earlier narrative about how someone must have molested Sarah, which is why she is not a "real woman." I am trying to tune him out, but his words sting, and I feel nauseous. We continue to chant "lies" sporadically as the antis continue to march and play their music, which is a creepy whispery child singing a song on repeat.

We ignore the Coach. Then, he narrows in on Jaye, an AAF activist who is also a transwoman. "What about *him*?" He emphasizes "him," saying it louder than the rest of his words. "What about *the man*?" He shouts, "man." "That's what you are." *He points at Jaye*. "You think I wouldn't notice." *He feigns a hearty laugh.* "Young man," he yells. "I'm just going to keep calling you what you are," he sneers, "Young man!" He then proceeds to scream "young man" repeatedly into the megaphone. Jaye is quiet, and I can tell she is trying to come up with a witty retort. She is a comic, but it looks like an understandably challenging moment for her.

My blood boils. With the antis' loudspeakers blaring all day, they continuously force us to listen to Coach Dave's inane vitriol. It is dumb; it is hateful, it is deplorable. But we cannot stop him from saying what he says then, and we cannot prevent him from yelling what I would imagine are horribly triggering words to Jaye. My rage simmers, but what could I say to stop it? Then, Sarah starts screaming, "Leave her alone, you better leave her alone!" The coach continues to taunt, "Young man!" I am so upset. I do not know whether I will scream, cry, or be silent forever. And then, I open my mouth for what feels like the first time since we arrived for the week-long counter-protest. I open my mouth, and I sing. I sing my highest, loudest operatic note.

Stunned at my operatic interruption, the coach stops talking. A few lines of marchers up ahead of us turn around. Realizing that my high note cancels out his megaphone, I sing it again, take a breath, sing, take a breath, and sing. I feel light yet strong, rooted in my desire to snuff out his hate speech. I speak up and make myself vulnerable to interactions with the antis in my own way, and it works like magic. Well, the real magic happens next.

My sibling Abortion Access Front activists start to sing along with me, and since Coach Dave is so focused on gender, Shania Twain's "Feel Like a Woman" is our chosen song. I am not sure who starts the tune, but pretty soon we are all laughing, singing, and dancing as we march, Jaye included. So we sing: "The best thing about being a woman is the prerogative to have a little fun and oooh oh oh totally crazy, forget I'm a lady, man's shirts, short skirts, whoaoooooo, wanna be free and feel the way I feel…Man, I feel like a woman!" Defeated and annoyed that he instigated such a Jezebelian response, the coach rolls his eyes and returns to the rows ahead with the other antis.

It is a revelatory and spiritual moment for me. I have made myself vulnerable in the best way I know how, the apogee of my joy, which is singing. And although the rest of the protesters are tense, I feel relieved. My pent-up anger at them, the country, and myself is released. It is healing and fun—a moment for us to bond and laugh about ridiculously rigid notions of gender and the desire to police us into them. Coach Dave's voice will never be as strong as ours combined. He cannot dampen our joy. He cannot shame us into submission.

Abortion Access Front

Up until that point, I had been an abortion scholar, an advocate even, but that day in Indianapolis, with Abortion Access Front, I became an abortion activist. My work with AAF taught me (and continues to teach me) about myself—my limits, courage, and deep adoration for people who live out their values daily. Yet, this is not a story about me. Instead, I use my own experiences and reflections to guide the story, but ultimately, it is a story about tenacity, love, and terror. It is a story about abortion providers, the activists who support them, and the revolutionary way they work to expand abortion access in the United States. Abortion Access

Front inspired me to explore abortion access in the United States. My experiences with them shape my approaches, insights, and commitment to abortion justice.

Abortion Access Front is a feminist non-profit using comedy to destigmatize abortion and support independent abortion clinics. They have two primary arms that help them achieve their mission: (1) media advocacy and (2) what they call "boots on the ground" activism. Media activism includes creating YouTube videos, producing their "Feminist Buzzkills" podcast, and designing other digital media such as memes and gifs. Their activism includes their Abortion AF Tour, where they go from town-to-town volunteering for clinics, countering antis, and producing feminist comedy shows. One of the main goals of the comedy shows is to bring potential local supporters to the clinic, teach them about abortion access, connect them with the clinics, and have a good time shifting abortion discourse. In this dissertation, I focus on their activism and, more specifically, their summer tours, on which I accompanied them.

Ultimately, Abortion Access Front seeks nothing less than to expand equitable abortion access in the United States. After all, abortions are common procedures, with 24% of women electing to have one by age forty-five, about one in four women (Jones and Jerman 2017a).[5] Yet, a growing body of research shows that, even before the *Roe* decision that established the right to abortion was struck down by the U.S. Supreme Court in 2022, women experienced several barriers to accessing abortion in the United States. For example, despite the passing of *Roe v. Wade*, the landmark Supreme Court case did not ensure access for many women—especially those who have been historically (and currently) marginalized, such as women of color and poor women (Petchesky 1990, Petchesky 2000, Solinger 1998, 2001, Joffe 1995, Ginsburg and Rapp

[5] These are thought to be low estimates since the data reported is from 2014 and 2017. Additionally, they are thought to be low because they do not account for the recent closure of clinics with the overturning of *Roe v. Wade* and self-managed abortions.

1995, Krieger et al. 2016, Pro-Choice Public Education Project and Sistersong Women of Color Reproductive Justice Collective 2007, Marty and Pieklo 2013, Ely et al. 2017, American Association of Public Health 2015).[6] For example, the federal Hyde Amendment, active since 1977, bans abortion coverage for women insured by Medicaid (Donovan 2017). This amendment has prevented the following groups of women from accessing abortion if they live in a state which does not supplement Medicaid with state funding for this purpose: women with disabilities, incarcerated prison, Native Americans, military personnel, federal employees, and poor women living in Washington, D.C. (Donovan 2017, Boonstra 2016).[7] Additionally, in recent years, the increase of state-specific regulations and Targeted Regulation of Abortion Providers (or "TRAP laws")[8] has severely decreased access for wide breadths of people based on geographic location. As David S. Cohen and Carole Joffe say, accessing abortion is like an obstacle course where patients must navigate barriers at every stage of access from avoiding misinformation and roadblocks when making the decision to finding a clinic, obtaining the funds, entering the clinic front doors, enduring waiting periods, and waiting through government-mandated counseling (Cohen and Joffe 2020). *Roe*'s failure to provide abortion access to all people with the capacity to become pregnant is commonly cited as one of the

[6] Feminists of color have consistently pointed out the limitations of considering abortion rights as the sole indicator of reproductive freedom. Out of these discussions, several Black women in particular contributed to the conceptualization of reproductive justice; Loretta Ross and the Sistersong organization are the leading voices in reproductive justice theory and practice in the United States. Today, reproductive justice informs most of the work in the abortion rights movement. As a white-led organization, AAF does not identify as a "reproductive justice organization"; they identify as an abortion rights organization. However, reproductive justice significantly informs their work and they advocate for reproductive justice issues. To read more about reproductive justice, see: Sistersong Women of Color Reproductive Justice Collective (2007), Krieger et al. (2016) , and Luna and Luker (2013).

[7] To read more about state funding of abortion under Medicaid, see Guttmacher (2023b).

[8] Targeted Regulation of Abortion Providers (or "TRAP laws") are laws which attempt to restrict abortion by unnecessarily regulating physicians. I explain and discuss TRAP laws throughout the dissertation. For an up-to-date (as of April 24, 2023) table of current TRAP laws in the United States, see Guttmacher (2023c).

reasons that we need to work from a reproductive justice perspective—reproductive justice activists remind us that a 'right to privacy [of medical decisions]' does not adequately address social injustices or oppressive healthcare practices. This is why the phrase, "*Roe* is the floor" was popularized among pro-abortion forces.

As comics and comedy writers, Abortion Access Front aims to destigmatize abortion through comedic performance and satire. Scholars describe abortion stigma as a distinct (and historical) phenomenon (Hanschmidt et al. 2016, Kumar, Hessini, and Mitchell 2009, Norris et al. 2011, (Harris et al. 2011), Martin, Debbink, Hassinger, Youatt, and Harris 2014, Martin et al. 2017). Cockrill and Hesseni conceptualize abortion stigma as a socially produced phenomena across individual, community, institutional, structural, and societal levels, produced locally and "constructed, reproduced, and shaped" by its contexts (Cockrill and Hessini 2014, 593). They also theorize that the perceived violation of ideals of female sexuality and motherhood contributes to abortion stigma (Kumar, Hessini, and Mitchell 2009, Cockrill and Hessini 2014). Several scholars have used this definition as a foundation of abortion sigma and expanded it. For instance, Norris (2011) et al. build on Kumar, Hessini, and Mitchell's notion of abortion stigma to include "attributing personhood to the fetus, legal restrictions, the idea that abortion is dirty or unhealthy, and the use of stigma as a tool for antiabortion efforts" (2011). Stand-up comedy and their comedic arts activist strategies enable them to confront the fear that the antiabortion movement perpetuates head-on, expose their tactics and history, and celebrate independent providers.

As we piled back in the van that day in Indianapolis, I began to think more about how Operation Save America performed white male dominance—from the men speaking and quite literally standing over women to the antiabortion women's movements quietly pushing strollers,

in reaction to our actions, yelling back and taking up space on the plaza. Even during some of our side conversations with them, they interrupted, mansplained, and shouted in megaphones. Men were driving around the trucks and speaking out to the crowds of people walking by—all very active roles. Women were silent, most stationed by the baby casket—performing the type of womanhood that the men espouse— a quiet, nurturing, and demure femininity dependent on their husbands' and children's needs. Even the gruesome images they displayed were large and looming, towering over us in mimicry of the war memorial. Not to mention that while most of the anti men donned hats, shorts, and t-shirts in the blazing heat, many of the anti women wore long skirts or modest shirts with long sleeves. Additionally, every person in eyesight, on both sides, was white, except for the AAF activist Solange.

Normative gender roles and normative whiteness characterize everything about the antiabortion movement.[9] In her generative essay, Peggy Phelan demonstrates how the sex segregation of Operation Save America's protests reflects their own misogynistic ideology. She describes how men lead the 'rescues', performing boldness and violence, and women are often quiet, on the side, in a "prayer column." Hence, the landscape of the clinic protest becomes characterized by "speaking men and observing women" (1993, 385). She states that the separation of roles ensures that the main character of Operation Rescue's protest theatre is a male

[9] Although whiteness and white supremacy dominate the antiabortion movement, there are also Black and Latinx people who have influenced mainstream antiabortion discourses. For example, Dr. Mildred F. Jefferson (1975-1978), a Black woman, was the director of The National Right to Life, the self-identified oldest and largest national antiabortion organization. Jefferson was also one of the founding board members of the group. There are also several contemporary Black antiabortion organizations including Radiance Foundation, Blackgenocide.org, and National Black Pro-Life Coalition. For more information, historical and contemporary, see PBS video *Anti-abortion Crusaders: Inside the African-American Abortion Battle* (2017). For a discussion of Latinx involvement in the antiabortion movement, see Holland (2020). Holland offers a history of ethnic Mexicans and the Pro-Life Movement. She explains that although a majority of Latinx Catholics report (and have a history of reporting) antiabortion sentiments, they do not translate these beliefs into significant antiabortion political participation (2020, 105).

rescuer hero while women are relegated to the background of the "drama", made almost invisible (385). Further, during "rescues," Operation Rescue members transform the clinic landscape into a place where gender and sexuality are policed. For example, members of Operation Rescue often call escorts or counter-protestors "dykes" and women who enter the clinic "whores," ultimately revealing tensions about gender, sexuality, and reproduction. We will see the invisibilized woman theme continue in researchers' analyses of fetal s. In particular, one of the most generative writers on the subject, Rosalind Petchesky, focuses on how the fetal image, depicted as an individual male floating alone and completely autonomous from the pregnant person, became a potent symbol that decentered and demonized women within the abortion debate (Petchesky 1987).

Phelan's analysis offers a generative blueprint that informs how I analyze antiabortion protests and counter-protests. By paying particular attention to how gender is conceptualized and performed in protest spaces, she reveals some of the gendered tensions and anxieties that play out at the abortion clinic and abortion discourses more widely. Specifically, her series of observations of male dominance and gender policing in the protest space—name-calling (e.g., "dyke" and "whore"), the vocal role of men and visual role of women (i.e., the prayer column), fetal imagery, and performances of terror and "heroism"—are similar to events I have observed in the field and that I specifically observed that day in Indianapolis.

When reflecting on the day's activities, I also started to think about how even though so few of us abortion rights protesters were there, it felt like our presence mattered. And it did, just by being there and directly interrupting OSA's misogynistic ideas about women's purpose and how women should comport themselves. We were sturdy and unrelenting, disrupting their ideas of womanhood by existing and demanding a space in their space. We wore loud orange shirts

and held confrontational signs. We refused to let their speech and their presence go uncontested. More, through the singing, chants, and posters, we were not solely responding to them but creating our own narrative and having a damn good time doing it.

The experience also uncovered this dissertation's central argument: that terror infuses everything regarding abortion access, and that it needs to be understood in order to move forward and expand equitable access. More broadly, there is a significant relationship between terror, stigma, and access, and by targeting terror and reducing stigma, abortion access can be expanded. At that moment in Memorial Circle, for me, singing and humorously performing with my sibling activists—perhaps not the first actions one would think would be effective—is what made Coach Dave leave us alone. It made me vulnerable and was also liberating. It is no coincidence that the recent "Liberate Abortion" and "Shout Your Abortion" campaigns exist. These phrases imply a corporeal engagement and freedom, and in the case of Abortion Access Front, a creative pursuit in the name of reproductive justice, collective support, and personal healing. To uncover this, I had to be there. I needed to be with a group of sibling arts activists like Abortion Access Front. I needed to look closely, observe, and make myself vulnerable to terror. I needed to reply to fear with fun. Only then could I understand the gravity of what was happening at abortion clinics nationwide.

And although this particular example was at an Operation Save America national event, this type of "protest" happens every day, whether it is antiabortion protesters from OSA or another group. Referred to as the 'ground zero' of the abortion wars, standalone clinics have remained an ideal target for protesters because they provide the most abortions and often reside in easily identifiable buildings (C. Joffe 2009). Clinic protesters historically have posed—and continue to pose—major barriers for clinics, from daily annoyances to major crimes such as

bombing, arson, and murder. Even forms of violence considered minor, such as verbal harassment outside of clinics, accumulate week after week and may signify serious threats for providers against the historical backdrop severe violence against abortion providers (Russo, Schumacher, and Creinin 2012).

When it comes to clinic violence, most prominent in the public consciousness are illegal acts such as murder, attempted murder, bombings, chemical attacks, and arson. Since the 1993 murder of abortion provider Dr. David Gunn, antiabortion terrorists have murdered eleven providers and attempted to murder providers at least twenty-six times (National Abortion Federation 2020). The Feminist Majority Foundation (FMF) details that the percentage of clinics reporting the most severe forms of violence remains "dangerously high," with almost half of all providers experiencing some form of severe violence, the threat of severe violence, and/or severe harassment (Feminist Majority Foundation 2019, 2).[10]

Less familiar to the public is the relentlessness of quotidian violent antiabortion activities. For instance, 62% of clinics experience antiabortion protest activity daily or weekly (Feminist Majority Foundation 2019, 3). According to a report by the National Abortion Federation in 2021, almost all types of antiabortion violence and harassment have increased. They reported that the most significant increases were in stalking (600%), blockades (450%), hoax devices/suspicious packages (163%), invasions (129%), and assault and battery (128%) compared to 2020 (National Abortion Federation 2022). These numbers are thought to be low estimates because many clinics were short-staffed and had significantly fewer volunteers to monitor and report antiabortion activity during the COVID-19 pandemic (National Abortion

[10] Feminist Majority Foundation has measured clinic violence through their National Clinic Violence Survey every two years since 1993. They categorize antiabortion violence into three main categories: severe violence, severe harassment, and targeted intimidation and threats.

Federation 2022). Additionally, several clinics closed or moved locations which led to a reduction in antiabortion activity (2022).

Some additional violence categories that increased include burglary (63% increase), vandalism (54% increase), and bomb threats (80% increase). While some categories are self-explanatory, I'd like to detail what is included in the "vandalism" category—"multiple incidents of bullets being fired through clinic windows, damage to HVAC equipment, cutting of power sources, bricks and rocks thrown through or at windows, and signs damaged" (2022, 5). I have not seen any reports for post-June 2022 (overturning of *Roe*), but many escorts and activists have told me that the antis are emboldened, and the violence at clinics has increased. There is also concern that with fewer clinics, the antis' campaign of terror can cover more ground.

Studies find that protesters' tactics generally do not change patients' minds about abortion; however, they tend to make accessing abortion a harrowing experience for patients (Greene Foster et al. 2013). And they stymie access even further by making it very difficult for providers to provide abortion care. For one, there is the emotional burden of constant fear and vigilant safety procedures. Furthermore, they stymie abortion providers by demanding additional labor to comfort patients; as a result, many clinics rely on the consistent labor of volunteer escorts to comfort patients and help them navigate past protesters (Mercier, Buchbinder, and Bryant 2016) Additionally, protesters make it difficult for providers to secure a lease and tarnish their reputation with the surrounding community (Cohen and Joffe 2020, 142). For me, the lesson is this: the abortion movement needs to meet the antiabortion movement with our own performances and our own narratives. We must pay attention to their performative tactics and halt or counter them. We need to reveal these spaces as sites of performance in order to

understand the multidimensional attacks on abortion and how arts activist groups like Abortion Access Front make innovative moves to create a better world.

Using my ethnographic engagement with the nonprofit organization Abortion Access Front (AAF) as an entryway, my research demonstrates how the antiabortion movement terrorizes abortion clinics, providers, patients, and their communities. Drawing from feminist and performance theory, it explores the many ways clinics respond to this terror. By examining the work of AAF, I demonstrate how a nonprofit organization leverages humor to meet the needs of independent clinics, functions as an innovative public health education model, and shifts abortion discourses in the United States.

More patients access abortion through independent clinics than through any other portal. With the overturning of *Roe v. Wade* and countless other barriers, independent clinics across the United States have become increasingly threatened, with many shuttering their doors. The many arms of the antiabortion movement are primarily responsible for this. For decades they have terrorized clinics—providers, patients, and all within their orbit— evoking fear, inflicting violence, and reinscribing abortion stigma. With the impending peril of independent abortion clinics and increased difficulty in accessing their services, understanding their challenges, strengths, and needs emerges as a top priority.

My dissertation research contributes to the theoretical frameworks, conceptual tools, and arts activist strategies needed to center abortion access within progressive social movements. Additionally, my research offers unique insights into the perspectives of abortion providers, activists, and communities in the context of Abortion Access Front's revolutionary work. Unlike most previous studies of abortion, mine takes performance as both the subject and mode of analysis. As a subject, performances such as the Abortion Access Front Comedy Show offer

insight into how stand-up comics understand abortion politics, experiences, and opposition, and make meaning through their comedic performance form. As a mode of analysis, performance enables me to reveal the complexity of antiabortion clinic protests, including their historical relevance, planned and systematic nature, racist and heteropatriarchal values, and corporeal effects on providers and patients. Research that documents the independent clinic provider-landscape pre-June 2022, like mine, is crucial to understanding contemporary abortion discourses and actions the public can take to support abortion providers, as well as people seeking abortion in their respective communities.

Reproductive Governance and Justice

What Operation Save America was doing at Memorial Circle demonstrates the mechanisms of reproductive governance, a key concept in the anthropology of reproduction, and the guiding theoretical framework for my analysis. Lynn Morgan and Elizabeth F.S. Roberts developed this concept to describe:

> the mechanisms through which different historical configurations of actors—such as state, religious, and international financial institutions, NGOs, and social movements—use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviors and population practices. (2012, 241)

Based on this definition, Morgan and Roberts assert that several layers of structural influence have historically used legislation to control the population's reproductive behaviors. Morgan and Roberts establish that reproductive governance always considers how religious, political, and economic ideologies intersect in specific local contexts shaped by historical and global discourses and dynamics (Morgan 2019, Ginsburg and Rapp 1995). By linking bodily practices

with the political motives of the state, they also link reproductive practices with the state, and thereby with global economic logics.

Morgan and Roberts derived the concept of reproductive governance from Michel Foucault's influential notion of biopower and biopolitics. They foreground that biopower centers sex as an essential place of political tension because sex is a "'means of access' to both 'the life of the body' and 'the life of the species,'" linking anatamo politics, or discipline of the body, with biopolitics or the regulation of the health-related behaviors for the benefit of the population (Morgan and Roberts 2012, 243). They assert that reproductive governance is useful for thinking about how "rational" citizens are created through reproductive and sexual health options and the "moral regimes" which shape them.

Regarding abortion, Elise Andaya and Johanna Mishtal (2017) find reproductive governance useful when analyzing state and federal policy to uncover ideals of modern citizenship. For example, they write: "Attention to reproductive governance … highlights the relationship between abortion policy and state visions of modernity as governments sought to bring desired populations and futures into being through controlling birthrates" (Andaya and Mishtal 2017, 42). Therefore, according to Andaya and Mishtal, reproductive governance enables us to analyze how the government controls reproductive practices and produces ideals of citizenship through reproductive policymaking.

Regarding abortion access in the United States, Carole Joffe demonstrates how the regulation of abortion providers exemplifies reproductive governance (C. Joffe 2018). By examining reproductive governance through the example of TRAP laws, specifically Ambulatory Surgery Center (ASC) requirements, she argues that reproductive governance manifests most clearly through the legislative controls Morgan and Roberts describe. TRAP laws

are laws that attempt to restrict abortion by unnecessarily regulating physicians (i.e., requiring hospital admitting privileges and OBGYN certification) and abortion facilities (i.e., requiring structural standards comparable to surgical centers, transfer agreements with a nearby hospital, and other specific and unnecessary facility requirements) (Guttmacher Institute 2019b). These restrictions tend to fall into the five following categories: (1) unnecessary regulations on abortion clinics (or TRAP laws); (2) mandatory counseling designed to dissuade women from choosing abortion (e.g., doctors required to inform patients of inaccurate breast cancer and mental health risks) (Berglas et al. 2017, Guttmacher Institute 2018); and, (3) mandated waiting periods before an abortion, parental consent, and banning of state funding for medically necessary abortions (Guttmacher Institute 2019a). She elaborates that antiabortion movements linked to politicians reinforce these controls and describes how various reproductive governance controls work together (C. Joffe 2018, 1). In the case of abortion provision, she writes that TRAP laws disincentivize clinics from providing abortions, while abortion stigma and direct coercion further discourage providers from doing the work (2018, 14). Together, these controls reinforce one another; they create a reality of abortion access suffused with abortion exceptionalism which she defines as "the idea that abortion is treated uniquely compared to other medical procedures that are comparable to abortion in complexity and safety" (Cohen and Joffe 2020, 8). She adds that ultimately, these regulations, especially since the 2010 midterm election, reflect and contribute to abortion stigma (Joffe 2018, 1–2).

When it comes to my research on independent abortion clinics—the way most people access abortion in the United States—the political, religious, and economic links become clear. For instance, independent abortion clinics grapple daily with multiple barriers initiated by the state and its citizens and consistently reinforced by them. For example, antiabortion legislators

and the antiabortion activists and corporations who influence them propose these regulations and work tirelessly to pass them. Notably, many of these politicians are Christian Nationalists, self-identified Evangelical Christians who promote a variety of bills that conflate conservative political and social values (Whitehead, Perry, and Baker 2018). Ultimately, the regulations make running an abortion clinic akin to "a never-ending game of whack-a-mole" according to one provider. Every time a clinic thinks that they have complied with one TRAP law, another one is waiting in the wings. These regulations are what Morgan and Roberts call "legislative controls." By controlling independent clinics through TRAP laws, states control and monitor clinics, making it more difficult for them to care for patients and for patients to access them. Ultimately, by controlling clinics, the state also controls the populace. By making abortions more difficult to attain, the state signals which citizens are valued enough to be permitted to make the reproductive decision to end a pregnancy.

TRAP laws also illustrate the related concept of reproductive stratification. Theorized by Shellee Colen, reproductive stratification enables and values the reproductive capacities of some groups, while disabling and devaluing the reproductive capacities of other groups (Colen 1995). In her case study of West Indian childcare workers and their employers in New York, Colen conveys how reproductive processes produce and perpetuate oppression and systemic inequalities. By analyzing this case study, she develops the concept of stratified reproduction to demonstrate that parenting is transnational, interracial, intercultural, cross-class, and informed by a variety of state policies (Colen 1995, 98).

Ginsburg and Rapp use Colen's concept as a springboard and organizing principle in their generative edited volume *Conceiving the New World Order: The Global Politics of Reproduction* (Ginsburg and Rapp 1995). They assert that stratified reproduction reveals that

hierarchically organized cultural ideals and practices shape reproduction. Stratified reproduction describes the "power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered" (Ginsburg and Rapp 1995, 3). The application of this concept reveals how "appropriate" and "inappropriate" parents are categorized and stratified (and the consequences of their stratification). The authors emphasize that the concept destabilizes the "persistence of ethnocentric and (hetero)sexist assumptions that reduce the complexities of childcare to mothering, thus effacing the contributions of multiple caretakers including fathers, foster and adoptive parents, childcare workers, and state and cultural institutions," while holding mothers "solely responsible" (Ginsburg and Rapp 1995, 13, 77). Applying the stratified reproduction concept to my own work on abortion reveals whom the state empowers to make reproductive decisions. For instance, state-mandated abortion restrictions disadvantage people differently depending on their geographic location, socio-economic status, education, social support networks, and more, making it more difficult for people marginalized in these ways to achieve reproductive freedom. Additionally, the choice rhetoric often focuses on the individual decision-making of women, eclipsing the economic and cultural conditions which often motivate them to end a pregnancy.

Reproductive governance and reproductive stratification intersect as the theory of reproductive justice, which draws attention to economic and cultural contributors to reproduction and parenting. Developed by Black women from the South in 1994, many of whom are leaders in the present-day organization Sistersong, reproductive justice is an intersectional theory that describes "the complete physical, mental, spiritual, political, social, environmental and economic well-being of women and girls, based on the full achievement and protection of women's human rights" (Ross and Sistersong Women of Color Reproductive Justice Collective 2007). This praxis

stresses that it is important to ensure that Indigenous women, Black women, and women of color have the right to (1) have a child (2) not have a child, and (3) parent children in safe communities where they control their own birthing options (Ross and Sistersong 2007). In contrast to the Pro-Choice Movement, which focuses primarily on abortion rights, reproductive justice posits that a person's ability to make a choice is inextricably linked to the conditions in their community, and to intersecting axes of oppression.

Reproductive justice theory asserts that honoring the human right to become or not become a parent requires broader investments and social transformations outside of the reproductive health sphere—safe and affordable housing, accessible healthcare, quality education, living wages, childcare, environmentally safe neighborhoods and communities, and freedom from interpersonal and state violence (Ross and Sistersong 2007). Enmeshed in these conditions are changes ensuring that reproductive health options, such as abortion, are safe, affordable, and accessible (Ross and Sistersong Women of Color Reproductive Justice Collective 2007, 4). One founding theorist of reproductive justice, Loretta Ross, explains that by "shifting the definition of the problem to one of reproductive oppression (the control and exploitation of women, girls, and individuals through our bodies, sexuality, labor, and reproduction) rather than a narrow focus on protecting the legal right to abortion, we are developing a more inclusive vision of how to move forward in building a new movement" (Ross and Sistersong 2007). For Ross and other reproductive justice activists, that all social justice issues might be considered reproductive justice issues, because reproductive health and rights are only accessible to everyone when everyone has the resources they need to make the choices they need to.

To advance these goals, reproductive justice offers a multi-pronged approach that includes three main components: 1) reproductive health (i.e., health service delivery; 2)

reproductive rights (laws and restrictions); and 3) reproductive justice, which focuses on movement building (2007). Ross contends that these spheres work in tandem to improve the lives of all women, their families, and their communities. Reproductive governance, stratification, and justice are rich concepts that are explored by a broad spectrum of researchers working in various contexts in reproductive health studies (i.e., sociology, anthropology, gender studies, and public health). They reveal structural intersections, patterns, and dynamics. I aim to build on this group of concepts in a different way based on my performance studies training. But that requires me to begin with a basic question: what is "performance?"

Performance, Terror, and Humor

When I tell people I study "performance," they usually assume I am talking about a play or theatrical event. And they would be correct. However, "performance," as performance studies scholars have theorized, is that and so much more. Performance encompasses all actions and behaviors. Performance studies scholar Diana Taylor asserts that performances are "vital acts of transfer," which transmit "social knowledge, memory, and a sense of identity" through reiterated behavior (2003, 2). She describes performance as operating in this way on two different levels—on one level as the object/process of analysis and on the other as the methodological lens or epistemology. She refers to the former level as the "bracketed off" performance; this performance usually refers to a practice or event which involves rehearsal, theatricality, and/or behaviors that establish the event as a particular object/process of focus. The latter denotes a critical analysis of performances of daily life or embodied practices which vary greatly depending on cultural context. For instance, Taylor offers examples addressing citizenship, resistance, gender, ethnicity, and sexual identity (Taylor 2003). Conceptualizing abortion as

performance includes the procedure of abortion as well as government regulations that shape it, it includes small talk between doctor and patient and interactions between antis and escorts, it includes a comic doing stand-up and a provider reading a mandated consent script.

I use performance as both an object of study and an analytic. I find it useful because it enables me to connect the specifics and significance of Abortion Access Front comedy shows, such as word choice, gesture, content, and self-presentation, to larger social contexts, patterns, and power dynamics. Applying the concept of performance is/as to analyze AAF's Abortion AF Tour positions stand-up comics as performers and the work that happens on the comedy stage as "bracketed off" or "framed" performances. Additionally, applying the performance is/as concept enables me to look at the ways in which comics perform their own gender, sexuality, and class, as well as the way in which AAF performs their intervention. Thereby, performance helps me understand how AAF transmits knowledge about abortion. Specifically, using performance as an object of analysis *and* as a mode of analysis helps to reveal theater/stand-up comedy as a key stigma intervention strategy and advocacy tool, as well as simultaneously enabling critical analysis of the role of legal and healthcare institutions in abortion access.

A performance as/is approach also facilitates a magnified focus on the performing body. In an article for the UCLA Center of Women's Studies Newsletter, performance studies scholar Rosemary Candelario asks how "performance, activism, and concerted actions of body" can expand the phrase "performing abortion" beyond the medical procedure (2012, 20). She examines three artists/ensembles who grapple with abortion as part of their performance pieces. Candelario asserts that focusing on how "bodies are deployed to disrupt established discourses and reconfigure possibilities" can help shift abortion discourses. She contends this focus may shift abortion discourses away from moralist and consumerist discourses, which erase the body

of the woman, and toward "corporeal agency and reproductive justice" (Candelario 2012, 20). As I mentioned earlier, I was struck by what countering an antiabortion event feels like and, even more, what walking through a crowd of antiabortion protesters to the front door of the clinic feels like. Performance reveals how these experiences are shaped by policy and vice versa. It also reveals the dissonance between many abortion discourses, policies, and the actual experience at the clinic.

Although a lush history of performance studies research on HIV/AIDS performances and arts activism (Gere 2004, Crimp 1987, Roman 1998, Sandoval 1994) flourishes, as well as literature on feminist performances (Diamond, Varney, and Amich 2017, Dolan 1993, Lacy and Labowitz 1998, Schneider 1997, Harris 1999, Hart and Phelan 1993), performance studies literature on abortion activism and performances remains sparse. Characterized by its interdisciplinarity, performance studies provides a useful framework for examining life at the clinics, and the Abortion AF shows that aim to support them.

I could only find three articles that address abortion from an explicitly performance studies perspective—Jan Cohen Cruz's "At Cross Purposes: the Church Ladies for Choice" (1998), Jennifer Doyle's "Blind Spots and Failed Performance: Abortion, Feminism, and Queer Theory" [11] (2009), and Peggy Phelan's "White Men and Pregnancy: Discovering the Body to Be Rescued" (1993). While Cohen-Cruz and Phelan construct vivid and informative descriptions of antiabortion protests and counter-protests, their essays are both relatively short and therefore limited. However, they do serve as models of performance as/is approach, particularly when examining protest events.

Using a performance lens, I can apply a reproductive governance framework while tuning

[11] Although Doyle earned her PhD in English, she consistently contributes to performance studies discourse.

in to the everyday corporeal experience at the clinic. Throughout this dissertation, I will refer to performance in different ways. I will discuss how memory is performed, indexed, and corporeally experienced (Part One); how providers, antiabortion protesters, and escorts all perform at the abortion clinic, which is itself a stage for these performances (Part Two); and how stand-up comics perform comedy and humorous skits to confront abortion stigma and the fear that so often accompanies it (Part Three). My training in performance studies makes me particularly attuned to theatricality. One of the most notable aspects of arriving at abortion clinics is noticing the grand gestures, signs, and sometimes wailing that accompany a patient's entrance and then dissipates once the patient is inside. One of my escort interlocutors often refers to their "performances," saying "Ok, everyone, get ready for the noon 'abortion is murder' show!"

Before moving on, I would like to clarify that I use the words fear, violence, and terror interchangeably. Fear has long been associated with abortion. Often, in abortion literature, fear and stigma go hand-in-hand. For instance, Carole Joffe explores how the image of the "backalley butcher" [12] pre-1973 continues to haunt abortion providers and contribute to abortion stigma (C. E. Joffe 1995). In fact, she historicizes abortion to show that some medical doctors who provided abortion felt morally compelled to help women and were usually successful. More, scholars since have described the fear-inducing and intimidating tactics antiabortion protesters have used

[12] *In Doctors of Conscience*, Joffe explains that practitioners providing abortion in the pre-*Roe* era were often called "abortionists" or "back-alley butchers" interchangeably. She writes that the phrases "evoke greedy, incompetent, and exploitative individuals, who often injured their patients, sometimes sexually abused them, and occasionally, due to their ineptness, even killed them" (1995 VII). However, she asserts that the "butchers" are only one aspect of the complex illegal abortion reality and contrasts them with providers she calls "doctors of conscience." Doctors of conscience were established medical professionals who were compelled by the ethical obligation to help patients and pushed for abortion legalization both within medical and broader political contexts (1995).

on providers and patients (Cohen and Connon 2015; Doan 2007; Russo, Schumacher, and Creinin 2012; Carroll et al. 2021; Cohen and Joffe 2020). For example, in *Living in the Crosshairs: The Untold Stories of Antiabortion Terrorism*, David S. Cohen and Krysten Connon emphasize that antiabortion harassment is not a relic of the past nor limited to high profile doctors, but "rather, it is a severe, ongoing, and nationwide problem" (Cohen and Connon 2015, 8). They conduct extensive interviews with abortion providers to illuminate how antiabortion protesters harass and threaten individual doctors who provide abortions. In doing so, they reveal the inadequate protections afforded to abortion doctors by the law. They, along with other scholars, document the extreme precarity providers navigate on a daily basis. What's more, a recent report (2023) shows that antiabortion violence is on the rise (National Abortion Federation 2023). In addition to making it increasingly difficult for providers to live their everyday lives and provide care, fear also saturates abortion procedures, clinics, and doctors.

Antiabortion protesters have perpetuated violence at clinics since the establishment of the first freestanding abortion clinics in the early 1970s. The antiabortion movement encouraged participants to show up at clinics in protest as a dominant direct-action tactic. Referred to as the "ground zero" of the abortion wars, clinic sites have remained an ideal target for protestors because they provide the most abortions and they are highly visible due to their often easily identifiable buildings (Abortion Care Network, 2020; Joffe, 2009). As I described earlier, antiabortion violence at abortion clinics takes many forms and may range from verbal harassment outside of clinics to bombing, arson, and murder—from daily accumulating annoyances to insurmountable hurdles (Feminist Majority Foundation, 2019; National Abortion Federation, 2022).

In this dissertation, I consider instances ranging from sign-holding to protesters wearing military garb screaming into a bullhorn that a patient will "die in there" as occurring on the spectrum of terror. I also include the proliferation of Crisis Pregnancy Centers as events that fall along the terror spectrum. Not because they oppose abortion, but because they actively deceive and mislead patients, often by posing as clinic staff and luring patients away from their intended destination, the actual abortion clinic. A common tactic is to aggressively beckon patients to their van or bus, where they have been known to corner patients and make it difficult for them to leave. The persistent deceptive practices of CPCs qualify as practices that contribute toward a climate of terror. All of these examples are instances of terror because they occur in a space that has been terrorized for decades, where bombs have exploded and providers have been shot, as well as the everyday racial, gendered, and sexualized violence that is communicated through signs, gestures, and sayings. More, they purposefully deceive, scare, and shame.

In her book *Opposition and Intimidation: The Abortion Wars and Strategies of Political Harassment*, Alesha Doan draws attention to the historical context of extreme violence against abortion providers, such as provider murders, clinic bombings, arson, and chemical attacks (Doan 2016, 3). She writes, "The inflammatory rhetoric and extreme forms of violence (occurring at the national level) create an atmosphere of reasonable fear among individuals affiliated with clinics (at the local level), even if their objective probability of being a victim of extreme pro-life violence is minimal" (Doan 2016, 28). According to Doan, in this context, when protesters use militaristic rhetoric and create an atmosphere of fear, it is especially potent. Public health researchers Russo et al. affirm this point when they say, "Even minor harassment implies the threat of murder, given the history of violence in the United States" (Russo et al., 2012, 565). One major contribution of Doan's work is her argument that their activities should not be

classified as political protest but rather should be seen as instances of intimidation, harassment, and violence. Doan also explains that, unlike political protest, antiabortion protesters seek to change the behavior of non-governmental actors. As such, she categorizes their activities as political harassment (Doan 2016).

I agree with Doan and build on her notion of antiabortion violence by adding a performance element. Influenced by Rustom Bharucha and Peggy Phelan, I theorize "performing terror" as a way to emphasize the quotidian of terror in the abortion clinic context. To that end, I analyze political, historical, and experiential role of the clinic terror simultaneously, and I center the embodied, phenomenological experience of patients in that analysis. I define "performances of terror" in the abortion clinic context as the deployment of performance techniques (i.e., aesthetic bombarding, sonic infiltration, and physical interference) to scare and deceive patients, as well as the occupation of space to insist on their self-perceived moral (and often gender, as well as racial) superiority. I contend that these performances are not "spur of the moment" acts but are often meticulously and strategically planned. To be clear, like Bharucha argues, I am not saying that terror itself is a performance. Rather, the actions people take to perpetuate it, the ways in which people react to it, and the measures put in place to prevent it are performance.[13]

My concept branches off of Doan's because I assert that "behavior change" (i.e., stopping a patient from getting an abortion) is not the singular motivation of protester activities. In addition to agreeing with Ziad Munson that people protest outside of clinics for diverse political and social logics, I contend that some protesters deploy performances of terror in order to

[13] My performance studies training emphasizes that all actions (and inactions) are indeed performances on a broad spectrum of performance. However, here I am using performance to speak specifically to the theatrics of antiabortion protesters such as, visual imagery, sound and music, and movements and gestures which project their narrative.

explicitly perform their values (for themselves and each other), discharge political anger, and explicitly shame patients (Munson 2009). Indeed, I have observed antiabortion protesters yelling when they know the clinic walls are soundproof, creating chaos outside of clinic operating hours, and approaching patients who are leaving the clinic, having already had their procedures. Rather than categorize these actions as "political harassment" and consider clinic protesting on a continuum of political participation like Doan, I examine them on a spectrum of terror—which includes all activities of antiabortion protesters outside of clinics as exhibiting varying degrees of violence. The mere presence of a protester can represent decades of fear, bombings, threats, and murders. The context of the histories of the clinics means that anyone showing up in the space to visibly, audibly, and choreographically display their dissent is a potential murderer, bomber, or purveyor of terror —for providers and for patients. I also accentuate that terror is not just fomented by the protesters' words, but also by their visual aesthetics, sounds, and choreographies.

My background in performance and research on stand-up comedy make me particularly attuned to comedy. Starting from my undergraduate studies, I wanted to explore the potential of comedy—what could it do? I quickly found that stand-up could be a propelling force in creating queer women's communities. I also spent several years working with the UCLA Sex Squad, learning about their novel approach to sex education. Inspired by Pieter-Dirk Uys and Miguel Sabido, students asked how to use the performing arts—poetry, theatre, music, puppetry, and more—to destigmatize HIV and other taboo topics in the realm of sexual health.

Inspired by the arts-based interventions used to destigmatize HIV, I am curious as to how humor and/or humorous storytelling, such as stand-up comedy, can be used to destigmatize abortion. There is not a lot of literature on this subject, but humor studies scholars frequently

begin with Sigmund Freud to theorize on this topic. In *The Joke and Its Relation to the Unconscious*, Sigmund Freud demonstrates how fear can be managed through humor via the telling and receiving of jokes (Freud 1905). He explains that jokes can provide a way to question and engage with social processes that can be safer, more comfortable, or more pleasurable than other forms of communication. Freud examines the different types and techniques of jokes and illustrates how jokes can be used to lift inhibition by producing pleasure through laughter and "joke work" (1905, 151). He describes the telling of the joke and the receiving of the joke as a very physical experience characterized by psychological processes and the physical release of energy that occurs in laughter. I find this to be a useful foundation for theorizing the potential of stand-up comedy to alleviate the stress or tension of a topic.

Several authors from the humanities examine stand-up (Seizer 2017, 2011, Gilbert 1997, Auslander 1993, Goltz 2017, Brodie 2014, Pelle 2010), adopting a performance studies (or performance studies-adjacent) approach by positioning the comic as a performer and analyzing the show as a meaningful cultural performance. Additionally, these approaches self-reflexively acknowledge the observer's role as an audience member and researcher. Focusing on the destigmatizing potential of humor, laughter, and jokes (Freud 1905 Goffman 1963, Chattoo 2017), several scholars examine the significance of the stand-up comic as cultural critic and the potential for stand-up comedy to activate social change (Gilbert 1997, Meier and Schmitt 2017).

For example, In *Performing Marginality: Gender, Humor, and Cultural Critique*, Joanna Gilbert explains that stand-up comedy is not necessarily activism, but it can be transgressive because it has the ability to disarm and relax the audience into listening and understanding. She argues that this happens particularly when comics perform marginalized humor, which includes jokes that poke fun at the process of marginalization based on gender, race, ethnicity, sexuality,

etc. She admits that although these events may not immediately change existing power structures, the "inherently subversive power of humor" makes jokes a good place to start (Gilbert 1997, 167). Furthermore, Auslander (1993), Lockyer (2011) and Merrill (1988) explore how stand-up performances do the explicit work of feminist politics through joke material and delivery.

Applying a performance framework, I analyze what goes on at abortion clinics and suggest that arts activists like AAF use performance in a revolutionary way. Throughout this dissertation, I develop several concepts using my understanding of performance and my observations at clinics (e.g., the collective memory of terror, security bind, and performing terror) to demonstrate the multi-layered challenges providers, escorts, and patients navigate on a daily basis and the tremendous efforts they employ to counteract them. Focusing on the experimental realm and taking a performance approach to abortion access is not a common path in abortion research. However, it is necessary to understand how stigma and fear are inexorably linked, and to combat stigma we must confront antiabortion terror.

For me, performance is a useful approach for analysis because it links structural power differentials with the sounds, movements, speech, and routines of everyday life, making the implications of power inequities stark and defined, while also revealing opportunities for counteractions. A performance lens helps me explain how decades of conflict, fear, intimidation, health inequities, and misogyny can manifest in one regular day at an independent abortion clinic.

Abortion Access in the U.S.

The abortion access landscape has changed drastically in the past year and has been changing rapidly even since Carole Joffe and Faye Ginsburg created some of the first ethnographies of abortion clinics in the United States in 1986 and 1987, respectively. When I was conducting fieldwork in 2018 and 2019, the access climate was in crisis, with abortion inaccessible to those who did not have the means to pay, travel, take off work, and secure childcare. As of March 2023, the rapidly changing regulations have devastated abortion access—especially since the overturning of *Roe v. Wade* this past summer. As of November 2022, there are fourteen states with no abortion-providing clinics, and even more states with gestational bans (Abortion Care Network 2022).[14]

Although most people think of Planned Parenthood when it comes to accessing abortion, independent clinics provide the majority of abortions (55%) compared to Planned Parenthood (41%), hospitals (3%), and physicians' offices (1%); they also provide the most comprehensive access (Abortion Care Network 2022, 3).[15] Referred to as the "mom-and-pop shops" of abortion, the term "independent abortion clinic" or "indie clinics" usually connotes any clinic that is not a Planned Parenthood, hospital, or individual doctor's office. Indies provide the vast majority of

[14] As of May 3, 2023, forty-four states ban abortion after a certain point in pregnancy. Thirteen states ban abortion, completely while others ban it at: six weeks (1 state), fifteen weeks (2 states); eighteen weeks (1 state); twenty-two weeks (7 states); twenty-four weeks (4 states); and twenty-five weeks (1 state). All of these gestational limits are calculated from the person's last menstrual period. Further, thirteen states have legislation which ban abortion "at viability," which means the point at which a fetus can survive outside of the uterus. Guttmacher clarifies that viability can be different depending on the pregnancy, but that, generally, a fetus reaches viability between twenty-four and twenty-eight weeks from the last menstrual period (Guttmacher Institute 2023d).

[15] One provider referred to Planned Parenthood as the "pink elephant in the room." Most clinics agree that Planned Parenthood is a great organization; however, they can be a barrier for independent clinics because they are what most people think of when they think of "abortion," even though they are not providing the most or most meaningful access. Additionally, Planned Parenthood has more resources than indies and several of my interviewees suggested that Planned Parenthood strategizes to maintain its dominance, often taking business from indie clinics and refraining from opening clinics in places that have the need but are unlikely to deliver a significant profit.

abortions as pregnancy progresses, representing more than half of all clinics (66%) that provide care at and after 16 weeks of pregnancy, 69 % of clinics providing care at and after 19 weeks of pregnancy, and 79 % of clinics that provide care at or after the 22 weeks of pregnancy (2022, 6). When it comes to abortions after 26 weeks of pregnancy, they are the sole providers in the United States (Abortion Care Network 2022, 6). However, without the institutional support, name recognition, or funding capacity of national health centers and hospitals, the local communities where independent providers operate often remain unaware of their existence until they need to use their services (Abortion Care Network 2018).

Providing care as pregnancy progresses is especially important in a post-*Roe* climate where many patients must travel for care and experience long wait times in their own states and yet, these clinics continue to close (Abortion Care Network 2022). Even before the summer of 2022, indie clinics closed at alarming rates, partly due to proliferating TRAP laws (2022). In fact, since 2012, the overall number of brick-and-mortar independent clinics in the U.S. has decreased by 35 % (Abortion Care Network 2022, 11). Independent abortion clinics have been steadily closing since 2017, with by far the greatest number of closures (more than double) in 2022 (2022, 11). As of November 2022, 42 independent clinics have closed (Abortion Care Network 2022, 11). The devastation is especially stark in the Midwest and South, where 93% of the independent clinics that were forced to close or stop providing abortion care in 2022 were located (Abortion Care Network 2022, 14). The Midwest and South are precisely where I traveled with Abortion Access Front. Unlike most national abortion organizations, Abortion Access Front visits independent clinics in some of the most politically hostile places, partly because they are the most vulnerable to antiabortion violence (Abortion Care Network 2022). These states are also usually the places where pro-abortion events, tours, etc., do not go. AAF

visits these clinics on their annual multi-town/city summer tour, which in its latest iteration was called "Abortion AF the Tour."

The tour is a part of their "boots on the ground" work. They travel to multiple cities, usually in a large, rented white van. AAF visits one or more clinics in each town and usually schedules a "clinic service day" and a comedy show. They describe their clinic service day work as the "Habitat for Humanity for abortion clinics." They basically will do any project that the clinic requests. While I was traveling with AAF, this ranged from planting bushes as a visual barrier to shield the waiting room from antis to hosting a neighborhood festival and bookbag drive for kids. They also hang feminist and pro-abortion artwork, and sometimes they will volunteer as escorts and counter the local regular antis if the clinic requests or allows it. The comedy show includes a lineup of local and nationally famous, recognizable feminist comics, with an emphasis on diversity, and usually features comics of color, comics with disabilities, and trans comics.

On the 2018 tour, I was the anthropologist in the backseat of the van from late June to late July. I accompanied them to Columbus, Ohio; Nashville, TN; Huntsville, AL; Detroit, M; South Bend, IN; Indianapolis, IN; Minneapolis, MN; and Duluth, MN. We conducted clinic service projects at six independent abortion clinics. We participated in one week-long Operation Save America counter protest, one Families Belong Together protest[16] in Nashville; and two street theatre protests—one in Detroit and one in Minneapolis. Along the way, AAF produced five stand-up comedy shows.

[16] Families Belong Together is a campaign that works to end family separation and detention at the U.S. borders. The campaign counters the Trump administrations inhumane detention practices and seeks to "build an immigration system centered on humanity, compassion, and dignity (National Domestic Workers Alliance n.d.).

The 2019 tour was broken into two phases —Phase One (July 2019) and Phase Two (the last two weeks of September 2019). For Phase One, I accompanied AAF to Milwaukee and Madison, WI; Minneapolis, MN; And Des Moines, IA. We participated in one week-long OSA counter-protest and one clinic service day and produced five stand-up comedy shows.[17] For Phase Two, I accompanied them to Austin, TX; Houston, TX; And Baton Rouge, LA. We participated in one clinic-side counter-protest, two clinic service days, and produced three comedy shows.

Notably, I have also participated in other events that AAF has hosted and invited me to attend, such as the Golden Probe Awards in New York City (2019), National Abortion Care Network Conference (2019), countering the National March for Life (2020), and multiple additional LA-based community building and fundraising events.[18] I was hoping to join them on another tour in the summer of 2020, but due to COVID-19, touring was put on pause. However, AAF has activated various members in their abortion activist network to attend various protests and counter-protests over the past few years. I accompanied them to one of these events, which was a week-long counter-protest to OSA's annual "Summer of Justice" in June 2021.

When traveling with AAF, I met many providers and volunteered at several clinics. However, I did not feel like I could really interview providers while visiting, mainly because conducting interviews would be asking something of them while AAF was there to do something for them. AAF was there to bring joy, celebrate, and help, so asking providers multiple questions about their work during AAF-time felt inappropriate. Providers often participate in research

[17] One of the shows in Milwaukee, WI was a burlesque comedy show instead of the usual comedy show-talkback format.
[18] The Golden Probe Awards was produced and hosted by Abortion Access Force, a 501(c)4 organization related to Abortion Access Front that was closed at the end of 2021.

interviews on top of already hectic schedules, a contribution that is time-consuming and can be emotionally exhausting. After my first tour in 2018, I decided to return to a few clinics at a time that was easier for them and make the process as seamless as possible, a la AAF style.

With the escalation of violence and the popularity of digital technologies, many clinics have established strict security policies (which are covered more extensively in Chapter Two), including policies forbidding phones, bags, companions, etc. There is also a general air of suspicion as a person enters a clinic because it is difficult to know if the person entering is a patient or an anti posing as a patient in order to harass other patients (e.g., a Red Rose Rescue), or even to threaten the clinic itself.[19] The culture of vigilance that often accompanies many providers and people associated with the clinic extends to people's families, friends, and the greater community. In fact, due to a long history of violence at clinics and the ways in which abortion stigma manifests in the interpersonal life of providers, many clinics isolate themselves from their surrounding community.

Because of clinic isolation, one of the greatest barriers for abortion researchers can be connecting with clinics and establishing trust. Often referred to as "vetting," most clinics and providers require a trusted connection to communicate with a researcher, or even a volunteer for that matter. Thanks to my association with AAF, I did not experience access challenges because many clinics know AAF and are enthusiastic about participating in an activity associated with the organization. Almost every clinic I spoke with genuinely loves and appreciates AAF's work and sees it as unique and completely vital.

[19] Red Rose Rescue is an antiabortion group who harasses clinics by posing as patients and then taking over the waiting room. They hand out red roses with messages encouraging patients not to get an abortion and refuse to leave in order to be in "solidarity" with the "unborn baby." I describe Red Rose Rescue in greater detail in Chapter One.

I connected with almost all the clinics I worked with through AAF or an activist or abortion movement professional I met through my work with AAF. Working with these clinics was dependent on their responses to an AAF introductory email, whether I had met them previously in the field before, their availability and capacity, and my availability (which was narrow since I was driving and had to be in specific areas by certain times to meet up with AAF). I prioritized working with clinics in the Midwest and South, clinics I had visited previously with AAF, and clinics that were renowned for various reasons (i.e., had a provider that provided later abortions, had a reputation for having hostile antiabortion activists, etc.).[20] Notably, most clinics AAF partners with are not necessarily the most under-resourced, although I argue that all independent clinics are underprivileged in some way. They tend to be clinics that are already affiliated with National Abortion Federation and/or Abortion Care Network, so they prioritize professional affiliation and can pay the dues.[21] They also usually have the capacity to communicate with organizations, even if it is only one or two.

Most of my visits or revisits to independent clinics for interviews without AAF fall into three main time periods: (1) 7/23/19-8/2/19; (2) 9/8/2019 – 9/13/19; And (3) 9/25/19-11/14/19. During period 1, I visited four clinics in the Midwest. During period 2, I visited two clinics in the South. During period 3, I visited 13 clinics in the south, Midwest, and Southwest. Overall, including my visits with AAF, between 6/29/18 and 11/13/19, I visited 23 independent abortion clinics, engaging five clinics twice.

[20] I am using "later abortion" to refer to abortions that happen in the second and third trimester.

[21] Many clinics apply for and receive scholarships for NAF and ACN membership. To learn more about NAF membership, see "NAF Membership" (n.d.). To learn more about ACN membership, see "Become a Member of ACN" (n.d.).

At the independent clinics I visited during my research, I noticed that many of the components of each clinic were similar. Therefore, I will describe some of the primary elements of the space here for reference throughout the dissertation. One of the most important things to know about the layout is that the variations of type and space drastically affect the access antis have, as well as the overall experience of the staff and patients.

There are three provisional types of clinics: (1) stand-alone; (2) multiplex (a building in a series of office buildings); and (3) office building floor (an office in a large building, usually affiliated with a hospital that one must enter from a lobby and elevator). For each type, the following are important considerations: distance to the sidewalk, parking lot (location, capacity, etc.), clinic entrance vicinity to public space, locked front door, and property owner. The distance from the entrance to the sidewalk and the positioning of the sidewalk to parking are the most important components because sidewalks are considered public spaces and thus are the places where antis can legally walk, run, sit, and block access unimpeded. Additionally, the property owner can be a significant barrier for a clinic if they refuse to rent to or renew a lease based on the protester trouble the clinic attracts. In some cases, they might increase the rental price due to the special status of the clinic, and/or refuse to enforce any trespassing law. For example, at an Alabama clinic, the administrator told me that the police do not enforce the trespassing laws, and a Crisis Pregnancy Center clinic moved in next door because the property owner was an anti.[22]

[22] Establishing outposts next-door to clinics under a similar name is a common antiabortion strategy for CPCs. The location gives CPC volunteers access to abortion patients looking for the clinic entrance; thereby providing an opportunity for CPC volunteers to lead patients to the CPC instead.

Additionally, there are several designated spaces for people outside the clinics. For patients, there is usually an outdoor waiting area where their companions can sit (as the process of getting an abortion—not the abortion itself—can take a long time). Additionally, many companions choose to wait while sitting in their cars. For staff, there is usually a staff parking area and a posted security guard somewhere near the entrance or sitting in a car in the lot. Legal observers usually stick close to the entrance and may walk around to have as much of the property in sight as possible. For escorts, there is typically a space near the entrance, and they walk between the patients' cars and the entrance. For antiabortion protesters, there is the sidewalk, neighboring properties, or buildings (often, antiabortion supporters purchase lots next door to clinics so they can harass patients from close proximity). Sometimes there will be an actual line on the pavement where the state or local buffer law kicks in. At some clinics, antis obey the law and stay on their side; at other clinics they do not.

Inside the clinic, patient-facing, there is usually a waiting room (sometimes two), counseling rooms, procedure rooms, and recovery rooms. Additionally, some clinics have additional rooms for birth control services and/or LGBTQ health services. Staff spaces usually include a medical lab, storage facility, front desk, and billing desk (sometimes these are the same), a break room, and a security room where cameras are monitored by staff and administrative offices.

The reason I am stressing the types of space and ancillary issues is because all these factors determine how much access antis have to the patients, providers, and clinic buildings. Office building clinics and multiplex clinics tend to have fewer problems because the buildings or complexes are usually private property, and it is more likely that an actual office or waiting room will be far from the sidewalk. Stand-alone buildings often have the most difficult problems

with the antis. Clinics want to be near sidewalks and bus stops for patient convenience, yet it makes them more vulnerable to antis. Antis can also easily identify the clinics and often surround them. Additionally, clinics with little parking or far away parking can be most difficult because antis can chase down patients and quite literally block their entry. I have seen this happen on many occasions. Escorts can be especially helpful in these circumstances. However, all things considered, many clinic owners and administrators do not feel like they have many choices at all when it comes to these factors. Ultimately, the architecture of these spaces can drastically affect patients, providers, and escorts' experiences at the clinic.

The Abortion Process/Procedure

There is no single universal experience of providing or obtaining an abortion; each provider and patient has their own experience. However, as this dissertation is about abortion access, I would be remiss to leave out a description of what an actual abortion is. I will provide a very brief overview here. For more specific medical instructions, consult "Abortion Care" on The American College of Obstetricians and Gynecologists website ("Abortion Care" ACOG 2023).

An abortion is the termination of a pregnancy which occurs any time between three weeks since the last menstrual period (LMP) and twenty-five weeks LMP, depending on a person's geographic location (i.e., state).[23] There are two main types of abortion: medication abortion, which is sometimes also referred to as "medical abortion," "pill abortion," or "pharmacological abortion;" and procedural abortion, which is sometimes referred to as "surgical abortion" even though it does not involve surgery. A medication abortion requires that the

[23] Six states have no gestational limits on abortion; however, only Colorado, New Mexico, Maryland, and D.C. have known facilities offering abortions during the third trimester (Guttmacher Institute 2023e).

patient take a combination of mifepristone and misoprostol. The procedural abortion is either dilation and evacuation or vacuum aspiration of the products of conceptions (POC).

The first part of a medication abortion usually occurs at the clinic, and the second part is at the patient's home. At the clinic, patients take mifepristone orally on the day of their appointment and then are instructed to take the second pills, misoprostol, at home the next day. Mifepristone (also known as “Mifeprex” and “RU-486”) initiates the shedding of the uterine lining, as it does during a period, and halts the growth of the pregnancy by blocking progesterone (UCSF Health 2023). Misoprostol (also known as “Cytotec”) causes the uterus to contract and inducts cramping and bleeding (UCSF Health 2023). Within a few hours of taking the misoprostol at home, the combination will cause the products of conception to be expelled. The pregnant person will pass the products of conception (i.e., POC), which they may not even notice depending on the gestational age. They will likely experience severe cramping, heavy bleeding, fever, chills, diarrhea, and nausea. These side effects could linger for a few days after taking the pills. Patients usually return to the clinic two weeks later for an ultrasound to confirm that the pills worked and that they are no longer pregnant.

A procedural abortion happens in the outpatient setting of the abortion clinic. The vacuum or suction procedure is used up until about sixteen weeks of pregnancy and the Dilation & Evacuation procedure is used after sixteen weeks, but both procedures involve the use of suction to empty the contents of the uterus. These procedures usually involve the use of sedation using local anesthetic and oral or IV medication (Paul et al. 2009). The procedure usually takes anywhere from ten to thirty minutes to perform. After providers administer the sedative, they insert a speculum and numb the cervix with local anesthetic (usually lidocaine). The cervix is dilated with thin metal rods, and a thin tube (cannula) is inserted in the uterus. After the

aspiration machine is turned on, gentle suction removes all the POC from the uterus. Patients who opt for sedation usually fall asleep during the procedure; however, many insurance companies do not cover pain medication for abortion, so women with fewer resources tend to opt for no sedation and are fully awake. After the procedure, patients are led to a recovery room where providers monitor their vital signs and give them snacks, and often there are journals from other patients, books, heating pads, and pillows for comfort.

The main difference between the two procedures is that one requires taking pills to induce a miscarriage, whereas the other physically removes the POC. Additionally, medication abortion in the United States can only happen within the first twelve weeks of pregnancy, so if the pregnancy is more than twelve weeks' gestation, a person would need to have a procedural abortion which increases the cost and complexity of the procedure; another reason why timely access to abortion is important. Also, the actual experience in the clinic is different; for a medication abortion, the person must take the first pill under the supervision of clinical staff and receive instructions for the subsequent pills. By contrast, procedural abortions are performed in the clinic. Time is also different, with the procedural abortion procedure taking about ten to thirty minutes and concluded within a single clinic visit and the medication abortion lasting for several hours and typically happening over two- three days. Another significant difference is that, in a clinic a person can receive sedation, whereas at home a person is limited to Tylenol unless otherwise prescribed by a clinician.

Since the reversal of *Roe v. Wade*, there has been a big push to educate people about medication abortion because it is an abortion method that can also be self-managed at home. When people order abortion pills and take them outside of a clinical setting, it is referred to as self-managed abortion (SMA) (Berro Pizzarossa and Nandagiri 2021). Pill delivery services have

been especially important for people who cannot access abortion in their state.[24] People who use self-managed abortion (SMA) have reported that they chose the method because of access issues (i.e. legal restrictions and bans) and/or for privacy reasons (Aiken et al. 2022). However, it is important to remember that many people cannot self-manage based on preexisting health conditions, lack of private space, and gestational age. Further, many people may not be able to access pills, although several virtual independent clinics and pro-abortion websites do a good job of providing them. Regardless of the pros and cons of each procedure, only the patient can decide what is best for them.

I cannot discuss SMA without addressing abortion criminalization. Criminalization of doctors who provide abortion has always been a part of abortion in the United States (C. E. Joffe 1995). However, in the past decade, criminalizing those who seek abortion has emerged as an antiabortion tactic and people have been criminally charged with infanticide, feticide, misuse of medications, and more (Huss, Diaz-Tello, and Goleen 2022).[25] Enforcement of these laws relies on medical and other care staff (e.g. social workers) reports to law enforcement and has fomented fear and distrust of healthcare staff. For example, one of the most well-known cases is the story of Purvi Patel, an Indian-American woman arrested in Indiana after having a miscarriage. Described as "a cautionary tale about what can happen to Black and brown women when they face bias and betrayal by health-care workers who are supposed to help them," Patel's story is emblematic of racist and carceral health practices in the United States (Gandy 2021) In

[24] Some websites with pill delivery services for self-managed abortion (SMA) include: https://www.plancpills.org/ and https://consult.womenhelp.org/en/get-abortion-pills. Several independent clinics also have online pill delivery services, but since they are medical providers, they are not technically included in the SMA category. To see more about ordering pills online, see McCann (2023).

[25] Although abortion criminalization has become more visible in mainstream news in the past decade, people have been criminalized for abortion since the 1700s. The volume at which abortion has been criminalized has rapidly increased. For instance, Pregnancy Justice has documented roughly three times as many abortion criminalization cases from 2006-2020 compared to 1973-2005 (Pregnancy Justice 2022, 5).

Patel's case, health providers at the hospital reported her miscarriage circumstances to the police, who arrested her for an illegal self-induced abortion, and the local government sentenced her to twenty years in prison for feticide and neglect of a dependent (Gandy 2021). Over a year later, a judge overturned her sentence and reduced her prison time to eighteen months; she was immediately released for time served (Cooney 2016). Researchers have also found that women of color are more likely to need SMA due to obstacles to access abortion (Huss, Diaz-Tello, and Goleen 2022). Further, women of color who use SMA (or experience a miscarriage that reads as suspicious to providers) are more likely to be prosecuted for it (Pregnancy Justice 2022, 5).[26] So, even though pro-abortion websites and virtual clinics provide abortion pills for self-management, many individuals, especially women of color, can be prosecuted after using this common, safe, and effective method.

When I observed abortions, the simplicity and ephemerality of the procedure struck me. With all the stigma and cultural hoopla, I had thought it would be more involved. As Joffe and Cohen remind us, not only is abortion a simple procedure, but it is fourteen times safer than childbirth (Raymond and Grimes 2012).

Research Methodology

To investigate how terror manifests at the abortion clinic, I apply a critical feminist interdisciplinary approach that relies primarily on feminist ethnography. I look to Ruth Behar and Deborah Gordon's working definition of feminist ethnography as one that commits to feminist textual innovation and analyzing relationships across differences. After describing the

[26] Pregnancy Justice reports that women subjected to pregnancy-based prosecutions and forced medical interventions are overwhelmingly low income and people who use drugs, as well as disproportionately Black and Brown (2002, 5).

1988 debate between Judith Stacy and Lila Abu-Lughod about whether there can be a feminist ethnography, Behar and Gordon settle on Kamala Visweswaran's definition of feminist ethnography as a "project bridging the gap—to which writing culture had so bluntly drawn attention—between feminist commitment and textual innovation" (Behar and Gordon 1995, 14). They specifically reference *This Bridge Called my Back: Writings by Radical Women of Color* to assert that feminists of color have been particularly influential in conceptualizing approaches to feminist ethnography, particularly when it comes to closing Visweswaran's "gap," while attuned to the "relationships between women across differences of race, class, and privilege" (Behar and Gordon 1995, 15, Moraga, Anzaldua, and Bambara 1983). Feminist ethnography enables me to conduct a reflexive research project by guiding me to question where my responsibilities lie as a feminist researcher and how I can most ethically conduct research, and helping me identify the potentialities to contribute to activism and social justice through my work.[27]

Not unlike feminist ethnographers researching reproductive and sexual health before me, I employ an interdisciplinary approach to abortion access. However, unlike most scholars in my field, I explicitly draw on both public health and performance studies research. I summon health research into conversation with the critical humanities (i.e., performance studies, anthropology, and gender studies) to analyze, theorize, and discover practical implications for reproductive and

[27] By arguing that applying "ethnographies of the particular," an acutely reflexive strategy, can minimize the distance between the ethnographer "self" and cultural "other," Lila Abu-Lughod trailblazed a pathway for feminist ethnographers to conceptualize reflexivity that invokes accountability and action based on their positionality (Abu-Lughod 1991, 472). In her generative essay, "Writing Against Culture," Abu-Lughod criticizes *Writing Culture* authors James Clifford and George E. Marcus's for neglecting to include feminist ethnographers as textual innovators. In fact, Abu-Lughod, along with many others including Behar and Gordon (1995) assert that women ethnographers have used textually innovative methods for decades—yet they remain unrecognized due to male hegemonic power in the field of anthropology. The conversations which emerge among these scholars query how contemporary feminists can best practice reflexivity and contribute to combating structural oppression through their choice of research topics and respective methodologies. Ultimately, they contribute to a rich body of research on feminist methodologies at a critical moment, which guides my own research.

sexual health education and advocacy initiatives in the United States. I employ this approach because I believe working interdisciplinarily between public health and the critical humanities is one of the most effective ways to conduct research and advocacy regarding health inequities. Discourses in each field provide insights and simultaneously fall short when it comes to analyzing abortion access and arts activism. While the public health literature features empirical data about abortion, it misses a robust application of feminist and performance theory to abortion and notions of abortion access. Additionally, this data frequently focuses on population-level statistics of women who have had an abortion rather than emphasizing actors at multiple levels of abortion access, such as abortion providers. Significantly, the literature also fails to explore arts-based approaches to educate on, advocate for, and destigmatize abortion. On the other hand, performance studies have a rich history of applying critical theory to art activist projects but lack specific analyses of abortion and abortion-related performances. Performance studies approaches also do not typically explore the specific pathways for structural change—for example, they do not usually engage with the bureaucratic processes of educating and advocating for change on a large scale. I affirm that concepts, tools, and discourses from each field complicate and expand our knowledge about abortion access and the ways in which that knowledge can be used to advance reproductive justice.

Because I am referencing and conducting some quantitative research in sexual and reproductive health, I must stress that I am not relying on a positivist framework to analyze health data, but rather rely on an intersectional feminist perspective as described by health researchers Amy Schultz and Leith Mullings (2005). For Schultz and Mullings, an intersectional feminist approach is crucial for public health research. Developed by Black feminist social scientists seeking to counter essentialist assumptions of early second-wave feminist approaches,

a feminist intersectional approach for public health research focuses on women of color and empowerment of oppressed groups; describes race, gender, and class as culturally-specific social constructions; analyzes health considering multiple levels of power relations; emphasizes the connections of inequalities (instead of hierarchized differences which tend to rank inequalities); and engages in a range of activities to foster interdisciplinary collaborative research in order to understand dimensions of health differences (Schultz and Mullings 2006, 33–34, 37, 40, 43).

Feminist ethnographers Davis and Craven stress the importance of using research to advance social justice. They note that policymakers often perceive academic research as more rigorous than research presented by political campaigns (Davis and Craven 2011, 198). They argue that by using the cultural capital of academia, feminist ethnographies have the potential to legitimize social justice issues further (Davis and Craven 2011, 198). They explain that generating both qualitative and quantitative data enabled them to advocate for the needs of the most marginalized within their respective grassroots movements. Using their research as examples, they demonstrate that feminist ethnography has the potential to "counter neoliberalism's apolitical stance and its tendency toward reductive individualism and faulty dependence on objectivity," as well as its global effects of increasing inequalities (Davis and Craven 2011, 191). Using a feminist interdisciplinary approach, I aim to generate research that abortion rights organizations such as the Abortion Access Front and independent abortion providers can use toward reproductive justice—which is more critical in the current political context than ever.

Methods

Specific ethnographic methods I use include participant observation, interviews, questionnaires, and performance analysis. As my project focuses on the Abortion Access Front and independent

abortion clinics, most of my ethnographic fieldwork utilizes participant observation and interviews. Participant observation on tour entails caravanning from city to city, staying at the same hotel (or Airbnb), and assisting with all activities. Tour activities include: attending daily morning strategizing meetings, running show errands, show tech assistance (i.e., staffing the merchandise table, collecting donations, and setting up/breaking down), visiting independent abortion clinics, volunteering at partner independent abortion clinics, participating in their Human CPC Direct Action[28] and mission-related protests, socializing with local feminist activist groups, and counter-protesting the annual Operation Save America[29] summer convention. Additionally, it also includes joining them on road pit stops along the way. For instance, in 2018, I joined AAF on a visit to The Creation Museum, an anti-evolution museum in Petersburg, Kentucky.

My main modes of data recording on tour consist of fieldnotes, photos, and social media (both mine and AAF's). I recorded daily fieldnotes in a notebook (and when holding a notebook was not feasible, I texted abbreviated notes (or what Sharlene J. Hesse-Biber calls "jottings") on my phone (Hesse-Biber 2014). AAF granted me permission to take photos of the shows and behind-the-scenes shots, as well as everyday moments. In return, I have also granted them permission to use any of my photos in their materials, and they have done so. Additionally, AAF

[28] AAF's "Human CPC Direct Action" is a participatory theater piece performed in heavy foot traffic location. AAF recruits local feminist activists (and in this past summer's case, me) to wear costumes, which when worn together, form a human CPC. The main aim of the piece is to educate people about CPCs in general and specific CPCs in their local community. AAF also hopes that people will take action to expose CPCs based on the information they provide as part of the #exposefakeclinics campaign. To see a recording of the skit, see "Human Fake Clinic Theatre Piece in Washington Square Park"(Abortion Access Front 2018).

[29] Operation Save America (formerly known as Operation Rescue) is a national fundamentalist Christian antiabortion organization. This organization enthusiastically spouts anti-Muslim and anti-LGBTQ vitriol too. The organization consists of almost all white members, with a male majority. Many of their leadership (all male) have been convicted of crimes related to their protest activities. They are the organization who hosts the annual "summer of justice" described at the beginning of the introduction. I detail more about the group in Chapter One.

documents their own work on the Abortion AF tour meticulously on their shared Google drive and social media. They shared their Google drive with me, and I follow them assiduously on their Instagram and Facebook pages. Along with my fieldnotes, I tracked relevant photos and media as part of my fieldwork, such as social media posts and captions that capture pivotal tour moments. In addition to the Abortion AF Tour, I joined AAF for other significant events, such as the Golden Probes Awards Shows (2018), the Abortion Care Network Conference (2019), countering the National March for Life (2020), and countering OSA in Phoenix (2021).

Participant-observation at clinics included volunteering as an escort and observing the antiabortion protesters, sitting in a waiting room or common area of the clinic, and observing the clinic's workflow; and touring the clinic, noting observations of artwork, resources, and clinic layout. During these observations I took copious field notes or jottings depending on the setting. I also took photos inside clinics with permission and videos of antiabortion protesters. I mention these observations because they will be used in the analysis phase.

To analyze everyday life at the clinic and AAF's comedy shows, I used performance analysis. I examined the gestures, self-presentation, content, and rhetorical choices of antiabortion protesters, escorts, providers, and comics. I took notes during the live comedy shows, primarily stand-up comedy sets, in my notebook and analyzed any filmed sets afterwards. When available, I conducted semi-structured interviews with clients before or after their set (described above as AAF members). In addition to closely paying attention to comics, I also paid close attention to myself—especially when I was participating in a theatre performance such as the Human CPC Direct Action. As an explicit "co-performer" in these actions, I attuned to my own embodied experience—emotions, thoughts, and physical sensations, including comforts and discomforts (Conquergood and Johnson 2013).

Insights and methods from scholars in humor studies buttress my performance analysis.[30] Specifically, they help me analyze how humor works through stand-up comedy mode in the context of their comedy tour. Influenced by Joanne R. Gilbert's (2004) concept of performing marginality, I pay particular attention to the potential healing capacities of stand-up comedy performance.

Data Collection

To investigate providers' experiences of working at independent abortion clinics, I developed semi-structured interview guides. Guides went through multiple rounds of review by me, Dr. Jessica Gipson, and colleagues who interview abortion providers in a clinic setting. The guides intentionally began by prompting interviewees to describe their daily routine, what brought them to abortion work, and what keeps them in abortion work. These questions led to many stories and heartfelt statements. Some interviewees apologized for being "emotional" and mentioned that it was nice to get to talk to someone about their work because in their personal lives, they do not feel like they can. The guides were not piloted due to time constraints but were flexible, allowing me to adjust based on emerging findings.

Clinics were chosen based on their availability and willingness to participate. Connection with clinics was facilitated by Abortion Access Front and a contact from National Abortion Federation, who sent out my recruitment email to their independent clinic contacts. Overall, I reached out to thirty-four clinics and ended up visiting nineteen based on the availability and capacity of the clinic. All interviews took place in private spaces at the clinic (e.g., empty

[30] Humor studies is an interdisciplinary humanities field comprised of researchers from communication and performance studies, as well as anthropology. I will particularly focus on/be informed by scholars investigating stand-up comedy.

counseling offices or empty break rooms).[31] Participants were selected by the clinic director or recruited by me upon arrival. Once one interview ended, I asked the participant to alert the next interviewee on the list. Clinics are often hectic work environments with no set schedule because they cannot anticipate what their days will look like. I prioritized showing up to the clinic and making it as seamless for the interviewees as possible.

Interviews were facilitated by me and lasted between twenty minutes to two hours, depending on the participant's availability and enthusiasm. As I guided the interview, I also recorded the interview and took notes. After each interview, I asked participants a brief series of demographic questions, which I told them were optional to answer. Participants were also given the choice to remain anonymous or be identified as part of the study. Although many participants selected that they could be identified, I chose to identify most participants using generic terms based on the region where they worked (i.e., "a provider from the Midwest). I gave some providers pseudonyms generated by an online name generator (except for interlocutors who were public figures). Additionally, I identify their clinics geographically by saying a clinic in the Midwest, Southeast, etc. I called my committee chair, Dr. David Gere, approximately every two weeks to discuss my emerging findings.

At most clinic sites, I also administered an Abortion Provider Stigma Survey (APSS). This thirteen-item scale is comprised of three domains: disclosure (seven items), resilience (four items), and discrimination (two items). The scale includes items both positively and negatively worded, each with five-point Likert scale response options ranging from "Never" to "All of the time." Selected items are coded 0-4, with higher values corresponding to higher stigma. Once

[31] Interviewing providers in private was important as participants frequently discussed sensitive topics based on their personal and work experiences.

standardized, the full APSS scale ranges from 0-52, with varying maximum subscores for each domain (disclosure max = 28; resilience max = 16; discrimination max = 8).

I administered the APSS scale to 128 participants who worked in various capacities at twelve independent abortion clinics in nine states. Clinic employees were given verbal and written information about the study and provided verbal consent to participate in the anonymous survey. When staff consented or completed the surveys, clinic directors were absent and were unaware of who participated. The survey took approximately ten minutes to complete. The inclusion criteria were that participants were A) employed by the clinic and B) could read and write in English. Participants per clinic ranged from three to nineteen people.

To measure the impact of the AAF comedy show, I disseminated a ten-item, retrospective questionnaire, which consisted of validated scale items from Cockrill et al.'s Individual Abortion Stigma Scale (Cockrill et al. 2013), a three-point retrospective scale, and short answer questions. The questionnaire aimed to glean audience members' perceived knowledge, attitudes, and intended behaviors before the show compared to after the show. It asks questions such as: "On a scale from low to high, how comfortable would you say that you are saying the word 'abortion?'" And "On a scale from low to high, with low being unlikely to contribute to a local abortion provider in at least one concrete way (e.g., donation, volunteer, host event) and high being very likely to contribute to a local abortion provider in at least one concrete way (e.g., donation, volunteer, host event), how likely are you to contribute to a local abortion provider?"

Piloting the ten-item tool as a post-retrospective questionnaire, I gathered n=50 responses and am currently calculating the results. Recruitment was established by self-selection and was relatively seamless. It took respondents anywhere from five to twenty minutes to complete the questionnaire.

Research Populations/Interlocutors

The primary populations for this research were: 1) abortion providers, 2) volunteer clinic escorts, defenders, and activists, 3) Abortion Access Front staff and affiliated stand-up comics, 4) abortion movement workers, and 5) abortion researchers. I detail brief descriptions of these interview populations below, noting some demographics.

I define abortion providers as anyone whom the clinic employs. This includes physicians, administrators, nurses, patient counselors, medical technicians, sonographers, patient advocates, phlebotomists, and other clinic staff. I deliberately made this choice because much of abortion research is about physician providers, and I think it is important to include all staff who provide abortion care and deal with daily harassment as "providers." Additionally, Abortion Access Front, who introduced me to the abortion world, defines providers in this manner. The sample of provider interviews I analyzed for this dissertation is a sub-sample (n=40) of a larger data set (n= 85). I narrowed the sample by eliminating any participant who has worked at their clinic for less than five years. I limited the sample this way because experienced providers have worked in abortion through political changes.

Before and after my interviews with providers and during my volunteer escort shifts, I informally spoke to countless volunteer escorts. In short, clinic escorts are volunteers who direct patient parking and entry, offering accompanying patients to shield them from antiabortion protesters. I met escorts on the spot upon my arrival and through AAF's abortion activist network. Most escorts were white, and almost all escorts presented as assigned female at birth and identified as either female or non-binary. At all the clinics I visited, only one clinic had more than one male escort. Several escorts identified or presented as queer. The volunteered for varying amounts of time, from several months to several decades. Their reasons for volunteering ranged from past abortion experiences to growing up with antiabortion parents to feelings of

wanting to contribute after the (2016) Trump election. Out of all of the populations I worked with, escorts knew the most about antis in general: their local protesters or "regulars," the legal landscape, and national pro-abortion (and adjacent) networks. After my introduction to a network of escorts at the 2019 Garbage Fyre Festival organized by AAF, I developed personal relationships with multiple escorts with whom I remain in regular contact.

The research population I spent the most time learning from was Abortion Access Front staff and affiliated stand-up comics. Although I have no formal, recorded interviews, I absorbed information from them constantly—during long road trips, over cigarettes and rosé, and in the middle of safety scares. I have endless field notebooks brimming with stories about antis, how they came to abortion activism, what it's like counter-protesting, and memories of their own abortions. I have also kept in touch with several members from the tour and consider several to be dear friends.

AAF employs stand-up comics in Lizz Winstead's network. Most of the comics identify as feminists and range in age, race, gender identity, and class. AAF intentionally seeks to feature comics from marginalized groups such as queer, Black, and trans comics. For each show, they usually showcase a local comic in addition to a nationally well-known comic. Some of the comics who have performed at AAF events in the past include Sarah Silverman, Lea Delaria, Maysoon Ziad, and Greg Proops. During my fieldwork, I informally interviewed several comics on tour and formally interviewed five, including Sarah Hartshorne, Joyelle Johnson, and Mehran Khaghani.

Last, I interviewed a few abortion or pro-choice movement workers and researchers. These interviewees work primarily for non-profit political and support organizations that advance abortion rights and access and university research centers. The movement workers

provided information about collaborating with clinics and supporting patients; and they offered a broad perspective on national abortion networks. The researchers provided insight on the scope and history of abortion in the United States and the politics of conducting abortion research. I interviewed five abortion researchers who work at an abortion research center in a West Coast city.

Limitations

While the findings from this sample of abortion providers are not necessarily generalizable to all abortion providers, the in-depth ethnographic methods used in this study provide "thick" description of provider experiences to help us better understand barriers and facilitators to abortion access (Geertz 1973). This study has two primary potential pitfalls: (1) potential selection bias; and (2) researcher positionality. Participants may have selection bias based on my low barriers for inclusion and informal recruitment methods for a convenient sample. My sample may include people who self-selected because they wanted to contribute to abortion research. However, participants seemed diverse in their views about the Abortion Movement and research. Additionally, some participants were not self-selected but chosen by clinic directors for various reasons, including staff availability. When it comes to my own positionality, I must acknowledge that I am very immersed in the independent abortion provider community based on my extensive research and participation with Abortion Access Front, the breadth of my research, my attendance at independent provider events, and my experiences escorting at multiple clinics. This is a strength for this project because it contributes to my seamless rapport with several participants. However, it also requires that I examine and reexamine my reflexivity to ensure I am not superimposing my feelings on the data. Additionally, I reduced this possibility by

developing a codebook with the assistance of Dr. Lori Freedman, a researcher who is not as immersed in the independent abortion provider community as I am.

Positionality

Feminist scholar Joey Sprague affirms that, when conducting feminist research, it is crucial to acknowledge one's standpoint and account for any biases. She describes that a standpoint is not the "spontaneous thinking" of a person, but the "combination of resources available within a specific context from which an understanding might be constructed" (Sprague 2016, 41). Consisting of a "specific matrix of physical location, history, culture, and interests" that changes based on location, one's standpoint is never static (2016, 41). Others describe a standpoint as one's positionality and stress its importance when conducting a feminist ethnography. Here is mine.

I am a white, cisgender, lesbian performance studies and public health scholar. As a graduate student at a prestigious university, I have both class and educational privileges. Additionally, I am a U.S. citizen during a time when Immigration and Customs Enforcement (ICE) tortures, deports, and threatens my undocumented colleagues. Due to these privileges, I have access to many systems of knowledge. These privileges also afford me the opportunity to research a stigmatized topic without compromising my citizenship, professional aspirations, and personal relationships. Specifically, I could be in high security or highly policed environments without fear that I would be unjustly arrested or physically assaulted by the police. More, if I was arrested, I knew my family support could pay for bail, lawyers, etc. My access based on my race, citizenship, and class background guides my reflective process.

My relationship to abortion: I have not had an abortion. However, I'd be hard pressed to name a friend or family member of mine who has not had one. Growing up, I always knew if I

accidentally got pregnant, my parents would support my decision to get an abortion (not to mention, at the time, Georgia had significantly fewer abortion restrictions than it does today). Throughout high school and college, several of my friends confided in me that they had had an abortion. As I began to engage in this work and talk about it with friends and family, even more women disclosed to me that they opted for abortion. Stemming from my feminist politics, to my decision long ago that I would opt for abortion if I needed to, to the many women in my life who have had abortions, to my newly made friends who provide abortion, to my informants, the Abortion Access Front who advocate for abortion—I wholeheartedly believe in abortion rights and justice for all people. This is a bias that fuels and characterizes my work. And, it is a bias I will continuously need to reflect on throughout my research process.

Chapter Outline

In order to investigate the relationship among terror, stigma, and access, my dissertation explores three primary research questions: (1) What is the experience of providing abortion at independent clinics like?; (2) What are the experiences of accessing abortion at independent clinics like?; and, (3) In addition to legislative advocacy, what are some of the ways in which activists/advocates/public can confront/interrupt/mitigate the terror surrounding abortion (or support their local clinics to expand/make more equitable abortion access)? [32] To answer these questions, I have divided the dissertation into three main parts: Part One: Remembering Terror to explore question one; Part Two: Performing Terror for question two; And Part Three: Confronting Terror for question three. Each part has its own corresponding chapters.

[32] Notably, I did not interview patients themselves, but I observed them as part of participant-observation research. I also learned much about patient access from providers during interviews.

In **Part One: Remembering Terror,** I investigate the histories of violence at the clinic, ask how they compose the collective memory of terror, and explore the ways in which independent providers respond to them. In **Chapter One: The Collective Memory of Terror,** I establish the collective memory of terror as extreme violence (i.e., murder of doctors), and the everyday actions of violence that have historically occurred (and continue to occur) at the clinic, reinforcing the clinic as a site of potential danger. In **Chapter Two**: **The Security Culture of Clinics**, I discuss clinics' current security culture, including their practices and significance. I explicitly take a Foucauldian route to theorize the security culture at clinics and discuss how this setting affirms and challenges previous thought on security, policing, and the state. I also include interview material from providers about how they feel about security to introduce the concept of the "security bind," which I conceptualize as the impossibly difficult position where they must police and infantilize their patients to ensure the continued existence of the clinic.

In **Part Two: Performing Terror**, I address performances outside of the clinic, drawing primarily from my ethnographic experiences as a clinic escort. I argue that antiabortion protesters perform various sensorial and symbolic assaults on the clinic staff, patients, and escorts at the clinic every day. I claim that these performances occur in the realm of terror and that they should be considered seriously. I demonstrate the experiences of this violence by taking a phenomenological approach describing the visual (**Chapter Three: Antiabortion Aesthetics of Deception**), aural (**Chapter Four: Antiabortion Sounds of Violence**), and choreographic (**Chapter Five: Antiabortion Choreographies of Aggression and Domination**) realms of the clinic landscape, and the performances which vivify them. I ultimately question the notion of protester engagement and introduce potential discursive or performative strategies to mitigate the terror at the clinic.

And in **Part Three: Confronting Terror**, I take a deep dive into how the non-profit organization Abortion Access Front uses humor to confront antiabortion terror and support independent clinics (**Chapter Six: Showing Up Abortion AF**). I examine how AAF creates counter-protest strategies, street theater skits, and comedy shows to educate the public about antiabortion terror, empower themselves, and advocate for abortion rights and access. I also demonstrate how, ultimately, AAF exemplifies a performance approach to destigmatizing abortion to improve access.

When I started this research in 2017, abortion access was already extremely precarious---especially for low-income women and pregnant people living in the Southeast and Midwest. Currently, since the overturning of *Roe v. Wade*, abortion access is in complete crisis with clinics, many of which I have visited, closing rapidly state-by-state. Research that documents the independent clinic provider landscape pre-June 2022 is crucial to understanding contemporary abortion discourses and actions the public can take to support abortion providers and people seeking abortion in their respective communities.

PART ONE: REMEMBERING TERROR

You know, we had the fire where we lost everything essentially. I don't think there's a day that I don't think about that. I know there's not a day that I do not think about George.

--Dr. LeRoy Carhart[33]

Contextualizing pro-life protest activities forces us to conceptualize these tactics as more than unconventional political tactics. The inflammatory rhetoric and extreme forms of violence (occurring at the national level) create an atmosphere of reasonable fear among individuals affiliated with clinics (at the local level), even if their objective probability of being a victim of extreme pro-life violence is minimal.

--Aleisha Doan

Bellevue, Nebraska
August 2, 2019

I pry the heavy, grey bullet-proof door open and enter a small room. I have left my backpack in the car because entering a clinic with any bag can cause immediate suspicion. Behind the thick, bullet-proof glass, the receptionist asks why I am here. I sheepishly respond, "I am a friend of Michael's, and I am here to escort and conduct interviews." The woman nods. "Oh yes, he told me about you. Take your keys and phone out of your pockets and enter here." She indicates the metal detector. I am nervous about going under it. Even though I know I do not have any weapons, going through a metal detector makes me feel like I have done something wrong. I think, "What if I forgot something metal and it beeps, and they think I am dangerous?" I inch under the detector into the waiting room. *Beep!* I panic. I think my AAF leather cuff must have set it off. I look at a sea of confused faces in the patient waiting room. The next thing I know, Michael has come to save the day. I apologize profusely, show him the metal screw in the leather cuff, and he tells me not to worry about it. He tells the receptionist that all is fine and whisks me down the hallway toward the interview room.

Until today, entering a clinic using a metal detector would have been a novel experience for me. I would not say I like it, but knowing the history of abortion clinic violence helps me

[33] Sadly, Dr. LeRoy Carhart passed away during the writing of this dissertation. I am incredibly grateful to have met him and visited his clinic. His kindness and dedication to reproductive autonomy has touched the lives of many throughout the decades, including me (Traub 2023).

understand it. Many abortion clinics have metal detectors and several other security measures. Security is critical at this clinic as it is one of only two clinics in the state. Security is also vital here because it is Dr. Carhart's clinic, who is a later abortion provider and as such is one of the most targeted abortion providers in the country.

As Michael leads me down the hallway, I notice several hand-painted portraits of horses lining the walls. They are large, about two by three feet, enclosed in thick wooden frames. There are many of them; I would later learn twenty-two. On the other side of the hallway is a panoply of various framed photographs and documents. Finally, we pass a large display of handwritten thank you cards, at first glance more than fifty.

Inside the interview room, there is a desk and some scattered chairs. Artwork, photos, and framed documents fill the four beige walls. I immediately feel comfortable recognizing a horizon of familiar abortion-positive artwork and sayings, such as images from the "Shout Your Abortion" campaign, such as "Abortion is normal," and "Our stories are ours to tell." One framed document appears to be a poem. However, as I inspect it more closely, I realize it says "Dr. Tillerisms" and is not a poem but a list of lines he used to say, such as, "You can change the world—if you do not take credit for it," "When you have to eat 'crow,' chew rapidly, and swallow quickly—it does not taste too bad," and "The only requirement for evil to triumph is for good people to do nothing." Above that dangles a button that reads "attitude is everything," and, in smaller letters around it, "In loving memory of George R. Tiller MD." My heart sinks as I exhale a sigh and remember Dr. George Tiller. Tiller was a leader in the abortion provider community and a beloved physician brutally murdered by an antiabortion terrorist at his church in 2009.

As I continue to take stock of the room, I notice two large posters with close-up portraits of Dr. Tiller. One portrait is formal, with Dr. Tiller clad in a black suit. A dove with an olive branch rests below the date. Then, along the bottom, in more giant letters, it includes a Dr. Tiller quote: "Abortion is not a cerebral or reproductive issue. Abortion is a matter of the heart. Until one understands the heart of a woman, nothing else makes sense about abortion at all. George R. Tiller M.D." The other shot is casual with a friendly-looking Tiller wearing a blue t-shirt and donning a button that says, "attitude is everything." The caption reads: "Rest in peace 1941-2009." I feel crestfallen remembering the film that featured his life and legacy, *After Tiller* (2013). The film includes montages of Tiller with the other later abortion doctors he trained, including Dr. Carhart. The group of physicians emanates an unmistakable bond. They tell stories of Tiller's humor, wit, and tenacity— sometimes laughing and sometimes teary. I wonder what Dr. Tiller would think of abortion access today.

The images and words of Tiller prompt me to reflect on the clinics I have visited so far, the providers I have met, and the patients—especially those who affirm that their abortion saved their life. The heaviness of these memories weighs on me, and then I laugh at the painting that says: "If it feels good, do it." This is how abortion research feels: highs, lows, and the more people I meet, the more stories I hear, the more determined I am to contribute to the work. I smile and sit at the desk, but I am still puzzled over the horse portraits.

Later, when it is time for my interview with Michael, I chuckle and ask him, "Ok, so what is with all of the horses?" He gives me a sympathetic half-smile and then says: "The horses, like from the barn, the barn that was burned down by the antis." I immediately cringe. I cannot believe I did not connect that horrific story with this clinic. He continues: "There is a portrait for each horse who was murdered." I flashed back again to a scene from *After Tiller* when Dr. Carhart explains how the antis burned down his barn, murdering his beloved horses, and he feared, at the time, his daughter as well. Thankfully, she was not in the barn when it happened. All that was left was death and the note justifying the murder of abortion providers.

We continue to discuss targeted terrorist acts aimed at Carhart, and I add, "I also noticed that there are several photos of Dr. Tiller." Michael responds, "Well, yes. He was Lee's best friend. He talks about him all the time." We both pause for a moment. We continue to discuss the losses and challenges Dr. Carhart and other physicians have faced providing this vital healthcare service. It makes me think about how Tiller came back to work the next day after being shot (the first time; the attempted murder), and how Carhart, too, went back to work the next day after the fire. At that point, he was only doing abortions part-time, but after the fire, he made it his full-time job.

* * *

Terror is part of the everyday lives of abortion providers. The murderous histories surrounding providers hangs in the air at every clinic, prompting action, fueling motivation, and shaping the emotional landscape of abortion work. Most clinics do not have as many direct references to the murderous past as Dr. Carhart's does, but many keep a remembrance for George Tiller somewhere. Several providers mention him by name in their interviews, comparing their clinics to his clinic or their realities to his. He was a leading voice among abortion providers and is genuinely, deeply missed.[34] But Tiller is also not the only U.S. abortion doctor who has been murdered. So far, the murder of eleven U.S. abortion providers have been documented, and there have been twenty-six attempts to murder doctors, clinic staff, and others. In addition, between 1977 and 2021, there have been 472 clinic invasions, forty-two bombings; 196 arsons; 100 butyric acid attacks; 663 anthrax and bioterrorist acts; 652 instances of stalking; four kidnappings; and 1,064 clinic blockades (National Abortion Federation 2022). The extreme

[34] The story of Dr. Tiller's work and murder are well documented in the film *After Tiller* (Shane and Wilson 2013).

violence is real and has persisted throughout the decades (Doan 2007, 23–24; National Abortion Federation 2022, 14). Even if extreme violence is not ever present, the reminder of extreme violence and the consistent presence of antiabortion protesters is a constant reminder of the grim history and contemporary reality.

Additionally, although most clinics I visited did not have metal detectors, many do, along with multiple and sometimes elaborate security measures. Much of how providers talk about safety, their fears, stigma, security, and everyday actions and challenges in the clinic rely on the history of what I call the "collective memory of terror."

But before I go any further, first, a word on "terror" and "terrorist." I investigate the term "terror" in a more nuanced manner in the introduction to the dissertation. However, I want to clarify that, in this chapter, I use "terrorist" and "antiabortion protester" interchangeably—not because I think that the individuals who perpetrate extreme violent acts are the same as the so-called "peaceful protesters," but to draw attention to the reality that when one considers the historical context of terror at the clinic that I am about to lay out here, there is no "peaceful protester." All actions that can be defined as protesting also exist on a spectrum of violence. Sometimes I use "terror" to describe this, and sometimes I do not.

Additionally, I am not the first person to refer to "antis" or "antiabortion protesters" as "terrorists." My first lesson in this shift in language was from Lizz Winstead, the founder, and director of Abortion Access Front, who took me aside early in this research and told me, "Don't call them pro-life; they are not pro-life. They are terrorists." Additionally, other scholars have long used these terms, including Philip Jenkins, who chronicles one of the first uses of "terror" in relation to abortion. He explains that "terror" was first used by an Alabama newspaper to

describe the activities of antiabortion protesters after a clinic bombing. They used "the face of terror" to describe a nurse whose face was severely maimed in the bombing (Jenkins 1999, 319).

Jenkins criticizes journalists and academics for not using "terror" language to describe these acts more consistently. He explains that "terror" language was not used earlier because antiabortion terrorist acts were falsely constructed as unrelated phenomena. More, the politicians in charge of this type of language delegation were politically right-leaning (Jenkins 1999, 321, 325). He explains that with the election of Bill Clinton in 1992, the antiabortion labeling rhetoric shifted to include terror (Jenkins 1999, 320). Additionally, in 1999, Jenkins made a point that is now prominent in the pro-abortion zeitgeist: he insisted that antiabortion terror parallels white supremacy and white supremacist movements of the time. In fact, many in the pro-abortion movement currently (2023) contend, and rightly so, that the reluctance for antiabortion protesters to be labeled as terrorists is at least partly due to the fact that the vast majority of protesters are white. Therefore, I will continue using the word "terror" to describe their intent and activities.

From the instances of extreme violence, such as the murder of Dr. George Tiller, to the everyday violence outside clinics, antiabortion protesters perpetuate terror and have done so since the 1970s. Providers, escorts, and pro-abortion movement members remember this history, sometimes daily. For example, writing about antiabortion terror as a public health epidemic, Russo et al. explain how, "even minor harassment implies the threat of murder, given the history of violence in the United States" (Russo, Schumacher, and Creinin 2012, 556). I felt this in the field; every time I saw a protester or a photo of a murdered doctor, I remembered the threat and felt it in my body. I call this the activation of the collective memory of terror.

I use the term "collective memory" because this history and its memory initiation rely on the shared historical knowledge of abortion providers, escorts, activists, and allied non-profits

more broadly. As others have argued, shared memories are an important part of group identity formation, and in this case, the group identity of abortion providers and others who work and volunteer at abortion clinics (Hirsch 2008). Knowing the history of terror and acknowledging it rhetorically often facilitates trust among providers and allies. It can also serve as proof of membership. For instance, introducing myself upon arrival without any bags or phone in hand was one of the ways I demonstrated my knowledge of this history to the Nebraska clinic and other providers I met.

The history of terror was a constant presence at the clinics I visited, whether more obviously, like the clinic I described earlier with the numerous pictures and memorials for Dr. Tiller, or more tacitly in a passing comment or suspicious glance. Even the providers who insisted they had no fear or did not think about safety often engaged in several activities that acknowledged these security threats. In my interviews, many providers disclosed that when they saw a protester as they arrived or were involved in a recent active shooter training, they remembered their work's history and dangerous realities. Some providers also told me that they were incredibly anxious if there was something in the news or if they knew of an attack in another clinic. Viewing and discussing violence and experiencing protesters upon entry prompted a remembering of the threat. Thus, this memory of terror and its history is inextricably bound to social processes, as memory scholar Elizabeth Tonkin and others have argued (Tonkin 1995; Connerton 1989).

When I asked many providers about their fear for their safety, they responded that it was "not that bad" compared to the 1990s when multiple doctors were shot in a short period of time. Alternatively, when I asked if their community supported the clinic, one provider told me that she felt pretty lucky that her community supported them, unlike Dr. Tiller's community. Also,

when I asked about challenges, many providers responded that their challenges were not as inhibiting compared to other clinics where more extreme threats of violence or actual violence had occurred. Nevertheless, when probed, these providers shared their experiences of significant challenges, including multiple safety breaches and unsupportive communities. Yet, they were unlikely to frame their persistent barriers in this way because they compared their everyday experiences to the history of murdered doctors. Tonkin also argues that memories and histories are mutually constructed, so the current context of violence also shapes the history of violence. The past and present are interwoven.

Memories of this history of violence are particularly vivid for clinic staff as they enter their workspaces. I noticed that I often thought about the history of violence when I was in the clinic space itself. This, too, illustrates what memory scholars assert—that space is central to memory-making and remembering (Tonkin 1995; M. N. Roberts and Roberts 1996; Connerton 1989). Experiencing space often signals memory as sensory knowledge that is place-specific.

More, the pictures of Dr. Tiller in the abortion clinic did not simply symbolize a history, but it made me feel the memory of him and the fear that still accompanies abortion work. Allen F. Roberts and Mary Nooter Roberts remind us that visual representation is central to memory work; that images and artifacts can spark mnemonic processes, including the premise of memory (1996). Beyond aesthetic appeal, they argue in their exploration of Luba art, pictures can initiate mnemonic processes, which include narrative and other creative performances (Roberts and Roberts 1996, 101). They demonstrate that these processes are not static but performative because "historical recitation never occurs precisely in the same way twice" (M. N. Roberts and Roberts 1996, 101). So, my memory of the murder of abortion doctors and Dr. Tiller is different every time. Being in his friend Dr. Carhart's clinic affected the activation of my mnemonic

process. Moreover, the images are not purely symbolic; they symbolize thoughts and feelings about the past as much as they "stimulate and provoke it" (M. N. Roberts and Roberts 1996, 101).

The Roberts' argument about Luba art suggests that memory is more than thoughts contained in the mind; remembering is a performance involving sensory and embodied elements. The "lived body is the site where place and memory are actively joined," they explain, affirming that "the body is the filter through which historical facts are negotiated" (M. N. Roberts and Roberts 1996, 101). Their insights into Luba and other arts of central Africa can be applied cross-culturally to help us understand that the body is a text which is "written" and "read." The past is reified through the embodiment of memory which is lived and enacted in the present.

In the context of Dr. Tiller, the photographs serve as what Connerton calls a "living connection" (Connerton 1989). And not only are they reminders, but Connerton tells us they can be used as legitimization for the present, which could be the case for Carhart and others who display Tiller's picture (Connerton 1989). They also function as what performance theorist Diana Taylor terms "vital acts of transfer," for their identity as providers and why they do the work. Taylor explains that performances are "vital acts of transfer," which transmit "social knowledge, memory, and a sense of identity" through reiterated behavior (Taylor 2003, 2). The images remind them of the importance of their work despite (or in spite of) the opposition. Dr. Tiller's life and work are remembered, as well as his horrific death.

The drawings of the horses also spark the mnemonic processes of death and the terror perpetuated by antis. As well as creating an inviting environment for patients, the drawings and photographs in Carhart's clinic serve as *lieux de memoire* or sites of memory (Nora 1989). The activation of the memories through the photographs and discussions between Michael and me are

social processes that inform our experiences at the clinic, the ways we view abortion work of the past and present, and the ways we conceptualize our physical safety in that abortion clinic space. Not only are memories told and recreated in the present, but they are also acted upon in what I term the "security culture" of the clinic. As much as providers work to create a positive and warm patient-centered environment, they are often doing this in the context of implementing multiple security measures, which may counteract these efforts. In addition to the tension it elicits for providers, enforcing security creates an environment where patients often feel that they are being policed and are not trusted. This is one of the sad ironies of abortion clinic culture.

Surveillance and vigilance feel obligatory for most providers simply to secure the physical safety of themselves, their staff, and the clinic, but the intense attention to security is also antithetical to the environment most abortion providers are trying to curate. I argue that the culture of fear surrounding most clinics is one of the significant successes of the Antiabortion Movement. Antis have succeeded in making the clinic landscape a place where many feel "on edge" at the least and "terrorized" at the worst. My observations reveal that the mere presence of the protesters in memory or real time marks the clinic space as a place of potential danger. Alesha Doan suggests this is precisely the protesters' aim when she explains that "the point of the confrontational tactics taking place at clinics is not one of executed threat, but rather shaping an environment of continuous, implied threat and fear. Many of the tactics the pro-life movement relies on foster a sense of fear that has come to epitomize the culture surrounding abortion clinics" (Doan 2007, 29).

Not only has this history and the constant reminders of it created a culture of fear, but it has also created what I term a "culture of security," or "security culture," in response. The security culture of abortion is probably one of the most striking aspects for people newly

interacting with clinics. For instance, volunteering at a clinic is not easy. First of all, most independent clinics do not have the time or money to have a volunteer coordinator. Most clinics have been infiltrated in the past and receive multiple training and procedure recommendations from the national non-profits that monitor abortion security, the National Abortion Federation, and Feminist Majority Leadership. So even trusting a volunteer is not a common part of clinic culture. At most clinics, one has to know and be vetted by a staff member or escort personally before they are given any information and access, and even then, one must prove they are trustworthy. This is another unfortunate reality for clinics because most could use the additional assistance of volunteers. With the shifting political climate around abortion, many progressives will feel compelled to help but may not have the dedication, attention span or patience to check-in continually and be treated as suspicious.

Remembering Terror

Throughout Part One of the dissertation, I argue that the collective memory of terror affects the everyday actions of providers, including the ways they protect themselves, their colleagues, and their patients. I rehash some histories to illustrate the power of a single sign outside a clinic and its potential to activate this memory and put providers and patients on edge. As political scientist Aleisha Doan demonstrates, antiabortion protesting is not a strictly political action but an act of terror on a broad spectrum due to the wider context and history of terror.

In Chapter One, I introduce some of the discourses of terror. In addition to revisiting histories and current realities of terror, this chapter serves as a topography of current antiabortion protester landscapes. It is meant to briefly introduce several concepts I use throughout the dissertation. Therefore, I have organized the chapter for easy navigation. Finally, I conclude by

analyzing some of my provider interviews that explore specifically how providers conceptualize their safety and the challenges that antiabortion protesters pose.

In Chapter Two, I discuss clinics' current security culture, including their practices and meanings. I explicitly take a Foucauldian route to theorize the security culture at clinics and discuss how this setting affirms and challenges previous thought on security, policing, and the state. I also include interview material from providers about their feelings toward security to introduce the concept of the "security bind," which I conceptualize as the impossibly fraught position of paradox where they must police and infantilize their patients to ensure the continued existence of the clinic.

The collective memory of terror was present for me throughout my fieldwork. In my travels, I glanced nervously in my rearview mirror to ensure I was not being followed and turned off the location services on my phone. I recounted the long drives imagining what the last week of Dr. Tiller's life was like. In reality, researchers and activists are relatively insignificant targets for antiabortion terrorists unless they happen to be at the wrong place at the wrong time—the wrong place being the clinic—where I spent the majority of my time. Antis aim for physicians first but end up harming anyone on or near the clinic, as we saw in Florida, North Carolina, and Colorado. Regardless of the statistics about who is most likely to be murdered at the clinic, just by participating in the abortion provider community and by physically being at clinics, I was engaging with the collective memory of terror.

Chapter One: The Collective Memory of Terror

Just like my experience in the Nebraska clinic—the everyday actions of physically navigating a clinic can open a portal of memory. From memorials to metal detectors, the collective memory of terror is always present at or just below the surface. Here I offer multiple histories of terror that form and inform this collective memory. I provide an overview of the chronological arc, as well as the current specific groups, spheres, and discourses of terror. I conclude by analyzing the ways in which these histories affect providers and how they conceptualize their own identities within them.

Furthermore, in this chapter, I explore the following questions: How have antiabortion groups attacked the clinic in the past? How have antis framed or legitimized these actions? What tactics have they used? What tactics do they still use? What does violence at the clinic look like currently? I pose and reflect on tentative responses to these questions in demonstrating how the historical context of extreme violence at clinics creates a collective memory of terror. This memory and the historical contexts of its creation makes antiabortion presence at the clinic particularly charged—beyond just political protest—and may be considered on a spectrum of violence.

I want to clarify that although I have separated out many of the terrorist groups and activities as distinct from one another, there is much overlap, and as Ziad Munson contends, there is no single reason that someone joins the Antiabortion Movement or decides to protest at abortion clinics (Munson 2009). In fact, the words "Antiabortion Movement" are a misnomer; I do not use the term to connote a static or distinguishable group from other domestic terrorist and hate groups. Rather, I use it as an umbrella term to describe a wide spectrum of groups that oppose abortion and work to limit it in the United States. My aim is that after reading this

section, readers will understand some of the reasons, motivations, and worldviews that contribute to the pervasive environment of terror faced by abortion clinics. And, more importantly, my goal is to provide readers with at least a basic understanding of the everyday terror and memories of terror that providers navigate to do their critical work.

Timelines of Terror

Antiabortion protesters have perpetuated violence at clinics since the first freestanding abortion clinics were established in the early 1970s. Referred to as the "ground zero" of the abortion wars, clinic sites have remained an ideal target for protesters because they are highly visible due to their often identifiable, stand-alone buildings (Abortion Care Network 2020; C. Joffe 2009). Antiabortion violence at abortion clinics takes many forms and may range from verbal harassment outside of clinics to bombing, arson, and even murder—from daily accumulating annoyances to the finality of death. The severity and relentlessness of this terror depend on many factors, including the layout of the building and clinic space, the surrounding property, and the histories and discourses that animate it. Specifically, the outer clinic landscape—the sidewalk, parking lot, clinic entrance, and surrounding community—is where much violence and terror are enacted. The exterior clinic landscape is the gateway to abortion services for patients, where clinic staff, escorts, and antiabortion protesters work to achieve their respective goals.

Dominant narratives describe antiabortion protesters as initially drawn to the clinic by their dissatisfaction with *Roe v. Wade*, the 1973 Supreme Court case that legalized abortion, and their increasing anxieties about shifting gender roles ignited by the women's liberation movement (Supreme Court of the United States 1973). Protesters and other members of the burgeoning "Pro-life" movement flocked from various Christian-affiliated (i.e., Catholic,

Evangelical, Protestant) backgrounds to form an unprecedented coalition known as the "Christian Right" and "Christian Coalition" (Grzymala-Busse 2015). Simultaneously and strategically, the Republican Party enveloped this newly formed voting block, centering the party on so-called moral traditionalism for social issues. Chief among these issues: abortion.

Opposition to abortion unified and strengthened the Christian Right, becoming a hallmark of their politics in the 1980s and 90s. A key recruitment strategy, it also became a galvanizing issue that represented broader ideas about "taking back" America as a country ruled by "God's law"—although the precise meaning of this phrase differed for disparate groups within the movement (Grzymala-Busse 2015; Ginsburg 1998). As such, antiabortion advocates framed clinic protests as direct-action tactics to salvage the quickly disintegrating (white) Christian "American Family" imaginary and uphold the supposed sanctity of the Christian Nation (Ginsburg 1998; Grzymala-Busse 2015). To achieve this mission, the Antiabortion Movement took its politics to the sidewalks, entrances, and properties of abortion clinics with an unrivaled vehemence.

The antiabortion presence at abortion clinics crescendoed in the mid-1980s and early 1990s with mass actions that were often more aggressive and violent than protests in previous years. The antiabortion group Operation Rescue was at the helm of this shift and was, according to their founder, Randall Terry, redefining the "extremes of pro-life activity" (Ginsburg 1998, 227). To recruit, Operation Rescue members engaged participants from popular Christian broadcasting networks. They relied on the existing infrastructure of independent fundamentalist churches and Christian activists for their base—mobilizing much larger numbers of protesters than had ever been at clinics. Additionally, their highly organized and incessant combative tactics radically deviated from previous organizing (Ginsburg 1998, 234).

Following direct orders from male leaders, antiabortion protesters crowded clinic interiors, entrances, parking lots, and adjacent streets to "save" the "unborn" or "pre-born" from being aborted. These groups caused as much disturbance as possible inside the clinics and blocked clinic entrances with a militaristic fervor. They would gather in clinic waiting rooms and pray or sing loudly; they used their bodies as physical barriers, chained to clinic doors, and blanketed the surrounding neighborhoods with images of mangled fetuses. Their goal was to shut down the clinic for as long as possible. Most attempts were unsuccessful, but a few, such as the 1991 six-week siege (forty-six days to be exact) in Wichita, Kansas, caused a significant disturbance in abortion care delivery. During the Wichita siege, which the group would later commemorate through their "Summer of Justice" event (See Part Three Section Introduction), Operation Rescue targeted three abortion clinics, including the clinic of Dr. George Tiller (Feminist Majority Foundation n.d.). During this time, police arrested 2,700 antiabortion protesters for blocking the entrance to Tiller's clinic (Feminist Majority Foundation n.d.). Two years later, Tiller was shot in the arms five times by antiabortion extremist, Army of God-affiliated Shelley Shannon (C. Joffe 2009). Nevertheless, Tiller made it a point to return to work the very next day (Joffe 2009, 134).When ultimately arrested after one of their large-scale "rescue" events, members of Terry's group would give their names as "John Doe," "Jane Doe," or "Baby Doe" to conceal their Operation Rescue affiliations, show supposed solidarity with the unborn, and clog the jail system (Joffe 2009, 223; Phelan 1993). They strategized to halt clinics' operations and to create a general culture of chaos and fear surrounding the clinic by attracting the media's attention with the volume and dramatics of their demonstrations.

And grab media attention they did—using it to amplify their message that abortion was evil and that America should be governed by Christian fundamentalist law. They contrived their

protests as "civil disobedience," "non-violent sit-ins," and "rescues," as well as characterizing their arrests as anti-Christian oppression, which violated their freedom of speech (Phelan 1993, 235). Notably, Alesha Doan points out that although antiabortion groups like Operation Rescue framed their activities at clinics as political protest (and continue to do so), they are protesting at non-governmental medical clinics. As such, what they are doing must be seen as harassment.

Although Operation Rescue's "saves" were predominantly led by loud men supported by quietly praying women, historian Karissa Haugeberg points out that women were enthusiastically violent members too. In fact, "rescue work" provided opportunities for women to gather outside the home, travel, and engage in what they took to be meaningful, even divine, labor. For some, it offered the space to question authority and rules—behaviors generally proscribed or deterred in evangelical homes and churches (Haugeberg 2017, 133). Overall, participation provided women a chance to "see themselves as heroes in a holy war against abortion" (Haugeberg 2017, 133).

Further, Haugeberg elucidates how women often devised and created the violent tactics used by Operation Rescue. For example, Haugeberg traces the story of how Catholic antiabortion protester Julie Loesch taught aggressive protester tactics to Operation Rescue men. In fact, Haugeberg claims that Catholics coming from radical social justice movements "set the foundation for future violence"(Haugeberg 2017, 57). Indeed, Randall Terry hired Loesch as Operation Rescue communications director to teach these tactics. Initially, Loesch had hoped that this role would extend to the visibility and leadership of women in the Operation Rescue movement and wider grassroots antiabortion efforts.[35] However, as many Catholics were called

[35] To Loesch's dismay, Operation Rescue brought their pastor-like protesting style to the clinic landscape complete with men receiving the consistent spotlight and filling all paid leadership roles, with women working tirelessly

off from clinic violence by their more united leadership (i.e., the Vatican), Evangelicals (a more decentralized religious sect) were encouraged by the booming TV culture at the time to participate at the clinics in the most disruptive activities possible.

Guided by concepts such as "higher laws ideology" and the "doctrine of necessity," Operation Rescue helped create a climate where the murder of abortion doctors was considered "justifiable homicide" to prevent greater violence (i.e., abortion)—establishing an insidious logic underwriting the murders of abortion providers that would follow (Ginsburg 1998).[36] By 1993, antiabortion violence reached an unprecedented extreme with the murder of Dr. David Gunn and the attempted murder of Dr. George Tiller. (Antiabortion terrorist Scott Roeder would ultimately murder Tiller in 2009.)

When it comes to clinic violence, most prominent in the public consciousness are illegal acts such as murder, attempted murder, bombings, chemical attacks, and arson. For instance, since the 1993 murder of abortion provider Dr. David Gunn, there have been eleven murders and twenty-six attempted murders of abortion providers in the United States and Canada. Much of the public was outraged and blamed Operation Rescue for promoting justifiable homicide and creating a frightening environment for providers (Ginsburg 1998). These events, in addition to the arrest and subsequent renunciation of leader Randall Terry, the mobilization of pro-choice organizations at clinics, and the introduction of clinic protection legislation such as the Freedom of Access to Clinic Entrances Act (FACE), led to the eroding of Operation Rescue. Passed by

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behind the scenes (Haugeberg, 2017, 70). For instance, Operation Rescue member Bryan Brown proclaimed: "We [Operation Rescue] are patriarchal. We believe that men are supposed to lead and that a man's greatest role in our society is to protect a woman." (2017, 97) Ultimately, women like Loesch felt pushed out and perturbed by the idea that women were too fragile to be leaders.

[36] "Higher laws ideology" is the idea that "[…] G-d's law takes precedence over civil law" while the "doctrine of necessity" is a belief that violence is an acceptable way to prevent greater violence (i.e., in their view, abortion) (Ginsburg, 1998, 229).

Congress in 1994, FACE restricts clinic protest activity by prohibiting force, the threat of force, or physical obstruction of an abortion clinic. It protects providers, patients, escorts, anyone who enters the facility, and the building itself. If a clinic is able to prove FACE violations, perpetrators may receive injunctions including jail time and fines. Indeed, the FACE Act precipitated the dissolution of Operation Rescue. However, clinic violence and Operation Rescue (as Operation Save America) would survive as antiabortion protesters continued to develop new tactics to terrorize patients.

Although the public primarily blamed Operation Rescue for creating the environment for "justifiable homicide," antiabortion terrorist network Army of God members (many of whom overlapped with Operation Rescue) were responsible for enacting it. According to the Southern Poverty Law Center, the Army of God "compares its adherents to soldiers in a battle against Satan" (D. Johnson 2017). They explain that Army of God is "fighting a war with Jesus Christ at their side in an effort to save the unborn" (D. Johnson 2017). Army of God is loosely organized with no official membership. Affiliation is primarily determined by the invocation of the network by individual actors when committing crimes such as bombing a clinic or through the distribution of and engagement with their literature (i.e., website, manual, and other documents/statements associated with the group). One way to determine affiliation is to read the signatories of their "Defensive Action Statement,"[37] which holds that murder or "any godly action necessary […] including the use of force" is legitimate to save the life of an "unborn child" (Army of God n.d.).

[37] There have been multiple versions of the statement with thirty-four documented signatories. To read the statement and see a list of signatories, see Southern Poverty Law Center (1998).

Army of God affiliates and discourses live on through the actions and voices of current antiabortion terrorists (many of whom we have come into close contact with at the Operation Save America "Summer of Justice") and continued online engagement. Southern Poverty Law Center reports that violent antiabortion extremists manage several websites which promote violent behavior. Essential among them is the "Christian Gallery" website, formerly run by Army of God supporter Neal Horsley (now deceased) (The Irish Times 2001). In the late 1990s, Horsley included a section on his website entitled "The Nuremberg Files." There, he created a hit list of abortion providers, including their personal information such as name, address, etc. (The Irish Times 2001). Once an abortion doctor was wounded or murdered, a black "X" was marked across the name. Eventually, a court order shut down the Nuremberg Files (Silverberg et al. n.d.).

Although clinics experiencing severe violence and mass protests generally decreased after the passing of the FACE Act, antiabortion violence is not a relic of the past. In fact, violence has been sharply increasing during the past decade (National Abortion Federation 2020; 2018; Feminist Majority Foundation 2019). According to the Feminist Majority Foundation (FMF), a non-profit which has consistently measured clinic violence since 1993, the percentage of clinics reporting the most severe forms of violence remains "dangerously high," with almost half of all providers experiencing some form of severe violence, threat of severe violence, and/or severe harassment. FMF categorizes antiabortion violence into three categories: (1) severe violence, including serious illegal acts such as physical violence, clinic invasions, bombing, arson, chemical attacks, gunfire, bomb threats, death threats, and arson threats; (2) severe harassment, defined as insidious acts that seriously disrupt operations of the clinic and may cause emotional harm, such as protesters using racial slurs towards patients and staff, luring patients away from the clinic, and disguising themselves as clinic staff by wearing vests, security guard

outfits, or posing as parking attendants to confuse and harass patients deliberately; and, (3) targeted intimidation and threats towards clinic staff, including death threats, stalking, vandalism of home or personal property, harassing emails and/or social media posts, harassing phone calls, and tracking of activities (Feminist Majority Foundation 2019a, 6).

Likewise, NAF reports startling increases in violence from 2018 to 2021. For instance, the number of antiabortion assaults at clinics rose from fifteen (2018) to 123; stalking of providers and staff increased 600% from 2020; clinic invasions increased by 129%; number of hoax devices or suspicious packages left at clinics rose from four (2018) to 71; and clinics received 80% more bomb threats than in previous years (National Abortion Federation 2022). In addition, they outline that providers experience significant increases in antiabortion online hate speech, clinic obstruction, vandalism, and trespassing. Further, they report that the number of antiabortion protesters has increased significantly from 21,750 in 2015 to a startling 99,409 in 2018. I want to stress that, although rarely covered in the news, this violence happens daily or weekly at most clinics (62%) and is not rare or happenstance (Feminist Majority Foundation 2019a, 3). Notably, the statistics from both organizations are thought to be low estimates considering low survey response rates and the capacity of most clinics to report. One act of violence not captured in these reports is throwing nails, glass, deformed baby dolls, and dead animals on the property. One provider told me that the baby dolls with nooses around their necks got to her. An Abortion Access Front member described a horrifying story when she noticed a dead rabbit had been placed in front of the clinic, and she disposed of it before the providers could detect it. I will discuss several other violent theatrical strategies in Part Two.

Notably, the clinic takeovers, thought to be a relic of the 1980s and 1990s, have extended to the current (2023) influx of invasions—especially by the Red Rose Rescue (RRR) (NYC For

Abortion Rights 2021). Police arrested Father Fidelis Moscinski (aka "Father Fidelis") at least nine times for invading clinics with the Red Rose Rescue.[38] Additionally, Operation Save America continues to do occasional blockades.

In addition to the increase in violence, there has been a proliferation of Crisis Pregnancy Centers (CPCs) which highlight a parallel violence of deception (Haugeberg 2017; Kelly 2012; Swartzendruber, Steiner, and Newton-Levinson 2018). As Haugeberg stresses, "although CPC volunteerism initially seemed friendly and helpful, a close examination of tactics deployed by women pro-life counselors since the 1960s reveals that deception, coercion, and terror have been central features of women's work in the antiabortion movement" (Haugeberg 2017, 55). To add fire to the flames, she explains, "The explicitly religious services they offered were subsidized by taxpayers and tacitly enforced by underfunded, secular social services for poor women" (Haugeberg 2017, 69).

As of the writing of this dissertation (2023) and the ruinous reversal of *Roe v. Wade*, the clinic landscape is rapidly changing, with many clinics forced to shutter and others moving to more abortion-amenable states. In addition, clinics have experienced a surge in invasions and blockades in the past year—primarily led by Red Rose Rescue. The antis are not backing down, even if they have already won so much ground in the courts. Habituated to traveling to terrorize providers, patients, and communities, these violent antis are actually increasing their zeal, perhaps because they now have fewer clinics to target.

[38] Father Fidelis leads New York's controversial "Witness for Life" Program. As part of the program, he leads a group of antiabortion protesters to harass patients at the Brooklyn Planned Parenthood. On the second Saturday a month, he marshals the group in "sidewalk counselling," holding graphic signage, and attempting to coerce patients to forgo abortion. Despite their claims of "non-violence," his group is known to be violent with abortion activists and escorts. The group is also known to don pink vests similar to the Planned Parenthood escort vests in order to trick patients into conversation (NYC For Abortion Rights 2021).

The scope and history of clinic violence and harassment are vicious enough, but less emphasized are the very practical daily disturbances that this violence contributes to the already "invisible labor" of abortion providers, thereby diminishing abortion access (Mercier, Buchbinder, and Bryant 2016). The terror promulgated by the antis takes its toll. For example, antis' antics stymie abortion providers by requiring additional labor to protect patients; as a result, many clinics rely on the consistent labor of volunteer escorts to comfort patients and navigate them past protesters (Mercier, Buchbinder, and Bryant 2016). Additionally, protesters make it difficult for providers to secure a lease or otherwise tarnish their reputation with the surrounding community (Cohen and Joffe 2020, 142). They prevent providers from receiving essential maintenance services such as roof repair, plumbing, and landscaping. I have heard accounts from several providers across the country detailing these incidents. One provider told me they had a leaking roof for a year because they could not find anyone willing to fix it for a reasonable price.

Providers at independent clinics share a collective memory of murder and everyday terror. The daily reminders of this are palpable, particularly in the actions and awareness of providers. Any antiabortion activity in the clinic space is a form of violence. The mere presence of a protester can represent decades of terror, bombings, threats, and murders. The context of the histories of the clinic means that anyone showing up to display their dissent is a potential murderer, bomber, or purveyor of terror—for patients and especially for providers who have historically been the targets of their attacks. Which is why it is so important to see the antis for what they are: terrorists. Here then is a brief lexicon of antiabortion terrorist groups and their strategies, all of which contribute to a Collective Memory of Terror for independent abortion providers.

Perpetrators of Terror

The history of terror at clinics leads inexorably to what I term the Collective Memory of Terror for independent abortion providers, who are forced to live with its deleterious effects on a daily basis. Key to the collective memory of terror is how everyday activities at the clinic trigger and reinscribe it. From the mere presence of a sign-holder at the clinic entrance to the blockade and takeover of the clinic, these actions spark memories of murder, arson, fear, and loss. This section brings the experience of collective memory into focus, within the timeline and context of the current study (2018-2023). First, I describe what I term as the main categories of independent clinic protesters based on my interviews with providers and experiences escorting. Next, I provide a general description of the groups as providers and escorts describe them, which is not always synonymous with how they define themselves. Furthermore, these descriptions do not represent every protester who might identify or be placed in that category, as all groups have diversity and outliers. After describing the main types, I will take a deeper look at some specific groups perpetuating terror at clinics today.

"The Catholics"

This is the group most people envision when I talk about antiabortion protesters: followers of the Roman Catholic Church who view abortion as anathema to sacred human life. Abortion providers call them, quite simply, "The Catholics." Catholics usually arrive in church groups, with family members, and sometimes alone. Several providers I interviewed referenced them as the most "harmless protesters" as they typically pray silently or quietly. Most Catholic protest groups I have observed consist of female-presenting people—specifically, mothers with children, and elderly women. They often hold rosaries and sometimes wear religious garb. They cradle

drawings and figurines of the Virgin Mary in their arms. Many mainstream pro-life organizations have their roots in the Roman Catholic Church; however, the protesters who foment the most terror are usually affiliated with evangelism in some way, or their own brand of Christianity, distinct from mainstream American Catholicism.

Mainstream Pro-Life Organizations

Most mainstream pro-life organizations organize at the political level with protesters who terrorize clinics. A few examples include National Right to Life Committee, Heartbeat International, Care Net, Students for Life for America, Pro-Life Action League, and Susan B. Anthony Pro-Life America. Notably, during my fieldwork, the official groups I saw represented most consistently were the National Right to Life Committee and 40 Days for Life. Self-proclaimed "world's largest grassroots movement to end abortion," 40 Days for Life sponsors an annual campaign that lasts for forty days (40 Days for Life n.d.). In a purposeful echo of Jesus's biblical fast in the desert, during which he grew in spiritual power, the campaign includes praying and fasting for forty days (e.g., in 2022, the campaign took place from September 28th-November 6th), as well as protesting outside abortion clinics. They call their presence outside clinics a "constant vigil" where participants stand outside and pray for forty days straight, twenty-four hours a day. They claim to be a "peaceful and educational presence," suggesting that they are called to "stand witness" to send a "powerful message to the community about the tragic reality of abortion" ("40 Days for Life" n.d.). According to providers, these groups are usually somewhat tame; however, this depends on the specific location. Most of the 40 Days people I observed held signs and stood or sat quietly or used moderate speaking volumes. Notably, even though the event happened during my fieldwork, I never witnessed anyone standing at the clinic 24 hours a day.

Crisis Pregnancy Center Protesters and Volunteers

Crisis Pregnancy Centers (CPCs) are non-profit organizations, often overtly or covertly evangelical Christian, created with the primary goal of intercepting women with unintended pregnancies to divert them from seeking abortions. Some of their many tactics include protesting at clinics to direct patients to the (usually nearby) CPC. In addition, they aim to convince patients to forgo abortion by administering what they call "sidewalk counseling," providing a free pregnancy test and/or ultrasound in a van or bus while spreading misinformation about abortion, for example, that abortion causes breast cancer, infertility, and depression. In some cases, a CPC protester would lead a clinic visitor to the nearby CPC building to receive the "counselling" there. However, research shows that they rarely succeed at this and instead obfuscate the entire access process for the patient, causing problems for patients and clinics. They interrupt but generally do not circumvent. For instance, patients often miss or delay their appointments—not to mention reporting emotional distress from the experience—but in most cases they return to the independent clinic.

CPC protesters and volunteers are almost exclusively women trained to be approachable and kind, speak in inviting tones, and differentiate themselves from some more aggressive protesters. Based on two years of ethnographic research at a CPC, sociologist and ethnographer Kimberly Kelly explains that CPCs transitioned from using the fetus-centered language of the broader Antiabortion Movement to using women-centered language co-opted from the feminist movement as an explicit tactic (Kelly 2012). CPC protesters mislead patients by using words like "choice" and "options" as they beckon patients toward them or lead them to the neighboring entrance of the CPC (NARAL Pro-Choice America 2017; 2015). I have heard volunteers say things like, "Come learn about your options" and "Let's talk about your choices." They also say

"We want to help you" and "We can help take care of you and your baby." During my research, I also noticed that many were holding signs and advertising abortion pill reversal for those who started the medication abortion process. They claim that they can help a person halt the abortion process; however, there is no evidence to support this practice, and it may, in fact, be dangerous (Bass 2022).[39]

Federal and state governments, as well as extensive networks and umbrella organizations, fund CPCs. As of 2022, at least twenty-nine states divert state funding to crisis pregnancy centers (Women's Law Project n.d.). In addition, many state governments funnel money through programs such as the "choose life" license plate (Bryant and Swartz 2018). Some well-known umbrella organizations are Birthright International, Care Net, Heartbeat International, and the National Institute of Family and Life Advocates (Bryant and Swartz 2018). Organizations like these provide services to the CPCs in their networks, such as legal support and ultrasound training.

Operation Rescue/Operation Save America

Operation Save America is the antiabortion group derived from Randall Terry's Operation Rescue, made notorious for its theatrical tactics and clinic blockades in the 1980s and 1990s.[40] They claim to be a "religious" organization but, according to the Southern Poverty Law Center,

[39] The American College of Obstetricians and Gynecologists have stated that abortion pill reversal is "unethical" and "unproven" (n.d.). Yet, the antiabortion movement continues to advertise "abortion pill reversal."

[40] In the 1980s and 1990s, Operation Rescue became less of an official group and more of a movement that many antiabortion protesters claimed. However, the 1994 FACE Act (and the fines and lawsuits that accompanied it) began to dissolve the group, and Randall Terry filed for bankruptcy in 1998 (Salmon 2009). Antiabortion leaders claim conflicting statements about the Operation Rescue split. Needless to say, Troy Newman created a group called Operation Rescue/ Operation Rescue West. Meanwhile, local leaders of the other Operation Rescue arms, continued as a unified group with local or regional chapters, all known as "Operation Save America." Since Operation Save America is the group that is supported by Randall Terry, remains consistently active, and is the group I have come across in my fieldwork the most, when I refer to Operation Rescue, I am referring to Operation Rescue/Operation Save America (Anti-Defamation League 2011).

are more like a hate group. Their three-pronged approach to "saving" America is to 1) outlaw abortion, 2) criminalize homosexuality, and 3) eradicate Islam. For instance, they have protested outside of mosques since 2001, originally initiated by their theory of the 9/11 terrorist attacks (they believe that the religion of Islam is responsible for the attack). On their website, they have previously described Islam as a "false religion, birthed from the very pit of hell [that] has led to the eternal damnation of billions of precious people" (Anti-Defamation League 2011).They most certainly have a flair for the dramatic, if not genocidal. They also believe that gays are a "problem" that the government needs to eradicate and have said that homosexuality "needs to be suppressed through the force of law" (Tashman 2013). Ultimately, their notion of an America free from sin is one in which white, cisgender, straight, Christian men rule. Although they have been known to harass events or groups associated with Islam and the LGBTQ community, their main focus is to ban abortion. In addition, they lobby politicians to follow (and vote aligned with) their guiding text, *The Doctrine of Lesser Magistrates*.[41] In short, AAF describes the doctrine as, "Boiled down, it means powerful men should disregard any U.S. law or SCOTUS ruling that goes against their interpretation of biblical teachings."

Randall Terry started the group, and when they went bankrupt in 1994 (due to fines accumulated with the FACE Act), Philip (Flip) Benham became the director. Benham's tenure as director is perhaps remembered most for his strategic "befriending" of the former abortion provider and "Jane Roe" in *Roe* v. Wade, Norma McCorvey. In 1995, Benham moved Operation Save America headquarters to the office space next to the abortion clinic where McCorvey was

[41] *The Doctrine of Lesser Magistrates* is written by Matt Trewhella and promoted by Operation Save America. The Doctrine argues that government officials have a duty to defy federal law and court decisions on issues like abortion and gay rights ("Radical Anti-Choice Group Operation Save America Claims To Be 'Working Within The State Government' Of Kentucky To End Legal Abortion | Right Wing Watch" n.d.).

working. Soon after, Benham baptized her, and she publicly renounced abortion, becoming a staunch antiabortion advocate (Doan 2016, p. 178). However, in 2020, McCorvey confessed that the Pro-Life Movement paid her to become the antiabortion poster child. The admission debuted in Nick Sweeney's documentary *AKA Jane Roe* in 2020 and reverberated throughout the news (Sweeney 2020).

After Benham stepped down in 2014, Rusty Thomas[42] directed the group until 2021, when Jason Storms commenced leadership. Pastor of the Mercy Street Church in Milwaukee, Wisconsin, and filmed at the January 6th insurrection, Storms, has said that people who get abortions should be prosecuted as murderers (Abortion Access Front n.d.).[43] As a gun enthusiast, Storms has ushered in a militaristic fervor. Although they have drawn far smaller crowds for the past thirty years, Operation Save America members reside across the country and continue terrorizing clinics in their home states and from clinic to clinic across the United States. The organization's active website proclaims: "We unashamedly take up the cause of preborn children in the name of Jesus Christ, and we employ only biblical principles" (Operation Save America 2022b). Their main event is their so-called "Summer of Justice," which is a weeklong national gathering held every July to commemorate the before-mentioned 1991 "Summer of Mercy" in Wichita, Kansas.[44] In the introduction of Part Three, I describe my experience counter-protesting Operation Save America's 2018 "Summer of Justice" with AAF.

[42] Rusty Thomas is also the president of "Rachel's Park Memorial" which is a memorial park for fetuses, showcasing the "tomb of the unknown baby" (Operation Save America 2022a).

[43] According to AAF, Jason Storms operates the "Faithful Soldier School of Evangelism." The school is a summer camp that teaches kids to mistrust mainstream media, "defend" Christianity in a secular world, and "that homosexuality, abortion, and the separation of church and state are diseases as infectious as COVID" (Abortion Access Front n.d.).

[44] I have attended this event to counter-protest Operation Save America with AAF in 2018, 2019, and 2021.

Army of God

Army of God is an unofficial terrorist group that has been linked to the murders of several abortion providers. Numerous murderers and attempted murders have been linked to Army of God affiliates, including Shelley Shannon (attempted murderer of Dr. George Tiller), Scott Roeder (murderer of Dr. George Tiller), Paul Hill (murderer of Dr. John Britton), Michael Griffin (murderer of Dr. David Gunn), James Kopp (murderer of Dr. Barnett Slepian), and Eric Rudolph (bomber of Southern clinics and attempted murderer at the 1996 Olympic Games in Atlanta, Georgia).[45] Army of God has also been linked to other violent acts, such as the 1984 death threat to Supreme Court Justice Harry Blackmun, the bombing of the American Civil Liberties Union and the National Abortion Federation, and the mailing of more than 550 anthrax threat letters to clinics after September 11, 2001 (Clayton Wagner was convicted of this last crime) (Sturgis 2009).

The documentary *Soldiers in the Army of God* (2000) features several key network members, including Michael Bray (Levin and Pinkerson 2000). I watched this film for the first time in 2021 with sibling activists. I was horrified to witness an almost-giddy Bray (referred to as the chaplain of the Army of God) hosting the annual White Rose Banquet, which celebrates antiabortion extremists with a dinner and award ceremony—complete with commemorative plaques, food, photos, and smiles. Bray named the banquet after the German secret society that opposed Hitler, further equating their cause with the Holocaust of World War II. It is held on the anniversary of the *Roe v. Wade* legal decision. On a personal note, while watching, I felt

[45] Terrorists affiliated with the Army of God have also been accused of bombing the National Abortion Federation office and the American Civil Liberties Union, as well as mailing more than 550 anthrax threat letters to clinics shortly after 9/11. Other terrorists linked to the Army of God include Clayton Wagner, Donald Spitz, Neal Horsley, and Michael Bray(Southern Poverty Law Center 2018).

physically ill. I tried to wipe away my tears swiftly; however, my attempt was futile, and I was in good company. I cried for many reasons, including the horrifying reality that I know and love abortion providers, and twenty years later, antiabortion terrorists still terrorize them. I have met the families and friends of doctors who were murdered. The loss of these doctors and the continuing threat spearheaded by many in the documentary and connected to the documentary persists.

The Army of God manual, which several antiabortion networks, including Prayer & Action News, distribute, features a how-to guide to carry out the murder of abortion providers (Sturgis 2009; D. Johnson 2017)**.** The manual includes this opening proclamation:

> We, the remnant of God-fearing men and women of the United States of Amerika [sic], do officially declare war on the entire child-killing industry. After praying, fasting, and making continual supplication to God for your pagan, heathen, infidel souls, we then peacefully, passively presented our bodies in front of your death camps, begging you to stop the mass murdering of infants. Yet you hardened your already blackened, jaded hearts. We quietly accepted the resulting imprisonment and suffering of our passive resistance. Yet you mocked God and continued the Holocaust. No longer! All of the options have expired. Our Most Dread Sovereign Lord God requires that whosoever sheds man's blood, by man shall his blood be shed. Not out of hatred of you, but out of love for the persons you exterminate, we are forced to take arms against you. Our life for yours—a simple equation. (Sturgis 2009)

The reference to abortion as a "holocaust" is a common theme in antiabortion rhetoric used by many groups to legitimize "justifiable homicide." According to the Southern Law and Poverty Center, the manual insists that murdering providers is the only way to stop abortions (D. Johnson 2017).

Despite the lack of official membership status for the Army of God, Operation Save America and Army of God have much historical and current overlap. Known speakers and participants of Operation Save America events have signed their "Defensive Action Statement" promoting the murder of abortion providers (i.e., a method used to trace unofficial membership),

including John Brockhoft, Matt Trewhella, and Mike Myer (recent speakers at the 2022 Operation Save America Nashville event). Additionally, Trewhella (member of Operation Save America and father-in-law of Jason Storms) and his church "Missionaries to the Preborn" have been linked to Army of God member Michael Bray's "Prisoners of Christ" church. Bray's church funnels money to fund abortion clinic bombers.[46] Army of God continues to exist and maintains a website run by Donald Spitz.

Abolish Human Abortion/Free the States

Abolish Human Abortion is a loose coalition of antiabortion protesters who call themselves "abolitionists" and equate ending what they term "child sacrifice" to the other anti-slavery movements throughout history (Carmon 2014). Abolish Human Abortion separates itself from the mainstream Pro-Life Movement, repudiating its strategy for incremental legislative moves (which has primarily been successful). They often pit themselves against those who they call the "personally pro-life" and demand the outright abolishment of abortion. Abolish Human Abortion members reject the term "pro-life" and refer to themselves as abolitionists. They say,

> Pro-life is the expression of a moral opinion. Abolition is the expression of a moral action. When you call yourself "pro-life" you are letting people know what you think about abortion. When you call yourself an abolitionist, you are telling them what you aim to do about it (Tilove 2018).

And they believe that every Christian is called to do something to end abortion. Notably, many antiabortion protesters not affiliated with Abolish Human Abortion refer to themselves as

[46] Prisoners of Christ auctions off personal items to support those is prison for bombing clinics and murdering doctors. This is done during a ceremony called the "White Rose Banquet" and is featured in the film *Soldiers in the Army of God* (Levin and Pinkerson 2000). However, there is no evidence that one of these banquets has occurred since 2004.

"abolitionists" and despise the mainstream pro-life organizations almost as much as they hate the clinic escorts.

T. Russell Hunter runs Abolish Human Abortion out of Norman, Oklahoma. Hunter also started an affiliated 501(c)(3) organization called Free the States, which focuses on pushing abolition legislation, working in support of several political candidates. Free the State's mission is to "free the states from participating in the American Abortion holocaust" (Free the States: Asserting State Sovereignty to Abolish Abortion n.d.). The organization will not promote any candidate who does not support murder charges for an abortion provider or patient. Additionally, Abolish Human Abortion and Free the States produce and sell merchandise, often featuring drawings (created by Hunter) of demons giving abortions.

According to many escorts I have spoken with, Abolish Human Abortion tends to attract the most hostile protesters—the people holding the most extreme and graphic signs, as well as using aggressive tactics to approach patients and escorts. For example, one escort told me that Abolish Human Abortion was known to surround escorts and yell at them while filming, hoping to get someone to snap and then broadcast it on the internet as an example of the "immoral pro-aborts." And escorts are not the only ones concerned about Abolish Human Abortion's activities. Several groups have raised issues with Abolish Human Abortion and started a blog to cover their dangerous activity.[47]

Apologia Church and Studios

Apologia is a church located in Phoenix, Arizona. The church has several ministries, including the End Abortion Now Campaign/ministry and Apologia Studios. The Church has four pastors,

[47] One example is the "AHA Watch" website. It has not been updated since 2014, but there are multiple articles and blog posts connected to the page ("AHA Watch: Keeping an Eye on Abolish Human Abortion" n.d.).

including Jeff Durbin, who leads the End Abortion Now ministry and co-hosts Apologia TV and Radio of Apologia Studios. The End Abortion Now ministry is a movement of local Christian churches led by Apologia that seeks to end abortion by spreading the gospel of Jesus Christ. They engage in local legislation and "sidewalk ministry" at clinics. When recruiting other churches, they send free protest materials and a five-part talking point guide (End Abortion Now n.d.). Their Apologia Studio ministry is an antiabortion content creator. They host a well-known online show on their YouTube channel, which has about 340,000 followers (Apologia Studios n.d.). Additionally, they produced a documentary about the Pro-Life Movement called *Babies Are Still Murdered Here* (Pittman 2019).

Red Rose/Pink Rose Rescue

According to AAF and escort activists, Red Rose Rescue is one of the most active antiabortion protest organizations in the clinic landscape (and one of the most quickly growing). In the past three years, activists have told me that Red Rose protests have increased dramatically in the United States. Red Rose Rescue originated more recently (2017) and was in part initiated by Monica Miglorino Miller's mission to bring back the rescue-style format of the 1980s and 1990s.

In the neo-conservative *Catholic Magazine*, Miller explains that the reasons for the disintegration of clinic rescues are complex but that it was caused mainly by the introduction of the FACE Act, where protesters would be fined and even jailed for obstructing clinic entrances. She resigns that few "prolifers were willing to face the sacrifices such defense of the unborn requires" (Miller 2021). Inspired by Canadian antiabortion protester Mary Wagner, Miller declares that there is a solution that involves "rescuing the lives of the unborn without technically blocking clinic doors" (Miller 2021). She explains that she plans to enter clinics (disguised as a patient) and sit next to women in the waiting room—persuading them to forgo the

abortion. This persuasion will be accompanied by "words of encouragement," she adds. The giving of a red rose with a note that reads, "You were meant for love and to be loved. Your goodness is greater than the difficulties of your situation. Circumstances in life change. Give yourself a chance and let your baby live." On the back is the number of a crisis pregnancy center. She says if the women continue with the abortion process, the rescuers will stay in the waiting room for as long as possible to be in "solidarity" with the fetuses, offering a "non-violent act of defense for them" (Miller 2021). Miller stresses that the rescuers cannot leave and must be physically "taken away---" all captured on Facebook Live, of course. And still, after law enforcement physically removes them, the rescue continues, as Miller claims that the protesters will continue to "witness the sanctity of life" to the police officers and people in the courtroom (i.e., judge, jury, bailiffs, and spectators) when they are later put on trial. Up to today (2023), this remains the basic format of a red rose rescue.

One notable member of Red Rose Rescue is Lauren Handy. Currently, the director of activism for the antiabortion organization Progressive Antiabortion Uprising (PAAU) and mainstay protester at Planned Parenthood of Metropolitan Washington, D.C., Handy has emerged as a notorious presence at clinics across the country. The 28-year-old is especially notable because, without reading the text on the pins that adorn her shirt, one might read her as a young progressive. For example, Handy wears a jean cut-off vest littered with pins and long sleeve plaid flannels. She dons glasses and often dies her hair—all the aesthetic trademarks of a young progressive feminist. However, her pins carry phrases like "PRO human ANTI racist" and "divest from abortion now!" She has been documented holding protest signs that say: "Atheist, Progressive, and Pro-life."

Handy reports that she has been arrested five times for trespassing at clinics in Red Rose Rescues and clinic blockades ("5 Fetuses Removed From Home of Anti-Abortion Activist, Group Says - The New York Times" n.d.). She claims to have entered at least 100 abortion clinics since

2013 (“Why Were There Fetuses in an Antiabortion Activist’s Home?” n.d.). In March 2022, police confiscated five fetuses from her refrigerator in Washington, D.C. (“Why Were There Fetuses in an Antiabortion Activist’s Home?” n.d.). Handy, along with another PAAU leader, Terrisa Bukovinac, claims that these fetuses were only part of a more significant haul that included 110 smaller ones. The two claim to have obtained the fetuses from a medical waste truck driver; however, their actual method remains unknown. Handy claims to have invited a priest to come to D.C. to perform a funeral mass in front of her refrigerator. They drove the 110 smaller fetuses to bury in West Virginia but held onto the five because they suspected they were born alive; however, officials determined that the clinic aborted the fetuses within the terms of D.C. law. *The Cut* reports that “Overnight, she became a public figure, regarded as a hero by the Antiabortion Movement and a “creepy fetus hoarder” by everyone else”; however, many abortion advocates, activists, providers, and escorts have known about her for years (“Why Were There Fetuses in an Antiabortion Activist’s Home?” n.d.).

Students for Life

Among the organizations that claim to be “abolitionists” is Students for Life. The first header displayed, bold and centered, on their website reads, “Students for Life of America exists to recruit, train, and mobilize the pro-life generation to abolish abortion” (“Who We Are - Students For Life of America,” n.d.). Started in 2006, the organization came to full-time fruition under the leadership of Kristin Hawkins and the sponsorship of an “angel investor” (“Who We Are - Students For Life of America,” n.d.). Mostly known for starting student groups on high school and college campuses, they are also one of the self-proclaimed “leading pro-life advocacy organizations in the world” with enormous budgets (“Who We Are - Students For Life of America” n.d.). They mainly recruit and train young people to advocate the eradication of abortion by visiting schools and campuses. I have never witnessed them at any clinics but only

encountered them at the national pro-Life march in 2020. They held their signature "I am the Pro-life Generation" signs while grinding to a Kanye West song.

"Street Preachers," Operation Save America Specific Churches, and One-offs

Street preachers are usually men who protest alone and recite directly from the bible or some type of personal manifesto.[48] They almost always have a sound amplification device, such as a bullhorn. They often hold large banners that tower over them and say things like, "Homos and whores go to hell. Repent. Obey Jesus," in big block letters (Gibson 2020). One distinct difference between many antiabortion protesters and street preachers who go to clinics to spout antiabortion rhetoric is that street preachers are known to go anywhere where large groups of people gather—especially locations or events that they perceive as un-Christian, such as pride festivals, mosques, bars, casinos, and college campuses (Gibson 2020). Although they yell about most groups of people "burning in hell," they shout against abortion and "homosexuals" most vehemently. Ruben Israel is one of the most well-known street preachers, due to his national exposure via *Viceland's* "Hate thy Neighbor" series in 2017 (Gibson 2020; Vice TV 2017). In the *Viceland* clip, various men with Israel's group are protesting the Southern Decadence Parade, an LGBTQ pride event that attracts thousands to the streets of the French Quarter in New Orleans. One can hear them say things like, "Faggot! Sodomite!," or "We are here to take out the trash, and the trash is Y-O-U!," as a bulky, bald, bearded Israel looks on with pride (Vice TV 2017).

[48] Street preachers have been known to protest in groups occasionally, but they are usually not affiliated with one another. On the *Viceland* episode, the preachers describe themselves as "a group of men" who are "here to tell people about the good news" (Vice TV 2017).

Sometimes protesters are simply church groups who identify on the broad spectrum of Christianity. Many providers shared with me that the church groups that come most frequently are not even local to the area. Instead, they often come from more rural or conservative parts of their states. In fact, one antiabortion organization called Love Life in Charlotte, North Carolina, capitalized on this trend and organized for a different church to host each Saturday clinic protest during the "40 Days for Life" period. By managing the churches in this way, Love Life has been able to mobilize large swaths of people, sometimes in the thousands, to protest outside the clinic on Saturdays (Love Life 2022). And last, there are miscellaneous people or "one-offs" who oppose independent abortion clinics and claim no affiliation. Usually, a "one-off" protester will cite a religious belief or "a calling" that attracts them to the clinic.

Spheres of Terror

Although I primarily focus on the terror that happens at the clinic affecting patients, providers, and surrounding communities, I must acknowledge that for providers, terror extends beyond the workplace; terror follows them home. During my interviews, I heard many stories about antis flyering providers' neighborhoods, posting grotesque signs outside providers' children's schools, and protesting at their places of worship. After all, an unsuspecting Dr. Tiller was murdered in his own church (A. Young 2009).

A significant portion of provider-targeted antiabortion terror happens in the virtual world. There are three main types of online harassment: surveillance, direct threats, and defamation. Online surveillance includes posting a doctor's personal information, such as a home address or place of worship. Protester sites often contain recordings of doctors engaging in mundane activities. (Notably, antiabortion protesters also record the license plates of patients and film

them entering and exiting the clinic.) When posting this footage online, antis are making the provider's personal life and location available to the larger Antiabortion Movement. They may also send footage or written evidence of knowing the provider's comings and goings, simply to intimidate them.

Although I contend that surveillance is also a threatening action, threats articulated in emails and text messages often include direct death threats to providers or threatening the destruction of a clinic. While alarmingly high in 2019 at 22,366 (thought to be a low estimate), the incidents of hate email and internet harassment increased to 24,646 in 2020 (National Abortion Federation 2020, 3).[49] Death threats and threats of harm outside of online delivery (i.e., mail and phone) also increased from 92 cases to 100 cases (National Abortion Federation 2020). The "wanted" posters, such as the one I described earlier, set a tone of exposing the personal details of providers' lives to the surrounding community and the larger Antiabortion Movement to do them harm. Antis aim for this exposure to induce shame and ostracization.

One prominent way in which antis expose the personal information of abortion providers is through the Abortiondocs.org website (Operation Rescue n.d.). Reminiscent of the previously mentioned Nuremberg Files, the site serves as a national database of abortion doctors and abortion clinics for antiabortion protesters and terrorists (Feminist Majority Foundation 2019b). Started in 2012 by Troy Newman as a project of Operation Rescue, the website describes itself as "a clearinghouse for information gathered by activists from all over the nation […] The Purpose of Abortiondocs.org is to provide the public with comprehensive-to-date information about the abortion cartel" (Operation Rescue n.d.). It is no mistake that the website has such a

[49] 24,646 is thought to be a low estimate as the numbers rely on clinic reporting and often clinics do not have the capacity to report all incidences.

common name. The hope is that potential patients will encounter information about their doctor that will dissuade them from getting an abortion. Additionally, the website seems like a professional public health website, with AbortionStats2022 in the top left corner. They list medical school, clinic, and work history. They also link to articles that suggest malpractice and "botched abortions." Each doctor's profile has the following subsections: Disciplinary, Malpractice, License, Audio Files, and Miscellaneous.)

Abortiondocs.org endorses doxing, a word I was completely unfamiliar with until I started traveling with the AAF crew. I noticed escorts would mention it in casual conversations, discussing the time they were "doxxed" or online security actions they were taking to avoid "doxing." Although not exclusive to abortion discourse, doxing refers to releasing someone's private information, such as phone number and address, with malintent. For some in smaller communities, it can be especially harmful. For example, many providers disclosed that they do not tell their doctors, clergy, and even some friends and family what they do for fear of conflict, unfair treatment, or discrimination against their children, spouses, and family members. Doxxing may also lead to stalking and blurs the lines between online harassment and stalking. Additionally, antis are committed to online defamation. They will spam providers' and clinics' websites and email accounts to hinder daily operations. They write scathing google and yelp reviews and seize any opportunity to embarrass, belittle, and threaten providers and clinics on online forums. They will also spam any business they perceive or witness as servicing or supporting the abortion clinic.

With SB 8 and the antiabortion laws that have followed, a new type of online surveillance has emerged concerning the aiding and abetting abortion clause. What some have termed the

"bounty hunter" hotline, there are now phone numbers and websites for people to report those they suspect of helping someone obtain an abortion.

Discourses of Terror

Now that I have provided several examples of phrases these groups use and where and how they use them, I want to address their content. As one may imagine, there is so much that I can say about how antiabortion protesters talk (and shout) about abortion. Several researchers have documented analyses of antiabortion discourses. I want to specifically focus on some of the themes of content I have seen regularly at clinics. I term these themes discourses of terror because I argue that antis use this language to incite fear—sometimes explicitly and sometimes implicitly. Moreover, there is a broad spectrum of fear, from fear of physical safety to fear of moral failing. While most concentrate on how antis use religious language and themes, other discourses are at play, such as militaristic/war, patriotic/citizenship, economic/mercenary, fetal personhood, disinformation, and gender and sexuality, as well as racial discourses. Notably, these discourses are complex and are not mutually exclusive. For instance, the themes of conspiracy and co-option of progressive social movement rhetoric are interwoven with all of these main discourses.

By discourses in the clinic context, I mean written or spoken language by antiabortion protesters at or in the vicinity of the clinic space. Many of these discourses extend into the online and home spheres just described. Additionally, they extend into the political and legal realms. However, here I am focusing on types of words, stories, tropes, and ideas shouted, whispered, emphasized, and written by antiabortion clinic protesters. Beyond words, discourses constitute ways of thinking, meaning, and power relations (Foucault 1972). It can be challenging

to disentangle these discourses, but it is crucial to demonstrate the specific rhetorical strategies and harms perpetrated by the protesters. Therefore, I will briefly describe the discursive categories here and dive deeper into these discourses throughout the dissertation—especially in Part Two.

When I mention that I research antiabortion protesters, many people retort something about religion or religious people. When I say "religious discourses" in this context, I am referring to psalms spoken and inscribed on posters, photos, and figures of Jesus and Mary, rosaries, shofars, and the invocation or writing of God, hell, lucifer, the devil, and angels. These symbols convey multiple meanings for people, depending on their religious identities and practices as well as their religious histories. Antis use diverse tones when communicating religious messages. For example, some reference a loving God who "will forgive you if you just walk away from this place." Other speakers portray a vengeful God when they say, "God will punish you" or "Thou shall not kill. You will go to hell for killing this baby." Some antis invoke God in desperation when they scream, "Please, God, save this baby!" And some deliver messages in all these tones—sometimes in the same fifteen minutes.

Admittingly, to me, a Reform Jewish-raised feminist, the religious messages start to sound the same outside the general tone or presentation of the message. However, providers tell me (and I have started to notice myself) that these messages can often be discerned from one another by the religious identity of the speaker. For instance, Catholic protesters tend to bring rosaries, pray in Latin, and carry figurines of Mary and Jesus. They tend to pray silently, whisper, or chant at moderate volumes. Evangelical protesters favor God and Jesus-centered imagery and seem likelier to emphasize hell, yell, and scream. Additionally, street preachers of multiple Christian sects, usually Protestant-affiliated, have their own distinctive style of

delivering religious messages, which typically includes a microphone or amplification device and reading straight from the bible or reciting their own sermons. While these have been the three main types of religious discourse speakers I observed, I want to emphasize that protesters (and patients and providers, for that matter) identify with multiple religious sects.

Most scholars who write about abortion discuss the religious discourses of the Anti-Abortion Movement, so I will not comprehensively review that here. However, for my purposes, it is worth mentioning that a recent book (2020) on the Antiabortion Movement details how antis transformed the clinic from a medical space into a quasi-religious space that was explicitly political (Holland, 2020, 113). In *Tiny You: A Western History of the Antiabortion Movement*, Jennifer L. Holland argues that antis converted the space outside the clinic to a public place where redemption from sin was possible. She explains that they did this with their use of ecumenical rhetoric and religious ephemera and their perpetual presence in the clinic landscape (Holland 2020, 112, 115). She states that antiabortion material became "tools of religious devotion" and reflected the merging of religion and politics (Holland 2020, 112).

The public nature of the outer clinic space was a critical part of its appeal to Christians and a crucial part of their strategy to stop abortion through public prayer. Holland explains that prayer looks different between evangelicals and Catholics, with Catholics preferring the quiet recitation of the rosary and evangelicals engaging in large call-and-response and music-making activities. Although she discusses this difference, she also argues that public prayer at clinics is a gateway for other more direct actions at clinics, like sidewalk counseling (2020, 112-113).

Holland explains that this transformation of the clinic space has been used for broader arguments of the newly formed ecumenical Christian majority that religion not be made private but public and devotional and about religion's role in society more broadly (Holland 2020, 116).

Ultimately, Holland insists that this change redefined the cities' geography. She says, "When activists made functional pathways to medical clinics into ecumenical religious space, they changed the geography of American cities. Fetal crucifixes, pop-up graveyards, and signs calling for God's wrath invited casual passersby to rethink previously generic city streets" (2020, 116). Whether large numbers or not, the publicness of antiabortion protests became deeply intertwined in the public's perception of these spaces. And more than religious spaces, antis branded the clinic space as an aggressive, graphic, violent, and ultimately, highly contested space.

Militaristic/war discourse includes the language of war and war rhetoric such as "battle," "bloodshed," "war," "warrior," and "soldier"—emblematized by the term "abortion wars," a term that both antis and pro-abortion or pro-choice groups use. Antis, however, use a wide range of militaristic language more frequently with one another and on their signs, t-shirts, and other anti ephemera. Additionally, some protesters look dressed for battle, carrying a gun and wearing army fatigues. These discourses, verbal and visual, imply that abortion is a serious event—a life-or-death event. And more, that clinics, patients, and escorts need saving from themselves and their "wicked ways."

The way militaristic language is used is gendered. In "White Sexual Politics: The Patriarchal Family in White Nationalism and the Religious Right," Sophie Bjork-James discusses the use of militaristic language in the white nationalist movement to assert gender boundaries when it comes to the realm of action (Bjork-James 2020). She writes, "While women are seen as mothers and nurturers in this movement, men are its warriors and representatives." This concept is reflected outside the abortion clinic and explored in Peggy Phelan's generative essay about Operation Rescue protests and gender that I described in the introduction: men loudly lead the rescues while women pray quietly on the side (1993, 385). Men position themselves as the

rescuers—"saving" the "pre-born" from their impending "murder" (1993, 388). Men are in the spotlight, "saving" the day.

Often, outside of clinics, antis intertwine militaristic discourses with religious ones. For instance, the name Army of God invokes a vengeful, harshly punishing, and militaristic God who leads an army of followers. As of the writing of this dissertation, on their website, Army of God honors Scott Roeder and Paul Hill, labeling them as "American Heroes," and they include a photo of Dr. George Tiller's casket. Above the picture, it says, "Babykiller George Tiller Being Buried." The text above the image reads: "George Tiller would normally murder between 10 and 30 children each day." Under the photo, it says:

> Psalm 55:15 Let death seize upon them, and let them go down quick into hell: for wickedness is in their dwellings, and among them. How many unborn children scheduled to be murdered by George Tiller were spared by the action of American hero Scott Roeder? A very large number. George Tiller, the Babykiller, reaped what he sowed. Now George Tiller will never murder another child. (Spitz n.d).

Here, Army of God sanctions the ruthless murder of Dr. Tiller with a Psalm. As God's "army," they have positioned themselves to carry out what they determine to be God's will, ushering the "wicked" swiftly to hell. The statement is also an example of carrying out and glorifying the concept of "legitimate homicide." Further, by labeling Roeder as an "American hero," they bestow upon him a title often reserved for those who risk or lose their lives in the United States military forces. And Army of God is not the only group to use militaristic language. During the writing of this dissertation, a quick Google search of Operation Save America's website reveals the following text: "OSA Regional Event: Personal Tactics in Kingdom Warfare."

Related to militaristic discourses are patriotic discourses. Patriotic discourses usually include how antis talk about their work. They refer to themselves as "heroes" who want to "save" this country and "defend" the "pre-born." They talk about God's anger and wrath for the

sinners of this country and their desire to save it. Additionally, many signs and clothing worn by protesters will show the American flag or the American eagle.

In the previous Army of God example, Scott Roeder, a man who murdered a doctor as he stood in the entryway of his church, is an "American hero." And it is not just Army of God who uses patriotic phrasing, but also Operation Rescue/Operation Save America—it is quite literally in their name. They claim to "save" or "rescue" babies/potential citizens, and in doing so, they claim to "save America." The speech in their discourse is often along the lines of loving this country and wanting to save it.

In addition to successfully appealing to many politicians, antiabortion protesters directly call out politicians outside clinics and online. For example, during the 2016 presidential campaign, Father Frank Pavone released a video of an aborted fetus on an altar urging Catholics to vote for Donald Trump (Pullella 2022). In her visual media analysis, Lauren Berlant theorizes the fetus as a citizen and child of the nation's parent (Berlant n.d., 183). She expounds that the fetus symbolizes the nation and the womb is merely a nation-making machine, erasing the mother (Berlant 1997, 148). She further clarifies that the public then identifies with the fetus and interprets its annexation as their own destruction or as the destruction of "man." In the context of Berlant's analysis, Father Frank's gory pleas may be considered a cry to save the nation and its rightful citizens (Pullella 2022).

Faye Ginsburg first analyzed antiabortion economic discourses in her groundbreaking book, *Contested Lives: The Abortion Debate in an American Community* (Ginsburg 1989). Ginsburg explained that in the 1980s, antiabortion protesters were suspicious of the siloing of abortion services from general healthcare services. They asserted that abortion became its own "for profit" industry, making millions at the expense of women (Ginsburg 1989, 56). This idea

was a part of their more general critique of the increasing materialism of the United States (Ginsburg 1989, 56). Ginsburg points out the irony that abortion clinics are deemed suspicious due to their marginalized status in healthcare. The separation of abortion services from other health services is due in part to abortion stigma within American medicine. Studies have shown that independent or network abortion providers do not make more money than doctors performing comparable procedures. The price of abortion has barely increased in the past twenty years due partly to many abortion providers' dedication to the cause to provide abortion to the most marginalized patients.[50] These discourses still resonate today. Antis will often discuss the abortion clinic as an "abortion mill" filled with eager "money-hoarding" doctors. More, they claim that these doctors are not even qualified as physicians or refer to them as "backalley butchers" who provided clandestine abortions pre-*Roe*.[51]

Generally, fetal personhood refers to the claim that fetuses are people, citizens with ostensibly the same rights as pregnant women (Cohen and Joffe 2020, 228). Many scholars have written about fetal personhood at length, including Rosalind Petchesky, who discussed the fetal focus of the antiabortion rhetoric in the introduction of her generative book *Abortion and Woman's Choice* (Petchesky 1990). She explains that the Antiabortion Movement's construction

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[50] According to the Guttmacher Institute, in 2011-2012 the average cost of an in-clinic abortion procedure abortion at 10 weeks' gestation was $495, with pill abortion costing $500. Notably, prices increase with later gestation, staying about the same during the first trimester and increasing with time after that. Prices varied based on facility size with larger caseload clinics on the lower end at 450.00, and clinics with the smallest caseloads charging the most at 650.00 In 2009, the average cost of the same procedures was 503.00 and 534.00 respectively (adjusted for inflation) (Jerman and Jones 2014). A more recent article (2023) from U.S. News and World Report summarizes the average costs by U.S. region in 2020. They report that pill abortion in the first trimester can range anywhere from 490.00 in the South to 730.00 in the Midwest and West North Central regions. A procedure abortion in the first trimester can range from 492.00 to 755.00 respectively. The article reminds readers that abortion costs depend on several factors including: gestation, type of abortion (i.e. pill or procedure), insurance coverage, geographic location, and access to financial help from an abortion fund, employer, or other source (Knueven 2023).

[51] "Backalley butchers" or "abortionist" are derogatory terms used for practitioners providing abortion before legalization in 1973 (Joffe 1995, VII).

of and focus on the fetus is relatively new and has had a tremendous effect on the public's ideas about abortion (Petchesky 1990, xi). She details that the centering of the fetus decenters women and neglects the interconnected relationship between mother and fetus (Petchesky 1990, xii). She also argues that the fetus is highly symbolic, providing a rationalization for military takeover and dismantling social welfare (Petchesky 1990, xiii). Since then, other researchers have dedicated books to the subject, such as Morgan and Michaels's *Fetal Subjects, Feminist Positions*, *Tiny You*, and countless essays by other authors (Morgan and Michaels 1999; Holland 2020). In my clinic experience, antis engage in both of these discourses enthusiastically. I detail the construction and focus on the fetus in Part Two, Chapter Three.

Particularly in the legal sphere, antiabortion rhetoric has used scientific and medical language to assert misinformation about abortion, specifically when it comes to adverse mental and physical health outcomes (i.e., abortion can cause suicidality, abortion leads to infertility; abortion is linked to breast cancer, etc.). This language has been a vital component of the terror of deception. Not only do the mandated consent processes that physicians in many states are forced to fulfill cause them moral and professional distress, but their proliferation only adds to the suspicion of abortion doctors and the health system in general. Most people do not realize that these statements are untrue and trust that a medical facility will indeed provide medically accurate information. This rhetoric has also made its way to the clinic site on posters, specifically in the materials the CPC-affiliated antis distribute. Not only is the information incorrect, but it can be dangerous. It also reflects a co-option of rhetoric from progressive social movements and the health sciences.

A recently documented but long-known reality of people who work at clinics is the overlap and inseparability of antiabortion protesters and white supremacists/nationalists, which

was made clear on a national level during the insurgency of January 6, 2021. Since then, news articles have documented this overlap, and reproductive justice organizations have launched panels and events on the subject.[52] At one such Zoom event entitled "Outside the Clinic, Outside the Capitol," providers discussed their experiences with antiabortion protesters, most of whom have been on their radar as misogynist racists for years. In fact, one provider shared that she felt triggered as she watched the events unfold on TV, based on her experiences at her clinic with similarly presenting rioting people. Other panelists commented that although America was shocked by the event, many providers were not because it was akin to the violence they see every day.

Abortion providers, advocates, and activists have spoken about the intersection of white nationalism and misogyny presented at the clinic landscape for years. For example, a provider on the panel mentioned that antiabortion speech is acutely racialized and threatens her Black staff. She commented that most of her team are Black women, and the threatening, racialized language antis use intimidates them, their communities, and their children. I also heard providers of color speak about how they experience the inherent gender violence of antiabortion protester presence combined with insidious racial violence hearing antiabortion protester racist speech. At a national conference, one Black provider explained their frustration with national abortion organizations' safety recommendations, prioritizing police contact and relationships. Not only do some Black providers know that their local law enforcement is anti-Black, but often, even when

[52] Reproaction and Abortion Access Front both hosted panels on antiabortion protesters and white supremacy, specifically discussing the well-known antis who were part of the insurrection. Also see Carol Mason's article "How Trumpism Fostered Anti-Choice Violence," and Lauren Rankin's "How Antiabortion Terrorism Fueled The Capitol Attack" (Mason 2021; Rankin 2021).

they call for help, they are disrespected. Indeed, seeing a white man in a hat and a conservative t-shirt can prompt worry at best and, depending on the setting, utter terror.

Much analysis has documented the gendered, sexualized, and raced speech outside abortion clinics, including Whitney Arey's recent essay on the subject. Arey describes how masculinity is constructed outside the clinic by analyzing protester speech (Arey 2020). She explains that antis use of this language is wielded to incite action, and often violence, by aggravating tropes of Black masculine identity. She explains that antiabortion protesters, usually other men, will use "negative cultural stereotypes of men as deadbeat, irresponsible and weak fathers" (Arey 2020, 12). She underlines that this type of speech is used explicitly to elicit responses, and it often does. At a clinic in the U.S. South, the police arrived saying they got a call from an anti about being assaulted. I heard the escorts explain that a companion reacted to being explicitly and aggressively provoked by an anti, and that no physical harm occurred; they attempted to persuade the cops from taking any action. I did not see the incident the police described, but it was not difficult for me to imagine. Afterall, I heard protesters yell at Black patients and staff that they are contributing to "Black genocide" and that "Babies lives matter." To co-opt the language of the Black Lives Movement to further their own agenda rings especially cruel—especially considering the racist rhetoric and overlap with other white supremacist groups. They effectively weaponize the language not only to induce potential emotional harm but also to incite a response that they can report to police and further contribute to racial injustice and criminalization of Black men.

Even if the comments are not explicitly targeting someone's race or gender, they can still be harmful in other inconspicuous ways. When considering the potential of terror-inducing speech, it is essential to consider the positionality of the provider and patient. The religious

themes, imagery, and taunts may be harrowing for some who identify as religious. The patriotic speech may antagonize a patient or companion who has served in the U.S. military. The economic/mercenary discourses may scare people who fear health services based on past experiences. A fetal personhood-themed remark may upset someone having a later abortion due to fetal demise. And the signaling out of people based on their gender, race, sexual identities, or presentation may elicit a particularly acute fear —significantly depending on the person's marginality.

Effects of Terror

As I hope readers will discover in this dissertation, it is one thing to read about the history of terror at clinics, and it is another to experience it every day as part of your job. After a few weeks of asking providers about their challenges, I knew I needed to ask about their experiences of fear. Fear and safety hung in the air during our interviews and were mentioned in almost every conversation. I started asking, "Do you fear for your safety working here?" I phrased the question this way to further probe their specific experiences, if they offered them, but so that they did not feel pressured to do so. Some providers answered this question directly, while others offered stories of terror during other conversation points. Regardless of precisely when interlocutors discussed it in the interview, fear and safety almost always came up, one way or another.

Although I interweave these stories throughout the dissertation, I want to outline some of the main themes of provider fear here. I believe these experiences demonstrate how providers embody the collective memory of fear and the means they use to navigate it. Providers discussed three primary stages of experiencing fear: (1) fear activation; (2) fear coping strategies; and (3)

reflexivity (or, in other words, how their reactions to fear made them feel about themselves and their own identities). Within these categories, the following themes emerged: remembrance and hypervigilance, dissonance, and self-concept. I describe examples of each theme in this section and conclude the chapter by discussing how providers use humor to cope with fear.

Several providers discussed the moments in which they are most aware of in their safety. Generally, such instances include when they see protesters, hear or think of violence at another clinic, and on specific days when clinic violence happened (e.g., the day that George Tiller was murdered). When asked about working at the clinic, one provider responded: "I would say the only challenge is worrying about my safety. […] There's days where I'm more concerned than others. Um, it's usually based on seeing the protesters outside that might get me a little more heightened." In this example, the mere sight of a protester reminds the provider that she should be careful and alert. Notably, she does not describe when protesters are particularly aggressive or loud, but merely seeing them reminds her that her safety is threatened.

Some providers describe constantly feeling on edge or paranoid regarding their safety and the greater safety of the clinic. For example, one provider said, "We're much more aware of our surroundings. We're always looking at our building. We're always assessing things that seem weird." Another provider explained that:

> […] the woman that hired me and trained me [was] an incredibly paranoid person and made me constantly think that everything I said or wrote was going to end up in court. And so I constantly am thinking like, write this correctly and say this correctly so that you don't have to, like, backtrack your words. So I was just trained that way. And so I'm always like, what if they're recording my conversation?

In this example, the provider worked in reception and described her worry about accidentally saying something wrong that might harm the clinic. Many providers fear potentially making the clinic vulnerable. I have that fear too. I often think, what if an anti could use what I say against

me—or worse, to harm a clinic? Antiabortion protesters have often used "gotch-ya" tactics. A prime example of this is the invasion at a Colorado clinic where an anti posing as a patient took misleading photos inside the clinic. Another prime example of hypervigilance is described in the Part One introduction when the clinic director was convinced that a man on her plane was there to attack her.

While some providers express hypervigilance, many convey dissonance between the actual threat on their lives and their own perceived threat. In fact, this has been discussed in other research on abortion providers and extensively among abortion researchers anecdotally and in the hallways of conferences. As a result, many providers do not consider their environments secure even if they and their clinic take extensive safety measures. A few providers even mentioned that they should probably be more careful but that the dissonance helped them cope with their fear.

One provider in the South told me, "When it's your time…, it's your time." He offered this philosophical insight in relation to the proliferation of gun violence in the United States, especially at such mundane everyday places as shopping malls and grocery stores. Something bad could happen anywhere. Still, he continued, "it's definitely on your mind.

> But if you really get obsessed with it, I mean, of course, we take measures to ensure the safety of the staff and the patients and the physicians. But, you know, it's one of those things that you can only do so much. And if you get caught up into, I guess, the, you know, is this going to happen? What can happen? And all that, then to me, you really wouldn't be able to focus on the work.

Here the provider reflexively says that he cannot get too caught up with safety because it would distract him from work. Yet, he also normalizes fear for safety when he references anyone's security could be threatened by going to a shopping mall. Indeed, several providers told me that they were no more unsafe than anyone else due to the pervasiveness of gun violence.

Additionally, another provider normalized her fear when I asked if she feared for her safety by responding, “Um, yes, but don’t we all?”

A few providers communicated a safety dissonance when they described a need to block, compartmentalize, or ignore their fear. For example, one provider in the South whose clinic experienced several violent acts, including arson, said:

> I mean, some people just kind of have their baseline as anxiety, and I think they tend to be the more anxious ones about it. And I'm just not one of those. It's just, you know, like I don't, I try really hard not to let the protesters get what they want…. They want to take your time away from your work, and they want you to call the police, and they want you to get upset. And, uh, it takes a lot to get me there.

Here, he acknowledges that he is generally not an anxious person but that having or expressing fear or antagonizing the protesters is giving them what they want. His ability to keep his anxiety at bay reflects his principle of standing up for abortion work. Another provider in the South acknowledges that even though she is proud of her career, it is still “not normal” to have people screaming at you every day when you walk into work. She says:

> I feel extremely proud of the work that we do here as a whole. […]. It is not a normal thing to have people, um, you know, screaming at you that you are, you know, “destroying families” and participating in “Black genocide” and all of those kinds of things. Um, as you're walking into your workplace, it's just, it's not, um, it never gets easy or comfortable. I mean, we certainly get a little bit numb to it sometimes and just have figured out coping mechanisms to like turn it off.

In this example, the provider mentions that emotional numbing (i.e., “turn it off”) is a coping strategy to mitigate the difficult and uncomfortable feeling of walking into work.

Some providers demonstrated a safety dissonance when they confronted an antiabortion threatening presence. For example, a provider in the Midwest shared a story with me:

> Provider: Well, there's been a couple of times when I've done stuff that I shouldn't have, um, for my own safety. […] Someone came in, and he started talking about killing the

> babies, and he was here to represent the Irish people, and the Native Americans, and he was obviously mentally ill. And I said, “No.” And he said something about killing and all that. I said, "Well, we don't kill or murder here." Um, I said, "But you need to leave." And he said, "I don't have to leave." And so, you know, we went back and forth. And I said, "Well, I'm gonna call the police then if you don't leave." And then when he turned to go, he took his hand, and he went like that. [demonstrating a shooting gun hand motion] […]
>
> Me: You weren't scared?
>
> Provider: No, I really realize I wasn't. I was just more pissed off. […] After he left, I followed him out because I watched him go down the stairs on the monitor, and I wanted to make sure he left the building. […]. So then he went out the door, he went out the plaza. So then I waited a few seconds, and I went back, and I went to the plaza. And then he was sitting in front of our building on the sidewalk. And, um, he had this big, like all-you know, the army coats with the fur pulled over his head. I should have just went inside, but I sat out there because I knew the police were coming, and I wanted to make sure they knew where he was. But that was not my—I never should have even followed him outside. I should have just let the police handle it. But he finally did it [left], but yeah, that was stupid. I mean, some of the things I do, I don't think about until after. So I need to just learn to, um, stay in the clinic where it's fairly safe rather than going and trying to be a martyr because I wasn’t know if he had a weapon or anything.
>
> Me: I mean, that's very brave.
>
> Provider: Yeah, and my husband was really mad at me when he found out that I had done that, and even the police officer said too, "You shouldn't do that." And I said, "Yes, I understand now that I shouldn't." [laughs]

In this story, the provider acknowledges that her actions were ill-advised; after all, he gestured a shooting motion, was yelling, and refused to leave the clinic. However, she explains that she was angry, and she did not think it through. This provider has worked at this clinic for over 20 years. She is very experienced and adeptly manages her fear. Yet, she admits that she was not thinking clearly about that specific threat. Her demeanor remained cool as a cucumber. Indeed, other clinic staff described her, in separate interviews, as a calm and fearless anchor.

Perhaps one of the most surprising forms of safety dissonance was friendliness. When I asked them about their interactions with the neighboring CPC director (who shows up at the

clinic explicitly to disrupt its everyday functioning and to pressure pregnant people to continue their pregnancies), a provider in the South said:

> Provider: She'll come by, and she'll be like, "Could you help me to … fix my phone? Could you help me do this?" It's like-
>
> Me: She sounds annoying. [laughter] And y'all help her?
>
> Provider: Yeah. Like, oh my God. You know? She's one of us. She's just one of us!

I was fascinated by this interaction. The provider told me that not only did he help her fix her phone but also took the CPC's staff photo. In hindsight, I wish I had asked what the provider meant when suggesting that the CPC director was "one of us." In context, I hypothesize that he means a person who works with pregnant people or just a friendly and funny person because, earlier in the interview, he says that she is "fairly nice," unlike the last CPC director. Originally from the South myself, I laughed with this provider that this "would only happen in the South." And, in fact, the examples in my research of providers being friendly with the antis—whether protesters or CPC staffers—were always situated in the South. This is a cultural difference that begs more investigation. Friendliness with protesters can also be an escort surveillance strategy, which I explore more in Part Two.

Traveling from clinic-to-clinic, I started to notice that people attributed much meaning to the ways they responded to terror. I noticed when they told me how they navigated fear in their work, their judgments about how they dealt with it contributed to how they conceived of their identity. Often, they interpreted their reactions as central to who they are, and they used it to judge themselves as being "cut out" for the job or not. I found that the descriptions reflected a "fight or freeze" mentality. For instance, one provider told a story about tackling an intruder who knocked a patient to the ground and how, subsequently, four other female staff members piled on

to ensure he could not escape. When I expressed amazement at their courage, she responded, "I know. […] We all fought. Nobody—no one tried to hide." As mentioned earlier, Dr. Lee Carhart reflected that he doubled down to fight for abortion rights after antiabortion terrorists burned down his barn, murdering twenty-one of his horses and two family pets. When looking back on the event, he said, "You know, we had the fire where we lost everything essentially. And yeah, that, you know, I don't think there is a day I don't think about that."

More than just fuel to "fight the good fight," some providers spoke about their experiences dealing with abortion terror at work as surviving a war. One provider commented, "You know, like, I went and worked in a war zone for a year. And I came back feeling that way too, like I've got some health issues because of it." Another provider compared the way he deals with fear in abortion work to the way he dealt with fear in the Air Force. He said: "You know, we got up every day knowing that people were gonna try to kill us until we got back home. So that's really what you're doing now, and it really is."

Conversely, another provider judged herself harshly for being afraid of an intruder. She explained:

> I was not feeling I could stand my ground at all. And it just really, really shook me up. And I was upset for days afterwards. And I was just like, I don't think I can do this anymore. Like, I don't know if this work is for me. I don't think I can do this. Like I did not have it in me to be confrontational or stand my ground to this guy. […] [It] like totally made me feel unsafe. And, um, yeah, I just kind of was like questioning everything. […].Yeah, it was traumatic. It was. […]. And so, I couldn't help but think I need to be like the people who are not as upset as me, because I'm a leader, and I should be like in that category. And I definitely was not in that category. And so I started questioning, like, how can I, how can I be the one that people look to? […] I've been a failure, you know, you feel like, like imposter syndrome, you know, like everyone thinks, I'm so good at this and look at it. I'm not good at this at all. Just faking it. So I just thought like, this is not; I can't be the face of this anymore.

This provider explained that because she was frightened by the intruder and needed some time off afterward, unlike other staff, she was an imposter—that as a leader, she should have stood her ground and that she could not be the face of abortion anymore because of her cowardice. During the interview, I suggested that it was not cowardly to be afraid of someone who entered the clinic yelling threats, especially considering the violent history of the Antiabortion Movement. However, her comments about being "the face of abortion" also reveal that abortion providers are often positioned as representatives of abortion in general, that they are fighting for a human rights movement.

In my final interview at the very last clinic of my fieldwork, I spoke for over an hour with one of the few providers in the country who offers later abortions, one of the most stigmatized types of abortion due to gestation period. Antiabortion groups have long vilified the few doctors that provide later abortions. Later abortion providers have been the targets of some of the most extreme violent acts as depicted in the documentary on the subject, *After Tiller*. After all, Dr. Tiller was one of only five later abortion providers at the time of his murder. Other later abortion providers have survived murder attempts, stalking, and damage to their homes. In general, I was especially careful around the later providers I interviewed because they deal with sobering safety threats and are fairly high profile as a result. The last thing I want to do is pressure them to relive trauma. So, for my last interview, I was well versed. I felt most prepared to approach antiabortion violence questions tactfully.

For this particular interview, it was nighttime because she was still working with patients. I felt especially relaxed because I bonded with the provider fairly quickly. She was significantly younger than most of the providers I met and struck me as someone with whom I would be friends. We had been talking for about thirty-minutes and she was making me laugh, discussing

the different challenges people working in abortion face. I did not want to dampen the mood with my next question, but I knew that I needed to ask her about safety and antiabortion violence—especially since she was a later provider. When I asked her about it, she did not skip a beat. Unphased, she launched into a series of stories starting with this one.

> There was a time, several years ago, in which there was a twenty-week ban that they [the antis] were working on here in the city. And I'm pretty sure it was around that time that they started protesting outside my house.[…]. And they sent postcards with my picture and like a mangled fetus, and then it said like (*whispers in a nefarious tone),* "A killer amongst us." It was very dramatic. And I feel like they could have doctored the picture to make me look more evil, but it was okay, it was pretty good.
>
> And then they had my home address, and the phone number of the clinic here, and they sent it to like half of [Southwestern city] and everyone in my neighborhood. And when they were protesting on my block, I think they were expecting the neighbors to come out with torches or something, but the neighbors were like, "Ew, gross signs."
>
> And a bunch of people called the cops and like didn't let their children play outside that day, you know. And then- we got zero phone calls 'cause it said (*she hisses)*, "Call her and tell her to stop killing babies." We got zero phone calls as a product to that postcard and they must have sent out like 100,000 of them. Like people all over the city got those postcards. I know because they all texted me in a panic, and I'm like, "I know, I know, I know, relax, it's fine. I don't even look like that anymore."
>
> And then—it was a really old picture, I was like, "Oh, my god, I should send them an updated picture, like something more glamorous […]. I look way better than that.

As an ethnographer traveling with Abortion Access Front, I was particularly attuned to humor—how providers, escorts, and activists use it. However, when I began my research, I did not expect to hear much humor when it came to providers' lived experiences of targeted harassment and violence. In fact, so much of what I heard about was the collective memory of terror and the ways in which it affected the everyday activities of the clinic—especially when it came to safety procedures and communicating with people outside of the clinic environment. Here, the provider reveals that the antis protested outside of her house, in her neighborhood. She explained that many neighbors reacted and that her photo and phone number were distributed widely across the

city. These are trademarks of targeted harassment and quite dangerous ones at that, especially the disclosure of her home address. Yet, the way she tells the story uncovers the irony and humor in the antis' unsuccessful effort to scare her family, ostracize her from her neighborhood, interrupt her workflow, and ultimately get their twenty-week ban bill passed.

When she uses the low, intense whisper when saying "a killer among us" and "call her and tell her to stop killing babies," she reveals the ridiculousness of the statements. She builds up their efforts and hints that they were unsuccessful in the impression of her neighbors who did not use the experience to harass her but were creeped out by the photos and called law enforcement on the antis. And then the ultimate punchline is when she explains that the photo that they used in the flyer does not even look like her and that she should send them a more "glamorous" photo for the future. The punchline hits hard because her concern over the actions of antiabortion protesters, which has escalated to murder in the past, is over her appearance and not her corporeal safety. She controls the narrative, revealing their inanity and using it to entertain herself and me in that moment. She uses humor in the face of terror, displaying the phenomenon that springboards this dissertation.

In fact, several providers spoke about using humor to deal with their everyday worries working in an abortion clinic. Specifically, providers discussed how making fun of the antiabortion protesters—revealing their hypocrisy and mocking their presence—was essential to dealing with their everyday fears. One provider said, "We just, like, joke about different things around abortion. And it just like helps us [to] get through the crap that we have to deal with specifically. A lot of clinics have a lot of jokes about … their antis [...] 'cause they say some interesting things for sure." Another provider shared:

You know, even now, I'm at the point where I find humor with the protesters because

> what they say, especially this one guy, in particular, is so funny. He gets mad, and I tell the staff, this is what you do. You kill them with kindness and humor. He got me one morning. […] He said, "Aren't you concerned about Black genocide? Aren't you concerned? What, what about your people?" I said, "You don't know anything about me or my people, okay?]…] Maybe you need to go back to—oh, I don't know, when was it?—1650, when the first Africans were brought over here against their will. Why don't you look that up? Why don't you do a little history check on that?" He said, "Lady, you're a piece of work." I said, "You ain't seen nothing!"

As she told the story, she laughed to herself, and I laughed along with her. Pointing out the hypocrisy and inaccuracy of antis' claims is a source of entertainment among clinic staff. Joking about this particular protester seemed especially important for this clinic in a Southern city with a Black majority, a long racist history, and a racist present reality. The irony of a white man yelling at a staff of primarily Black women about destroying the Black race compounds the potential harm of his presence. The provider's witty retorts offer a way for her to regain some power in the interaction.

Another provider described that laughing about the protesters' threats helps them deal with the persistent fear of going to work:

> Like one of our protesters just recently posted that he was going to stop abortion in [a Southern city]. Uh, he's the one that passed the things out in my neighborhood, the one that went to Dr. Pierce's church, and all of this. So, you stop and ask yourself, "How's he going to stop it?" You know, and after we saw it posted—I mean, we have to laugh about it because if we took it serious, it'd probably drive us nuts. But I laughed the next day, and I told Dr. Pierce, I said, "I was trying to let you get here before me, just in case he was going to take the first one out." But then, you stop and think, surely he's not that stupid, but I'm sure Dr. Tiller never thought he would get shot in church that day, either. So, it's something that you do think about, something I worry about, not so much for me, but for my youngest son, um, I asked what would happen if he lost his mother?

Here, the provider is not only using the joke about the anti taking "the first one out" in response to the stupidity of the anti's comment, but also to process her own grave fear that she could be murdered like Dr. George Tiller. Additionally, the provider tells us she had to joke about being threatened, or she would "go nuts." She explained that she decided to come back the next day

laughing. Her use of humor transformed the abortion clinic workplace into a workable setting for herself and her staff. Although some may describe this as “dark” humor, this intelligent posturing not only showcases the wit and creativity of this provider, but it establishes her insider status, bonding her with the doctor at her clinic and the other staff and ultimately enabling them to continue to go to work—the main goal of their resilience.

Regarding Dr. Tiller, one provider who was a close friend of Tiller said his humor was epic. He laughed with patients and colleagues, and he laughed about the antis. The provider remembered when Dr. Tiller asked him to visit during Operation Rescue’s forty-day siege.

> They surrounded his home…. He lived outside of Wichita a little bit. They had a farmer's field that they rented. They didn't tell the farmer what they wanted to do. They just said they want to have a bed there. But they all put up tents, and they were protesting at George's house right across the street for, oh, my God, for forty days, was only like that was forever. […]. And so he said [to me], "Well, you can go down, and you can stay with us. And, uh, we'll have something to talk about while we watch the idiots sitting." [laughs]

The forty-day siege was an intense and notorious time in antiabortion terrorist history, as described earlier in this chapter. Yet, the reality that Dr. Tiller shared a laugh about this situation reflects his resilience. The provider also shared that Dr. Tiller joked about his safety on their shared sixty-fifth birthdays.

> The funniest conversation I ever had was […] we're sitting on the sofa, and he says, "What do you think you're gonna be doing in ten years?" And I said, "Oh God, George, I don't know, I'll probably be sitting on the sofa talking to you." He says, "No, that is not gonna happen because if I'm still practicing when I'm 70, I'm gonna go buy a gun, fly to," I think it was Seattle, or Oregon, “bail Shelley out of jail […], give her the gun, and tell her to shoot me again." [laughter] […]. When he hired me was right after Britton was killed. And he said, "You know, we're both targets. I think we need to work together, so if something happens to one of us, we can keep the practice going."

In the story, when Dr. Tiller refers to “Shelley,” he is referencing Shelley Shannon, the antiabortion terrorist who attempted to murder him in 1994. She was also rumored to be involved

in his 2009 murder, when Scott Roeder killed Tiller at his church. The reality that Tiller's comments foreshadowed his death is macabre. However, it seemed that when the provider was telling the story, he was comforted by the memory of Tiller's humor. As I stood in his office, I slowly realized that photos of Dr. Tiller surrounded me. At that provider's clinic, Tiller was not only remembered as a part of the collective memory of terror but also as a hero, a colleague, and a friend.

The collective memory of violence at the clinic lives in the bodies of most providers and, although not always apparent, appears in jokes or offhand comments like these examples. Providers work in stressful environments due to the antiabortion violence that saturates every aspect of abortion delivery at the independent clinic workplace. Abortion providers confront threats of severe violence at their homes, places of worship, their children's schools, and work (for some, all day, every day). Whether less severe or more, this daily occupation of the clinic workplace indexes a collective memory of terror characterized by the murder of abortion providers. Terror permeates the clinic landscape and necessitates security measures to protect providers and patients.

Chapter Two: Security at the Clinic

One of the sadder aspects of the abortion wars is the degree to which these clinics, which want to provide a warm and welcoming place for their patients, have had to turn themselves into armed fortresses with bulletproof glass windows, security cameras everywhere, and ID checks.

--Carole Joffe

Reproductive healthcare facilities have become twenty-first-century equivalents to medieval cities where walls and moats were once used for security from intruders. Except now, protection depends upon advanced security systems including multiple surveillance cameras installed around and in entire properties and doctors' residences, multiple zones of bullet-proof glass at clinic entrances, the wearing of bullet-proof vests, and fulltime federal protection.

--Lori Brown

A Clinic in the South
October 15, 2019

As I drive up to the clinic, I see a police car surrounded by a group of people. An officer has parked his car next to the line that the antis cannot cross; he seems to be corralling them behind it. Seeing a police car arouses conflicting feelings in me. On the one hand, I think, "Good, law enforcement is taking antiabortion threats seriously, and if something happens, the staff and I will be safer." But I am also angry that a common health service is so threatened that there may need to be physical force to halt antiabortion terrorists. Simultaneously, I think just seeing a police car reminds me how unsafe an abortion clinic can be; it reinscribes the stigma and "exceptional" status of abortion clinics (Cohen and Joffe 2020). Moreover, seeing a police car also conveys a political charge. Two months earlier, I marched with my Black peers in Los Angeles, yelling, "defund the police." And I think about how social movements have revealed and amplified systemic police violence in recent years. To listen to the fear that the sight of police initiated for people of color makes me wonder how Black people must feel entering a clinic with a police car sitting outside.

Throughout my day at the clinic, I think about the police presence—especially because I notice that the entire staff, except for one admin person and the director/owner, are Black. Many of the patients are Black too. I jot down this fact in my notebook to remind me to ask about it in my interviews. However, police presence arises organically in my first interview with the owner/director when I ask about the clinic's relationship with various community organizations, including the local abortion fund. Frustrated, she explains that their relationship with the local fund is not great. She explains that, customarily, the fund would help with anything patients or clinics need, which in her case is the cost of hiring the off-duty police officer, which amounts to $800 a week. But when she told them that she needed help paying for police security, they refused. She says:

> I asked them to help me with my police officers. Uh, I didn't ask them to pay all of it. I just said, "If I could get some assistance from you guys," and they tell me that was not in their mission and vision statement. And I was like, "I just can't believe that the security of the staff, the escorts, the patients is not important."

Later, a few of the staff also disclose that they believe the fund gives more financial assistance to the patients who go to different clinics in the state. The story strikes me as particularly unfortunate because this is a clinic with little community support. In addition, their local abortion fund, one of the few pro-choice-aligned organizations in the region, does not want to support this need.

When I ask some of the Black providers at the clinic how they feel about police security, they tell me they do not feel safe seeing police in their neighborhoods but feel safer when they are at the clinic. They elaborate that, for better or worse, the antis respect police officers and tend to follow the rules and cause fewer problems when police are there. They also mention that when they do need to call the police for any reason, the police were more responsive because they knew the officer who was moonlighting there. Yet, they also comment that many of their patients—especially their Black and immigrant patients who may already experience surveillance and violence from the police—feel upset about the various precautions. Like many other clinics, they affirm that they wished they did not have to have all the rules and could operate like a "normal" healthcare center. They tell me they tried to allow cell phones. However, there were problems, from patients filming other patients and posting on social media, to antis infiltrating the clinic and halting operations.[53]

A few weeks later, when I bring up this situation to providers at another clinic in the South, one provider responds, whether police are at the clinic or not, "We become the police." The other provider sitting with us nods in agreement. She elucidates that they must tell patients, "no bags, no phones, etc." "We constantly have to say 'no.' We constantly have to set boundaries." Looking defeated, she says, "I hate doing it. We hate doing it." She explains that outside of her anti-police sentiments, constantly telling people "no" is difficult. More, reminding patients of rules and regulations disrupts the warm environment they seek to create.

The Security Bind

There is no question that the everyday violence and history of violence which comprise the collective memory of terror require security measures for clinic staff and patients (Brown 2013;

[53] There have been numerous occurrences of both types if incidents, documented and undocumented. One of the most notably are antiabortion organization Live Action's secret filming of Planned Parenthoods across the country. Once they have the footage, they heavily edit it, include medical misinformation, misrepresent the providers, and release the footage to their massive online following. Also, their founder, Lila Rose influences legislators towards antiabortion policymaking ("Live Action" n.d.).

Joffe 2009; Cohen and Connon 2015; National Abortion Federation 2020; Feminist Majority Foundation 2019). However, implementing security measures challenges providers because they often diametrically oppose their patients', community members', and their own reproductive justice values. Put another way, they are damned if they do and damned (or nonexistent) if they don't. I call this phenomenon "the security bind." First, I would like to define what I mean by "security" in the context of the abortion clinic. "Security," "clinic security," or "clinic protection" refers to the precautions and actions taken to mitigate threats against the clinic. Hazards can be legal, political, or corporeal. Threats against the clinic affect staff, volunteers, patients, and entire communities. I often refer to "surveillance" when discussing clinic safety. "Surveillance" refers to monitoring activities at the clinic. In the case of the abortion clinic, the state surveils the clinics; the antiabortion protestors (antis) surveil the clinics, along with the escorts, providers, and patients present; and clinic staff and escorts surveil the antis.

But what does this entail in practical terms? Safety measures in the abortion clinic space usually involve regulations surrounding ID checks, cell phones, bags, and companions. They might also include being buzzed into a clinic after identifying oneself or walking through a metal detector and facility measures such as bullet-proof doors, windows, and rooms, locking features, and security systems. Security measures also include constant surveillance of patients and protesters by security guards, police, and clinic staff.

These procedures are costly and laborious for clinics and providers, and they reinscribe the provider as an enactor of the patriarchal state. More, they reinforce the narrative used to legitimize many Targeted Regulation of Abortion Providers (or "TRAP laws") and stigma in the first place, which is that abortion is a dirty, dangerous procedure that requires much thought, consideration, and armor. Along this line of thinking, abortion should be taken seriously because

it involves the "death of a child," and also "risks the woman's life." In this way, clinics and providers are forced into a certain level of complicity to keep themselves, their patients, and their communities safe and ensure their existence to provide abortion. Thus, security comes with a cost to providers and how they wish to practice medicine to prioritize patient-centered care.

In this chapter, I explore the "security bind" concept, including providers' experiences with security and their implications in the context of abortion provision. First, I describe abortion provider terror by characterizing its different domains. By examining the multiple types of terror providers face, I reveal the numerous restrictions they navigate. Then, I outline the history of protective laws at abortion clinics and explain what maintaining security looks like today. I emphasize the limitations of these laws and their lack of enforcement. To conclude, I investigate some of the problem(s) with security at the clinic, arguing that security is a spatial and political hindrance to the clinic environment that providers aim to create.

Provider Terror

In Chapter One, I discussed the effects of terror on providers. I demonstrated how providers discuss their fears in three main stages of experience: (1) fear activation; (2) fear coping strategies; and (3) reflexivity. I also analyzed the themes of provider fear, illustrating how notions of remembrance and hypervigilance, dissonance, and self-concept characterize provider terror. As I explained in Chapter One, provider terror includes worries for physical safety based on the collective memory of terror and the everyday terror that indexes that history. These affective experiences are only one aspect I conceptualize as provider terror because, as Rustom Bharucha and Karissa Hauegberg have argued in their respective works, terror is not simply the fear of physical harm; rather, it can manifest in multiple ways (Haugeberg 2017; Bharucha

2014). When it comes to abortion providers, in addition to corporal safety, I argue that they experience terror in numerous realms: (1) institutional fear, including state/legal and political surveillance, (2) professional/ethical harm (e.g., mandated scripts, distributing misleading information), (3) economic, (4) and patient emotional weight/secondary trauma. These terrors may not apply to providers who do not work in independent clinics, although many of them likely do.[54]

In an Abortion Access Front podcast that aired April 15, 2022, Lizz Winstead phrased it well when she said that the numerous abortion restrictions, especially TRAP laws, make the state a "daddy state" that "polices the womb" (Winstead, Alawode-El, and Khan 2022). Based on my extensive interviews with providers, they overwhelmingly agree with Lizz. They describe TRAP laws as unnecessary attempts to close their clinics and control women's bodies. Lizz continues that the never-ending abortion restrictions were like "death by 1,000 cuts" for independent clinics struggling to keep their doors open. She commented that these restrictions always affect the most vulnerable, which when it comes to abortion providers, are independent clinics, and in turn the patients they serve, who have the fewest resources.

TRAP laws, adherence to them, and the state audits accompanying them remain among the most significant challenges and sources of fear for providers. TRAP laws attempt to restrict abortion by unnecessarily regulating physicians (i.e., requiring hospital admitting privileges and OB-GYN certification) and abortion facilities (i.e., requiring structural standards comparable to surgical centers, transfer agreements with nearby hospitals, and other specific and medically

[54] I studied providers at independent clinics, which is a distinct context. Abortion Care Network, a non-profit dedicated to supporting independent clinics, insists that communities need clinics and clinics need communities. They remind us that indies have difficulty staying open due to the everyday challenges of running an independent business and the lack of institutional support, visibility, name recognition, and fundraising capacity that national health centers (i.e. Planned Parenthood) and hospitals have (Abortion Care Network 2022).

unnecessary facility requirements) (Guttmacher Institute 2019b). These restrictions tend to fall into the five following categories: unnecessary regulations on abortion clinics (or TRAP laws), mandatory counseling designed to dissuade women from choosing abortion (e.g., doctors required to inform patients of inaccurate breast cancer and mental health risks) (Berglas et al. 2017, Guttmacher Institute 2018b), mandated waiting periods before an abortion, parental consent, and forbidding state Medicaid, state employee public insurance, and state marketplace private insurance from covering almost all abortions (Guttmacher Institute 2023b; 2023a; 2023c).[55]

Once a TRAP law passes, providers are forced, often with little time and community support, to comply with the law. This can range from hiring additional staff, to crafting their own individual disclaimers about the state-mandated information they must distribute, to filing lawsuits on behalf of their patients (Ahmed 2015, Joffe 2013, Joffe 1995, Goodwin 2017, Weinberger et al. 2012, Minkoff and Ecker 2012, Mercier et al. 2015, Mercier, Buchbinder, and Bryant 2016, Cohen 2018). Subsequently, the state conducts random audits without warning, keeping providers in a suspended state of fear. Many providers told me they try not to think about the audits or the impending TRAP laws too much; however, not knowing if they will have a job next year, next month, or next week can take a stressful toll.

Before the onslaught of TRAP laws, mainstream medicine made abortion exceptional by ostracizing it from standard OB-GYN care. Sociologists Carole Joffe and Lori Freedman

[55] In most states Medicaid is ostensibly required to cover abortion for life endangerment, rape, or incest (though how many actually do is probably negligible). For an up-to-date (as April 2023) table of current TRAP laws in the United States, see Guttmacher Institute (Guttmacher Institute 2023c).

demonstrate how the siphoning abortion care to the independent clinic model facilitated abortion provider stigma within medical communities and initiated professional fears for physicians. For instance, in *Doctors of Conscience: The Struggle to Provide Abortion Before and After Roe v. Wade* (1995), Joffe argues that mainstream medicine has largely ostracized abortion care. Contributing to the marginalization is the idea that abortion provision is not difficult, does not offer the opportunity for medical advancements, and is directed by the patient. She theorizes that due to these conditions, providers feel like "mere technicians" instead of medical doctors (Joffe 1995). Joffe suggests that the technician association may be one of the reasons for abortion provider stigma within medicine and thereby the contemporary shortage of abortion providers. Freedman finds that, in addition to stigma, structural constraints of medical institutions dissuade (if not ban) many willing physicians from providing abortions (Freedman 2010). She explains how the shift in medicine in the 1980s, when the power transferred from physicians to their managers/employers/insurers, and the proliferation of conscience clauses (especially at Catholic-owned hospitals) bolstered the marginalization of abortion within medicine. As a result, she points out, many physicians now work for hospitals and health maintenance organizations (HMOs) rather than starting their own practices. In addition, she describes that physicians who join pre-established practices often are forced to abide by previously established rules and standards set by the senior physicians (Freedman 2010). Not only does the marginalization of abortion within medicine deter physicians from providing in the first place, but for those who do, the structural realities of healthcare make it especially difficult (not to mention the constant fears of losing their medical licenses in the context of TRAP laws).[56]

[56] Although Freedman and Joffe's research is specific to physician-providers, stigma within medical communities can affect other abortion providers too. For instance, some non-physician providers feared that they would not be

But more than their professional identities, many providers express ethical tensions about complying with TRAP laws, especially those that require them to give medically inaccurate information to their patients. Specifically, these concerns come into play for mandated consent procedures (Cohen and Joffe 2020; Buchbinder 2016; Berglas et al. 2017; Ahmed 2015). All clinics I visited have had elaborate counseling and consent processes; however, the state requires additional procedures, many of which are medically false and only cause fear or confusion for patients. Some providers told me that they say, "What I am about to read to you is not true, but the state requires me to read it" or they shake their head in a "no" motion when reading it. These disclaimers and gestures delivered by providers exemplify what anthropologist Mara Buchbinder terms "scripting dissent" (Buchbinder 2016). Buchbinder uses the term to argue that by interpreting and enacting mandated scripts on their own terms, providers co-create laws. Their performances of dissent contribute to the social and moral power of the laws by "rejecting, challenging, or otherwise subverting the state's ideological message" (Buchbinder 2016, 772). Providers' performances of resistance reflect their often conflicted feelings about delivering state-mandated scripts, while simultaneously demonstrating a performative component of abortion restrictions. These acts of opposition also showcase the inventive ways providers use performance to protest the unfair laws and show support for their patients.

Many providers also fear whether their clinics will exist in the future based on their

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able to get a job at other medical facilities with the abortion clinic on their resume. Although many staff feared professional repercussions in medical communities outside of abortion care, when it came to applying for other jobs within abortion care or at other independent clinics, they felt that working at an abortion clinic gave them an advantage over other candidates. In fact, I interviewed several abortion providers who worked at multiple clinics overtime, sometimes in multiple different states. Also reflecting antiabortion sentiments in medicine, several abortion clinic staff mentioned that they would never tell their own doctors where they worked for fear of receiving poor care as a result.

economic challenges. Economic challenges for independent clinics include late or insufficient reimbursements from the state, decreasing abortion rates,[57] serving patients who cannot afford to pay for the care, exorbitant insurance costs, and responding to "abortion exceptionalism" and the everyday financial challenge of running a small business or non-profit organization (Dehlendorf and Grumbach 2008, Henshaw et al. 2009, Freedman 2010). Regarding decreasing abortion rates, Jones and Jerman (2017) admit that the cause of the decline cannot be definitively diagnosed with the information available. However, based on available data, the analysis suggests that abortion declines are related to the overall decline in unintended pregnancies and improvements in contraceptive access and use. They also hypothesize that accumulating restrictive laws at the state and federal levels, especially since 2011 when TRAP laws significantly increased, may contribute to the decline in abortions. Additionally, in my research, several administrators mentioned they had had high staff turnover because they could not afford to pay good wages or provide benefits. The turnover stressed their respective economic status further. Finally, the presence of antiabortion protestors at clinics can directly take an economic toll. For example, antis call and make fake appointments at clinics; they distract and re-direct patients trying to enter abortion clinics to nearby Crisis Pregnancy Centers; they write terrible reviews of the clinics on social platforms like Google, Yelp, etc.; they terrorize local businesses who support or provide maintenance to the clinics, leading to a low supply of vendors and thereby driving up prices for the clinics; they file specious lawsuits; they vandalize clinic

[57] Jones and Jerman established that abortions are common procedures with 23% of women having one by age 45. Although all demographic groups experienced declines in abortion rates between 2008 and 2014. Jones and Jerman found significant differences between groups (white women with the lowest rate of 10 per 1,000 and Black women with the highest rate of 27.1 per 1,000). Additionally, low-income women accounted for 49% of abortions. The authors surmise histories of racism and discrimination, combined with lack of access to high quality, affordable healthcare likely contribute to racial and ethnic differences in abortion rates (Dehlendorf and Weitz 2011; Jones and Jerman 2017).

property; and, their presence requires ongoing surveillance, which can be costly.

Providers' fears do not solely live in the realm of themselves and their co-workers but extend to the safety and wellbeing of their patients. In fact, when I asked providers about their feelings of safety at work, most, if not all, mentioned patient safety. In response to their unprompted concerns over patient safety both inside and outside of the clinic, I added a question to my interviews about their experiences with secondary trauma or secondary stress.[58] I phrased it, "Do you experience secondary trauma as a part of your work?" When prompted, I explained secondary trauma as emotional stress resulting from hearing about firsthand, traumatic experiences from others. I added this question because, during my interviews, I noticed that providers wanted to tell me about their patients, particularly their challenges and their lives. I also noticed this focus on patients when traveling with Abortion Access Front, as providers had many needs themselves, but found it difficult to express them, and instead focused on patient needs. When AAF asked them how we could help, they usually told us how to help their patients. Providers told me heartbreaking stories about what patients went through to get to them. One account from a provider from the South told me that a patient had recently come in and only had enough money for the abortion procedure. The patient did not realize that due to the mandatory waiting period, they would have to return for the procedure the following day. They had no funds for a hotel and said they did not think the beaten-up old car they had driven down would make it back. They asked if they could sleep in their car in the parking lot. Several providers stayed with the patient trying to see if they could find them somewhere to stay, but nothing was available.

[58] Often used in the professional context of social workers, first responders, and psychologists, secondary trauma refers to "the mechanism by which real or perceived distress of another in turn distresses us and the process by which we become undistressed" (Ludick and Figley 2017).

The provider said it broke her heart to tell the person to come back tomorrow, not knowing if she would get the procedure she needed and I could tell by the expression on her face, it did. And providers did not only talk about patient struggles in the clinic setting, but patients' experiences that led them there. These stories were not exceptional; rather, they were a common, everyday reality.

Providers constantly fend off attacks from every direction. The state regulates, surveils, and inspects them. A cacophony of protesters harasses them, their families, patients, and the public. Additionally, patients are often unaware of the difficult circumstances that clinics and providers negotiate daily just to keep their doors open and provide abortion care. The terror they experience due to these attacks manifests in several ways. There are multiple strategies providers skillfully employ to quell or mitigate this fear, as I detailed in the discussion of provider humor at the end of Chapter One. Since I discuss other strategies elsewhere and this chapter focuses on security, I will concentrate on how providers respond to bodily and legislative fears and the various barriers they encounter while doing it. But first, what do they have to work with? What are the legal protections for clinics, and who is responsible for their safety?

History of Protective Laws and Security at Clinics

Before 1994, the federal government neglected to protect abortion clinics. The House diluted the potency of antiabortion violence when they refused to categorize it as domestic terrorism. Liberal political leaders urged the Justice Department and Federal Bureau of Investigation (FBI) to investigate antiabortion violence as a component of domestic terrorism, to no avail (Jenkins 1999, 333). Instead, the Reagan-led government insisted that antiabortion violence constituted random individual criminal acts, rather than organized terrorist violence. As a result, the media

invisibilized the intensity and frequency of antiabortion violence, leaving the public with little to no knowledge of its existence. Additionally, the burden of monitoring and tracking this violence and clinic security more broadly fell on pro-choice groups (still the primary clinic monitors today) (Jenkins 1999).

After a significant uptick in violence in the early 1990s and the 1992 election of Bill Clinton, the government shifted its stance. Specifically, Operation Rescue's clinic blockades, combined with the murders of Dr. John Britton and Dr. David Gunn, forced the Democratic-led government to take the threat to physicians' and women's health more seriously than the previous administration.[59] In 1994, Congress passed the Freedom of Access to Clinic Entrances (FACE Act) and the Department of Justice (DOJ) deployed federal marshals to clinics across the country (Jenkins 1999, 339).

The FACE Act prohibits force or threat of force toward an individual obtaining or providing an abortion (Blasdell and Gross 2006). In essence, the law prevents antiabortion protesters from any activity that may restrict a patient's movements. It also prohibits the damage or destruction of abortion facilities (2006). Specifically, the Act authorizes the federal government, reproductive health care providers, and state-level Attorneys General to file civil lawsuits for monetary damages or to acquire injunctions against perpetrators. By increasing jail fines and sentences for protestors who violate its provisions, the FACE Act emerged as an essential tool to decrease clinic violence. Ultimately, it seeks to protect anyone who works at or visits a clinic (i.e., patients, patient companions, escorts). The penalties for violating the Act

[59] Carole Joffe has previously discussed the relationship between clinic violence and the presidential party administration (i.e., Democratic or Republican president). She explains that violence tends to be worse when Democrats are in office and less when Republicans are in office (C. Joffe 2009). However, some emerging research shows that this pattern generally held until the Trump presidency when violence at clinics significantly increased. (National Abortion Federation 2023).

vary, with some resulting in jail sentences and steep fines. Many credit the FACE Act for the decrease in clinic violence afterward, specifically the sharp reduction[60] in clinic blockades since then (Cohen and Joffe 2020, 136). However, according to the providers I spoke to and my own observations, most of these protections go largely unenforced.

Simultaneously, in the early 1990s, state and local clinic protections (i.e., buffer zones, bubble zones, safe zones, and injunctions) began to pepper the abortion clinic landscape. All of these clinic protections regulated protesters in some way. For example, a buffer zone is a fixed, protected zone; at a specific distance, it demarcates an area where protesters are prohibited (Cohen and Joffe 2020). For instance, a thirty-foot buffer zone would mean that no protestor could be within thirty feet of an abortion clinic's entrances, even if a sidewalk stood between the protestor and the entrance (Cohen and Joffe 2020, 129–32). Regarding other clinic protection legislation, there are additional laws at the state and municipal levels, including noise ordinances and state criminal laws.[61] State criminal laws regulate antiabortion protesters by restricting harassment, assault, trespassing and arson laws, loitering laws, and residential picketing (Cohen and Joffe 2020). Local ordinances also help by regulating public signs, distribution of pamphlets, protest permits, and impeding traffic (Cohen and Joffe 2020, 137). The use of these laws to protect clinics, providers, and patients leads to mixed results at best.[62] Their effectiveness largely depends on local support, specifically of law enforcement, the prosecutor's office, and the local

[60] According to the Feminist Majority Foundation's National Clinic Violence Survey, "severe violence and threats" decreased from 52% in 1994 to 20% in 1999. They define "severe violence and threats" as acts which include: blocking clinic access, invasions, bombings, arson, chemical attacks, stalking, physical violence, gunfire, bomb threats, death threats, arson threats, and other incidences of severe violence (Feminist Majority Foundation 2019, 4).

[61] For further delineation between buffer zones, bubble zones, and injunctions, see Cohen and Joffe's *Obstacle Course* (2020).

[62] Clinics with a protection, such as a buffer zone, which is consistently enforced by police, tend to experience fewer hindrances from antiabortion protesters (Cohen and Joffe 2020).

judiciary. Unfortunately, many clinics I visited reported that police were reluctant to enforce any regulations because they were politically conservative, did not have time to monitor the clinic constantly, or did not want to deal with the cascading countersuits from antis.

Two weeks after the murder of abortion provider Dr. Barnett Slepian in 1998, U.S. Attorney General Janet Reno established the National Task Force on Violence Against Reproductive Healthcare Workers (Jenkins 1999, 339). Housed in the Department of Justice, the task force investigated (and still examines) organized antiabortion violence ("National Task Force on Violence Against Reproductive Health Care Providers" 2021; Jenkins 1999, 339).[63] Clinics at risk of extreme violence are assigned a federal Marshal contact. However, their support has been inconsistent. For example, it is reported that Scott Roeder (the killer of Dr. George Tiller) vandalized another Kansas abortion clinic twice leading up to Tiller's murder, including the day before the event. Joffe reports that the clinics reported the assailant's driver's license to local police and the FBI in both instances, and apparently neither took any action (C. Joffe 2009, 163). Regardless of its effectiveness, at the time, the task force signaled the importance of clinic security to the public (Jenkins 1999).

Yet, as of the writing of this dissertation, legislation and established legal conventions do not seem able to protect clinics, and antiabortion protesters' assaults remain largely unregulated. Clinics have little recourse, as their requests for city and state regulation of protesters are often stymied by concerns about violating protesters' freedom of speech. The debut in the early 1990s

[63] Staffed by Department of Justice, the Federal Bureau of Investigations, Federal Marshals, and the Bureau of Alcohol, Tobacco, and Firearms, as well as the U.S. Postal Inspection Service, the task force serves the following functions: coordinate national investigations of abortion violence, collect and coordinate data on trends of clinic violence, provide security recommendations to providers, enhance the training of local, state, and federal law enforcement on clinic violence, support federal civil litigation of clinic violence, and assist the work of the U.S. Attorneys local working groups on abortion clinic violence ("National Task Force on Violence Against Reproductive Health Care Providers" 2021).

of protester regulations (e.g., buffer zones, bubble zones, and injunctions) ushered in debates about the First Amendment that continue to the present day. Despite their early success, protester regulations have resulted in various and inconsistent rulings; antiabortion protesters insist that their speech cannot be muted. However, the First Amendment supports the rights of abortion patients and passersby in public spaces as well. Although speakers' rights tend to prevail if "captive audiences" (patients) can reasonably avoid their speech in public forums, if they cannot avoid their speech (which is the case when entering most clinics), the First Amendment allows the government to prohibit "offensive" speech. Abortion providers and clinics assert that their patients are indeed "captive audiences," and that the medical procedure of abortion necessitates insulation from the public forum.

Due to these challenges, many clinics do not get protective laws passed, and the clinics that do rarely have them enforced. Even if a clinic obtains a buffer or bubble zone, it is unlikely that the ruling will significantly quiet the protesters—often, they just yell louder or use amplification equipment. For example, a Texas provider told me that when they call law enforcement for help, police often blame the clinic for the antis' violence. She remarked that they often say, "You should have known this would happen, working there." So not only do providers continue to experience daily terror, but they are also blamed for initiating that terror simply by working at the clinic. This provider continued explaining that the police mostly treat them like a nuisance. She said, "They act like if we just went away, the police wouldn't have this problem…they just want us to go away." Not only does the lack of enforcement allow antiabortion breaches to continue, it often emboldens antiabortion protesters to intensify the violence. One provider explained, "When police don't follow up with small things like trespassing, the antis feel emboldened and sometimes supported by the police." She offers the

example that when trespassing was not taken seriously by the police, the antis felt empowered to tear down their fence. Additionally, patients and escorts are not the only "captive audience" for the protesters, as the surrounding communities of the clinic are forced to listen to protester noise. The sounds of protesters regularly infiltrate facilities near abortion clinics (such as businesses, schools, and physicians' offices). At one clinic in the Southeast, for example, escorts said that no one ever drives down their street unless they are headed to the clinic because everyone in the neighborhood tries to avoid the noise. Communities and patients often blame the protester noise on providers instead of the protesters.

Maintaining Security

The responsibility of clinic safety often depends on the hypervigilance of abortion providers and abortion-affiliated organizations. The National Abortion Federation (NAF) and the Feminist Majority Foundation (FMF) guide clinics in security practices. NAF has been gathering and reporting antiabortion violence since 1977. They collect and compile these statistics from their member clinics and allied organizations to determine patterns in the violence and report the trends to local and federal law enforcement. They also provide staff preparedness training, facility and residential security assessments, and law enforcement assistance to clinics (National Abortion Federation n.d.). The Feminist Majority Foundation has also collected antiabortion violence statistics through their National Clinic Violence Survey. Launched in 1993, the survey measures antiabortion violence and harassment at clinics with multiple organizational affiliations and independent clinics. The survey is part of their National Clinic Access Project, which was established in 1989 to lead "efforts nationwide to reduce antiabortion violence, to keep abortion care personnel and patients safe, to keep clinics open, and to bring violent antiabortion extremists

to justice" (Feminist Majority Foundation n.d.). The task force also mobilizes community support for clinics, organizes antiabortion counter activities, and provides clinic security financial assistance and training, legal assistance, strategic media outreach, and law enforcement communications and briefings (2023).[64]

Both of these organizations emphasize the importance of relationship-building with police as a primary safety protocol, and linking clinics to law enforcement is an important role they fill. The Feminist Majority Foundation stresses relationship building with police because they have found that clinics that have "poor" or "fair" relationships with law enforcement are nearly twice as likely to experience high levels of severe violence and harassment (28%) than their counterparts who reported "good" or "excellent" relationships (15%) with law enforcement (Feminist Majority Foundation 2019). So, when police are responsive, it helps, but most clinics do not report a healthy relationship with law enforcement. In fact, only one clinic explained that their community officer was friendly and responsive and conducted active shooter training for staff. Most providers I interviewed relayed that police expressed bad attitudes and facial expressions that communicated disgust and annoyance when they interacted with the providers. One provider said, "We had to call the police department. It took them forever to get here. And they…their body language showed us how they did not want to be here or bother with us." In the field, I heard multiple stories like this underscoring how police did not respond to clinic calls or did not arrive in a reasonable amount of time to address the threat.

[64] With the Planned Parenthood Federation of America and the National Abortion Federation, Feminist Majority Foundation provides local and state law enforcement with information about antiabortion violence, trends, and threats through their Law Enforcement Briefing Project. Through the project they "secure intervention of local, state and federal law enforcement to stop clinic violence, frequently serving as a vital communications link between clinics and law enforcement officials" (Feminist Majority Foundation n.d.).

Providers and escorts also old me about police siding with protesters and refusing to enforce clinic legal protections. Even a police officer who supported the clinic seemed overly friendly with the protesters, acting as if they were not harassing the clinic. I had a side conversation with him while drinking coffee that I had brought for the clinic staff one day at the clinic, and he explained that the antis were starting to get on his nerves. He said, "They really got to me the other day because I hate littering. And they put these [plastic] babies everywhere [on the ground]." I nodded with a closed-mouth smile and thought, "Really, the littering is what pushed your buttons? Because for me, it's because they are screaming at women and threatening staff." In part, as a result of police inaction and malfeasance, some clinics employ security guards or off-duty police officers who serve as security guards. Clinics contract the guards, often stationed in the parking lot.

In addition to the clinic staff themselves and the security guards, much of the security depends on volunteer labor. For instance, many clinics have escorts and legal observers. Escorts monitor security and protect patients upon entry and exit. Clinic escorts play a crucial role in protecting the safety and well-being of the clinic and the patients who enter their doors. Many escorts call themselves "clinic defenders." As escorts or defenders, these volunteers facilitate clinics' operations and contribute to patients' well-being by monitoring antiabortion protesters through constant cellphone video documentation. Documentation enables escorts to capture when antis breach the current clinic protections and to log the antis' activities to determine potential threats. Most escort groups have a binder that records how many protesters were present on a specific day, what they did, and if any protesters made specific threats or violated regulations. Groups often store this binder in the clinic and have a point person who communicates between the group and the clinic administrator. Some groups also prefer to

maintain online databases. Additionally, with cellphones in hand, escorts can quickly record any particularly theatrical and hateful displays. They often share the footage for informative purposes and as a way of bonding. Many escort groups have private Facebook groups and text message chains for sharing this footage to laugh at the foolishness of the antis or collectively process events after a traumatic incident. I focus on escorts and their role at clinics in Part Two. Affiliated with the Feminist Majority Foundation's National Clinic Access Project, legal observers document events at clinics and note any evidence of antiabortion protester violations and other evidence which may support current or future court actions taken by the clinic or an affiliated pro-choice organization. Written accounts, photography, video, and sound recordings serve as documentary evidence. Notably, these volunteers do not take photos of patients or speak to patients or escorts. They are trained to be "neutral" at all times and not engage with anyone. Legal observers are usually present at clinics once a week in the early mornings, but sometimes more often.

Ultimately, most security is up to the clinic staff as it relates to their facilities, practices, and regulations. In effect, security practices constitute additional labor for providers on top of surmounting barriers. Mercier et al. use the term "invisible labor" to describe the adaptations that providers must continuously make to comply with TRAP laws (e.g., ranging from hiring additional staff to crafting their own individual disclaimer about the state-mandated medically inaccurate information they must distribute) (Mercier, Buchbinder, and Bryant 2016). I contend that security practices are also part of the "invisible labor" of independent clinics as the antiabortion movement constantly threatens their safety. Still, the actions needed to respond to them are constantly changing and often exhaustive. Security, which is a large and weighty responsibility, is only one challenge providers may face from a snowballing and accumulating

list. Now that I have set the stage for the need for security and the multiple layers of fear that providers must navigate, I can return to the concept that initiated this section, the security bind.

The Problem(s) with Security

I introduce the security bind concept to describe providers' compulsory and problematic relationship with security. I use it to describe the impossible position they often find themselves in when it comes to protecting themselves and their patients, while also trying to cultivate a warm patient environment. My interviews and experiences, like the one at the Southern clinic that employed a police officer to the disapproval of their local abortion fund, most influence my thinking about these problems in the field. My analysis is also guided by the work of both Carole Joffe and Lori Brown who have talked extensively to providers about security. The reality is that providers are often caught in this difficult and problematic position which causes additional stress for them and can exacerbate other barriers they face such as community support. I will outline a few of the specific problems that bind framework brings into view but intend for this to be a starting point and not an exhaustive list.

Influenced by Lori Brown, I contend the problem with security is ultimately a problem of space —both practical and metaphorical. Drawing from feminist and spatial theories, Lori Brown examines how security concerns and infrastructure affect the abortion clinic experience (Brown 2013). She explains that the main problem at the abortion clinic is that providers simultaneously try to claim and defend space. Through her interviews with providers, she finds that maintaining security while simultaneously creating a warm patient environment proves to be extremely difficult (Brown 2013, 168). On the one hand, Brown stresses that providers must show visible signs of protection so patients can feel safe. Yet this too requires a balance where providers

create “both the perception and reality of protection while not creating a fortress-like facility” (Brown 2013, 185). Several providers I talked to agreed that their patients needed to see that they are protected and feel safe. However, multiple providers also told me that security features make patients feel uncomfortable, especially for patients who already feel policed in their everyday lives based on their immigration status, race, and gender presentation. Future research should ask patients how they feel about the security features at clinics and differentiate between each of them (i.e., ID check, no phones allowed, metal detectors, and presence of police and/or security guard).

Brown mentions that these visible signs of protection are not just for the staff and patients but also a signal to anyone attempting to harm the clinic. One provider reflected on this idea when I asked her about police presence. She said:

> I think it [police presence] also makes the patients feel comfortable. I think we, as employees, feel a little more comfortable. Um, at least you know that there’s somebody that’s out there in the event that shit happens or if things get crazy, a little rowdy or anything that goes on. I think anybody—anybody that’s in this facility— you know, it’s a plus for them, and that’s just due to time, uh, because as we’ve seen, you could have a gunman walk into a church, a synagogue or, you know, a temple or school or mall, you know, [it] like lets you know that you can, you know, hopefully, that a cop’s in there to deter somebody from it.

In this example, the provider describes that patients and other providers feel safer because an officer with a gun could stop an active shooter. They also claim that the presence can deter potential threats. However, I think it depends on the patient, their experiences of being policed (or not), and how much they know about clinic violence. Unlike providers who are well-versed in the collective history of terror, most people know very little about the safety threats at clinics. Brown echoes the provider’s concerns that visible signs of protection can sometimes get too extreme. She describes an example when she relays a story about a privacy hedge at a clinic. The

clinic had a hedge of bushes that partially blocked the window and entrance for patient privacy. The police urged them to remove the barrier because they asserted that explosives could easily be hidden there. In response, the clinic replaced the hedge with a rebar fence which identified how far away the antiabortion protesters needed to stay from the clinic entrance. However, they reported that the fence was moved closer to the clinic daily, presumably by the antis. Then police persuaded the clinic to replace the rebar fence with an actual wooden fence that could not be moved; they claimed that doing this would help the police protect the clinic. However, the six-foot fence did not deter antis. Instead, they brought ladders and loudspeakers and stood above the fence, making their presence even more noxious. Brown reports that as a result, "The clinic feels imprisoned by the fence. The law is not enforced, people continue to use ladders, and […] the fence feels like a joke" for clinic staff (Brown 2013, 168). I also heard providers lament that the need for security has gotten to the point where the clinic feels more like a place of punishment than a place for healthcare, at least outside the entry. Thinking about security as a spatial concern offers an opportunity to think about how to make these spaces safer for all staff and patients while deterring unwanted antis.

Security also hinders a Reproductive Justice approach, which guides most independent clinics I visited. Although not all independent clinics would describe themselves as "feminist" healthcare centers, many would.[65] By feminist healthcare, I mean that most practices reinforce the patient-centered nature of the care they provide, including a consistent explanation of what is going on during the appointment and abortion procedure, consent at every step, feminist literature in the waiting room, feminist art on the walls, and spaces for solitude and connecting

[65] What I mean by this is that even if a staff member did not explicitly identify as feminist, although many did, most staff I spoke with mentioned that their work was important for "women's rights" or "equal rights."

with other patients.[66] For example, at a clinic in the Midwest, a provider facilitated required informational sessions for pill abortion as group sessions for patients so they had a cohort of support. In several recovery rooms, I have seen journals for patients to write their thoughts or read the stories of past patients. I have also seen care packages for each patient, like in Figure 1. It reads "you are loved" on the front and providers fill them with self-care items. These practices and alignment with feminist ideas makes sense because many abortion clinics sprouted out of the feminist health movement in the 1970s (Singer and Ostrach 2017; C. Joffe 2013; Morgen 2002). Calling back to the Joffe quote at the beginning of this chapter, the contrast between the warm environment providers want to cultivate and the armed fortress people may experience is unfortunate, considering all of the hard work and thoughtfulness that goes into serving patients at abortion clinics. And like the provider from the example in the introduction to this chapter mentioned, many providers hate enforcing security practices.

[66] Some providers explicitly mentioned that they provided "trauma-informed care." The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma as "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." And, in turn, they define trauma-infirmed care (TIC) as follows: "[care that] that includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. TIC views trauma through an ecological and cultural lens and recognizes that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. TIC involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma. TIC upholds the importance of consumer participation in the development, delivery, and evaluation of services" (Substance Abuse and Mental Health Services Administration 2015, 1).

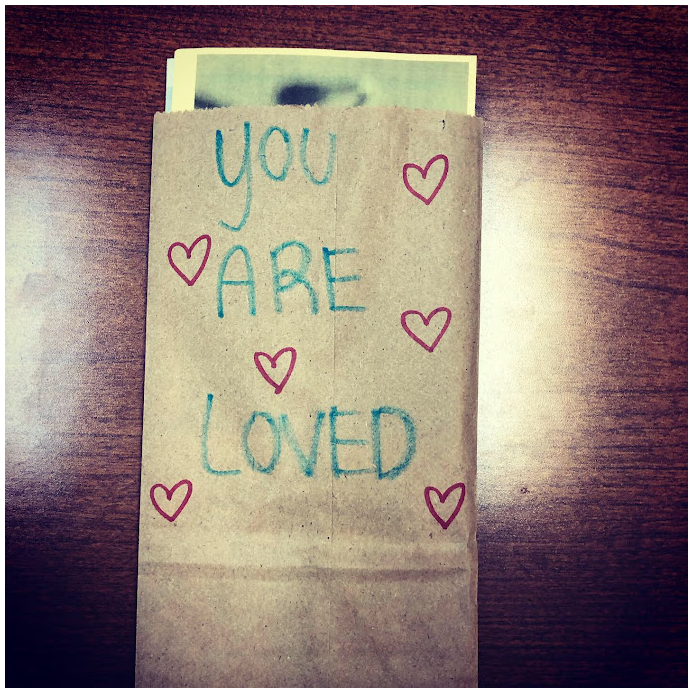

Figure 2

Security practices further diverge from a Reproductive Justice approach when they fail to prioritize the experiences of people of color, especially Black providers and patients. When I attended a conference for independent abortion providers in 2019, I was most struck by something a Black abortion provider said in a panel on clinic safety. Quite frankly, it stopped me in my tracks. She explained that when the National Abortion Federation tried to facilitate a relationship between her and the police where she lived, it felt wrong. For her, the police were not people to approach for help or protection, but rather authority figures to be feared. Until then, I had focused on police responsiveness and the lack of protection they offered to clinics. I had read the statistics that clinics with good relationships with police tended to be safer (National Abortion Federation 2022). But admittingly, I had not thought about what it might be like for a Black provider who is already policed in society to be encouraged to seek help from the police. I also want to acknowledge that this provider's experience is not every provider's experience. A

provider's feelings about the police are likely informed by many complex factors. However, many Black providers in attendance nodded in agreement after her comment. Many in the room agreed that abortion organizations made security recommendations without thoughtfully considering the racial dynamics between police and Black providers.

The panelists further explained that their perspectives as Black providers were often overlooked, not only in the context of security, but also in the context of racial tensions within the workplace. For example, one provider described that she needed extra armor as a Black woman working in an abortion clinic and that clinics could be more supportive environments for providers of color if the physicians, often white, did not speak down to them. On the other hand, one clinic director told me that her Blackness served as a type of protection against the antis due to their racist assumptions. She says:

> The benefit I feel like I have of being a Black woman who looks relatively young— even though I'm older than people think I am—is that a lot of those protesters, they don't think I'm in charge. They don't think I'm the boss. They—I mean—I really truly believe that they don't take me seriously because they think I'm just a little girl. […] I think they've seen my car enough that they know that I'm not, um, a patient, but they don't think I'm in charge because I'm not what a leader looks like [to them]. Um, so that, in some ways, I believe, could shield me from some of the threats that could be there. Um, because they're looking for the white lady to be in charge […] or the white man that they think is the doctor. So when some of our physicians come in who are women of color, they also don't take them seriously. They don't think that they're the doctor. They think that they're the patient. Because they, their expectation is that white men are physicians and white women are directors, and the rest of us are the help. […]. A sort of like small example is our public affairs coordinator, um, and lobbyist, um, who was white. They called her by name. They don't call my name. They've never…no one has ever said my name to me…maybe it's because they can't say it, or maybe it's because they don't know. But there's a way in which she is seen as gettable, like we can recruit her, we can pull her away, she is desirable, like we want her, or that she is seen as more powerful or more influential or more prominent. I don't know all of the reasons why they know her name and they don't know mine, but it is a thing that I have noticed and that I'm aware of.

Another comment that sparked much discussion from the panel was about who was included as a "provider" when organizations discuss "provider safety." The physicians who perform the abortion procedures tend to be the most direct targets, but who is their first line of defense (Cohen and Connon 2015)? It is usually the nurses, the receptionists, and the people at the front of the clinic; after all, antiabortion terrorists have murdered non-physician providers too. And more, non-physicians in politically hostile climates are often isolated, with little social support outside their co-workers. Unlike physicians, non-physician providers almost always live in the communities where they work. Their locality often comes with another layer of vulnerability. For instance, if someone finds out they work at a clinic, their children and families can be threatened at their schools and places of work in addition to themselves.

During the height of the Black Lives Matter and Defund the Police protests in 2020, many escorts and activists discussed what divesting from the police would look like for abortion clinics. Abortion Access Front (AAF) distributed an online survey to their network of activists and escorts during that time. They found that respondents generally distrust the police and asserted that police presence makes people marginalized by race, immigration status, and other characteristics feel uncomfortable and unsafe (Abortion Access Front 2020). Additionally, some police departments or individual officers are known to be complacent when complaints occur, sometimes siding with the antis. Police responsiveness varies widely from state to city to clinic. Some clinics report that "there's not much they [the police] can do," even when they are responsive (2020). Notably, the participants of this survey were not providers, but they still work on the ground in abortion access and are often quite literally the first line of defense. Divesting from the police also sparked discussions of community support. For example, how can

communities better support clinics? Should escorts and legal observers extend their hours? Could a community safety mechanism be devised for clinics that do not use surveillance or force?

Abortion clinics have a history of isolating themselves from communities for security and self-preservation. Therefore, in the past, it was thought that clinics should keep as low a profile as possible. However, more recently there has been a sea change. Many providers are proud of their work and want their community to know about them. Several clinics expressed interest in more AAF collaborations and connections with other community organizations. Often, clinics feel that they do not have the capacity for community connections and need a dedicated staff person to assist with that outreach. Lizz Winstead and I have talked extensively about the need for community outreach coordinators at clinics in the past. We continue to question how to obtain funding for these positions. With such little community support and anticipated violence for existing clinics, security and community support are vital. The question of how we keep our providers safe and create a warm environment for all patients should continue to lead the work.

PART TWO: PERFORMING TERROR

Far from being exceptional, terror can be regarded as the new banality of evil in our times, functioning in a diversity of ways, open to a spectrum of causes, manipulations, rumours, fears, tensions, and resentments, ranging from the most global and national of political interventions to the most quotidian intimacies of everyday life. Terror can strike when one least expects it, not just in cyberspace or the anonymity of the global city, but in the most familiar of neighbourhoods and streets as well.

--Rustom Bharucha

Bellevue, Nebraska
August 2, 2019

With my right hand securing the bagels in the passenger seat and my left hand gripping the wheel, I swing my Subaru in a U-turn. How do I keep missing the clinic entrance? I am starting to distrust Google maps. Easing my foot off the accelerator, I slow my approach. I notice two people clad in bright pink vests at the entrance. "This must be it!" I think. I turn carefully into the parking lot. I can now clearly see the sign on the building: "Bellevue Health Clinic, LeRoy H. Carhart, M.D., AbortionClinics.Org." I've reached the clinic! And it's not just any abortion clinic. It's the clinic of Dr. Lee Carhart—a hero of the abortion movement and mine, who has been providing compassionate abortion care for over twenty-five years. Referred to by Lizz Winstead as "the RBG of abortion," Carhart is one of only four physicians in the United States who provide abortion care during the third trimester. Despite being a target of relentless antiabortion violence, including the murder of twenty-two of his horses, he has persisted and remains a formidable advocate for abortion rights (Kliff 2009; Greenhouse 2000).

As I edge into the parking lot, a woman's body blocks the entrance. I instinctively halt my car. She grips a clipboard and appears to be an escort clad in a pink vest. Smiling, she motions for me to roll down my window. I automatically oblige. As soon as my window inches down, I sense something is off. She then retrieves a brochure from her clipboard. As she outstretches the brochure towards my open window, she grins and says, "Ma'am, don't kill your—…" Peripherally, I glimpse the escorts near the clinic entrance, one of whom I know, vigorously motioning for me to keep driving. I lean on the pedal and sail past the interloper. "Damn! I can't believe I fell for this!" I've been visiting clinics for over a year; I should have known better. The clinic told me about these pink-vest-wearing antis beforehand, but I forgot at the moment. I feel foolish.

This is not my first clinic visit, nor my first time wading through antiabortion protesters to find a clinic entrance. I visited my first few clinics with AAF in the summer of 2018. Up until

that point, antiabortion protesters were mythical to me. I knew they existed because I saw them on the news, but they were not people I knew and were not part of my everyday life. So experiencing antis at the first few clinics was more difficult than I'd anticipated but was made slightly better by having a group of activists support me. And I wasn't there for an abortion, but as an advocate.

Traveling with AAF was like taking a crash course in all-things-abortion, including all things antiabortion protesters. The histories that had once been abstract to me, like the murder of Dr. Tiller and the Operation Rescue blockade days, came to life through the stories and the providers I met with them. Like many people, I thought the crescendo of antiabortion terrorism had passed. Yet, through their vast knowledge and networks, I learned about a world of antiabortion terrorists who were still active, and their influence was growing. I witnessed firsthand how they relentlessly harassed patients, providers, and escorts. It motivated me to document as much as I could of this violence and more of the incredible resilience of the people I'd met. So, here I am, ten clinics later, in Nebraska. I took AAF's words about treading lightly at the clinics to heart and followed their example. I was there with food, to lend a helping hand, and to hopefully learn more about abortion.

Once deeper into the parking lot, the real escorts, clad in rainbow vests, approach. They indicate an ad hoc parking spot on the periphery of the lot. They inform me that parking along the lot's perimeter helps block the protesters. I park my car as instructed and roll up my window. I take a deep breath, anticipating the cacophony I already know will erupt as I emerge from my vehicle. I open my door and, as expected, I'm hit with the sound. "Mother!" "Mom!" "Mommy!" Shrieks and bellows come from multiple directions, echoing one another. (This happens at every clinic, and it jolted me at first. Antis always think I am a patient.) The escorts strategically stand by my car, blocking my view of the pink-vested antis. As the antis' words jumble, I try to focus on the escorts. My escort friend chuckles and says, "Welcome to Nebraska."

The escorts tell me that they've alerted the clinic that I am on my way and that I can begin my approach. They advise me to leave bags behind for my initial entrance and to return for them once I've met the clinic staff. I know my arrival is sensitive and that entering a clinic with bags is generally prohibited. Due to decades of antiabortion violence, clinics must be wary of anyone who enters their property—especially a person with a backpack. Visual cues are monitored closely, usually by security cameras, a security staff member, and sometimes, the police. (Also, antis also monitor visitors with photos and video recording.) When I enter clinics, I try to look pleasant and relaxed, sans accessories. Even when I do these things, I sometimes feel guilty, purely stemming from anxiety that clinic staff may perceive me as an intruder. Building strong relationships with clinics, being vetted by someone they trust, and consistently communicating about the details of my visit have been essential components of my work at abortion clinics. This felt jarring at first, as I was not accustomed to being treated with suspicion. However, my sibling activists insist that I must not take it personally and be persistent. After I learned more about antiabortion violence, I understood why.

Before entering the clinic, I notice signs, posters, men in hats, and rosaries. Antiabortion protesters are in every direction—behind me, to my right, to my left, behind the clinic, and in front of the clinic. I am surrounded. Although protesters are not permitted beyond

the public sidewalk, I notice several spreading out in the grass of the parking lot between the lot and the sidewalk. They enclose the clinic with their signs, sounds, and bodies. There are even cars parked in the adjacent parking lot, surrounding this one adorned with posters propped on their windshields. I think, "If I wanted to leave right now, I'd have to walk through a group of them or drive past the antis at the entrance. What if they tried to stop me again?" I try to shake off this fear and look closely at the signs. The posters say, "babies murdered here" and "remember the unborn." One man holds a sign that says, "text helpline to 313131."

Another man in camouflage shorts has his head bowed as if I were too shameful to look at. Five people pray in a line, reciting in Spanish and clenching rosaries. The woman at the end holds a Virgin Mary figurine, and the woman in the middle reads from a prayer book, with the others joining her in unison. The "remember the unborn" posters seem endless, held by many and leaning on the surrounding cars. A framed 2' by 3' portrait of the Virgin Mary joins them. I see two older men in straw hats sitting on the sidelines in folding chairs as if they were there to watch a sports game unfold. Yet, they eye me—my movements, my car, my body.

I am shaken by a loud male voice booming from above, "You don't have to do this!" I look up and notice that there are antis near the top of the parking lot on the other side of the building, literally yelling down at me. I didn't initially see them. Then, I hear, "Mommy, mommy, don't kill your baby." I am inundated with angry images and raucous noise. The energy is tense. I realize that, in response, I feel anxious, nervous, sad, and angry. And, the reality is, I am not even a patient who jumped through endless hoops to get here—I am just here for a highly-anticipated visit with the clinic staff.

"Good morning, Mommy," a woman shouts brightly. My escort friend rolls his eyes and activates the Bluetooth speaker with his phone. Finally, some sonic competition! I am quickly whisked away by the familiar Spice Girls song, "Wannabe" (1996). The escorts gesture to me, suggesting that I should climb the staircase to the front door. A dark awning covers the stairs, creating a semi-concealed entrance. As soon as my foot hits the first stair, I feel slightly eased by the shelter. As I approach the front door, I notice that a tunnel of music causes the sounds and sight of the antis to fade. I am immediately grateful for this breath of fresh early-aughts pop. The past ten minutes have shaken me, but I don't want to appear as if I am impacted—in my mind, that might make the antis think that they have won. I take a deep breath and make a bold choice. Instead of hurrying to the front door in fear, I pause and listen to the music. I decide to dance. Reaching the top of the stairs, I open the door and breathe a heavy sigh of relief. Finally, I safely reach the front door of the clinic.

* * *

During my time in the field, this was a typical experience of entering an abortion clinic. It was one of many instances that exposed the sensorial tactics antiabortion protesters use to terrify all attempting to approach clinic doors. The experience, although now familiar, always instigates fear and anxiety. According to performance studies scholar Rustom Bharucha, for

many, terror is familiar. Bharucha describes terror as "the new banality of evil of our times," which includes the "quotidian intimacies of everyday life" (Bharucha 2014). While conducting fieldwork, my daily clinic visits were characterized by the terror Bharucha describes.[67] I regularly braced when I saw an antiabortion protester reach into a bag for fear he was grabbing a gun. I glanced nervously behind my shoulder as I drove away from clinics with worry that the antis might record my license plate or follow me. I automatically switched my phone to airplane mode to avoid being doxxed by protesters.[68] What seemed like extraordinary safety precautions at my first clinic visit quickly became rote. All the while, I reminded myself that this was not my everyday life, or my everyday terror, because I chose to experience it as a researcher who would eventually go home.

Antiabortion protesters perpetuate terror outside of abortion clinics where patients engage in what should be the mundane routine of going to a doctor's appointment to receive healthcare. For many clinics and their patients, terror is ordinary and does not merely occur during a murder, bombing, or blockade. Rather, terror is an everyday experience of abortion work of which many Americans remain unaware. The world of the outer clinic landscape—the sidewalk, parking lot, clinic entrance, and surrounding community—resonates with a distinct note of terror, fueled by violence, deceit, surveillance, and invasion of space. Terror is the

[67] Notably, even in my fieldwork, there were often days or stretches of days when I was not at a clinic, so I did not experience terror as many staff do, on a daily or weekly basis—for years. I also did not experience it as a pregnant patient might with deeply entrenched abortion stigma and fears that I may die in the clinic or suffer severe physical and emotional consequences.

[68] Doxxing refers to publicizing a person's private information. In the context of the abortion clinics, antiabortion protesters and/or advocates will find an abortion provider, escort, volunteer, or advocate's private information and publicize it online to other antiabortion protesters and/or advocates. The ramifications of doxxing can escalate fairly quickly and result in dangerous consequences, such as antiabortion protesters and/or advocates arriving at a person's house to cause emotional and/or bodily harm. Therefore, digital security is tantamount in the Abortion Access Movement. In fact, there is a non-profit organization founded to specifically protect abortion clinics and other people working in the abortion access movement's online security called the Digital Defense Fund (Digital Defense Fund n.d.).

normalization of fear, it is the sense that violence could follow a person out of the clinic and into the rest of their lives. And sometimes, depending on how the clinic and its escorts counter the mayhem, it is a terror assuaged by care and humor. Nonetheless, this terror persists, made acute by the violent histories of the clinic landscape, the overload of its sensorial assaults, and the relentlessness of its occurrence.

When visiting multiple abortion clinics across the United States, I began to normalize the terror I felt there. However, I recognize now that this is part of the problem. Unfortunately, the public tends to normalize antiabortion protesters, with too many progressives writing off protesters as "crazy fundamentalists" who cause no harm and have no power. They may normalize antis until they visit the clinic and see the images, hear the yelling, and feel the energy—especially when Crisis Pregnancy Centers (CPC) trick people into thinking they are the abortion clinic they wish to visit. They may not realize the amount of resources that antiabortion protestors have until they investigate, discovering the intentionally opaque ways that well-funded and influential legislators, conservative think tanks, and Christian law firms support antiabortion protesters. As my friend and escort Derenda Hancock says, to say people are "terrified is probably an understatement because a lot of women come here alone" (WJTV News 2021). Yet, capturing the terror of entering or exiting a clinic is difficult, and few attempt it.

Corporeality and Embodiment

Much of the abortion research does not address the corporeal experience of entering the clinic space. Instead, it focuses on abortion politics and the representational significance of antiabortion protesters' actions.[69] Of the literature that exists, several historians, political scientists, and

[69] There is robust literature that explores abortion politics and the implications of antiabortion protester actions. It

anthropologists investigate the rationale and motivations of antiabortion protesters, emphasizing the Christian, nationalistic, sexist, and white supremacist narratives underpinning their actions. Public health Research on abortion tends to hone in on the practical issue of "abortion access" (Myers, Jones, and Upadhyay 2019; Redd et al. 2023; Kortsmit et al. 2021; Lazzarini 2022). More specifically, researchers investigate access disparities and how these disparities burden patients and providers (Bowler, Vallury, and Sofija 2023; Mercier, Buchbinder, and Bryant 2016; Chowdhary, Newton-Levinson, and Rochat 2022; Cohen and Joffe 2020). And the reality is, we don't have many stories of what approaching the clinic feels like from a patient's perspective. In recent years, activists have started to tell their stories publicly with the support of non-profit organizations such as Abortion Access Front, Exhale, Shout Your Abortion, and We Testify.[70] However, these stories have not notably influenced scholarship or mainstream discourse on the subject. These narratives are often told in retrospect, often many years later, and as such, not foregrounding physical experience.

A few recent studies look deeper into the effects of antiabortion protesters and find that many patients are "quite upset" by the protesters outside the clinic but that their presence does not change their decision to have an abortion (Greene Foster et al. 2013). But what does "quite upset" mean? And more, how can providers/escorts/allies counter the terror and mitigate patient distress? After walking the made-treacherous path from the car to the clinic in several states,

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includes and is not limited to: Luker (1984), Ginsburg (1989) Munson (2009), Holland (2020), Haugeberg (2017); Doan (2007), and Wilson (2013).

[70] Some organizations such as We Testify, Exhale, and Shout Your Abortion have offered online platforms for patients to share their stories of entering clinics. Additionally, some organizations have created virtual reality experiences of walking through protesters to the front door of a clinic. For instance, Planned Parenthood's virtual experience is called *Across the Line* (2016) (Planned Parenthood n.d.). *Across the Line* uses 360-degree video and computer-generated imaging, real audio recorded at abortion clinics, scripted scenes and documentary footage to create a typical abortion entry experience. Notably, Planned Parenthood conducted an evaluation of the film by analyzing a survey of people who viewed the experience at film festivals (n=284). They found that viewing *Across the Line* was associated with greater disapproval of clinic harassment (Planned Parenthood n.d.).

from Louisiana to Minnesota to New Mexico, I am more interested in these questions than I am in the most recent policy analysis or the varied motivations of antiabortion protesters. I understand that these questions may extend beyond this chapter. However, based on my fieldwork, scholarship, and research, I insist that existing legislation to protect clinics is not working and that perhaps new ways of thinking can emerge by prioritizing the experience at the clinic landscape.

In her 2019 article, "To Be an (M)other: A Feminist Performative Autoethnography of Abortion," Shelby Swafford tells her abortion story by focusing on her own bodily experience as she enters the clinic (Swafford 2019). Not only does Swafford's narration describe multiple components of the abortion experience that are often absent in abortion research, but she describes the bodily effects of these experiences when she writes that the words of the protesters "pierce" her skin and that their voices overwhelm her "mind and tear ducts" (Swafford 2019, 95). She depicts a scene where protesters non-consensually accost her, shouting antiabortion sentiments that she is a "lost woman," a "monster, a sinner, a whore, immoral, and inhuman" and displaying poster images (2019, 95). She explains that by doing this, they project their own perspectives onto her body, ultimately othering her body as she approaches. She elucidates: "They tell stories of who I am, of what my responsibilities and desires are, of what my decisions about my body mean, of the needs of a possible life I carry. They say nothing—ask nothing—of my needs. I learn I do not control my body the way I once thought I did"(Swafford 2019, 95). For Swafford, the protester's messages about her body and the reality that their right to speech trumps her right to access healthcare makes her body "unworthy of embodiment" (Swafford 2019, 95).

"Embodiment" is a generative concept, one which has been used by several different disciplines to describe the experience of being in a particular body in a specific space characterized by multiple contexts, including historical, political, and cultural. One lineage of "embodiment" that I find particularly useful evolves from the merging of phenomenology with feminist theory, best articulated by Iris Marion Young (I. M. Young 1980). Influenced by Maurice Merleau-Ponty and Simone De Beauvoir, Young emphasizes that the habituation of knowledge must be connected to one's lived experiences, which requires a gender analysis. In other words, the body's movements must be analyzed with an understanding of structural oppressions and experiences in everyday life because these power dynamics shape our bodies and how they move (or do not move) (I. M. Young 1980). She explores this idea comprehensively in her influential essay, "Throwing Like a Girl."

In the essay, she argues against a "natural" female body or female essence (I. M. Young 1980). She clarifies that society and social power dynamics influence female comportment more than any "natural" predisposition. For instance, she observes that women in the U.S. display a distinct comportment. She theorizes that they tend to walk, sit, and carry objects to occupy less space. She expounds that timidity, uncertainty, and immobility characterize female movements. She specifies that women (and she is sure to clarify not all women) perceive danger and tend to wait for things to approach (Young, 1980). She underlines that this distinct comportment is not because women are naturally shy, weak, or small but because of the social conditions created by a sexist industrial society. In other words, a sexist culture physically shapes women's bodies.

Applying Young's insights to the clinic experience, we can understand that space matters and how bodies move in that space reflects active social processes and dynamics. Specifically, the experiences of female comportment—waiting for danger to approach, displaying small and

defensive movements, and to use the words of my interviewees, being polite, pleasant, and submissive to male voices and demands—women are particularly challenged (and perhaps vulnerable) in these spaces and susceptible to the overhaul of nonconsensual protester assaults. Again, I would like to point out that not all women take on this comportment. However, most protesters assume all patients are women and will take on traditional female social conventions. I use this theory to emphasize that the mere presence, not to mention the often loud and aggressive presence of men outside of the clinic, bears a certain weight because of the patriarchal dynamics of the United States. Even for women who do not take on this comportment (I would argue that perhaps I fall into this category), it takes quite a lot of energy, effort, and perseverance to avoid falling into a hegemonic dynamic.

Female comportment can also be complicated by what Young terms a "pregnant embodiment" to describe a subjectivity that is "decentered" or "split" (I. M. Young 2005, 46). For Young, the boundary between her body and the world during pregnancy is in flux (2005, p. 50). Although Young seems to be discussing pregnancies continuing into the third trimester, many people who enter abortion clinic doors are pregnant. And as Rebecca Lentjes theorizes, drawing from Young, pregnant bodies are otherized from themselves and objectified by society (Lentjes 2018). Lentjes writes, "Pregnant people can expect to be stared at, to get asked personal or even inappropriate questions, and to have their bodies touched without consent as they move through public space. The presumed ownership over female-presenting bodies is magnified when these bodies are perceived as housing another living being presumed to be the progeny and property of a male 'father figure'" (Lentjes 2018). This idea further reflects Swafford's feelings that her body no longer feels like hers. And perhaps for some pregnant embodiment, a "split" and

complex embodiment may make the orders, threats, and harassment from the antis all the more piercing.

Performing Terror

In his book *Terror and Performanc*e, Rustom Bharucha applies a performance (and performativity) framework to crack "open the multiple languages of terror" and to insist that terror should be understood through experience and lived histories rather than within the global discourse of terrorism (Bharucha 2014, 3). By parsing out terror from the dominant global discourse, he emphasizes the lived experiences of terror, which occur in many diverse forms and include everyday actions and ordinary people. He argues that performance analysis is a particularly useful way to do this because it is adept at connecting lived experiences and ideas—synthesizing multiple realms of analysis, such as the political, historical, and experiential (Bharucha 2014, 28). Through performance analysis, Bharucha demonstrates the unique potential of performance to center embodied experience and to excavate the power of language and its discourses. He asserts that key concepts associated with performance studies—embodiment, corporeality, and reflexivity— offer a unique analysis that can potentially reveal the covert and unquantifiable ways terror inhabits our world (Bharucha, 2014, pp. xiv–xv).

Bharucha's argument focuses on disrupting dominant global narratives of terror—questioning who gets to experience terror in these narratives and what types of violence are considered terror. Ultimately, he seeks to free "terror" from the hegemonic discourse of "terrorism" centered in the United States context of the 9/11/2001 terrorist attack (Bharucha 2014, 2). He considers the entanglement of terror and terrorism in the global discourse to flatten and eclipse the dynamic national, regional, and local contexts in which terror occurs and is

perpetuated (Bharucha 2014, 3). He mentions that terror strikes some lives daily and invades "the most global and national of political interventions to the most quotidian intimacies of everyday life" (Bharucha 2014, 3).

Although my examples of terror at the clinic landscape and the level of analysis I use diverge significantly from Bharucha, who focuses on disentangling "terror" from politically motivated violence post 9/11, similar to him, I am also investigating terror through the lens of performance. I am expanding terror from acts of extreme political violence, such as the murder of abortion doctors, to include the everyday challenges and barriers providers experience, as well as the everyday activities of antiabortion protesters. After visiting my first clinic, I knew I needed to try and describe the experience of being there—precisely, the hyperawareness of my own body. Bharucha's approach inspires me to go further, to locate the broad scope of performances in the outer clinic landscape within the realm of terror. However, as Bharucha argues, terror itself is not a performance. Rather, the actions people take to perpetuate it, how people react to it, and the measures put in place to prevent it are performances or what I call "performances of terror."

To be clear, my performance studies training emphasizes that all actions (and inactions) are indeed performance on a broad spectrum of performance. However, here, I am using performance to speak specifically to the theatrics of antiabortion protesters. Antiabortion protesters employ performance techniques that penetrate people's sensorial worlds in the abortion clinic landscape. They use sight, sound, and movement or touch to scare and deceive patients. They are not "spur of the moment" acts but are often meticulously and strategically planned. It is far from radical to designate their actions as performances, as many escorts and providers already term the protesters' actions outside of clinics as "performances" due to their

planned, loud, and self-aggrandizing nature. They also often use loud, blaring music, microphones, military and medical costumes, as well as plastic baby props and nooses. Although escorts' actions could also be described through the lens of performance, I have chosen to discuss their actions as "counter strategies"—mainly because they often directly respond to the protesters' performances that day. More, most escorts do not use explicitly theatrical techniques as escorts do. When I talk about performances of terror in the clinic landscape, I am referring to everything from strategic positioning of fetal images, shouting of antiabortion harangues, and the impediments placed on patient movement.

Several scholars suggest that protester tactics likely negatively affect patients but have not empirically examined the issue. A few cases have found that protesters contribute to patients' stress and depressed feelings postabortion (Adler et al. 1992; Cozzarelli et al. 2000; Cozzarelli and Major 1994; Greene Foster et al. 2013; Harper, Henderson, and Darney 2005).[71] Foster et al. found that patients report a range of emotions about interacting with protesters from being mildly bothered by them to traumatized (Greene Foster et al. 2013; Kimport 2012). They also found that even the mere anticipation of protester presence can intensify patients' emotional difficulty with abortion (Greene Foster et al., 2013). More recently (2021), Carroll et. al examined patients' encounters with protesters in Mississippi to understand patients' feelings about clinic protection ordinances (Carroll et al., 2021). Patients reported concern with one third of patients feeling physically unsafe by the closeness of the antiabortion protesters. Patients were particularly afraid when protesters surrounded their cars or followed them to their cars after their

[71] For example, Cozzarelli and Major investigated the longer-term effects of protester activity on women's experience of abortion in 2000. They found that women accessing abortion in clinics in Buffalo, NY experienced negative emotions upon interacting with abortion protesters at one hour post interaction, but that these effects were not present during the follow-up data collection two years later. In other words, the negative effects of protester interaction did not extend beyond the short term (Cozzarelli and Major 2004; Cozzarelli et al. 2000; Cozzarelli and Major 1994).

appointment. Notably, several participants confirmed that the clinic security and escorts helped to allay negative protester confrontations. However, ultimately, antiabortion protesters created negative experiences for patients. These studies focus on the emotional impact, but not the corporeal experience in the context of specific antiabortion protester tactics.

In the following chapters, I explore what approaching an abortion clinic looks, sounds, and feels like. First, I investigate how protesters invade the senses of patients and what is being done to counter them. I argue that antis use sensorial strategies to terrorize patients and escorts and that escorts respond with innovative and courageous tactics that are limited in effectiveness without the community's support. Next, I show how often sonic, visual, and choreographic strategies are used to enhance the size, volume, and presence of antis, while highlighting the smallness of the patients and sometimes, the qualities that position them as socially marginalized less powerful (e.g., race, gender, immigration status, etc.). I do this ultimately to question the notion of protester engagement and introduce potential discursive or performative strategies to mitigate the terror in Part Three.

My argument is twofold: first, I insist that analyzing clinic landscape navigation as a performative act reveals both the phenomenological and representational dynamics of gender, racial, and citizenship oppressions perpetrated by the state and the antiabortion movement; and second, that antiabortion protesting is not the harmless exercise of a first amendment right, but the enactment of violence and terrorism. Ultimately, this enactment requires a performative (and rhetorical) shift for pro-abortion advocates to counter it, which may include rethinking the terms of engagement at the clinic.

I describe these performances from my perspective as a queer feminist researcher entering clinics for interviews and volunteer escorting. My goal is to describe and analyze these

experiences to show the palpability of space and the senses in the context of the clinics. Additionally, I hope to reveal the violence perpetuated on patients, providers, and escorts, as well as their limited resources for protection in order to think through potential solutions. Finally, in detailing some of the sensorial assaults I have experienced, as well as the ones I observed firsthand, I aim to: (1) describe how antiabortion protesters deploy performances of terror through sensorial tactics; (2) explore the discursive (and cultural) implications of terror at the clinic landscape; and (3) spotlight escorts (and clinic staff) who counter these assaults, focusing on blocking and/or diminishing the antis' sensorial tactics.

I do so cautiously with the awareness that I occupy privilege in this space—as a white person, ciswoman, researcher, and most importantly, as someone who has not jumped through multiple hoops to access abortion. However, as I will explore, little is written about patients' experience entering the clinic and the escorts who support them. Although this dissertation is overwhelmingly drawn from my ethnographic fieldwork with Abortion Access Front and abortion providers, it would be inadequate to write without including their *raison d'etre*, the patients. Further, as I sit here writing this dissertation—these images—are the ones that haunt me. Although one year and one global pandemic later, I still have nightmares about escorting, antis bombing clinics I am visiting and about the fear on patients' faces. I hope reading this section will transport you to these scapes and ultimately prompt you to support the activists and providers who work to stop the terror.

Chapter Three: Antiabortion Aesthetics of Deception

Over the past three decades, scholars have used antiabortion images to theorize antiabortion discourses (Petchesky 1987; L. M. Morgan and Michaels 1999; J. Taylor 2008; Hopkins, Zeedyk, and Raitt 2005; Holland 2020; Berlant 1997). They have found that placing these images in their social context—examining their creation, use, and how they circulate in the public sphere— reveals the underlying sexist, racist, xenophobic, and capitalist motives that shape them. For instance, Rosalind Petchesky, one of the most prolific scholars on the topic, theorizes that the fetal image has come to symbolize a variety of socio-cultural anxieties and fears—mostly surrounding hegemonic ideals of gender, race, and American citizenship (Petchesky 1987). In fact, she elaborates that the fetus has come to symbolize "a whole series of losses—from sexual innocence to 'good' mothers to American imperial might" (Petchesky 1987, xii).

When I think back on my experiences outside of the Nebraska clinic and clinics like it, three types of images stand out, epitomizing what I term "antiabortion aesthetics:" (1) antiabortion posters, which include fetal images; (2) medical aesthetics such as Crisis Pregnancy Center (CPC) trucks, scrubs, and escort vests; and (3) props, such as ephemera (i.e., pamphlets, fliers, business cards, plastic fetuses, roses and other "gifts") and personal accouterments which extend the messages from the posters onto the bodies of antis such as t-shirts, hats, and the children they hold. (I want to stress that I am not suggesting children are inanimate objects. Rather, I argue that antis objectify their children's bodies for aesthetic impact).

Not a comprehensive list of the types of visual phenomena performing at the clinic landscape, this trio of visual phenomena is useful for understanding how antis perform at the

clinic and patient experiences.[72] Antiabortion protesters create, distribute, and deploy these images. They design images to strike fear, disgust, and shame in the hearts of women who approach the clinic and to do so by deception. I am interested in how antiabortion images relate to abortion discourses—especially the images present at the clinic. I am keen to investigate the ways in which antiabortion protesters use these images and how they relate to very real, embodied consequences. In other words, how does the wielding of these visual images color the experience of entering the abortion clinic? I discuss how the particular use of medical aesthetics to confuse the patient under the guise of "woman-centered care" and how this subterfuge is indeed a substantial component of terror with potential horrific repercussions.

Medical Deception: from Fetal Images to Crisis Pregnancy Centers

In Petchesky's groundbreaking essay, "Fetal Images: The Power of Visual Culture in the Politics of Reproduction" (1987), she historicizes the lineage of the fetal image, beginning with *The Silent Scream.* She explores how the distribution and use of images like the ultrasound brought the fetus into the public realm, thereby contributing to the shift in antiabortion rhetoric from the religious/mystical to the techno-medical (Petchesky 1987). She demonstrates how these techno-medical images are framed as the "objective truth," ultimately erasing the womb and obliterating the interconnected relationship between the pregnant person and the fetus. She implores readers to reject the supposed "objective truth" of these images and instead consider the multi-layered context of them—who uses them, how, for what purposes, as well as who looks at them and their accompanying positionality—and to center the women whom they have erased (Petchesky 1987,

[72] Notably, I am not discussing most items in the props category. Although I collected and documented several of these materials, I did not focus on them when observing at clinics. Messages in pamphlets, and handout materials reflect the messages on signage and continue those discourses in other forms. Other ephemera are covered in other studies such as Jennifer Holland's *Tiny You: A Western History of the Anti-Abortion Movement* (2020).

285–86). She also emphasizes that the antiabortion movement has strategically shifted its rhetoric to appeal to the cultural allure of techno-medicine "in its effort to win over the courts, legislatures, and popular hearts and minds" (Petchesky 1987, 264–65).

Further, Petchesky stresses that the content of the fetal image and the aesthetics of these images which communicate meaning. In other words, the colors, angles, perspective, and style of images reveal (and create) ideas about abortion that suffuse the public discourse. More than symbolic, Petchesky shows how the antiabortion movement strategically introduced the fetus to the American public to consolidate conservative political power (Petchesky 1987, xiii). According to Petchesky, the antiabortion movement and their political allies used the fetus to demonstrate the need for paternal protection of the fetus from women to justify the neoconservative government's reprivatization efforts. She writes:

> The sinister idea of mothers who 'kill their children' becomes a salient part of the background noise accompanying policies that discredit women's right to make claims on behalf of their children and social programs that benefit poor mothers and children. Saving fetuses from their mothers distracts conveniently from society's failure to feed, house, educate, employ, and provide healthcare to millions of children, much less to solve the problems of AIDS, drugs, and environmental devastation (Petchesky 1987, xiii).

Because, in fact, unlike actual poor women and children, the fetus does not require any follow-up care (Petchesky 1987, xiii). Ultimately, this public fetus would saturate abortion discourse and epitomize public conceptions of "abortion images"—instead of "antiabortion images" used (and many times altered) to achieve specific goals. Images include sonograms, 3D fetal imaging, and mangled fetal remains.

One of the reasons Petchesky details that the fetal images are so powerful is because they are seen as scientific and "objectively true." After all, medical facilities in the United States tend to be trusted to disseminate medically accurate and scientifically confirmed health information.

Expected to provide safe medical services, medical facilities hold a powerful position in American society. In addition to fetal images, another type of image and its accompanying discourse entered the scene—"woman-centered" health messaging and Crisis Pregnancy Centers (CPCs).

The shift from focusing on the fetus's health to the mother's health was a strategic angle for the antiabortion movement. Indeed, Both Karissa Haugeberg and Kimberly Kelly write about the Crisis Pregnancy Center (CPC) Movement and how the movement's leaders have centered women in abortion discourses as part of their nefarious strategy. Kelly explains that the shift to female leadership of most CPCs in the early 90s, combined with their loss of popularity due to journalistic exposes and client lawsuits, inspired their shift to focus on the needs of women to stop abortion (Kelly 2012, 211). They felt that a more empathetic approach, which according to their essentialist gender views, meant more feminine, carried out "woman-to-woman," would be the most successful approach to prevent abortions and convert clients (2012, 211). Although I am primarily talking about aesthetics at the clinic, many of the visuals that appear there are connected to broader CPC Movement and the local, specific CPC facilities themselves.

Often overtly or covertly evangelical Christian, CPCs are non-profit organizations created with the primary goal of intercepting women with unintended pregnancies and inhibiting them from accessing abortions. Although CPCS are not new (they have existed since *Roe v. Wade*), they have spiked in number since the year 2000 and continue to increase rapidly, far outnumbering abortion clinics in the U.S. with an estimated 3,500 CPCs compared to 788 abortion clinics (Jones, Witwer, and Jerman 2019; NARAL Pro-Choice America 2015; Ahmed 2015a). Most CPCs offer the following services: pregnancy tests, STI testing, free parenting materials (i.e., diapers, baby clothes, and maternity clothes), and biased pregnancy counseling by

pseudo- clinicians dressed in medical garb. Some CPCs have been reported to offer financial assistance for pregnant mothers, social services referrals, parenting classes, bible studies, and abstinence seminars (Ahmed 2015; NARAL Pro-Choice America 2017; Kelly 2012). Often, free parenting materials that low-income mothers may need, such as diapers and baby clothes, are offered in exchange for attending the CPC's classes and seminars (Kelly 2012). CPCs use deceptive tactics on-site at their centers, at the sites of independent clinics (which are sometimes next door), and in their advertising materials which have been well documented by lawmakers and reproductive health advocacy organizations (NARAL Pro-Choice America 2017; Rosen 2012).

CPCs have been notoriously difficult to regulate, as the U.S. Supreme Court's case of *National Institute of Family and Life Advocates v. Becerra* shows, commonly known as the "Reproductive FACT (Freedom, Accountability, Comprehensive Care, and Transparency) Act." California legislators created the Act to inform pregnant people that CPCs were not licensed medical facilities and that the state offered free or low-cost reproductive health services, including abortions elsewhere (Holtzman 2017). The Act required that CPCs post this information somewhere visible in their facilities.(Holtzman 2017). Feeling that their freedom of speech and religious rights were impinged upon, the Pacific Justice Institute and the Alliance Defending Freedom filed lawsuits on behalf of several CPCs (2017, 78). Then, in the Summer of 2018, the Supreme Court sided with CPCs and overturned the FACT Act. To this day, CPCs continue to operate near clinics. Their volunteers engage in sidewalk counseling at clinics. They usually come to the clinic with posters and pamphlets or bring a bus or RV. Some of the messages on their signs are misinformation about the health effects of abortion (e.g. abortion

leads to suicide). In the past few years, they have carried signs about pill abortion reversal (Figure 3), which is inaccurate and dangerous.

Figure 3

Antiabortion Posters

Perhaps one of the most apparent visual assaults, and the one most robustly written about, is the antiabortion poster. When emerging from my car at the Nebraska clinic, I saw signs that said, "BABIES MURDERED HERE" and "REMEMBER THE UNBORN" in big black block letters. Although I knew babies were not murdered at the clinic, it was an upsetting picture to imagine—creating a macabre scene, to say the least. And then the sign that said, "text helpline to 313131."

I think, "help…for what?" The sign implies that the person reading it is in imminent danger and about to enter an untrustworthy place. The bold letters signal that this is a warning to be taken seriously. These images contribute to the *mise-en-scéne* of the clinic as an unsafe place.

Visually, it is hard to miss the posters because there is never just *one* poster; there are almost always multiple, and they are never in the background but usually placed directly in the patient's field of sight. In the Nebraska clinic example, the "remember the unborn" poster was inescapable, propped on the windshields of numerous surrounding cars and held by two protesters near the parking lot entrance. Many of these posters loom large, standing at least three feet tall, on sturdy foam boards, or supported by long PVC pipe. And then, there are the images featured on the poster.

Images on antiabortion posters range from messages in big, bold letters to mangled fetuses to happy babies to smiling mothers—often at the same time. Types of images tend to be associated with different antiabortion groups and/or discourses of the movement, such as fetal personhood and "woman-centered" health. For instance, fetal images are often associated with relatively more aggressive antiabortion groups such as Operation Save America or Abolish Human Abortion. (However, I have also observed several "one-off" or non-affiliated protesters hauling fetus posters outside clinics.) Fetal images have come to represent the public's notion of an antiabortion protester (and according to some, like Petchesky, to abortion more generally). They are prevalent icons of antiabortion aesthetics at the clinic landscape.

Figure 4

Figure 4 depicts two black-and-white fetal images in a two-dimensional sonogram style. The lay passerby cannot tell them apart, which is the point. The message reads, "Which of these human beings was conceived in rape? And which of these children does not have the right to live?" This rhetoric conveys the key antiabortion message of this specific group—Abolish Human Abortion—that there are no exceptions for abortion, including rape.[73] Rape, incest, life of the mother, and fetal impairment have long been exceptions to antiabortion legislation in the

[73] Abolish Human Abortion (AHA) is a loose coalition of antiabortion protesters. They separate themselves from the Pro-Life Movement by calling themselves "abolitionists" and repudiating the pro-life legislative strategy of incremental legislative moves (which has primarily been successful). See Chapter One to learn more AHA.

U.S. and abroad. In her book *Doctors of Conscience: The Struggle to Provide Abortion Before and After Roe v. Wade*, Carole Joffe explains that many physicians were actively advocating to legalize abortion pre-*Roe*. She writes that many were guided by the model developed by the American Law Institute (ALI). The "ALI model" permitted legal abortion if the pregnancy would (1) severely threaten the mental or physical health of the mother; (2) if the child was likely to be born with severe mental or physical defects, and (3) if the pregnancy resulted from rape or incest (C. E. Joffe 1995, 39). Examining the image, "human beings" and the "right to live" are even bolder than the rest of the black block-letter text, creating a visual effect arguing that human beings do have the right to live and that this is a "Black-and-white" issue. Additionally, the word "rape" is at least quadruple the size and in the middle of the poster, capturing an onlooker's attention with this taboo topic.

The use of the sonogram image here is intended to assert scientific authority. Petchesky explains that the fetal image gained attention through films and images like this one, made possible by sonogram technology. She disrupts the so-called "scientific objectivity" that these images have come to represent to insist that culture determines the ways we see the images. In other words, the sonogram technology takes on accepted cultural understandings of motherhood, such as America's hostility toward pregnant women (Petchesky 1987, 271). Petchesky explains that sonogram images like these are treated as neutral, transparent, and scientifically objective—posing as evidence of fetal personhood (Petchesky, 1987, pp. 276–278).

Assuming one uterus belongs to a person who has been raped in this image, one may surmise that the person's body is non-consensually invaded yet again through the taking of the sonographic image. A part of their body is being produced (and reproduced) and circulated to the public, intending to spark paternalistic protectionism from its viewers. Petchesky argues that the

sonographic image is, in fact, an image of surveillance because it is a medical diagnosis record-keeping image signifying scientific rationality and state surveillance (Petchesky 1987, 269). Not only do these uteruses belong to people not shown, but the uterus itself is magnified to be the size of a torso, thereby configuring the photo as an invasive view of the insides of an unmarked (and probably not notified) person—not to mention, altering the actual size of the fetus at this stage.

Figure 5 exemplifies another type of fetal image, what anthropologist Faye Ginsburg calls the "magnified fetus," which is usually depicted floating in warm and glowing hues (Ginsburg 1989, 105). We see a sac and an umbilical cord, but we do not see the pregnant woman sustaining the fetus; the fetus is extracted from the pregnant body. The text says, "Equal Rights for All," implying that this fetus is an individual human deserving of rights and that, in this case, the "right to life" is the right to be born, as if that process involves no one else but the public at large. Petchesky claims these images bring the fetal body into the public sphere as a legitimate, objective image. Thereby the public must believe in what it sees (Petchesky 1987, 270). Further, the use of colors in the image—i.e., warm hues and soft light—establishes a connection to nurturance and innocence, and compels the public, particularly women, to care for this "individual being" (Ginsburg 1989, 105).

Figure 5


THIS IS YOUR NEIGHBOR
FIRST TRIMESTER ABORTION
CREATION MUSEUM

Figure 6

Figure 7

Ginsburg explains that the "right-to-life visual material," often displayed on posters, offers two representations of the magnified fetus, which work together in juxtaposition: the floating fetus (Figure 5) and the mangled fetus (Figure 6, Figure 7) (Ginsburg 1989, 105). The floating fetus, she explains, focuses on tiny and perfectly formed features such as feet "in warm amber tones, suffused with soft light, rendered more mysterious by their separation from the mother's body" (1989, 105). Contrastingly, the mangled fetus is an image of (usually magnified) fetal remains that people in the antiabortion movement call "the war pictures" (1989, 105). These

images are harshly lit clinical shots; they are gruesome and bloody. By contrasting qualities of warmth, unconditional nurturance, and innocence in the floating image with the possible violent destruction in the mangled image, these images work in concert to try and dissuade pregnant people from choosing abortion (1989, 105–6).

Petchesky and other scholars have theorized floating fetal images or what Petchesky terms as the "fetus as spaceman" images. She describes that this archetypal image illustrates a (male) individual being, floating in space, self-sufficient, and ultimately erasing the subjectivity of the pregnant person (Petchesky 1987, 270).[74] She points out that in addition to excising the pregnant person, images like these reflect industrial capitalism by emphasizing the (misleading) notion of extreme individualism (Petchesky 1987, 264). She argues that the "spaceman," viewed through photography, which debuted due to industrial capitalism, is part of a "politics of style," which features the surface image as the meaning of the whole message (1987, 268). She writes: "Fetal imagery epitomizes the distortion inherent in all photographic images: their tendency to slice up reality into tiny bits, wrenched out of real space and time" (1987, 268).

Along with the declarations of personhood, fetuses are depicted as patients, usually assumed male, harmed by the women (their supposed adversaries) and their "corrupt" doctors—for example, Figure 6 and 7 show mutilated fetal remains. Not only are these images rarely shown, which may make them even more shocking, but they are clinical in style with bright white lighting and the biological details in the top right corner.[75] The blood and tissue here are

[74] Petchesky builds this concept off of Barbara Katz Rothman's idea that the fetus in utero becomes a metaphor for a man in outer space, "floating free, attached only by the umbilical cord to the spaceship," erasing the mother and its interdependence on the mother (1987, 270).

[75] Accurate images of pregnancy tissue at different stages of development are rarely shown. To learn about the ambiguous nature of pregnancy tissue viewing, see Andrea Becker and Lena Hanh, ""It makes it more real": Examining ambiguous fetal meanings in abortion care" (2021).

large and central. Figure 6 shows the head next to a coin for size comparison to provide even more "proof" that they are not distorting the image. Figure 7 includes a medical tool as a weapon conveying the demonization of the doctor. In the bottom left-hand corner, we are reminded that we can buy the posters and contribute to the maker's revenue. These images are examples of Ginsburg's previously mentioned wartime photos because antis frame them as the bloody remains of "murder" (Ginsburg 1989, 386). She argues that pictures like these imbue ideas of protectionism and guilt, reminding a viewer of citizens who allow their blood to be shed to protect the nation-state (1989, 387). Escorts say antis fetishize the fetus and that fetal images are like "fetal porn" for them.[76]

Medical historian Monica J. Casper suggests that the technological advances in fetal surgery enabled the fetus as patient discourses and images (Casper 1999, 101–12). She examines explicitly the advent and language surrounding fetal surgeries. Casper explains that the medical discourses of fetal surgery employed the rhetoric of the Pro-Life Movement. For example, a prominent fetal surgeon Dr. Michael R. Harrison said the following about fetal surgery: "treatment of the unborn has had a long and painstaking gestation […]. But there is promise that the fetus may become a born again patient" (Casper 1999, 107). Both "the unborn" and "born again" resonates with antiabortion rhetoric. She points out that fetal surgery was often framed as saving fetuses from women and, in this case, positioned the fetuses' doctor as a heroic savior of fetal life (1999, 108). She argues that this language cemented the pregnant woman's secondary status and served as a rallying call to stop the "murderous" doctors (i.e., abortion providers) and support the heroic ones (i.e., fetal surgeons) (1999, 107).

[76] Rosalind Petchesky also discusses the fetishization of the fetus; see Petchesky (1987, 2).

Another image that I did not see during my fieldwork but is notorious in the clinic landscape and beyond is "Wanted" posters.[77] "Wanted" posters usually include an abortion physician's name and photo in the style of posters from the Old West. They also accuse the doctor of committing crimes against humanity (2015, 99). They may also include the providers' home address or other personal details. David S. Cohen and Krysten Connon featured an excerpt from a provider about these posters. They write:

> Sarah Haupt described how a regular protester at one of her clinics gained prominence in the 1990s and appeared on a nationally televised show with a famous host. During his interview, the protester showed an Old West "Wanted"-style poster featuring Sarah. The poster said "Wanted: Dead" above a digitized photo of Sarah's face. Though her face was not recognizable because of the digitization, the protester talked about Sarah by name (Cohen and Connon 2015, 71).

Cohen and Connon clarify that these images were intended to incite violence as a "form of implied death threat, and historically they have appeared before the murders of doctors (2015b, 25, 98). Regarding the TV show appearance, they quote Sarah as remembering that the protester said, "if the poster incited someone else to do it [murder her], then he would have accomplished his goal […]" (2015b, 25, 98).

[77] Cohen and Connon explain that the "Wanted" poster style appeared before the murders of Dr. David Gunn, Dr. George Patterson, Dr. John Britton, and Dr. George Tiller. Although this style of poster still exists and circulates from time-to-time, they were more common in the 1990s (2015, 25, 98).


You have OTHER choices
We are here to HELP
Abortion
Hurts
Women
Figure 8

Figure 9

In my encounters with clinic protesters, an image that seems to be more and more prevalent is the "pro-woman" or "woman-centered" poster, with accompanying rhetoric. As I described previously, these types of images spawn from the CPC Movement. For example, the text of Figure 8 reads, "Abortion Hurts Women." The text is displayed on a pink background, and the word "women" is written in elegant cursive. Both the color choice and the style of the

word “women” reflects essentialist gender stereotypes about women. It also takes an entirely different discursive approach than the fetus posters. Instead of positioning the mother as bad or evil, it positions the doctor/medical industry (and even feminists) as evil for enabling abortion. This implies that the procedure may hurt physically and/or be dangerous and/or that it will hurt emotionally. The blatant deception and co-option of these images on posters ultimately reflect the moves of the broader CPC Movement —not only of Pro-Choice Movement language but also medical language and aesthetics. Co-opting the language of progressive medical care and progressive movements has been a successful strategy for many CPC-related groups.

Like co-opting the women’s health focus of the Pro-Choice Movement, antiabortion protesters also co-opt medical-technological aesthetics, including the “scientific” ultrasound images mentioned previously, specific styles of individual clinics, architectural styles, and medical professional clothing as part of antiabortion aesthetics. These aesthetic choices brought to life by the performances of the creators/wearers are cultivated to scare, confuse ultimately, and/or deceive pregnant people who enter the clinic. They are also perpetuated to create another obstacle for clinics, relentlessly infiltrating the clinic landscape.

Medical Aesthetics

Let’s begin with the pink vest. The vest has become an important symbol for escorts in the last decade partially due to the organization “The Clinic Vest Project.” According to their website, The Clinic Vest Project’s mission is to is “to provide free clinic escort vests to groups that service facilities that support the full range of reproductive health options including safe and legal abortion. We also offer free training materials to groups that need them” (n.d.). They specify that their vest should only be used for “clinic-sanctioned activities,” and they report that

they have sent vests to over 100 clinics in 43 states (Clinic Vest Project n.d.). Anecdotally, I have heard that the vest project has also been a key contributor to escort online communities. I have also seen several escorts who have clinic vest tattoos.

As I arrived at the Nebraska clinic, I was greeted by a woman holding a clipboard and wearing a pink vest (Figure 10). Historically (and sometimes currently), escorts have worn pink vests to indicate they are with the clinic (Figure 11, Figure 12). When I saw the woman in the pink vest, I wanted to trust her. The vest is designed like a traffic officer's vest to signal that she is someone with authority in the space. Upon arriving, I rolled down my window, and the misinformation invading my space commenced. For me, this overwhelmed and upset me. It jolted me into the reality that I needed to be on guard and trust no one. Unfortunately, posing as clinic escorts is a fairly common strategy that antis employ. Antiabortion protesters use the vest to deceive the patient, so they can infiltrate their space.

Figure 10

Figure 11

Figure 12

Antis use other medico-professional symbols to glean authority at the clinic, such as vans and buses posing as mobile medical units. For example, many antiabortion protesters park CPC vans (see Figure 13, Figure 15), often professional and expensive, outside the clinic, sometimes even blocking the actual view of the clinic building. These vans are usually staffed with

volunteers posing as licensed medical professionals, often donning scrubs and holding clipboards.[78] Not only are they co-opting the mobile medical unit model, but they are posing as an extension of the actual clinic with deceiving names on the outside, such as names with the word "choice" or "options," to lure potential patients (they also use these words in their advertisements) (Kelly 2012; NARAL Pro-Choice America 2017; 2015). Usually, signage will say something like "free pregnancy testing" or "free ultrasounds." By advertising a service specifically as free, the vans and buses are intended to target low-income patients (Figure 13, Figure 14, Figure 15) (Howse 2020; Fayette Pregnancy Resource Center 2023; Thomsen et al. 2022). [79]

[78] Notably, sometimes licensed nurses are in CPC vans, but not because they were hired to work there. If there is a licensed nurse on a CPC bus, it is usually because she is volunteering for the CPC.
[79] I did not take a photo of mobile CPCs myself, but here are three examples. Each example shows a different size van or RV.

Figure 13

Figure 14

Figure 15

Like many brick-and-mortar CPCs, the vans/buses associated with them use the vulnerability of the unaware patient as a moment to give medically inaccurate information, including images of fetuses (with incorrect gestational labeling) and/or ultrasounds with fabricated narration, all designed to dissuade the patient from choosing abortion or, at the very least, disrupting her path to her appointment long enough for her to miss it. Clinic-side, these vans/buses, or simply volunteers from the CPC surround the clinic and attempt to guide the patient to their CPC instead of the abortion clinic. Antis secure a location close by and sometimes literally right next door to the clinic. I have witnessed antis misdirecting patients to the neighboring CPC when the patient has clearly indicated that they are looking for the abortion clinic on multiple occasions (see Figure 16 to see a CPC neighboring a Planned Parenthood). And they do all of this without disclosing their affiliations; this is all completely legal.[80]

Figure 16

[80] In 2018, California took the Reproductive Fact Act to the Supreme Court to regulate CPCs. If passed, the act would require that Crisis Pregnancy Centers disclose their status as a licensed or unlicensed facility and also post

Particularly troubling is the government's legitimization of these fake clinics. At the state level, "choose life" license plate sales as well as state based legislative initiatives make funding available to CPCs (Ahmed 2015). Federal funding sources include Community Based Advocacy Education (CBAE) funding and Title V funds for Maternal and Child Health (Ahmed 2015). In addition to state and federal funds, CPCs receive direct funding from umbrella pro-life organizations, such as Heartbeat International, CareNet, and Family Research Council (NARAL Pro-Choice America 2015).

Escorts tell me these vans/buses are ineffectual at changing patients' minds about their procedures but are fairly successful at causing confusion for patients, scaring them, and additional burdens for the clinic. Many escorts have reported that patients told them, "They wouldn't let me leave." Clinics have to counsel patients about ignoring the vans/buses. When antiabortion protesters lure patients into their vans, they will try to keep them there as long as possible, so they miss their appointment. Clinics try to accommodate patients that miss their appointments for this reason, and these delays often mean workers must stay late and/or come in early to reschedule patients. In addition, some patients may skip their appointments because they are upset by the intrusion or are given misinformation by the people in the van, delaying time-sensitive care. For example, mobile CPC antis have been known to tell patients that there is no gestational limit for abortion; they can think about it more and return later. In reality, as discussed previously, this is far from the truth, considering state gestational limits.

CPCs read, understand, steal, and, thereby, "perform" the power of medical institutions to legitimize themselves and delegitimize abortions, those who provide them, and those who seek

information that explains that the state offers low or free reproductive health services. Unfortunately, the act did not pass and was deemed to impinge on the First Amendment rights of CPCs. For more information, see Beth Holtzman, "Have Crisis Pregnancy Centers Finally Met Their Match: California' s Reproductive FACT Act" (2017).

them. CPCs read, understand, steal, and, thereby, “perform” the power of medical institutions to legitimize themselves in order to delegitimize abortions, those who provide them, and those who seek them. They co-opt the language of public health institutions and they impersonate doctors by buying scrubs on Amazon.com. They masquerade as women’s health clinics who provide abortions by giving their “clinics” misleading names like “Choices,” buying facilities next door or across the street from independent abortion providers, and requesting that patients fill out fake intake forms using healthcare facility templates.

Children as Props

Antiabortion protesters use their children as props. I want to stress that I am not suggesting children are inanimate objects. Rather, I argue that antis objectify their children's bodies for aesthetic impact. This was never clearer to me than when white antiabortion protester Coleman Boyd held his adopted Black toddler over the fence as a Black patient headed to the door and yelled, “See, we’ll adopt your babies!” I could tell the child had no idea what was happening but was thrilled he was being held, as children often are. There are many depressing aspects of the clinic landscapes, but the use of children is one of the saddest to me.

Figure 17

When discussing children as props, I am generally talking about children twelve and younger (Figure 17). Certainly, every child is different, but twelve was about the cut-off when I noticed a big difference between children at clinics. The children twelve and under, especially babies and toddlers, seemed somewhat oblivious to the messaging. They slept, played, and ate snacks. Kids between six and twelve may hold a sign or shout a slogan, but it was obvious that they were parroting their parents or simply following instructions. Escorts tell me that the use of children can be especially difficult for patients procuring later abortions as often those pregnancies are wanted, but end in abortion due to fetal anomalies or maternal life endangerment.


CHRISTIAN!
YOU SAY YOU OPPOSE ABORTION...
Proverbs 24:12
Don't excuse yourself
by saying, "Look, we didn't know."
For God understands all hearts, and he sees you.
He who guards your soul knows you know.
He will repay all people as their actions deserve.
HOW?
CHURCHREPENT.COM
UNITED STATES POSTAL SERVICE

Figure 18

Figure 19

Many antis bring children on school days (they do not need to worry about missing school because most of them are home-schooled) to sit or stand in the hot sun on the pavement or sidewalk. There are always several children with a pair of traditional heteronormative-presenting parents. These kids often look overheated and mostly bored (Figure 18, Figure 19). At the 2021 counter-protest of Operation Save America's "Summer of Justice," the weather was over 100 degrees in Phoenix. Red-faced, the children suffered from heat stroke, and EMS were called. OSA members failed to see the irony of their children passing out while they were screaming at the clinic patients to "love your baby" and "we'll take care of your baby."

Escorts tell me they sympathize with these young children because they are not there by choice. Antis employ them as a symbol to add emotional impact to their messaging. Historian

Jennifer Holland explains that before the 1980s and 1990s, children were presented as explicitly depoliticized as symbols of innocence in an imagined past when abortion was illegal and "Americans were committed to nuclear, patriarchal families and religion" (Holland 2020, 149). After the 1980s, children were transformed into symbols of those who were aborted and American corruption. Holland explains that children were now portrayed as "psychologically damaged, perpetually at risk, lucky to be alive, and harbingers of America's end" (2020, 148). They became known as "survivors of the abortion holocaust," and antiabortion activists hoped that as "survivors," children would develop deep personal relationships with the cause. Many did, holding signs like "Abortion Kills Children," "I'm Glad I Wasn't Aborted," and "Survivors of the Abortion Holocaust" in hopes that their identities as young people would emphasize these claims (2020, 171).

In the 1980s, children became the targets of movement recruitment. Antiabortion activists visited schools, taught antiabortion lessons from home, and brought children to clinics, protests, and other movement events in hopes that they would lead the movement into a future when abortion would be illegal (2020, 150). Antiabortion businesses developed workshops for home-learning and merchandise ranging from books to t-shirts to balloons that said "I'm a Child Not a Choice" (Holland 2020, 172). Children were racialized through these processes too as almost all of the children selling these materials (i.e., featured in the advertisements) were white. Holland notes that there were a handful of images of children of color on these materials, but all instances ingrained racist tropes about women of color in the pretense of racial representation. For example, they featured Black children in books about teen pregnancy, adoption, and single parenthood (e.g., a book entitled *Do I Have a Daddy*?) (2020, 172). Youth mobilization during

this time has continued to generate an antiabortion children's culture and youth leadership.[81] Antiabortion images are rife with fetuses, babies, and actual children. Whether featured on a poster, used as a prop, or primed for prominent leadership, children distinguish the clinic landscape from other health facilities.

Escort Counterstrategies

Due to incessant visual assaults, clinics and their escorts have devised multiple strategies to try and block the site of the protesters and their images. Many clinics transform their entrances into cave-like environments. For example, even though the Nebraska clinic was at the corner of two streets with no trees in sight, they covered the stairs to the entrance with a dark green awning. All of the blinds were closed. (In fact, the only clinic I went to with open blinds was a clinic on a high floor in an office building.) Escorts and staff parked their cars strategically on the parking lot's perimeter to block sightlines for antis. And escorts positioned their bodies to partially block the patients from seeing the antis.

Escorts also invent ways to use the presence of protesters to benefit the clinic. For instance, at one clinic in the South, the escorts had a "pledge-a- picketer" initiative. Escorts counted the number of protesters and would report the total for that day, month, and year at the end of the last shift. They would post this information (sometimes on posters of their own) on social media such as Instagram and TikTok. They use the numbers to spread awareness about the volume of protesters and also as an opportunity to raise money for the escort program and/or clinic-affiliated non-profits. Many clinics have programs that they call "pledge-a-picketer" or

[81] For more on youth in the antiabortion movement and the racialized aspects of their participation, see Jennifer Holland, "Chapter 5: Politicizing the Young" from *Tiny You: A Western History of the Anti-Abortion Movement* (2020, 148-180).

something similar. For example, Planned Parenthood of Western Pennsylvania has a program, where they advertise that donating to the campaign will “directly turn their negativity and vitriol into financial support for PPWP” and their patients. They report that they have raised over $180,000 in operating funds (Planned Parenthood of Western Pennsylvania n.d.).

Figure 20

Clinics use foliage and fences to block the sight of antis. Escorts often extend the fence's blocking potential by adding black trash bags and cardboard between its slats. However, as I will discuss later, antis often find ways quite literally to rise above the barriers with ladders, platforms (see Figure 20), or deer stands. The clinic becomes smaller and darker as the antis become bigger and tower over their fences, shrubbery, and cars. Many escorts refer to themselves as clinic defenders, as many erect temporary walls to protect the building and those who enter its doors. Clinics work to make themselves invisible or protected from the outside. Many create a fortress-type atmosphere (described in more detail in Chapter Two). By the time I visited my fifth clinic, I felt depressed by this; their precarity requires thick armor.

Chapter Four: Antiabortion Sounds of Violence [82]

> Control of the sound world doesn't just mirror visual control over bodies and the worlds they move through, it enacts new and arguably more invasive limits on these bodies. Whether clamoring for an audience on the sidewalks of public space, or quietly sonifying potential life via Doppler technology, the sounds of sonic patriarchy continue to interrupt feminist endeavors for autonomy and agency.
>
> --Rebecca Lentjes

Images convey violence in an obvious and widely observed way. With surveillance cameras primarily documenting antiabortion activity that can be seen, law enforcement and subsequent legal action focuses on regulating antiabortion aesthetics and visual strategies. Sound often goes underexamined. Yet often the antiabortion soundscape at clinics can be just, if not more, traumatizing for patients. Patients can often avert their eyes, avoiding some antiabortion images upon entry; however, muffling antiabortion sounds can be more difficult. Antiabortion protesters frequently create a circus-like atmosphere around the clinic. Men often shout these messages and their content has explicitly sexist themes about traditional masculinity and femininity as they define it. They condemn mothers for being uncaring and echo "please don't kill this child" and they attempt to rally men to "be a man" because "real men love babies" (Arey 2020). Loud and unrelenting, their messages penetrate the ears of patients and sometimes echo inside the clinic procedure rooms, and there is little the clinic or escorts can do about it. Upon arriving at my very first clinic a year earlier, the antiabortion protester noise was one of the most palpable and chilling parts of the clinic landscape. Hearing the cacophony of the yells as I

[82] Portions of this section have been published in the following article: Lentjes, Alterman, and Arey, "'The Ripping Apart of Silence': Sonic Patriarchy and Anti-Abortion Harassment" (2021). Notably, this article is co-authored with scholars Rebecca Lentjes and Whitney Arey, who have provided explicit permission that I adapt our article for this chapter.

opened the door at the Nebraska clinic was par for the course during my clinic visits, but it still shook me. The noise outside of clinics served as a constant reminder that my healthcare as a woman was not prioritized by the state I was in; I had no recourse.

In this chapter, I argue that antis use sound to perform their sonic dominance in the clinic space. I contend that their sonic tactics are particularly gendered and constitute sonic patriarchy. To demonstrate this, I analyze a few typical examples of sound in the clinic landscape or what I call "antiabortion sounds." First, I explore three aspects of the sound realm: (1) ventriloquism, (2) amplified sound, and (3) speech content. Then, I analyze their impact through the theoretical framework of sonic patriarchy developed by ethnomusicologist Rebecca Lentjes and expanded in our collaborative article, "The Ripping Apart of Silence: Sonic Patriarchy and Anti-Abortion Harassment" (Lentjes, Alterman, and Arey 2020). Drawing from Whitney Arey's research at abortion clinics, I then discuss the gendered content of antiabortion speech and the ways it affects patients. I conclude by describing how escorts attempt to drown out protester noise and affirm that antiabortion sounds operate as a form of gendered sonic violence.

Sonic Patriarchy

Rebecca Lentjes' definition of sonic patriarchy is "the sonic counterpart to the male gaze,"[83] which encompasses speech acts such as mansplaining and catcalls.[84] Lentjes has expounded elsewhere that she theorized sonic patriarchy "to give name to the domination of a sound world

[83] Laura Mulvey first conceptualized the "male gaze" to describe the spectatorship and the objectification of women in film. Since her foundational article, scholars have applied the concept beyond the context of film to critique heteronormativity's pervasive effects in visual culture (Mulvey 1975).

[84] My use of the term "speech acts" is informed by anthropology literature such as Austin (1962), Rosaldo (1982), and Duranti (2015). I am also thinking alongside philosophers such as Judith Butler and Adriana Cavarero, who have written on "speech acts" and vocality in relation to gender domination and proliferating power structures through which gendered voices command authority and perpetuate gender roles even within mundane, everyday contexts (1988; 2005).

in gendered ways [….] In public space, sonic patriarchy can be heard in the catcalls and whistles and mansplaining that grope their way into the aural space of female and feminine bodies" (Lentjes 2018). The undercurrent connecting these speech acts is a lack of regard for the consent of the hearer. Although these sounds do not inherently constitute "violence" (and typically are not intended as such), in the public sphere they materialize as a form of aural invasion that forces the hearer into a position of nonconsensual listening. Lentjes explains that sonic patriarchy's range of intrusive sounds should be considered noise (in that the surrounding communities hear them as unwanted sounds) and sonic manifestations of gendered control.[85] The sounds of sonic patriarchy enact a mode of political domination in both the private and public sphere, an effect Lentjes terms elsewhere as "gendered sonic violence" (Lentjes 2016).

The sound world outside the clinic is typically cacophonous and unpredictable. For example, when I emerged from my car at the clinic, I immediately heard various cries of "Mom, Mommy, Mother" coming from every direction. During my research, I learned that this is part of one of the most common refrains at the clinic landscape—performing the fetus. To perform the fetus, protesters, who are almost always male, shriek, "Mommy, Mommy, don't kill me!" in a vocal performance that commands attention from those within earshot.

This vocal performance achieves a silencing of the pregnant person through a sonic animation that, according to performance theorist Peggy Phelan, "ventriloquiz[es] for the unborn child a fear of murder" (Phelan 1993, 387). Their sounds of anguish are alarming for patients, clinic personnel, and passersby, who sometimes stop in their tracks out of evident concern. Significantly, the male voice, typically heard as one of authority, is most commonly used to "give voice to the voiceless." Female voices fade into the background as the traditionally deeper,

[85] For more on the subject of religious noise, see Weiner (2013).

more robust male voice transforms into a high-pitched pleading whine—ultimately still recognizable as "male."

This act of ventriloquism issues forth from a voice that mere seconds before was preaching in deep, bellowing tones. When heard in Western contexts, these vocal tones have long been coded as "masculine" due to acoustic qualities such as a low pitch and booming volume. The sociolinguistic processes through which these sonorities are coded as "male" is significant, as Elinor Ochs has pointed out that "pitch has social meaning" (Ochs 1992, 339). Sound studies and voice studies scholars have also taken up the sociocultural contexts shaping pitch perception, asserting that the human voice itself "becomes an acoustic sign" through which gender roles are re/produced (Cavarero 2005, 3). These scholars argue that "analyses of sound [...] cannot be divorced from a sociohistorically bound consideration of its material condition and sensuous pulsation" (Eidsheim 2011, 149). In the case of abortion clinic protests, where the sound world is dominated almost exclusively by "masculine" voices, thunderous male vocal sounds can eclipse the content of the words being shouted. Sensation supersedes sense as the sheer volume of these vocalities commands a gendered respect that can be traced as far back as Aristotle's writing on the subject (Carson 1995).

Megaphonic Harassment and Speech Content

Protesters' use of sound amplification intensifies the inescapability of nonconsensual listening. Microphones, megaphones, bullhorns, and speakers infiltrate the clinic landscape. The level of sound contributes to intensified reactions to antiabortion protesting. *The Turnaway Study*, a research project that investigated the effects of abortion and unwanted pregnancy on women's lives, found that "two-thirds of women whom the protesters tried to stop from entering the clinic

reported that protesters were upsetting, compared to the 36% of women who only saw the protesters but did not hear them" (D. G. Foster 2020, 80). The results indicate that "loudness" is integral to patients' fear and anxiety at the clinic. Protesters rely on vocal sound in their efforts to captivate the ears of patients, volunteers, providers, and passersby, and the viscerally felt cacophony of these sounds is compounded by its cultural connotations. Amplified protester messages become inescapably loud, resonating through the waiting room, counseling offices, and procedure rooms. I did not notice amplified sound at the Nebraska clinic, but it was used at most other clinics I visited. One of the most extreme examples is from a clinic I visited in the South:

> At around 7:30 a.m., a hefty truck bulldozes down the road hauling an enclosed trailer. "Here comes the circus," quips Derenda. A man and several teenage boys open the trailer doors and heave the professional-looking sound equipment on the grass behind the sidewalk, leaning it against the gate. They prop the speaker on a tall stand that towers over the fence. I spot a microphone, multiple foldable chairs, a chorus of children ranging from infant to teen, and a sizable Bible.
>
> Escorts stand between the patients in the parking lot and the protesters, blocking patients from view, but they can't hamper their sounds. I can't hear Kim's conversation with the patient over the noise, but she distracts the patient with small talk, completely ignoring the cacophony. Then, suddenly, I hear "JESUS DIED FOR YOUR SINS!" booming from a male protester out of his giant speaker, which he has positioned to resound over the fence. Once Derenda hears him roar, she turns up the volume of the escort's speaker, not nearly as mighty. Their speaker blares metal music but fails to dull the man's yells. A few minutes later, I peer through a hole in the fence and see another has taken the microphone. He grips it tightly while yelling, standing as close as possible to the fence before the entrance. As escorts usher more patients briskly toward the clinic entrance, the protester screams, hoping they will hear him in the waiting room near the door.
>
> He takes a deep breath and addresses the "fathers" in the waiting room. He starts yelling into the microphone and proceeds to yell throughout his plea. He cries: "My child was almost murdered here … we wanted her dead […] you want your child dead because of some relief you may have … it's not relief, it's not relief … it is a guilt that you will never be able to get rid of […]. My daughter is 16, and she's beautiful; she wants to be a nurse. She wants to be a nurse so she can help people, but because of my sin, I almost destroyed her, but then I saved her […] do not do this abominable thing that is in your heart to do. I've been there with the tears in my eyes, so those of you who are crying in the other room right now knew what was going with your child, but because of your fear, you won't go in and say, 'STOP, STOP! I will not do this thing! Stop!' Go in. Go into the

> room and open up the doors and say, 'STOP! I will not do this. I want my child to live!'"
>
> A second wave of patients arrive. They rush through this gantlet of noise, some trying desperately to cover their ears, others guffawing in disbelief at the protesters' comments. I realize we can do nothing to block this noise—we've exhausted all our options. The protesters are too close, too loud, and too amplified. I write a thought that had never entirely occurred to me until that moment: "sound as weapon."

This story is one of many instances in the field when I witnessed the weaponization of amplified sound, and the multiple strategies escorts use to muffle it. Despite the many attempts of escorts to block protester noise, their amplification pierced through the fence and the escort's music. Moreover, the emphatic and aggressive message not only drowned out any aural reply but also relied on multiple gender stereotypes, which intensified the punch.

The protester uses sonic patriarchy to dominate the soundscape with his amplified voice, making the issue of abortion his own personal narrative. He *yells* into the microphone because merely speaking into the microphone is not loud enough for him. The tenor of his voice remains emphatic throughout his speech as if every word were gospel. He intonates his words, inserting rhythmic pauses, and repeats particular words and phrases to emphasize them, such as "you want your child dead" and "it's not relief." Patients hurry past his speaker as they enter; one patient covers her head with her sweater to block the sounds and shield her face. His imperious call saturates the moment. The space surrounding the clinic and the entrance become his domain; his speech prevails because he has the loudest speaker system.

Furthermore, the content of his speech adds irony to the sonic dynamic because the male speaker draws on specifically gendered tropes to incite action among "fathers" while muting pregnant people. In this example, the male speaker uses gender stereotypes to rally male companions to speak for women, take charge, and ultimately "save" their unborn babies. He implores men to "go in" and, "say STOP!"—to prevent the abortion with the might of their

orders. Here, the potential to save a life originates from a man's word—not the doctor's or the nurse's, not the pregnant person's.

The protester draws on patriarchal masculine tropes that men can control women's reproductive futures. At the same time, he also uses more recent social views on gender about men's role in shared decision-making when he mentions that "*we* wanted her dead" and that forgoing fatherhood might seem like a "relief" from responsibility. In her recent article on protest speech at abortion clinics, Whitney Arey explains that protesters use contradictory gender stereotypes to appeal to male companions—some indicative of patriarchal masculinity and some reflective of more contemporary notions of male involvement in reproductive decisions (Arey 2020). She explains that antiabortion rhetoric reframed abortion from a woman's reproductive issue into a man's reproductive issue to express the need for men to prevent women from having abortions, and often did this by co-opting "choice" rhetoric from the Pro-Choice Movement (2020, 7). She stresses that "By emphasizing men's roles in abortion, protesters are drawing on these contemporary discourses about pregnancy' tak[ing] two' to convince men that they have a larger role in the abortion decision" (Arey 2020). [86]

Drawing from her ethnographic research outside of abortion clinics, Arey demonstrates that protesters used mixed messages about fatherhood, strength, and masculinity to both valorize and shame male companions and compel male action in preventing abortion (Arey 2020). For instance, the male speaker discussed above draws on patriarchal masculine tropes by insisting that men should "save" their babies. Arey explains that this rhetoric is used to shame women and

[86] There is some interesting writing on reclaiming men's role in reproduction as a pro-abortion strategy. The articles tend to by emphasize how many men's lives have been drastically improved by their partner's decision to have an abortion—how many careers, happy relationships, and families have been allowed into existence because of an abortion decision. See Dragunas (2022) and Becker (2022).

communicate their status as secondary decision makers or as pariahs that "babies" need saving from; additionally, this rhetoric but that it is often explicitly targeted to the male companions who accompany women to their appointments (Arey 2020). She points out that antis use language to incite action, and often violence, by aggravating tropes of masculine identity. She explains that through speech content and framing, as exhibited above and extended in her extensive research, the speech outside of clinics is meant to "present men's participation in abortion as emasculating, shameful, weak and irresponsible" while at the same time "emphasizing male patriarchy, toxic masculinity, responsible fatherhood, and strength as characteristics that men inherently possess" (2020, 3). For instance, she describes how antiabortion protesters, usually other men, will use negative cultural stereotypes of men as "deadbeat, irresponsible, and weak fathers" (2020, 11). She underlines that antis use this type of speech explicitly to elicit emotional responses.

According to Arey, the use and content of this speech highlight how "protest speech is largely a gendered performance, designed to bring about social action while reinforcing gender ideologies on masculinity and fatherhood" (2020, 10). Further, she clarifies that it is a particularly violent gender performance, attacking men's masculinity in a manner aimed to incite action. She links her observations of protest speech to what legal scholars term "fighting words" (2020, 11). As defined by the U.S. Supreme Court Case *Chaplinsky v. New Hampshire*, fighting words are "words which by their very utterance, inflict injury or tend to incite an immediate breach of the peace."[87] Arey states that "fighting words" in the context of the clinic landscape include phrases shouted by protesters such as: "'You ain't no real man. Real men don't kill

[87] Fighting words were first defined by the U.S. Supreme Court in *Chaplinsky v. New Hampshire,* 315 U.S. 568 (1942). Furthermore, in *Texas v. Johnson*, 491 U.S. 397 (1989) the U.S. Supreme Court redefined the scope of the fighting words doctrine to mean words that are 'a direct personal insult or an invitation to exchange fisticuffs.'

babies,' 'Come out here and flex your muscles with us,' or 'Go in and drag your wife out of that clinic.'"

The notion of "fighting words" can be linked to the hate-speech-as-violence discourse in legal studies. In fact, some may categorize antiabortion protester speech as hate speech in general. Unlike dissent, which critiques powerful institutions, Brooks Fuller argues that "hate speech" targets the least powerful in a community and should be regulated to protect the rights of the less powerful" (Fuller 2019). When it comes to regulating hate speech, opinions diverge rather sharply, with many people believing that hate speech regulations threaten their first amendment liberties and others arguing that such regulations are necessary to protect the rights of those who have been and continue to be, denied access to the full benefits of citizenship in the United States (Matsuda et al. 1993).

Further, in the example of amplified speech at the Mississippi clinic, the male speaker draws on gender stereotypes to legitimize his position and convince hearers to take action. For instance, he justifies *his* action to "save" his daughter because she is "beautiful" and wants to be a "nurse" to "help people." First, he centers himself and other men as potential "heroes" who can choose to "save" or "rescue" the pregnant woman, the baby, and the family from the evils of abortion—and ultimately successfully perform masculinity.[88] Second, he legitimizes his action by detailing how his daughter lives up to traditional ideals of femininity. In other words, his daughter was worthy of saving because she achieved traditional ideals of womanhood—physical beauty and the desire to nurture or help. Not only is masculinity constructed through protester

[88] Peggy Phelan discusses how men position themselves as "heroes" to save the woman and/or the baby from abortion in "White Men and Pregnancy: Discovering the Body to be Rescued," (1993). I discuss the hero discourse of men in the antiabortion movement in Chapter One. Men as heroes is also implicated in Operation Rescue's revised name, "Operation Save America."

speech but so is femininity, even in the absence of women. Notably, there are no female speakers. The protester neglects to mention women at all, including his own female partner's perspective. The male speaker uses sonic patriarchy as a means to speak for women who remain unheard.

In addition to preaching over loudspeakers, antis have also employed the strategy of hosting large events outside abortion clinics. These events amp up the volume of their noisemaking. For instance, at one clinic in the South, an antiabortion group called Love Life purchased the plot of land directly next to the clinic. Love Life chooses a different church to sponsor each week, and they bus in anywhere from fifty to more than 200 people to gather outside of the clinic. Every Saturday, they obtain a parade permit and have a large march with hundreds of people outside the clinic. This event usually includes "testimonials" from women who talk about regretting their abortions; preachers; and loud, sweeping, heartfelt music. It may also include participants singing gospel music. The local noise ordinance does not affect them because they have a permit, and they are holding these events on their own property.

I witnessed one of the events and was taken aback to see the stage being built and to hear the sound system being tested along with the giant tour bus that rolled up next to the clinic. Dozens of people, families, and children emerged from the bus wearing matching t-shirts; they even clearly gendered their port-a-potties. Abortion Access Front and the escorts at the clinic jokingly call it the "Jesus parade" or "Jesus concerts." As a Jewish person, I did not know any Christian songs, but from doing this research, I now know several—mainly because they play the same songs repeatedly. To my chagrin, "Break Every Chain" is constantly stuck in my head, and I now know most of the lyrics. Joking aside, these large-scale events are major hindrances for the clinic, and there is not much they can do about it. In fact, they are such a hindrance that the clinic

has tried to close on the weekends, when these events typically happen; however, the clinic found that the patient need for weekend appointments was too high.

Patient Affect

From visiting clinics and talking to providers, I knew that protesters bother and upset many patients. However, but outside of the patient data listed in the introduction to Part Two, we do not have much information about how patients feel. While visiting one clinic in the South, I bemoaned the lack of data to a clinic owner. She responded, “Really? We collected that a few years ago. We used it to advocate for noise ordinances but never published it. I’d be happy to share it with you.” With the owner's and the previous research team’s permission, I conducted a secondary analysis of the survey data. I use some of the survey responses here to illustrate the effect that antiabortion sounds have on many patients.

Notably, they collected 732 surveys between September 2017 and December 2017 (two years before my participant observation there). The survey was A 20-item "Patient Experience Questionnaire" with two blank sections for additional comments; they designed it to capture anti-choice protester behaviors directed at patients and the effect of such behaviors. This study was different from previous research in that it specifically asked patients about the behaviors of the protesters after their immediate encounter with them, while in the process of receiving health services.

In the general survey comments, one patient stated, “[antis] yelling across the parking lot made me feel horrible.” For this patient, the “yelling” of the protesters stood out to her and triggered a negative emotional response; she felt horrible before she even entered the clinic doors for her appointment. Another patient said, “The megaphone and calling out specifically by what

you're wearing, you can hear from inside." This statement reflects the inexorability of the sound as well as the targeted nature of the content. Indeed, antiabortion protesters will often identify a physical characteristic of a patient or an item of clothing they are wearing to ensure that the patient is directly engaged and will listen (e.g., "you with the blonde hair" or "lady in the green shirt").

Also mentioned in the survey comments were reactions to the sonic competition of the escorts. In tandem with the antiabortion protesters, escorts and workers sometimes create positive or joyful sonic countering, such as playing the music of the Spice Girls at the clinic in Nebraska. For example, one person commented, "I appreciate the Pro-Choice people outside trying to over-chant the protesters with loud happy music and cheerful attitudes!" This statement suggests a recognition of the goal of the escorts in reducing the sonic damage done by protesters. However, a few patients also expressed conflicting sentiments about the sonic competition from the escorts with the negative onslaught from protesters. Notably, one patient asked, "Why does it sound like a party outside the clinic? This isn't a party time." This last comment reflects one of the realities of countering sonic patriarchy—often, when countering, one cannot hear anything except for noise. In other words, they cannot hear the content of the antis' speech, and they also cannot hear the content of the escorts' speech or the lyrics of their music. For this patient, it sounded like "a party," and she did not feel that the noise was appropriate. Often, countering the noise of antis or offering sonic competition bothers patients and providers. Providers will often tell escorts not to make much noise because it will just turn up the volume on everything outside the clinic and inhibit the medical procedures inside.

Legislating Sound

This brings me to an important question, which is: what can clinics do to control the noise? In the Introduction and in Chapter Two, I discussed the various legal protections that clinics can cite, such as the FACE Act and the failure of police to enforce them. But what about when it comes to sound specifically?

Regarding sound, the First Amendment supports the rights of abortion patients and passersby in public space: Speakers' rights tend to prevail if "captive audiences" (patients) can reasonably avoid their speech in public forums; however, if they cannot avoid their speech (which is the case when entering most clinics), the First Amendment allows the government to prohibit "offensive" speech (Wilson 2013, 25). Abortion advocates and clinics assert that their patients are indeed "captive audiences" and that the medical procedure of abortion necessitates insulation from the public forum (2013, 26).

Cohen and Joffe describe how some clinics have successfully combated the cacophony penetrating the clinic landscape with noise ordinances and injunctions (Cohen and Joffe 2020, 133–36). Noise ordinances and injunctions can take many forms, including the prohibition of noise that exceeds a certain decibel, noise made by amplification devices, and noise that "disturbs the peace" (2020, 134). Some ordinances apply to entire cities or towns, while others apply within a certain distance from a medical facility. Many localities have noise ordinances, and some places have enacted ordinances as a direct response to antiabortion protester noise, with variable success. One clinic that succeeded in passing an ordinance for their center, as well as all healthcare facilities in their area, focused on the negative effect noise had on patients' health and safety (2020, 134). In their case, a group of physicians testified how noise can increase patients' anxiety and raise blood pressure. As a result, a doctor may need to increase the

sedation medication for the patient, which increases patient risk (2020, 134). The ordinance's passing successfully halted the continued use of sound amplification outside the clinic. However, antiabortion protesters still yell and harass patients.

Noise ordinances tend to prevail in courts—especially since the 1994 Supreme Court precedent that states: "'The First Amendment does not demand that patients at a medical facility undertake Herculean efforts to escape the cacophony of political protests. If oversimplified loudspeakers assault the citizenry, the government may turn them down'" (2020, 136). However, ordinances can be difficult to enforce due to police's reluctance to write citations, their inability or hesitancy to consistently monitor clinics, and/or their disinclination to enter First Amendment litigation (2020, 134–36). Typically, protester noise (and the acute violence it actualizes) is often left unregulated and trivialized as everyday, innocuous speech.

Escort Counterstrategies

Escorts have developed strategies to distract patients from this overwhelming protester noise; however, there is only so much they can do when this noise exceeds allowable municipal decibel levels. They aim to hush protesters' sounds by creating sound shields. Derenda and Kim, from the previous example, arrived before the protesters and wedged pieces of cardboard at the top of the fence. They also attached a tarp to the bottom of the fence. Although this blocked the sight of the clinic and some of the noise, too, the protesters raised their speakers to loom above the tall fence. Protesters have been known to stand on stools or ladders or to squeeze a megaphone between the rods of a fence, to project their message.

Escorts also try to drown out the protester noise with their own amplification devices. In the fieldnote example, escorts wielded a large speaker near the entrance and played metal

music when protesters started to shout. Other clinics also play music to combat the protesters' yells with intentionally chosen songs. For example, one escort described playing upbeat and/or empowering songs to create a cheerful ambiance for arriving patients (and potentially to annoy protesters), such as songs like "R-E-S-P-E-C-T" by Aretha Franklin. Without access to a quality speaker or a powerful sound-canceling method, some clinics defy protester noise with alternative and/or ad hoc modes of amplification. For example, escorts at a clinic in the Southeast attached tiny Bluetooth speakers to the inside of their umbrellas to block the sounds (and sight) of the protesters with their own small speakers. An escort at another clinic in the South parked in front of the clinic entrance, rolled down her windows, and blared pop music from her car when a protester's sound device exceeded the decibel limit, also exceeding the decibel limit herself. To shield their ears and the patients, clinic staff and escorts invent strategies to eliminate the sounds, such as erecting fences and sound barriers, playing loud music, etc.; however, oftentimes little can be done to muffle amplified protester noise. Unlike blocking visuals or instructing the patient to simply turn away, sound is harder to diminish. Despite the many attempts of escorts to block protester noise, their amplification pierces through fences and cuts through the music escorts play to counter the noise. Moreover, the emphatic and aggressive messages not only drowned out any aural reply but also relied on multiple gender stereotypes, which intensified the punch.

At one clinic in the South, they instructed me to block the sight of the protesters with a giant rainbow umbrella they provided (Figure 24). Inside the umbrella was a mini-Bluetooth speaker. They demonstrated how I could turn up the volume to the speaker connected to one of their upbeat, girl-power-themed Spotify playlists. This way, the umbrella and speaker I held could quite literally act as a visual and sonic shield. However, due to the number of protesters and their noise volume, it was impossible to completely block and drown them out.

Figure 21

Escorts and clinic staff use diverse and creative strategies to dilute sonic patriarchy. However, as Joffe and Cohen insist, women should not have to rely on a network of inventive and dedicated providers and volunteers to obtain a legal and safe medical procedure (Cohen and Joffe 2020). They emphasize that "just because women will walk through throngs of screaming protesters to get basic medical care doesn't mean they should have to endure this behavior" (2020, 145). And, many of these strategies often fail to prevent the harms of sonic patriarchy.

In the context of the abortion clinic, antiabortion sounds constitute the multi-sensory experience. More, the specific context of the clinic makes these sounds, these words, so repugnant and harmful. As Lentjes reminds us, "the situatedness of any sound is imperative for understanding its cultural implications, especially given that language (in these situations audible, spoken language) perpetuates gendered norms and sexual domination" (Lentjes, Alterman, and Arey 2020, 89). The sound of speaking or yelling may not be inherently "violent;" but it certainly becomes so when it occurs within the context of misogynistic antiabortion political actions and discourses, especially when patients explicitly say "no," or "no thank you," shake their heads or cover their ears to an approaching protester. The protesters dominate the sound world outside abortion clinics as a means of denying acoustical and political agency of those in earshot.

In sum: the non-consensual, loud, and aggressive nature of sonic patriarchy amplifies the experience of walking from one's car to the clinic doors; I heard it that day in Nebraska and at every clinic I have visited since. Antiabortion protesters use sound to shape and control the space outside clinics, sometimes inciting action from patients and their companions, sometimes making it difficult for the clinic to secure their space, and sometimes directly increasing the physical risk of the procedure. They wield sound as a weapon, and it is a weapon that is difficult, if not impossible, to shield. Antiabortion protest sounds are used to "perform" the voice of the fetus, and furthermore, to perform the dominance of the protesters themselves.

Chapter Five: Antiabortion Choreographies of Dominance and Aggression

Arriving at the Nebraska clinic I began to note my hyper-awareness of my own body—from halting my car to being shielded by the escorts to noticing the many antiabortion protesters engulfing the property. I was also attuned to space—the places I could stand, the areas I should monitor. The emphasis on monitoring antis drew my focus to their corporeality and how their bodies relate to the clinic landscape and to the bodies of patients and escorts. I started to think about the movements of the body outside of the clinic just as central as its movements inside the clinic where the bodily experiences of abortion take place.

I noticed that both antiabortion protesters and escorts position their bodies in intentional, strategic, and practiced ways to meet their respective goals, and that their movements depend on their relationship with space and one another. They improvise—attuning to all their senses to take action at any moment. I argue that attention to the physicality of antiabortion protesters in the clinic landscape reveals the meticulous, calculated, and injurious violence of antiabortion protesting. This movement dynamic reflects offensive protester and defensive escort positions. Moreover, it captures the limitations and endurance of escort work, which is burdensome, exhausting, and unsustainable for ensuring abortion access (Cohen and Joffe 2020).

Once I started paying attention to the movements in the clinic landscape, I noticed that these motions were often similar from clinic to clinic and from state to state, creating a clinic landscape choreographic repertoire, or what I call "antiabortion choreography." Antiabortion choreographies include blocking, sprawling, pacing, prowling, elevating, conning, and chasing—all with a hyper-attunement to space. Escorts counter these choreographies with their own movements such as shielding and documenting, and demonstrate unbelievable emotional and physical stamina. The understanding repertoire helped me become a better escort—recognizing

antiabortion physical strategies and promptly countering them. It also informed my understanding of physicality in the clinic landscape and its implications for abortion discourse.

Building from my discussion of embodiment outside the clinic, I find dance studies scholarship a particularly useful context to consider the physicality of antiabortion protesters and escorts—specifically theories that grow from corporeality discourse. As a foundational tenet, theories of corporeality center the body—its movements, its pauses, its orientations— in social analysis (S. L. Foster 1996). I am not the first to suggest that protesters engage in choreographic activities or "repertoires." In her essay "Choreographies of Protest," Foster applies the corporeality framework to analyze protests as dynamic choreographies, focusing on the body as an "articulate signifying agent," which trains for protest actions including stillness and which requires practice and control (S. L. Foster 2003, 396). She highlights this bodily training process to redefine protests as choreographies, rather than unruly mobs as they are often described, and to prioritize how protesters prepare—physically, emotionally, and aesthetically. Although analyses of protests have primarily focused on actions residing on the political left and non-violent action, such as Foster's respective examples, her methodology is also relevant in the clinic landscape setting where physical strategies and training regimens inform and create emerging abortion discourses, all this while reflecting heteropatriarchal oppressions.

During my fieldwork at clinics, I found that protesters take up space in a dominating and aggressive way, mirrored in their choreographic techniques. Antiabortion protesters push the boundaries of clinic protection laws (sometimes surreptitiously and sometimes blatantly without apology), extending their limbs, chairs, and megaphones over the sidewalk line into clinic property. They approach patients. They block the clinic's entrance by sitting, spreading out chairs and signs, and pacing in front of the doorway. They block entrances of parking lots and insert

limbs inside and in front of patients' running vehicles. They chase patients; they shove pamphlets; they grip signs. They mock escorts and threaten providers. They pose as clinic workers to confuse and mislead. Clutching cell phones and video cameras or with Go-Pros strapped to their chests, they stare, and record clinic staff, patients, and escorts.

In this chapter, I explore "antiabortion choreographies" to argue that their presence—whether large or small in number—is highly significant in this context and is actuated by their physical techniques. First, I elaborate on theories of corporeality by looking at examples from the work of Susan Leigh Foster and David Gere. Then, I define and provide examples of some of the most common antiabortion moves I observed in the clinic landscape context. Next, I focus on escorts, investigating their methods of improvisation, training, and emotional regulation. I draw on scholarship from Janet O'Shea to stress that endurance characterizes escort choreographies. I conclude by exploring the question of escort engagement with antiabortion protesters and thinking through some potential strategies to quell the terror in the abortion clinic landscape.

Corporeality and Choreography

Theories of corporeality help me understand how the body and its gestures reflect cultural and sociological dynamics while creating new meanings. In a generative collection of essays on the subject of corporeality, *Corporealities: Dancing Knowledge, Culture, and Power*, Susan Leigh Foster foregrounds the body "as a tangible and substantial category of cultural experience"—neither natural nor fixed (S. L. Foster 1996, xi). She explains that the requirements of everyday life discipline the body. Further, in his book *How to Make Dances in an Epidemic: Tracking Choreography in the Age of AIDS*, David Gere applies this idea to his analysis of gay male dancers in the context of the dances made during the height of the HIV/AIDS epidemic (Gere

2004). He writes that gay male bodies "gesture in the direction of the society and the syndrome that constrains them" (Gere 2004). Not only does Gere examine how their bodies convey homophobic and AIDS-phobic discourses and oppressions, but he reveals how they generate new discourses. Gere shows that examining the body to understand oppression reveals both resiliency and humor from within its cultural groups and the complex social oppressions thrust upon them.

Inspired by Gere and Foster, I use choreographic analysis to include myself as an active participant in the choreography of the clinic landscape. For me, applying choreographic analysis means focusing on my own physical body as a dynamic site of meaning-making. I emphasize the sensorial realm of my own body in this setting—the visual (what do I see?) aural (what do I hear?), and physical (what gestures, movements, stillnessess do I make?). All of these aspects contribute to my emotions, how I feel escorting patients, witnessing their harassment, and experiencing intimidation myself).

The Choreography: Block, Sprawl, Pace, Prowl, Elevate, Con, and Chase

Antiabortion protesters use multiple choreographic techniques to block patients from the clinic, including sedentary sprawling, pacing and prowling, elevating with props, and the notably more aggressive conning and chasing. For sedentary sprawling, protesters spread out, taking up as much space as possible on the sidewalk area closest to the clinic. They bring folding chairs, ice chests, and umbrellas and jovially socialize with one another until a patient walks by, when they start hurling verbal assaults. Sometimes protesters crowd the sidewalk aggressively, taught, with their feet firmly planted. The patients must tunnel through them to reach the front door. Many providers and escorts refer to this type of set-up as a "gauntlet of hate," where antiabortion images, yells, and bodies envelop and overwhelm the clinic entrance.

According to the FACE Act, detailed throughout the dissertation, protesters cannot block the clinic's entrance, but they do so regardless. The FACE Act prohibits force, the threat of force, or obstructing a person providing or accessing abortion (National Abortion Federation n.d.). By sprawling out along the sidewalk and standing at the entrance of parking lots as they did at the Nebraska clinic, they block patients' paths for entry—even if temporarily or partially. I have often witnessed patients walking across lawns, mud, and pine straw to avoid the protesters stationed on the sidewalk. Even if they do not totally block the entrance, protestors make it impossible to pass without witnessing their presence. By strategically blocking the sidewalks and parking lots, they force patients and other passersby to get close—to hear their barks, see their signs and stumble toward their bodies. This nonconsensual invasion of space can be intimidating and potentially traumatizing on its own; however, it is made more acute by gender and racial dynamics. For instance, abortion patients are overwhelming low-income women and disproportionately women of color, while antiabortion protesters are predominately white, with men directing the protest activities and barking orders and women submitting to their instruction.

For pacing and prowling, antis constantly move on sidewalks, walking in circles around the clinic and/or in front of the entrance to the parking lot. These protesters tend to take the FACE Act more seriously, taking up space outside the clinic but continuously moving as to not technically obstruct access. Indeed, they must keep moving to claim they are not violating a clinic protection. For instance, I observed one protester in walking back and forth in front of the entrance for multiple hours. His presence made it difficult for cars to enter and offered multiple opportunities for the other protesters to swarm the cars.

For elevating with props, protesters devise elaborate props to extend their size. At the Nebraska clinic, they elevated their pictures of Mary using the height of their cars, ensuring that

patients would see them. At one clinic, protesters purchased the neighboring property and on it erected a deer stand, which extended several feet above the clinic's fence (Figure 22). The antis rotated position, each holding a sign and glaring down at the patients as they entered. At other locations, men will perch at the tops of ladders to yell and be seen above a fence.

Figure 22

During an Operation Save America counter-protest in Greenville, South Carolina, this past year, several tall and broad white men bulldozed an Abortion Access Front staff member to the ground with their giant ladder. Standing five feet and three inches tall, the AAF member refused to move from the clearing by the fence. The men were trying to place their over-fifteen-

foot ladder in the clearing so they could yell at patients from above the fence. The ladder would almost triple their already large size and ensure the sound penetrated the patients' ears. The AAF member held her ground and linked arms with other staff and activists. The activists kept the men at bay for a good ten minutes, and their resistance caused the ladder to break. Then, two of the OSA members slammed part of the heavy ladder on the AAF member, sending her to the emergency room with a dislocated shoulder. The men climbed the half-broken ladder and yelled at patients anyway. (This entire account is available on YouTube). [89]Frequently, the people who utilize these props are men, quite literally rising above whatever barrier has been constructed to shield patients from the protesters. Their signs, sounds, and bodies penetrate the path toward the clinic.

And then there is the conning that usually falls within the female protester's realm. Think back to the woman in the pink vest I described; she fooled me with her presentation, placement, and body language. When I drove up, she partially blocked the entrance to the parking lot. I automatically stopped my vehicle because her placement and vest appeared to be associated with the clinic. More, when someone stands authoritatively blocking the path of my car, I automatically hit the brakes. When she motioned for me to roll down my window, I complied. Her request resulted in an obvious invasion of space, but I missed her intention because I engaged in the rote social courtesy of rolling down my window when approached. Antiabortion protesters will also try and stop patients in their cars by inserting their bodies or flyers—injecting

[89] To watch the account between the AAF activists and the antiabortion protesters in Greenville, South Carolina, see: (Endora Data 2023).

their limbs in the car, placing a foot under the wheel, and/or throwing antiabortion pamphlets through the window opening.

Often escorts will stand close by with clinic parking signs and arrows so the driver can determine the correct direction. Patients usually stop and are confronted with a cacophony of escorts urging, “You don’t have to talk to them, drive this way.” At one clinic I visited, antis stationed themselves a mile up the road so they were the first people patients would see and could intercept them there. They were so far up in fact that the clinic escorts could not even see them. But knew they might be there since it was one of their local antis frequently-used tactics.

Chasing is an especially threatening maneuver. At one clinic in the South, protesters positioned themselves on the sidewalk across the street from the clinic, blocking the pathway to patient parking. In this case, their intent was obviously not to stop the abortion from happening but to intercept patients after their procedure to ensure they felt shame. Escorting at a different clinic in the South, I observed a young Black patient notice a pair of protesters blocking the sidewalk. Avoiding eye contact with the protesters, the patient chose to forgo the sidewalk and hurried down the middle of the street, risking an encounter with oncoming traffic to dodge the antis. At this point in the day, we were short a few escorts, and I was waiting with a different patient for her Uber to arrive. As I conversed with the waiting patient, I suddenly noticed an abrupt movement in my peripheral vision. A large middle-aged, white antiabortion protester barreled down the street clutching a stack of pamphlets. The fleeing patient walked faster, visibly trying to escape to the safety of her car. She chased her! Blood boiling, I signaled to the other escort and watched them quickly jump in their car to catch up to them. Sitting high in her SUV, the escort barked something at the anti. I could not hear what she said, but it worked because the

anti sauntered back to her original spot. Witnessing this chase was disturbing, to say the least, and one of my most difficult days in the field.

Escort Counterstrategies

In response to the antis' choreographies, escorts attempt to guard the clinic property and patients.[90] They communicate through facial expressions, gestures, and previously rehearsed routines. They disburse and watch—hyper-aware of the physical locations of all escorts and protesters. Many scrupulously log the antiabortion activities at the clinics. Similar to antis, they also clutch cell phones at the ready, quick to document an infraction in the hopes that cops will enforce a clinic protection. They block the sight of protesters and shield patients with rainbow umbrellas. They approach cars slowly and softly, one at a time with a second escort as backup, introduce themselves, and ask if the patient would like an escort. They don pink or rainbow vests and listen to distraught patients and companions, often acting as ad hoc counselors or friends. And they do this in a space that is already highly contested, partly because it is such a highly legislated bubble and partly because of its violent history (as described in Chapter One).

Escorts use blocking techniques too; however, since their actions are primarily in response to the antics of the antis, I call it shielding (I discuss shielding in more detail in Chapter Three). For example, at the Nebraska clinic, the escorts told me to park my car at the parking lot's perimeter next to theirs to block the bodies of the antis. Escorts also have their own versions of sprawling and pacing, as well as their strategies for muffling sound and providing sonic competition as detailed in Chapter Four.

[90] I do not mean to imply that every movement or physicality is a direct response to antis' presence—although many are—but more, I say "in response" because the escorts existence and presence at the clinic in the first place is predicated on the existence of the protesters.

And when patients arrive, unlike the protesters' aggressive, domineering, and non-consensual acts, the escorts are deliberately calm and use non-intrusive, patient-centered techniques. For instance, generally, one to two escorts will slowly approach the car. They announce they are with the clinic and ask if the patient would like an escort. When I arrived in Nebraska, the escorts stood by my car door, blocking the pink-vested antis. When talking to patients, I explicitly positioned my body to block the protesters and their signs as much as possible. I was constantly aware of the location and visibility of each anti and did my best to block them from the patient's view. I also knew where all of the other escorts were located and whom to contact if I spotted something suspicious.

Protester and Escort Training & Improvisation

All of this blocking and spatial placement/orientation relies on improvisation and stillness. Both antiabortion protesters and escorts employ improvisational techniques depending on the number of escorts, protesters, and patients, police presence, clinic layout, and/or presence of shields or blocking, monitoring devices, and even weather conditions. Often, protesters and escorts are prepared for almost any scenario based on formal and informal training or their previous experiences.

Some may assume that these types of improvisation and stillness do not require practice nor training, but they would be wrong. In her analysis of protest choreographies, Foster discusses the importance and training required for stillness. For instance, she demonstrates the physical and emotional effort needed to be still when she discusses the protesters of the lunch counter sit-ins of the 1960s. In this example, the protesters' ability to be still when surrounded by abusive patrons trying to remove them reaffirms their control and moral ground (S. L. Foster

2003, 402). Foster stresses the tremendous physical and emotional strength and practice it takes to stay still amidst an onslaught of abuse, and she describes how the protesters practiced beforehand. Foster's analysis of the sit-in resonates with the training and practice of stillness that escorting requires.

Most escorts groups have required training programs, and others take a learn-as-you-go approach. Ranging from formal trainings, including PowerPoint slides, to strikingly informal trainings consisting of a two-minute list of "dos" and "don'ts," every clinic I visited had some sort of training protocol for volunteers. Despite the training style, escorts are told "what to do if the cops come to the clinic" and how to document antiabortion protester infractions. For example, one training I attended was quite formal. It included vetting, a training session complete with a PowerPoint presentation and simulations, followed by supervised volunteer shifts. This clinic escort program was more formal and organized than most because it was facilitated by a non-profit that was created exclusively to manage escorts at this clinic. The training also included a mandatory pledge that they "understand and accept the responsibilities outlined" in the training guidelines and will be dismissed from the program if they fail to adhere to them (Anonymous Clinic Escort Program 2019, 9).

Clinic escort training is required for this often highly improvisational work and takes many forms. Many escorts are advised to stand silently outside the clinic and avoid interacting with the antiabortion protestors in any way, this is usually referred to as "non-engagement." For example, the clinic training I attended had the following written in their guideline packet that all volunteers were required to sign:

> Do not respond to the protesters in any way. This means: NO verbal contact and absolutely NO physical contact. You will learn to keep track of the protester's activities and movements without acknowledging them. Do not accept anything offered by the

> protesters, including drinks and propaganda (Anonymous Clinic Escort Program 2019, 3).

For most escorts, non-engagement takes skill and practice. Patients and escorts are continuously flooded with remarks, signs, and choreographic distractions to disrupt their respective. Escorts are expected to stand quietly and forgo verbal responses. As a result, most escorts and clinic staff will comment that "escorting is not for everyone," mainly because it is difficult for many people to stifle their responses. Activist and author Robin Marty writes that escorting is difficult because it is hard to not respond to the horrible things antis say, and on top of that, "You must assume that there is a camera on you at every moment, and you must be able to remain completely composed at all times" (Marty 2019, 116).

For me, inhibiting my responses to protesters can be just as exhausting as responding. It took energy to bottle my emotions and put on a calm and easy smile for the patients. Notably, most protesters not only yell at patients but frequently target assaults on all escorts and clinic staff. Escorts must stay outside and listen to the barrage. Researchers explain that protesters use specific taunts and insults —especially about appearance and minority status (Arey 2020). For example, I am a voluptuous woman and was frequently called "fat" and all other juvenile versions of the word. If I appeared to ignore their comments, they would include other descriptors to make sure I heard them, for example, "You, in the blue shirt with the blonde hair."

More pernicious were the taunts they directed at my Black sibling escorts. They accused them of participating in the "genocide" of their own people.[91]Almost always white (and usually men), the protesters who hurl these accusations commit racial violence towards Black escorts

[91] In addition to Dobbins-Harris, many scholars write about the myth that abortion is Black genocide. See Roberts (2017), Scott (n.d.), Sherman (n.d.), Denbow (2016), and Premkumar, et al. (2017).

(usually Black women). As discussed in Chapter One, this is a common argument used outside of clinics—usually a one-liner spoken by a white antiabortion protester toward a Black patient or companion. Legal scholar Shyrissa Dobbins-Harris calls this myth and its perpetration an example of "misogynoir"—a term developed by Black feminist Moya Bailey to describe "anti-Black misogyny targeting Black women" (Dobbins-Harris 2018, 90). Dobbins-Harris explains that the myth is an example of misogynoir because it "depends on denying Black women their humanity and their agency to make medical decisions regarding their reproduction" (2018, 90). As a result, after a long day of escorting, it was common to feel completely exhausted because resisting the urge to respond to heinous acts takes much energy and restraint.

But there were breaking points. For example, a Black patient waited in her car for nearly fifteen minutes at one clinic in the South. She appeared to be shaken up from her chaotic entrance when antis mobbed her car. Once she parked, an escort slowly approached her car, and they had a brief non-verbal exchange. The escort then indicated to us that the patient did not want an escort and wanted to stay in her car for a while. When she finally opened her car door and sprinted for the front door, one of the protesters stopped in the driveway, placed his hands around his mouth, and bellowed, "You're gonna die in there!" Considering the histories and current realities of Black women's healthcare in the state—particularly the maternal mortality rate—this was an especially appalling thing to scream.[92] Although I had listened to this particular protester yelling all day, this moment incensed me. I waited for the patient to enter the clinic. Once she did, I opened my mouth and quickly stopped myself as I heard another escort across the parking lot yell: "Fuck you, Chris…. Fuck you!" To my surprise, the yelling escort was one of

[92] According to the Centers for Disease Control, the maternal mortality for Black women in the United States is 2.9 times that of their white counterparts. This statistic reflects steep health inequities (Hoyert L. 2021).

the escort leaders who had previously stressed that we practice strict non-engagement, and not utter a word to the antis. After the scream, I walked over to debrief with her. We expressed our anger to one another, offered emotional support, and then continued escorting.

Judith A. Dilorio and Michael R. Nusbaumer, some of the few scholars who have written about escorting, would regard this exchange as an example of emotional monitoring. They explain emotional monitoring as observing others' emotional displays and looking for signs of emotional distress—then intervening to diffuse the tension (1993, 428). The authors explain that escorts need this tool because different styles of emotional responses to escorts could cause tension and disrupt their own sense of moral superiority and public support. In this case, their sense of moral superiority was based on the idea that they did not respond to the taunts; they did not, metaphorically, strike back when struck. They explain that emotional distress/loss of self-control usually looked like screaming too loud, arguing with sidewalk counselors, and yelling at police officers (1993, 429). They mention that physical touch, such as a hug, is usually involved in the interaction. They also describe a facilitated break and a "time out" with a simple job (i.e., one that does not include close contact with the escorts). So not only are the escorts monitoring every move of the antis, but they also check in frequently with each other through emotional monitoring. In my example, the escort leader and I were monitoring one another, and we improvised a time-out together to regain composure.

I want to stress that escorting activities can be physically taxing and emotionally demanding. Escorts often stand outside for long periods without food and water in extreme weather (or wearing masks for COVID). Escorting requires constant and acute monitoring and placing your body between patients and potentially armed and dangerous protesters. Sometimes escorts need to hold hands or lock arms to protect and block the entrance with the weight of large

protesters weighing on their backs. Although antiabortion protesters engage in physically demanding and sometimes risky behavior, they rarely stay long—usually arriving in shifts and/or leaving around lunchtime. Many escorts stay all day. Protesters also bring chairs and umbrellas, while escorts generally stay standing.

In her article "Prowess or Sentimentality," Janet O'Shea applies a corporeal analysis to the ethics of care, emphasizing the muscular effort required of caregiving (O'Shea 2021). Using a case study of her time volunteering at an animal sanctuary, O'Shea details the physical practices that encompass the everyday care work that happens there. She explains that there are two primary components of care—care as sentiment and care as physical action—and that the latter has received decidedly less attention. O'Shea implores us to understand care as action and sentiment and argues for rethinking the feminist care ethic to include muscular effort.

She explains that this corporeal care ethic would consider "how care is constituted socially, economically, and politically and why some bodies come easily under the rubric of care, and some are removed from it as well as considering why some bodies appear suited to care work" (2020, 19–20). By expanding how we think about care, she disrupts the splitting of care and action on a gender binary, with sentimental care categorized as feminine and action-oriented care as masculine. By rooting the concept of care in the physical experience of care, she ultimately delinks it from essentialized gendered notions while simultaneously revealing invisibilized care work.

Throughout this section, I have described physical strategies escorts use to counter antiabortion protesters. These all take training, effort, experience, patience, persistence, and, yes: upper body strength. Escorting encompasses both the empathetic and muscular components of care, with the muscular less emphasized. But escorting is hard, physical work, often performed

by elderly women and gender-non-conforming folks. Considering enduring sexist narratives about care, taking up space to engage in escort work that requires emotional and physical strength to protect and support patients can be particularly subversive for escorts who identify as women or non-binary.

Using their bodies to block and protect patients from attack flips the often-heteropatriarchal hero narrative. This greatly disturbs antis. I have heard several comments about how the presence of female or femme-presenting bodies in a position of protector and/or security disrupts antis' ideas of proper womanhood and ultimately enrages them. For example, one escort disclosed, "One anti screamed at us that he is sure none of us have husbands because husbands would never allow their wives to be out here. When another escort responded that she does have a husband and he supports her presence at the clinic, the anti responded, 'He is not a real man for letting her out of the house to be there.'"

Some days, it felt difficult to witness the harassment and throw my body in the middle of it. I watched heartbreaking scenes unfold with women being chased and yelled at, and no matter what I did, there was nothing I could do to make them stop. One day, after witnessing a particularly aggressive group of protesters for over six hours in the hot sun, I drove away, tears streaming down my face. I pulled over on a neighborhood street and just cried. Yet, on other days, I felt completely empowered and energized. Since the Trump presidency, I felt like a pot always on the cusp of boiling over with nothing to do about it—no way to act out my own feminist values in a context of permeating misogyny. But clinics gave me something to do. Physically engaging at clinics, seeing my work create something needed and appreciated, and showing providers that I cared about them and their patients gave me what I needed, and much more. Not to mention, I had made an incredible network of friends.

Escorts' emotional, physical, and enduring labor is often invisibilized and taken for granted. Yet, they coordinate their awareness and movements in a highly performative manner to antis, providers, and patients to make abortion accessible. They are unpaid and, considering the history and constant harassment, are enduring significant physical risk. They put their bodies on the line out of compassion and for the dignity of others.

To Engage or not Engage?

Escorts are doing this work at great potential risk to themselves and in a context of controversy among providers, abortion organizations, escorts, patients, and the public. The main source of conflict is whether or not to engage. Non-engagement is a concept in the cultural zeitgeist of abortion escorting and provision. It is generally interpreted as not speaking or responding to antis. I am talking about engagement between clinic escorts and protesters in the clinic setting—not counter-protests which happen between activists and antiabortion protesters in a non-clinic setting. In her recent book, *The New Handbook for a Post-Roe America*, activist Robin Marty stresses that counter-protests should not occur at clinics (Marty 2019). I agree that among escorts, this is the general rule and assumption, however, some clinics do allow activities that may resemble counter-protests. It is all about how you define protest, but I want to stress that "non-engagement" as I describe it here, is not necessarily considered counter-protest. I am talking specifically about clinic escorts. Notably, almost all of the nineteen clinics I visited claimed to have some type of "non-engagement" policy. Most who advocate for some type of non-engagement rule insist that it lessens the antiabortion protesters' impact. And in some cases, clinic staff assure me it does.

One provider explains it as a "don't feed the protesters" policy because the protesters "feed" off the conflict; they enjoy the intense interaction and the opportunity to "perform" their values; they want attention (I use "perform" intentionally here as many providers and escorts use this language). When explaining the reason for her non-engagement policy another provider told me they "don't perform when they don't have an audience." Some clinics do not even want escorts because they say that protesters are worse when escorts are there as a passive "audience member" or potential adversaries. Ultimately, this reflects the belief that many providers want abortion to be considered a "normal" part of healthcare sans politics. Further, many providers say noise is not good for patients, and any type of engagement will most likely amplify the actions already taking place.

Tension erupts among escorts at the same clinic, different clinics, and between escorts and clinic staff about how well they are complying (or not complying) with the clinic's wishes for non-engagement. Several escorts at different clinics told me that the type of people who could not control their responses were not fit to be escorts—they said they were in it for the "wrong reasons." Further, they claimed that some escorts who responded to antis were more focused on themselves and their own politics than the patients.

Organizations advising clinics on security practices, the National Abortion Federation and the Feminist Majority Foundation, also strongly recommend non-engagement. There are several valid reasons to recommend non-engagement, including the ones listed above. And also, I cannot help but see escort non-engagement as part of what I call the "go higher" strategy of the Pro-Choice Movement. My use of "go higher" refers to Michelle Obama's

famous speech at the 2016 Democratic National Convention.[93] For me, the "going higher" mentality gives name to what I have heard many activists and escorts discuss as the Pro-Choice Movement's failure to contend with the antiabortion movement. It includes a type of writing off of antiabortion protesters and advocates as powerless, uninformed, and nonthreatening. Additionally, it includes minimizing the more stigmatized topics, such as third-trimester abortion and feelings about fetal tissue (Ludlow 2008; Andréa Becker and Hann 2021; Lisa A. Martin et al. 2017). It tends to de-emphasize abortion in general, with organizations like Planned Parenthood insisting that it is only one of their many services (Andréa Becker and Hann 2021).[94] I understand these impulses, but traveling with AAF taught me that this approach silences the realities of abortion work and obfuscates the lines of power, funding, and organization of the antiabortion movement, thereby intensifying abortion stigma. Additionally, many providers, activists, and escorts I spoke with say that the mainstream Pro-choice attitude enables the antiabortion movement to dominate the mainstream narrative of abortion and contributes to abortion stigma. But does that mean that we should eradicate non-engagement policies?

The organization "We Engage," along with many other escorts and activists, thinks so—or at least, they want to push back on the non-engagement policy at their own clinics.[95] They insist that engaging antis and protecting patients are not mutually exclusive tasks. For example,

[93] My use of "go higher" refers to Michelle Obama's famous speech at the 2016 Democratic National Convention. She said, "when they go low, we go high." When she originally said the phrase, she was referencing that democrats would not "go low" to meet Donald Trump's bullying and predatory tactics (Ng 2022). When I say, "go higher," I am using it as a shorthand to describe an approach or mindset many independent clinics, abortion funds, activists, and escorts critique about the larger Pro-Choice Movement. Their critique includes ideas that the Pro-Choice Movement has taken a defensive position, almost apologizing for providing abortion.

[94] Leana Wen was quickly fired as CEO of Planned Parenthood after only eight months in the position due to her revealed antiabortion leaning position (Kliff and Goldmacher 2019).

[95] Abortion activists generally do not offer opinions on what other clinics should do because they acknowledge that every clinic is different, and they only know the context of their own clinic. Additionally, activists generally respect what clinics say is best for providers and patients. To learn more about the "We Engage" organization, see ("We Engage" n.d.).

one clinic created a spatial separation between clinic volunteers, with escorts focusing on patients inside the parking lot near the entrance and "clinic defenders" countering the antis with signs, indicating the parking area, and occasionally responding to their false claims. At this clinic, the volume of protesters is so vast and their tactics so overwhelming that they need people who engage with the protesters to, at the very least, document their legal violations and direct patients to the correct clinic entrance.

The defenders at this particular clinic also do important cultural work when they make fun of the protesters in-person and on social media. Not only do they shame them, sometimes prompting their departure, but they distract them from targeting patients, expose them to the online and local communities, signal to patients that the antis' harassment is wrong, and mobilize escort and provider communities online through comedy. In addition to this discursive work, using comedy can also be beneficial for the escorts themselves. Dilorio et al. explain that escorts rely on humor and fantasy to deal with the tense environment (1993, 431–32). For instance, they emphasize that escorts survive on jokes—inventing funny nicknames for protesters and joking about how the antis were "sexually repressed" (1993, 431). They describe humor as a "sanity-saving strategy" and write that using humor in this way affirmed the conflicts they heard about their own identities and values (1993, 431).

Escorts at another clinic who advocate for engagement elucidated that engagement is not a spontaneous series of yelling back per se but is strategic and often intentionally staged. They tell me, every escort has "a role they play" to distract antis, protect patients, and glean information from protesters. In this case, it is not just counter strategies but assertive, creative, proactive performances. These escorts tell me that "the antis have us up against a wall, and we are letting them pin us there. We must push back and change the 'we go high' mentality of

progressives when it comes to abortion because it's harmful and it hasn't worked." According to them, antiabortion protesters yell at patients regardless of what they do, so why not use every strategy available to them? They emphasize loudly that abortion is a moral act for themselves, for providers, and most importantly, for patients. For them, staying silent is violent. For them, this means fully counter-surveilling. It means challenging the comments hurled at them; it means engaging the antis in conversation, getting to know them, not because they think they can change their minds, but to distract them from the patients entering, to be able to predict their next moves and protect their clinic, and to expose their cruel harassment to the public. They are in it for the long game.

Although I understand why some clinics prefer less direct engagement, I think that at the very least, referring to the concept as "non-engagement" is a misnomer. After all, "engagement" is not just about a verbal response, but it spans the entire corporeal presence, including emotional territory; even silent anger is engagement (R. Rosaldo 1984; Dilorio and Nusbaumer 1993). Moreover, even the clinics that claim to have the strictest "non-engagement" policy usually engage in some way, from playing music to drown out the antiabortion noise, to blocking the sight of protesters from patients. As a result, I favor conceptualizing engagement on a spectrum and assuming that all presence at the clinic landscape is a form of engagement. From silent escorts who avoid eye contact on one end to escorts who talk to and/or "clap back" to antis by singing songs or creating skits to distract them on the other.

I want to underline that there is no "one-size-fits-all" solution to quell clinic violence—particularly around issues of engagement. As I have described, every clinic is in a unique position based on their architecture, community support, police responsiveness, anti history, and staff preferences. I emphasize, as AAF does, that the only people who can determine

the best way to deal with a clinic's antis are the people who work there. Independent provider voices must be centered and prioritized in this conversation. At the same time, after seeing the scope of what engagement can look like at over nineteen clinics, and as a performance studies scholar, I am implored to present strategic performance-engagement as a potential strategy to mitigate this terror. I believe that it is a strategy that when intentionally and strategically deployed could work for more clinics than are currently exploring these possibilities. Additionally, I seek to uplift the voices of the activists, escorts, and providers who are developing some of these innovative strategies and courageously insisting that new narratives are needed, narratives that do not merely respond to antiabortion initiatives but that forge new language and frames of thinking about abortion.

Antiabortion protesters perform terror. They transform the clinic landscape into an unsafe, scary milieu. What the antis are doing is an assault on the senses, and it is happening in different ways across the country—yesterday, today, tomorrow. They play on the power dynamics of social oppression, such as race and gender, to assert their dominance and quite literally make themselves seen, heard and invade the space of patients and the clinic. Dominating the clinic space reinforces their power and the notion that they are, indeed, above the law. Failure to take their violence serious is dangerous (Haugeberg 2017, 133).

I have described my experiences with terror at the clinic landscape—examining my own fear and observing the fear and confusion of others. I have investigated the multi-sensorial performance strategies that I witnessed antiabortion protesters deploy, and the ways in which they perpetrate violence. I have explored some of the strategies I have used and/or seen used by escorts use to distract, deter, and counter antiabortion protesters, some successful and some less successful.

I aim to have conveyed that the experience of entering the clinic matters. Understanding the experience grounds us in the reality of how difficult it is to access abortion, even when it is offered, which, in many states, it is not. It reveals that protesters' motivations move beyond their frequently cited "freedom of speech." Crucially, these experiences urge me to ask how we can halt, disrupt (or even mitigate) this publicly-sanctioned terror. Yet, clinics' and pro-choice advocates' capacities to respond are limited due to the lack of legal and community support, as well as the "go higher" mentality of the larger Pro-Choice Movement. So far, there have been many advocacy efforts for clinic protections. Yet, these protections have been largely contested by antiabortion legislators and protesters and seldom enforced by police.

PART THREE: CONFRONTING TERROR

Even if fear is regarded as pernicious, it implies taking action to remove it, thus creative thinking.

--Andrea Boscobonik and Hana Horakova,

Art does have the power to save lives, and it is this very power that must be recognized, fostered, and supported in every way possible.

--Douglas Crimp

Huntsville, Alabama
June 29, 2018

I join Abortion Access Front (AAF) and clinic staff as they strategize the day's activities over coffee and doughnuts. AAF folks are operating on only a few hours of sleep since our comedy show was just last night. Coffee is essential. We are here in Alabama for the "clinic service day" part of the AAF Tour. Clinic service days consist of volunteering for the clinic, assisting with various projects, and offering celebratory appreciation for their work. According to AAF, this is the most crucial part of their work.

Back in the clinic, the doctor and clinic director swing by to greet us, donning matching AAF "Property of No One" T-shirts; they seem excited that we have come to visit their clinic. Upon hearing that I am a researcher on my first clinic visit, one of the doctors offers to take me on a tour. Unlike most medical spaces I have been in, this clinic is warm in its decor. Accented with pastels, adorned with artwork, and complemented with a comfy couch, the clinic feels relaxing to me. I remember almost nothing of the yells we dodged moments ago as we made our way inside.

Rejoining the group, they tell me I am on " hashtag, teamholly," which means I will be driving to Home Depot to collect holly bushes. AAF and clinic staff have decided to plant holly bushes because they grow tall and can partially block the sight of the protesters from the waiting room. (Bonus: holly bushes have prickles.) The idea of our luscious bushes pricking the protesters provides plentiful source material for jokes and snickers. To me, planting a gaggle of holly bushes communicates, "Yeah, I can be down with Christmas, but also, back the fuck off of the clinic." We head to Home Depot, where we haul bushes, soil, flowers, and tools onto the rolling cart. We pack the cars and head back, ready to plant.

We heed Google Maps' guidance back to the clinic. As we approach, I know we have returned to the right place because protesters line the sidewalks. Men walk with signs, women with children, and there is a man with a tripod and camera pointed directly at the clinic parking lot. We

collectively roll our eyes. Then, thinking we are clinic patients, the protesters clamor as we emerge from our cars.

Confused by the cars filled with gardening supplies, the protesters gape with bewildered expressions. Most independent clinics do not receive visitors, especially visitors as colorful, unapologetic, and upbeat as us. Staff and escorts surge towards the cars to help us. We remind them that we are there to help and celebrate them. They can continue their work, and we'll take the gardening from here.

We begin by digging. With medical shoe covers on our feet, we dive into the mud with shovels. We water the existing bushes. We snap roots with gardening shears. All the while, we hear honking from passing cars. I ask an escort, "What do the honks mean? Are they doing it for us?" Oh, eyes rolling, she says, "People honk to show support for the protesters." "Oh," I respond, deflated.

Some of us fetch lunch for the staff and escorts and enjoy a brief break with them. We ask about their regular antis. They ask about other clinics, and we share what it is like to escort at them. We swap knowledge about different antis and anti groups and their whereabouts—in other words, abortion escort "shop talk." They also share the names they have dubbed for the antis and eagerly divulge the stories behind them. We all laugh. I overhear one escort say to Lizz, "You know, I fought for this in the '60s and '70s; I never thought this is how I would spend my retirement." Others chime in with similar sentiments.

As we head back to the front of the clinic, shovels in hand, some of the antis try to get our attention. I hear them ask: "Why are you helping them? Don't you know they kill babies in there?" We ignore them. An employee from a neighboring building peeks around the corner and asks me, "Are you doing that to deter them?" I explain that we are there to appreciate the clinic and help block the antis with a line of bushes. She responds, "Good. Thank you."

We continue digging. Here's the thing: I am super excited about digging, but I am not very handy. So, when escort Nancy gives me a mini-tutorial about digging holes for holly bushes, I am thrilled to receive instruction. The CliffsNotes version of holes for holly bush digging? The holes need to be much deeper and wider than you think. #Teamholly digs continuously for at least two hours as layers of moist dirt cake our arms and legs. My muscles begin to ache about thirty minutes in. But here's the thing: it feels fantastic. Through the physical act of digging and cutting roots, I feel like I am channeling my anger into something useful. From Kavanaugh to protesters to Operation Save America to Progressives' absence, I am incensed, and it keeps me digging.

Hole done; time to plant my first holly bush. Nancy and Cara help lower the bush into the hole and, as I cover it, I feel relief and pride. And there it is, two years of cut after cut with every news segment, every text alert, and the feeling of powerlessness that weighed me down, and now I have released it. Planting these bushes was a little thing, but a little something that made me feel better. Moreover, I showed abortion providers, protesters, and patients that providers are loved and appreciated and worth showing up for. I hope that, metaphorically, this symbolizes to the antis (and everyone else), "Back the fuck off of our bodies. THIS IS A BOUNDARY. DO NOT CROSS IT, OR YOU WILL GET…PRICKED!"

Madison, Wisconsin
July 19th, 2019

Donning a blue robe and plastic shofar necklace, I wait for the signal to walk toward the plaza. I am "Testifier 2" and am trotting along behind "She-sus" and "Vulva." She-sus, played by Sarah, sports a white billowing caftan. She wears a crown of thorns, holds a rainbow purse, and has a pink cut-out drawing of a uterus surrounded by thorns pinned to her dress atop her abdomen. She drags a Styrofoam cross that says, "Saves Abortion" (Figure 23). She and Molly, who is assuming the role of the vulva, both don microphone headsets. A pink spandex dress hugs the curvature of Molly's waist, and a puffy, three-dimensional pink-and purple vulva emerges from the body of the dress (Figure 23). I have memorized my lines, but I have a script just in case. We are a cast of seven: Vulva, She-sus, Testifiers 1, 2, and 3, and two alterpersons. Lizz and Kat are the improvisational stage managers, and the rest of the group hold signs or wear handmaiden costumes. We conga towards the plaza with signs and feathers. We are a party led by the one and only vulva. It is a celebratory march.

Figure 23

The group of activists with us, who carry posters, are also dressed in fabulous, celebratory garb. Parodying the "Wanted" posters discussed in Chapter Three, several people hold large signs with the names of Operation Save America (OSA) leadership, their photos, and especially problematic things they've said (Figure 24). Parodying the antiabortion Silent No More Awareness Campaign's signs that say, "I regret my abortion," activists created signs that say, "I do not regret my abortion," on the front, and "I do regret [fill in the blank]," on the back.

Figure 24

At the plaza, we mirror the formation of Operation Save America (OSA), except that all of our speakers are people assigned female at birth—whereas all the OSA leaders were assigned male at birth. We are upbeat, wearing bright colors, and having fun. At the same time, the OSA contingent is solemnly holding posters of bloody fetal remains. The AAF cast stands on the border of the plaza, slightly elevated. Operation Save America is doing their Ecclesiastical Court production of their "Summer of Justice." The Ecclesiastical Court usually involves various men (no women) reading aloud the "sins" of the state. They always perform the Court outside of the capitol building. (The year before, described in the introduction to this dissertation, six of us countered this event with signs, but this year there are close to sixty of us, much closer to matching their group's size.)

As they begin, so do we. Vulva starts the show using an announcer-type tone: "Thank you, thank you. Over there, Operation Save America is performing their 'Ecclesiastical Court," which is basically a lame parade, and we can't leave that taste in Madison's mouth. So let's get this party started!" Next, She-sus speaks to the rest of the cast and the crowd of passersby.

> She-sus: Brothers and sisters and gender non-conforming siblings. We're here today because some of my flock has lost their way. When I was here 2,000 years ago, glamping

in the desert, I thought I gave pretty clear instructions on how *not* to be a dickhead. But our friends over there at Operation Save America didn't pick up what I was putting down and have been butchering my message.[…].

Crowd: BOO!

She-sus: I know it's easy to boo, but we have to help them—get them back on track. That's *why* I came back. […]. Let's show them what a good person really looks like. Can I get a Praise Rapinoe?![96]

Vulva and crowd: Praise Rapinoe! Equal pay! Equal pay!

She-sus: We have many here who will be testifying today to help teach our befuddled brothers and (mostly brothers) about the facts of science; please welcome our first witness.

Testifier 1 is "on behalf of science" and schools OSA on the fetus. For example, she explains that the fetus doesn't have a "heartbeat" at six weeks, medication abortions are irreversible (and dangerous to say otherwise), and abortion is not infanticide. Then, it's my turn. She-sus announces, "Come forward and be heard!" I say:

Testifier 2/Me: Operation Save America! You are guilty of the following sins: By mailing postcards of doctors' names and addresses to their neighbors, you have committed acts of terror.

Vulva and crowd: OSA, YOU MUST REPENT!

Testifier 2/Me: When your members publicly preach that the killings of abortion doctors is justifiable homicide, it's condoning the mortal sin of murder.

Vulva and crowd: OSA, YOU MUST REPENT!

Testifier 2/Me: By burning Qurans outside of mosques, you are guilty of Islamophobia.

Vulva and crowd: OSA, YOU MUST REPENT!

Testifier 2/Me: You are guilty of neglecting actual children who have suffered under policies you advocate for because they weren't born in America.

Vulva and crowd: OSA, MUST REPENT!

Testifier 2/Me: You are guilty of threatening and verbally assaulting people as they enter

[96] AAF is referring to Megan Rapinoe, the FIFA World Cup Winner. Rapinoe has been a symbol of gender equity in sports since she filed a lawsuit against the U.S. Soccer Federation alleging pay discrimination in 2019. "Equal pay! Equal pay!" refers to Rapinoe's lawsuit and event during the 2019 when the crowd cheered "Equal pay!" as the triumphant players celebrated their win. See: Gross (2020).

clinics that provide abortion. You demonize women and doctors.

Vulva and crowd: OSA, YOU MUST REPENT!

Testifier 2/Me: You indoctrinate children into your web of hate with lies about queer folks and transgender people.

Vulva and crowd: OSA, YOU MUST REPENT!

Testifier 2/Me: You invited representative Matt Shea to speak today, who wrote a manifesto on how to establish Christian law through war, and who calls for the end of same-sex marriage, abortion, and for the death of all non-Christian males in the U.S. if religious law is not upheld.

She-sus: I say repent! Praise Michelle Obama!

Vulva and crowd: Praise Michelle O-bam-a!

Testifier 3 then reads a litany of sins committed by the Wisconsin GOP. Then we all yell, "Shame! Shame! Shame!" as we point to OSA. Their PA system is louder than ours, but we interrupt their speech. OSA stops and looks over at us. A few passersby stop to talk to AAF activists. We are challenging their dominance of this space and having fun doing it. After our skit, we dance. We groove to music like "Dancing in the Street," "Respect," "You Don't Own Me," and "Cherry Bomb."

Detroit, Michigan
July 10th, 2018

"You can play a brick, right?" "Huh...?" I respond curiously. "You can be a part of the brick wall for the Crisis Pregnancy Center (CPC) building…in the Human CPC skit."[97] "Oh yes, whatever y'all need." Sarah throws me a brown jumpsuit with bricks painted on the front, and I join the group of activists. There are about twenty of us. Activists hail from Columbus, Toledo, and Detroit. Amber explains that we must attach a vinyl panel with an image from the clinic interior to our backs, then line up in the order of the numbered panels. The vinyl panels display images of pamphlet holders, an ultrasound machine, and posters (Figure 25). Together, our bodies form a CPC building or, as they call it, "The Human CPC."

We attach the vinyl panels onto a neighboring activist and line up. Kat directs us on the fundamental movements we must do together; however, the main action occurs inside the human

[97] They wanted me to be a part of their #exposefakeclinics campaign direct action, which is a 10-minute political theater piece. Expose Fake Clinics is a national campaign to increase awareness about Crisis Pregnancy Centers or "fake clinics." Several non-profit organizations participate in the initiative including Abortion Access Front, Abortion Access Hackathon, NARAL, Abortion Care Network, and numerous other reproductive rights and justice organizations. AAF performed the action three times on our 2018 tour: Detroit, Minneapolis, and Milwaukee. I was present for two shows--Detroit and Minneapolis. In the first show I was a part of the brick wall and in the second show I played a clinic escort, providing information about CPCs to passersby (Expose Fake Clinics Campaign, n.d.).

CPC between the patient and the doctor, both with headset microphones. Solange is dressed as the patient in a youthful dress, and Sarah wears a white lab coat. Amber and Lizz walk along the periphery of the square wearing gold “Ask me about fake clinics” vests (Figure 26). Now that we are all suited up, it’s showtime! We head to the plaza center and take our places.

Figure 25

Figure 26

Since I played a brick in the wall of the CPC, I didn't need to do much except stand still and listen for my cues to open and close the clinic. But, just as the 10-minute skit informed passersby of the realities of CPCs, it revealed much to me too. As a part of my MPH program the previous spring, I learned about CPCs and wrote research reports about them, but I had never read about the specific experiences of people who visited them; I had never seen them "played out." Hearing the interactions between the "doctor" and the patient, I learned that the "doctor" was not a doctor at all but a volunteer wearing a lab coat. The doctor was intentionally vague in describing the clinic to the patient, instructed the patient to complete what looked like a standard medical form, and took the patient's phone away. Once alone in a private room with the patient in a hospital gown, the "doctor" explained that the patient could be a "mommy or murderer" and began to show the patient antiabortion information with medical misinformation.

As the action transpires, I notice Lizz and Amber talking to people about CPCs and handing out flyers about local CPCs and ways to expose them. However, not many people stop to watch the scene unfold. The foot traffic is not what we had hoped. Most people barely pause to hear our message. Perhaps it was the size the crowd, the subject matter, or the all-female and gender non-conforming ensemble? After the skit ends and we remove our panels, I notice some specific messages on the vinyl panels, such as "'clump of cells'" with a drawing of an embryo to a full human being. These messages are the types of messages found in actual CPCs.

* * *

These are all experiences from my fieldwork with the arts activist organization Abortion Access Front (AAF), which describes itself as a feminist non-profit that uses comedy to destigmatize abortion. "Destigmatizing" abortion in the context of AAF means exposing abortion stigma as perpetuated by the hetero (Christian) patriarchy. However, destigmatization also means normalizing and celebrating abortion as essential to everyday healthcare. The organization has two primary arms: media intervention and community intervention. The media intervention includes memes, online skits, videos, social media, podcasts, and Zoom events. The community intervention (which I participated in) centers around an annual comedy tour: AAF The Tour. The comedy tour consists of (1) clinic service day(s); (2) protest(s); and (3) comedy show(s). The Tour is a multi-city, stand-up comedy extravaganza that creates community support networks for independent abortion providers, and which functions (as I argue in this third part of the dissertation) as a public health intervention for abortion access.

According to their website, the Tour is the "USO meets Habitat for Humanity for abortion clinics," traveling to towns where abortion is severely threatened and mobilizing communities to support their local clinics (Lady Parts Justice League 2017a). The Tour has multiple moving parts. Although the activities of each stop on The Tour vary slightly depending on local needs, most locations include each element. For the clinic day, AAF partners with clinics to collaborate on needed projects, usually consisting of a work portion and a celebratory social component. AAF's program director loosely plans each clinic day ahead of time in concert with the clinic. Projects range from building a fence, to landscaping, to bolstering clinic escort programs. In the previous example, the clinic service day was planting the holly bushes. The protest component usually includes countering antiabortion protesters at clinics and antiabortion

events, street theatre, or supporting allied movement marches. The field stories in Madison and Detroit were two such examples of the protest portion of the Tour. The comedy shows function as the backbone of The Tour (and will be the main focus of Chapter Six). Attracting anywhere from 100 to 400 people (depending on the venue), AAF comedy shows act as the locus of the intervention, spotlighting the clinics and their needs, thereby connecting the clinics to their communities.

Even though clinic service days are distinct in their activities and location from the other types of protest described, I want to suggest that clinic service days, especially publicly viewable ones (such as volunteer landscaping), are also a form of protest. In this way, each example is a different type of protest: the first is an example of a protest at a clinic, the second of a protest at an antiabortion event, and the third of a protest in a public, community space. For AAF, the location of the protest depends on two main criteria: (1) what the clinic wants and needs and (2) where they will make the most impact. All examples seek to expose the antiabortion movement, educate onlookers, and take action in service of providers. At the clinic, antis and community members observed the celebration and support of abortion providers as we planted bushes. We did not need signs that said we supported the clinic; we were showing our support and doing it in a way that the clinic wanted it to be done.

As described in Part Two, some clinics invite AAF to counterprotest and/or support their escorts. For example, after asking the providers at a clinic in the South if their escorts needed support, the providers agreed that the escorts would love help. When we asked if they allowed engagement with their antis, one of the providers said, “Sure, it would be good to give them a taste of their own medicine.” So, the next day, we joined their escorts. Since this particular clinic had a noise ordinance, we did not try any amplified sonic competition, but we held feminist signs

and pestered the antis. Annoyed that people, especially women, were talking back to them, a few antiabortion protesters left, and the ones who remained broke character. By "breaking character," I mean they laughed or smiled even while the messages they were saying and holding were gory and gruesome. When an anti breaks character, they often get annoyed, distracted, and sometimes leave. Well-versed in improvisation, AAF and the comics affiliated with them are good at getting antis to "break character." One comedian said, "If I can make them laugh, I've done my job." Often, they can cause an anti to break character by using what Lizz Winstead calls "verbal judo." "Verbal judo" requires wit, speed, and an unshakable-ness in activating situations, a skill that stand-up comics have in spades.

Notably, AAF members do not simply mock antis. In describing AAF counterprotests at clinics, sibling activist and researcher Solange Azor writes that AAF "Does not engage to mock, they engage with intent to frustrate, find flaws in arguments, and entertain the escorts" (Azor 2018b, 29). And for escorts, she reports, and I affirm, AAF has a very positive impact. Reflecting on a counterprotest at a clinic in Michigan, Azor writes, "By the end of the day [the regular escort team] had repeatedly expressed gratitude for the catharsis" their presence offered them (2018b, 29).

In Madison and Detroit, the protest elements of the actions were more obvious. For instance, in Madison, we explicitly attended an event where antis usually pronounce their hetero-patriarchal values uncontested. We interrupted their public demonstration while simultaneously signaling to the public that OSA is not the dominant voice on abortion; we will not let them control the narrative here. In Detroit, we created the CPC event in a place with high foot traffic, although it was not bustling at the time of our performance. We employed this approach with the intention of attracting mass attention; we hoped to tell a large audience the abortion news for

their state—news that often goes under the radar. We initiated a conversation as part of the #exposefakeclinics campaign, and we did by parodying a CPC experience while adding our own witty commentary.

I explore these scenes to illustrate how AAF are art activists who harness the power of comedy in multiple forms of protest. Not only do AAF use comedy to attract attention in these scenarios, but they also use it to point out the uneven power dynamic between the antiabortion movement and abortion patients and providers. They use comedy to laugh at inane and unjust ways that antiabortion legislators and protesters continue to oppress them; and thereby regain some power themselves and for all who participate. When countering OSA's Ecclesiastical Court in Madison, we—AAF and I as an affiliated scholar—used their language and symbols and made them our own. We even parodied the format of their event in our skit, with testifiers yelling about repentance. In her essay, Peggy Phelan argues that OSA frames patients and babies as people who need to be saved by them; "them" being white, Christian men (Phelan 1993). In our skit, we flipped this script on its head. We positioned OSA as the souls who needed saving; they would be saved by learning the error of their ways by us, feminists, led by a feminist She-sus and glittery vulva. We yelled that instead of the citizens of Wisconsin and the United States, they should repent for their misdeeds, including terrorizing doctors, patients, queer folks, and Muslims.

Arts Activism and Humor

Working with arts activism scholar and public health practitioner David Gere has attuned me to humor and joy regarding stigmatized health topics, especially those featuring fear. Through reading *How to Make Dances in an Epidemic*, participating in his Art and Global Health course,

and working with the UCLA Sex Squad, Gere introduced me to a genealogy of arts activists who explicitly use humor to diminish fear and ultimately work towards health justice. While in the field, I connected what I had learned about arts activism, especially the HIV/AIDS arts activism of the 1980s, with the creative protests I participated in. But what is arts activism?

Arts activism employs creative means (i.e., visual and performing arts including theatre and music making) to critique injustices and sparks potential solutions or strategies to remedy them. Performance Studies scholar Paula Serafini describes arts activism as "the practices that employ artistic forms with the objective of achieving social and/or political change, and which emerge from or are directly linked to social movements and struggles" (Serafini 2018, 3). Characterized by creative tactics, theatricality, and striking images, arts activism is not just a part of "criticising social and political structures," but "it is involved in trying to effect change" (2018, 3).[98] Art historian and critic Douglas Crimp establishes a list of important premises for arts activism. He writes that in order to capitalize on their activist potential, art practices must be: a collective endeavor, reflect a clear understanding of cultural practices and political aims, be informed by a comprehensive knowledge of the social justice cause (e.g., HIV routes of transmission), be sensitive to cultural specificity, and pay attention to location and means of production (Crimp 1987, 8–10). In other words, arts practices must be engaged.

Crimp, in particular, has influenced the way I think about arts activism, primarily from his spot-on analysis of the work of ACT UP in *AIDS: Cultural Analysis/Cultural Activism*. In his generative essay, Crimp contests that idea that artists can respond to HIV/AIDS in only two

[98] In her interdisciplinary study of performance activism, Serafini acknowledges that much of the work on arts activism centers the art world, however, she focuses on creative interventions in grassroots movements. She also describes a gap in most art activist literature, explaining that most scholarship does not theorize the micro-politics of the everyday practices of arts activism. Like Serafini, I am also focusing on the creative performance tactics and the dynamics of the everyday processes which create them.

ways: (1) fundraising for scientific research and (2) developing works that reflect and communicate suffering and loss (1987, 3). He agrees that these responses can be useful, but makes three important caveats: (1) the government is responsible for healthcare, education, and research—not private institutions;[99] (2) "science" is not an objective truth separate from politics and culture; and, (3) solely raising money in a social crisis reinforces the idea that art is a commodity with no social function (1987, 6). With his dynamic prose, Crimp compels artists to push back against the idea that art is merely a commodity and insists "that art does have the power to save lives and it is this very power that, must be recognized, fostered, and supported in every way" (1987, 7). He asserts that artists do not need to "transcend the epidemic," but they need to participate in ending it through art (1987, 7). Artists must not merely generate reflective works, but they need to engage in change.

Drawing from the beforementioned premises Crimp outlined for arts activism, I confirm that, like ACT UP in their *Let the Record Show* campaign, AAF meets his criteria for engagement. To start with, although not nearly as large as most ACT-UP protests, AAF's theatrical protests are collective actions that are central to their activism. In particular, AAF aims to expose antiabortion forces and mobilize support for independent abortion providers and abortion access more broadly. AAF's protest actions of planting bushes at independent clinics, countering OSA's Ecclesiastical Court, and informing the public about CPCs all serve this mission. Their efforts also reflect a comprehensive knowledge of abortion, their own political aims, and a sensitivity to cultural specificity similar to the extensive knowledge ACT UP

[99] Crimp implores artists that if they are raising money for research, science, and education, they must point out the government's ineptitude (and in the case of HIV/AIDS criminality) for failing to do so (1987, 7).

collected about HIV and the bureaucratic systems which stymied its treatment. For example, at the Ecclesiastical Court counterprotest, AAF listed several specific false claims concerning abortion that OSA makes and corrected them with peer-reviewed health research. We informed the public, via our performance and live-streaming, of the names of specific OSA and elected officials (i.e., Matt Shae), and we linked direct ways to expose antis and support providers during the live-streaming of the event. Like ACT UP, we attuned to cultural sensitivity, location, and distribution. With the cultural specificities of online progressive publics and our own group in mind, we made sure to talk about the ways that OSA affected the most marginalized groups and used gender-inclusive language (e.g., "brothers and sisters and gender non-conforming siblings"). Regarding location and distribution, AAF staged the protest next to OSA on the capitol's plaza. They expanded the potential audience for the protest by streaming on Facebook Live, Instagram, and TikTok. They also involved collaborated with local activists and activist organizations to plan the action.

To my delight, activist and researcher Solange Azor has also expounds on the clear resonances between ACT UP and AAF. She identifies similarities in how both organizations use parody by comparing ACT Up posters with AAF memes. One of her comparisons is between an ACT UP billboard campaign that reads "Sexism Rears its Unprotected Head" and an AAF meme featuring Sean Hannity. The billboard depicts a giant erect penis. In the middle of the poster, it says, "Men: Use Condoms or Beat it." And at the bottom, "AIDS Kills Women." She writes: "The images' play on the word 'head' and its liking to sexism to an erect penis to attack the sexist attitudes that limit AIDS activism is demonstrative of ACT UP's goal in integrating somber experiences and justice-based concerns with humor" (Azor 2018b, 23). She explains that the shockingly graphic image demands the viewers' attention and consideration and educates

them that AIDS affects all sexes and genders (2018b 23). She offers an AAF meme of Hannity for comparison. This image is in the style of a 1950s novel cover, and it reads "Sean Hannity and the Temple of Sperm." The image centers on Hannity surrounded by swimming sperm and Twitter logos (i.e., blue birds). This image parodies Hannity's claim that there was "secret sperm" in the painting of Barack Obama by Kehinde Wiley.[100] Although not explicitly abortion, the image draws attention to the tediousness of the claim, with the giant swimming sperm demanding attention from the viewer. Mocking Hannity is in line with AAF's mission because Hannity is an opponent of abortion and contributes to its stigma, so revealing and poking fun at his analysis skills communicate that he is not a trustworthy source.

The strategic use of humor in arts activist projects is not limited to ACT UP. Pieter Dirk-Uys has been using humor in his activist work in South Africa for decades (Uys 2002). Regarding his work to destigmatize HIV and teach sex education, he chooses a comedic approach because it allows a more comfortable and open space to discuss taboo topics like sex. Dirk-Uys insists that to confront fear, we need to have fun, and one of the most direct routes to fun is laughter. He says by laughing at fear, we can give fear a name and a place; and he cautions, if we continue to avoid fear, viruses (like HIV) will continue to devastate South Africa (or anywhere for that matter). This statement supports the idea that once a feared health topic is given visibility and is named, it can be accepted and handled (2002, 1). Dirk-Uys emphasizes that humor must be rooted in honest storytelling about one's own experiences coming from his own personal experience as "the mature me, the fat me, the gay me, the frightened me" (2002, 142). He exemplifies reflexivity, commitment, vulnerability, and guts when he develops a theater

[100] To read more about the original incident, see Levitz (2018).

piece that confronts the realities of HIV using his own truths. He reflects that the connections he makes through telling his own stories and laughing with the audience can be used to facilitate collective healing, empowerment, and solidarity (2002, 4).

David Gere also explores how honest storytelling and humor can be used for healing in *How to Make Dances in an Epidemic.* In his analysis of Joe Goode's *Remembering the Pool at the Best Western*, he explores how camp, in particular, can be used to deal with death and dying from AIDS. He explains that as a queer sensibility, camp elicits "laughter, exaggeration, and gender critique" so that "our minds may become large enough to take in mind-expanding possibilities." *Remembering the Pool at the Best Western* deals with serious topics such as taking care of sick friends, losing dying friends, and questioning one's own mortality in the context of the epidemic. Gere explains that despite the heavy themes of the dance the sylph character, who facilitates these serious conversations, provides relief by embodying the gay notion of camp. He writes that the dance illustrates how a "strong dose of camp" can portray a "scene of utter seriousness" and that it does this so to affirm that gay men can keep living (2004, 222). In the AAF Ecclesiastical Court counterprotest example, we explicitly employed Sarah, a self-identified queer woman, to play the role of Jesus and changed the name to "She-sus." More the feathers, sequins, cross, and glitter of it all! Our campy aesthetics starkly contrasted the modest attire of the OSA who wore long sleeves and long dresses in the summer heat and epitomize notions of Christian nationalist femininity. The glitz and glamor of our costumes served as gender drag, as well as what Jan Cohen-Cruz calls "church drag." Not to mention that every person in the cast was assigned female at birth and identified as queer. Although we were there to counter antiabortion protesters who pose a serious threat to the health and wellness of abortion patients, and providers, we provided some relief for ourselves and our audience.

Cohen-Cruz christened the term “church drag” in her analysis of the Church Ladies for Choice’s counterprotest at an abortion clinic in 1993 (Cohen-Cruz 1998). Although written over twenty years ago, her observations still profoundly resonate with my observations outside of clinics in 2018-2020. Cohen-Cruz argues that the Church Ladies use of camp to undermine antiabortion group Operation Rescue bridges abortion activism with queer activism. She describes the ladies' “obvious” drag as a method to highlight the social construction of morality (Cohen-Cruz 1998, 92). She adds that the Church Ladies fuse abortion politics with queer politics by conceptualizing reproductive choice as a synecdoche of sexual choice. By doing this, she affirms that the Church Ladies “build coalitions, breaking the political hold that identity politics has had on leftist organizing over the past twenty years” (1998, 98). Thus, Cohen-Cruz is not solely spotlighting the performance tactics of the Church Ladies. Rather, she demonstrates the conceptual work that the tactics achieve, such as connecting political aims that are sometimes considered disparate but are compatible.

Further, Cohen-Cruz emphasizes that their humorous presence at the clinic enables them to transform the fear-inducing environment that antiabortion organizations like OSA curate. Drawing on the research of Faye Ginsburg (1989) and Peggy Phelan (1993), Cohen-Cruz describes the scene antis create as a scary environment akin to a religious revival (Cohen-Cruz, 1998). She asserts that by donning drag, rewriting songs, and chanting clever, campy retorts, the Church Ladies “neutralize” the scene with their irreverence (Cohen-Cruz, 1998, 95). More, even the Church Ladies' presence to counter is an act of witnessing the terror perpetuated at clinics. She defines witnessing as “publicly illuminating a social act that one does not know how to change, but must at least acknowledge. The site of such performance usually relates directly to the event being scrutinized” (1998, 5). So we see again what I have argued in every section of

this dissertation: being there matters; showing up to dissent, and counter, no matter how few people, matters.

One of the most frequently used hashtags by AAF is #weshowup. According to Lizz Winstead, to show up in the context of AAF means to show up both literally, in terms of traveling to communities where abortion is acutely under threat, and figuratively, in terms of an activist sense of presence and allyship. Showing up is mobilizing people in various formats to normalize abortion and support the independent provider community. AAF shows up for independent abortion clinics to assist in the safe and confirmative delivery of abortion services, affirm the necessity of abortion providers' labor, and celebrate the integrity and fortitude of all abortion clinic workers. They show up for patients and potential patients to create a warm environment to access services. They show up for everyone by shifting abortion discourse to emphasize humor, joy, and justice.

As explored in the other sections of this book, fear is not an emotion that lives solely in the mind but is embodied, saturating the cells. When it comes to abortion, some fear social stigma, the procedure itself, the religious implications of the act, the antis and potential violence of accessing the clinic, and more. Fear characterized my personal experiences in Alabama, Wisconsin, and Michigan. In Alabama, I feared the effect of the antis on the patients, I feared for our safety at the highly visible clinic, and I feared the lack of support reflected by the constant honks of discouragement. In Madison, I feared being followed by a violent OSA member, recorded for their records and later doxxed, and for my physical safety. And in Detroit, I feared the reality of CPCs and the experiences women had in them. Seeing so few people engage with our message, I feared for the future of abortion—with good reason, as it turns out. And I was sad and angry about all of it.

So far, this dissertation has been primarily about fear and terror, but with the fear I felt at clinics, I also experienced tremendous joy. From the joy of providers who love their work to the humor of escorts and the deep connection I felt with my sibling activists, joy fuels this important work and makes the everyday fear inherent in it more bearable. And underneath it all, the vehicle for pleasure has been art and humor. In Part One, I focused on fear and memory—specifically, the providers' collective memory of terror. In Part Two, I focused on fear and performance—how antiabortion protesters perform terror at the clinic and the potential impacts on patients. In this part, Part Three, I am focusing on the hope, the future, the reason I can sleep at night knowing that our government is hacking away at the legislation that enables people with uteruses to access abortion. In other words, I am focusing on Abortion Access Front, or, to stick with the theme: fear and humor.

In this section, I explore some of the ways the performing arts can interrupt abortion stigma and mitigate some of the obstacles interfering with abortion care. I argue that stand-up comedy, in particular, offers a cultural solution to destigmatize abortion stigma and expand access. I demonstrate how AAF's comedy show intervention challenges abortion stigma, educates about abortion politics, and models pro-abortion and pro-choice language. I argue that they do this while simultaneously creating space for providers and equipping audience members with ways to support indie providers. Thereby, I argue that the show works to expand access, and make access more equitable and sustainable.

Chapter Six: Stand-up Comedy & Social Change

Know that you can expose hypocrisy with humor and that when done well, you can make change.

--Lizz Winstead

Comedians who say something serious about the world while they make us laugh are capable of mobilizing the masses, focusing a critical lens on injustices, and injecting hope and optimism into seemingly hopeless problems.

--Caty Borum Chattoo

Columbus, Ohio
June 22, 2018

It's my opening night in Abortion Access Front's traveling comedy show, "Abortion AF: The Tour."[101] No, I am not a performer in the show, but researchers have opening nights too. The members of Abortion Access Front (AAF) describe themselves as a pro-abortion[102] "coven of hilarious badass feminists who use humor and pop culture to expose the haters fighting against reproductive rights" (Abortion Access Front n.d.). "Abortion AF: The Tour" is their annual multi-city, stand-up comedy show that celebrates independent abortion providers while strengthening their local community support networks. And here I am, emerging from my clunky, old Subaru, after four days on the road from UCLA—notebook in hand, business cards in pocket, donning a feminist t-shirt—hoping to volunteer with the organization and learn more about how stand-up comics use humor to destigmatize abortion and support abortion clinics.

I sit in the back of the venue, scrawling notes in the low light of the merchandise table next to Marisa, my fellow volunteer. We are still technically working the "merch" table and need to stay close. Marisa and I bond while conducting our duties throughout the night: applying golden uterus tattoos to audience members' hands and biceps, facilitating the postcards Thank Bank project, [103] and dispensing t-shirts that display phrases such as: "Property of No One," "Abortion

[101] "Abortion AF: The Tour" is the name of Abortion Access Front's annual comedy tour which has occurred in similar formats since 2017 (excluding 2020 due to COVID-19 travel restrictions). Technically, this experience is taken from my fieldnotes from June 2018.

[102] As mentioned in my introduction, I follow AAF's terminology, which is 'pro-abortion' instead of 'pro-choice.' This describes the same position of 'pro-choice,' but centers 'abortion' rather than obscuring it within the language of choice, which, they believe, leads to further stigmatization of the right to abortion.

[103] AAF's "Thank Bank" project asks people to write thank-you postcards for independent abortion providers. Once collected, AAF sends the cards to providers across the country, throughout the year. The front of the postcard features a feminist illustration designed by AAF. AAF facilitates their Thank Bank project at almost every event they organize.

AF: The Tour," and "Lady Parts Justice" with a uterus in a cowboy hat riding an American Eagle (my personal favorite). Furiously writing in dark-room chicken scratch, I try to capture quotes from the comics when I can, while laughing with Marisa at the punch lines.

The lineup is excellent, and the comics are on fire. A slate of all-women performers, they joke about dire political realities for women and people of color. They focus on the impending doom for abortion access, and their various coping mechanisms for surviving the patriarchy. AAF creator and comic Lizz Winstead drops facts about abortion access, such as the realities about mandatory waiting periods and gestational limits. She quips, "What's next, Ohio? Next thing you know exfoliating will be illegal here!" The audience roars. Although horrified at the current state of affairs, the joke allows me to release the tension of the news, while also laughing at the ridiculousness of the people who propose these regulations in the first place. And the more jokes I hear from Lizz, the more I realize how truly bleak the realities are for abortion access and the everyday fear that providers and patients experience at the Ohio clinics.

Next up is comic Joyelle Johnson. She describes herself as "the protest whisperer" at antiabortion[104] protests, throwing male antiabortion activists off their game by saying things like, "I'm sorry for your loss," after they admit that they voted for Trump. She explains that she responds this way because "no one who voted for Trump has a big dick…it's very sad for them!" She laughs and the audience joins her. I delight in hearing her insult the hyper masculinity of male Trump voters, while amusing herself (and us). I still can't believe that he is President and that we have indeed lived to tell the tale.

Then, Beth Stelling, the audience's home-state performer and headliner, takes the stage. I lean over in anticipation, clutching my notebook and pen, when Marisa lightly taps my arm. She whispers excitedly in my ear. I turn my body away from Stelling and towards her. She tells me that she had an abortion and has never talked about it until this moment. She never felt like she really could, after hearing messages from close family and friends that it was wrong. She was too afraid to tell them. She elaborates that seeing so many people in the same room, who support abortion and can joke about it shocks, comforts, and motivates her to be vocal about her experience.

We refocus on the stage for the second part of the show, the talkback. The stage transforms to resemble an informal panel set-up with chairs aligned in a half-moon shape towards the audience. Lizz moderates a discussion about abortion access with representatives from the local abortion clinic and other aligned non-profits. To my surprise, not one audience member leaves. In fact, the audience appears just as captivated by the Q&A as they were by the show. Lizz shifts their attention to focus on the voices of local providers.

She asks providers about the challenges they face. They respond by discussing the difficulties securing vendors for basic maintenance, the extreme targeted harassment of clinic staff, and the lack of support many of them experience from their own friends and family. I watch the faces of the crowd as they listen. Many appear surprised and several seem angry that

[104] Instead of "anti-choice," I adopt AAF's language and use "antiabortion." They also use "antis" instead of "pro-life" because they do not believe that antiabortion activists are, in fact, "pro-life." AAF asserts that antis are antiabortion (and usually anti-woman).

providers experience multiple and accumulating injustices simply because they provide essential healthcare in the form of abortion.

The first time I saw an Abortion Access Front show, just one year earlier, I felt both disillusioned and impassioned. I sat in the audience for several minutes after the show ended, writing in my notebook about the fear providers experienced and endured at the only clinic in Louisville, Kentucky. I learned about antiabortion CPCs for the first time and how they intercepted patients in the parking lot, preventing them from reaching the actual clinic. I was originally attending the AAF show to write about sex education in the South—my dissertation research project at the time. After the show, I meandered back to my car, thinking about what Lizz said about language. She implored the audience: "Don't call them pro-life; call them antiabortion; talk about abortion with your friends, family, colleagues like it is normal—because it is." I left inspired, feeling like there was something I could do, and feeling in that moment that perhaps this was my new dissertation research project.

Back at the talkback. Lizz poses the question: "What can we, the audience here, do to support you?" Each panelist provides an answer and gestures to their respective organization's tables where they collect volunteer emails, accept donations, and disseminate educational materials. NARAL Ohio says they need people at their upcoming advocacy day event. The local clinic needs volunteers to enroll for clinic escorting. And of course, the practical abortion fund, Women Have Options, need donations to support patients accessing abortion, such as procedure, travel, and childcare fees. They all implore the crowd to prioritize abortion when voting. The audience thanks them for their work with exuberant applause. Many give the providers a standing ovation.

After the talkback, Marisa leans in with a warm smile and says, "What Abortion Access Front does, it's really powerful." She meets my gaze and insists, "I want to be active now" and strolls to the NARAL table to learn more. In this moment, I realize that in witnessing Marisa's engagement, I am experiencing the crux of what AAF does on their tour. They use comedy as an instigator of fun and a mode of feminist analysis to relax, educate, and most importantly, involve the audience. During the talkback and tabling portion of the event, they provide audience members with the knowledge and tools to support abortion patients, abortion providers, and their communities.

* * *

What I experienced that night in Columbus inspired and enchanted me and was the start to one of the wildest rides of my life. Over the next six weeks, I joined AAF for five clinic visits, five comedy shows, five talkbacks with abortion providers and activists, two #exposefakeclinics campaign direct actions, one community block party, and two clinic garden makeovers. In other words, I ended up following them for most of the rest of their tour from that night on. The time I

spent with them and the people I met still echo in my head and in my heart. I felt reactivated, reenergized, and ready to fight.

As I introduced in Part Three, the tour has three main components: (1) clinic services day(s); (2) protest(s); and (3), comedy show(s). In the introduction to this part, I explored the clinic service day and protest portions of the tour. In this chapter, I focus on the comedy show and how it supports AAF's aim to expand abortion access by destigmatizing abortion and supporting independent providers. Through comedy, they tackle abortion stigma head-on. And through the format of the show, they introduce the communities of potential supporters to their local independent clinics, identifying the clinic's needs and ways to help. This is essential because, as I hope I have made clear throughout this dissertation, abortion access relies on independent clinics, and independent clinics struggle daily to stay open. To quote Lizz Winstead at one of the comedy shows: "We won't have access if we are not valuing [the] people providing it. Showing providers love helps to sustain the work. A daily reset; sustaining the way it works!"

AAF aims to support independent clinics, run by the most marginalized providers who offer the most comprehensive abortion access. As outlined in the Introduction, the term "indie clinic" or "independent abortion clinic" usually connotes clinics other than Planned Parenthood, a hospital, or an individual doctor's office. Such clinics provide the majority of abortions in the U.S. (55 %), often without the institutional and funding support that their colleagues at larger national health centers and hospitals receive (Abortion Care Network 2022). In the United States, independent abortion providers are profoundly impacted by external stressors, including Targeted Regulation of Abortion Providers laws (TRAP laws), antiabortion harassment and violence, funding and business challenges, insurance limitations, and stigma (C. Joffe 2018; Cohen and Joffe 2020; Abortion Care Network 2020; Summit et al. 2020). As a result, before the

overturning of *Roe v. Wade*, clinics were already closing their doors at a rapid pace. For instance, between 2015 and 2020, five states in the South and Midwest (Mississippi, North Dakota, West Virginia, Missouri, and South Dakota) were left with only one remaining clinic (Abortion Care Network 2020, 4,8,9).[105] The clinics remaining during that time in Mississippi, North Dakota, and West Virginia were all independent clinics. One hundred days after the overturning of *Roe* in June 2022, sixty-six clinics across fifteen states were forced to stop offering abortions leaving fourteen states with no abortion providers at all (Alabama, Arizona, Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, South Dakota, Tennessee, Texas, West Virginia, and Wisconsin) (Kirstein et al. 2022).[106]

Because of the low-profile that independent clinics often have to maintain due to safety concerns, they have few, if any, opportunities to reach out to their communities (Cohen and Connon 2015b; Russo, Schumacher, and Creinin 2012; National Abortion Federation 2022; Feminist Majority Foundation 2019; Jacobson and Royer 2011). Many providers feel that they cannot speak openly about their work due to antiabortion harassment. In fact, some providers report reluctance to disclose their jobs to their own family members and friends for fear of negative repercussions. Compounding the issue, many clinics have limited capacity and simply do not have enough time and/or money for community outreach and communication. Despite the fact that independent abortion clinics need community support in order to remain in operation,

[105] Since 2021, the overall number of independent clinics has decreased 34 percent. In 2019 alone, 27 independent clinics have shuttered. Furthermore, 76 percent of the 41 independent clinics that have closed over the past two years provided abortion care after the first trimester. These closures have disproportionately affected abortion availability after the first trimester, ultimately diminishing meaningful abortion access.

[106] While some clinics have closed entirely, others have remained open offering other reproductive and sexual health services. Additionally some clinics have moved to more abortion amendable states, such as New Mexico, for example.

there are few, if any, health interventions specifically designed to increase abortion access by focusing on increasing community support at the clinic-provider level.

Abortion Access Front fills this gap. AAF's comedy shows are a unique and vital part of their approach to supporting independent clinics. Attracting anywhere from 100-400 people (depending on the venue), the comedy shows are the locus of their intervention. They spotlight the clinics' needs, thereby connecting the clinic to the community, as well as connecting community members to one another. They wield their talents for comedy, satire, parody, and performance, and channel them toward the vital work of expanding abortion access.

The story of my first encounter with AAF demonstrates the power and potential of their work. Drawing from this example, I will now contextualize their groundbreaking approach. I explore humor and stigma theory to query how stand-up, in particular, can be a useful site for important political and cultural work. I do this to argue that "Abortion AF: The Tour" is not just a comedy show, but a health intervention. Through the show's format, AAF's organizers challenge abortion stigma by exposing antiabortion activist tactics, teaching abortion policy, conveying the precarity of providing abortions in their community, and enabling the audience to support their local clinic and pro-choice organizations right then and there. AAF exemplifies a cultural approach to destigmatizing abortion, which is geared ultimately toward improving access. In short, AAF demonstrates how to use stand-up comedy for social change.

Humor and Stand-up Comedy

Arts activists like AAF have long used humor as a propelling force for their activism, but what is humor exactly? And why might it be an important political tool? Humor theorist John Morreall references *The Oxford English Dictionary* to define humor. According to the dictionary, humor

is a "quality of action, speech, or writing which excites amusement" (Morreall 1986). He explains that amusement, in turn, is a mental state caused by the "enjoyment of a conceptual shift in sensory input" (Morreall 1986, 4). Laughter, then, is the bodily phenomenon that happens as a result of amusement; although not all amusement issues in laughter (1986, 4).

Philosophers have theorized why people laugh and what causes laughter since Plato's writing on the subject in 428 BC. Chronicling humor theory from Plato to contemporary theorists in the 1980s, Morreall outlines three main streams of humor theory: (1) superiority theory, (2) incongruity theory, and (3) relief theory. Superiority theory, theorized by Aristotle and developed by Thomas Hobbes, Plato, and Henri Bergson, relies on finding humor in feelings of superiority over other people or over their own former position (Morreall 1986, 5). Incongruity theory, developed by Immanuel Kant, Arthur Schopenhauer, Soren Kierkegaard, and many contemporary theorists since emphasizes the pleasure derived from violating a pattern or expected result (1986, 6). For instance, according to incongruity theory, the object of the amusement is incongruous with a person's expectations within a particular set of circumstances. And relief theory, developed by Sigmund Freud and perhaps most salient for this conversation, describes humor emerging from the release of a nervous energy-charge or restraint (1986, 5-6).

In his book, *The Joke and Its Relation to the Unconscious*, Freud demonstrates how fear can be managed through humor via the telling and receiving of jokes (Freud 1905). He explains that, through jokes, people can question and engage with social processes in ways that can be safer, more comfortable, or more pleasurable than other forms of communication. Freud examines the different types and techniques of jokes and illustrates how they can be used to lift inhibition by producing pleasure through laughter and "joke work" (1905, 151). Freud draws attention to the corporeal engagement of joke telling when he situates the process of laughing as

a physical pleasure that is related to an energy-charge. He writes that this energy-charge, often present concerning taboo topics or contradictions, is "lifted" and "released" through laughter (Freud 1905, 142). Therefore, the potential of stand-up comedy to alleviate stress or tension associated with a topic is supported by Freud's relief theory.

As described by Freud and others, humor is a full-bodied experience. According to Morreall, laughter "denotes a combination of bodily events, including the spasmodic expulsion of air from the lungs, accompanying sounds, characteristic facial distortions, and in heavy laughter, the shaking of the whole body" (Morreall 1986, 4). Laughter is usually an involuntary or semi voluntary response to a stimulus that results from a pleasant psychological shift. This shift may best be described as a sudden change, the pleasant quality of which is key. For example, in response to a sensory stimulus such as being tickled, one may laugh.

A note on laughter: According to the biomedical literature, laughter can, in fact, benefit wellbeing and satisfaction. A 2019 neuropsychological study showed that there are several types of laughter: *schadenfreude* (laughing at someone else's expense); tickling (involuntary laughter); friendly-joyful (laughing in play or at something funny); and taunting (teasing laughter) (Alter and Wildgruber 2018). A 2021 study categorized laughter in a more relational way, writing that laughter is either: affiliative (the sort of laughter that builds relationships or demonstrates playfulness); de-escalative (nervous laughter designed to defuse tension); or reflective of power status (laughing at someone else to express power) (Browdy 2021). This same study also points out that different types of laughter are associated with different sounds and that not all laughter is a sign of pleasure or joy (Browdy 2021). Regarding wellbeing, the study clarifies that laughter may improve certain aspects of mental and physical health: it ameliorates pain, supports subjective well-being, elicits desirable somatic symptoms, improves personal development, and

reduces depression, anxiety, and stress levels (Mayo Clinic Staff 2023). Notably, the health science literature on laughter remains scarce; some researchers suggest that with more research we may find even more evidence that laughter is good for our health.

Leading more recent conversations about the power and potential of comedy is Communication Studies scholar Caty Borum Chattoo. In her article "How Comedy Works [to Change the World]," Chattoo outlines five primary ways that humor engages the public on social issues and social justice concerns, which I paraphrase here as: (1) attracting attention; (2) persuading emotions (i.e., changing or shaping audience attitudes and perceptions); (3) making complex issues more accessible; (4) removing or addressing social barriers (i.e., introducing new information in non-threatening and non-othering ways; encouraging identification and connection; rather than alienation); and, (5) sharing with others (e.g., displaying personal identity; amplifying messages; commemorating cultural moments; expressing individual values) (Chattoo, 2016). As I will show later, AAF's comedy show demonstrates all of these functions to advocate for more equitable abortion access.

Chattoo also discusses the different genres of comedy that are used in the five ways described. She lists these genres as satirical news, scripted entertainment storytelling, marketing and advertising, and sketch comedy and stand-up. We will focus on the latter, but what is stand-up? Although the roots of stand-up comedy can be traced back thousands of years, the modern performance art form we know today as "stand-up" is relatively new. In fact, the phrase "stand-up comedy" was not used until the 1950s. But before exploring stand-up in the 1950s, we must rewind to the 1880s, to the precursor of modern stand-up, Vaudeville. And as we will see, as we trace its history from Vaudeville to the digital comedy boom, stand-up is—as performance is—always political.

From the 1880s to the 1930s, Vaudeville shows were a mainstay of the working-class circuit and sat anywhere from 500-5,000 people, indicating their popularity. According to historians, during these shows, proto-stand-ups would repeat jokes that were written for them by others (Faderman 2021; Nesterhoff 2015). Often the jokes expressed a judgment about various ethnic groups during immigration and relied on racial caricature (e.g., the Jew comic, Irish comic, Dutch comic). Additionally, black-face performances characterized these shows. Generally, comedy in the Vaudeville context, was almost always made at the expense of one group to elevate another (Nesterhoff 2015, 36).

As radio entertainment started to replace Vaudeville, comedy acts went on air (Nesterhoff 2015). Still, radio comics were not writing for themselves but often performed gimmicky routines written by other people. Performers like Rudy Vallee and Jack Benny were popular. And still, racist performances continued in this format. For instance, a performance duo called "Amos 'n Andy" featured two white male comics caricaturing Black people. Nesterhoff refers to this as "audio blackface" (Nesterhoff 2015).

Comedy acts returned to live performance forums in the 1940s. These clubs, many run by the mafia, were usually referred to as "supper clubs" and theaters. Clad in tuxedos, performers would memorize jokes from joke books and routines.[107] Some even transcribed jokes directly from the radio and performed them (2015, 198). Nesterhoff explains that the rehearsing of non-personal jokes and gags created a homogenous landscape, so much so that even the names of comics were the same with many performers choosing names that included Buddy, Jackie, Joe, Lenny, and Billy (2015, 200).

[107] Nesterhoff explains that Billy Glason, James Madison, Joe Miller, and Robert Orben all used joke books which were regularly rehearsed by others. One of the most popular was James Madison's annual collection of monologies called *Madison's Budget*. Performers bought these books and adapted them to their acts for one dollar (199).

However, what we know as modern stand-up today did not really take shape until the 1950s Beatnik cafes. There, performers began writing their own material about their own lives, attracting those with artistic sensibilities to contribute. The early comics of this era were people like Lenny Bruce, Nichols and May, and Mort Sahl (Nesterhoff 2015). These comics were often overtly political, but instead of rehearsing ethnic stereotypes or hackneyed gags, many—Lenny Bruce, for example—questioned societal norms. For instance, Lenny Bruce was one of the first white comics to talk about race in the context of racial injustice and the Civil Rights Movement. According to humor scholar Alberto Gonzalez, by making his whiteness visible and critiquing it along with other white supremacist institutions, Bruce instigated critical self-reflexivity in his comedy and could, quoting an accompanying essay by Meier and Nelson, "operate as a tactic for challenging whiteness" from within (Gonzalez 2017, 127). Gonzalez contrasts Bruce's personal, contextual approach to discussing race with Bruce's fellow white Jewish comic Don Rickles, who represents the older generation and approach to comedy at the time. He explains:

> While Don Rickles mined for laughs using the stereotypes that the civil rights movement wanted to move beyond, Lenny Bruce—the beat poet of stand-up—confronted the stereotypes and attempted to unmask white positionality in ways that could occasionally make audiences uncomfortable, forcing them to wonder if this was really an act (2017, 127).

Here, Gonzalez describes that unlike Rickles, who repeated unexamined stereotypes as a white man, Bruce often situated his comedy by inventing dialogue between people interacting, creating a social-cultural context in which whiteness could be critiqued. He continues that Rickles focused on the laugh while Bruce got the laugh and invited racial awareness (2017, 128).[108]

[108] For more on Bruce's comedy and counter arguments to Gonzalez, see Meier and Nelson (2017).

By the 1960s, comedy venues and mob connections had dissipated, and what we know as comedy clubs emerged, specifically *Pips* in Brooklyn in 1962 and *The Improvisation* in Manhattan in 1963 (Nesterhoff 2015, 357). Both of these clubs started with the format of the previous super clubs, including singers and musicians, but over time shed the music and formalities of tuxedo-wearing comics (2015, 357). By the early 1970s, multiple comedy clubs like *Ledbetter's*, *The Ice House*, *PJs*, *The Troubadour*, and the *Comedy Store* established an emerging comedy club scene in Los Angeles. Comics performing at these clubs, especially the Comedy Store, started appearing on *The Tonight Show*, writing for TV, and starring in TV programs (2015, 378-79). Then, in the 1980s, entire stand-up comedy shows started appearing live on cable TV, such as *An Evening at the Improv*, *The Big Laff-Off*, and *Comedy on the Road* (2015, 411).

In the stand-up comedy world, the 1980s are known as the "boom years" mainly because the number of comedy clubs sharply increased from a few clubs in cities like New York and Los Angeles to dozens of clubs in most major cities and towns across the country.[109] National comedy chains emerged, such as *Zanies*, *The Punchline*, and *The Funny Bone*, and existing clubs like *The Improv* added more locations. With the quickly proliferating comedy clubs and cable television comedy programming of the boom years came opportunities for more comics and more diverse comics—especially gender-wise. Despite notable exceptions, up until the 1980s, stand-up comedy was primarily a "boys club" (Kohen 2014, 154).[110] During and after the boom,

[109] The specific "comedy boom" language comes from the New York Time's 1983 reference to the "nationwide comedy boom" (Nesterhoff 2015,402).

[110] Notable female comics pre-1980 include Moms Mabley, Phyllis Diller, Joan Rivers, Anne Meara, Barbara Harris, Elaine May, Louise Lasser, Lilly Tomlin, Bette Midler, Whoopie Goldberg, Elayne Boosler, Carol Leifer, Sandra Bernhard, and Suzanne Sommers. For more on the history of female stand-up comics, see: Yael Kohen (2014) and Abbey Morgan (2017).

several women comics became well-known headliners, such as Roseanne, Joy Behar, Ellen DeGeneres, Paula Poundstone, and Rita Rudner (Kohen 2014). During this time, many stand-ups became celebrities themselves and two comedy channels debuted, Ha! and HBO's The Comedy Channel (402).

By the 1990s, mainstream comedy experienced a major slump. However, Black comedy and alternative comedy scenes emerged, experiencing their own boom. Eddie Murphy, one of the most popular comics of the 1980s, opened the door for a new, robust generation of Black comics like Chris Rock, Martin Lawrence, and Cedric (2015, 418). New shows like *Def Jam comedy*, *In Living Color*, and *Comic View* regularly showcased Black comedic talent. The alternative scene got its name from the change of venue from commercial comedy clubs to comedy club alternatives (i.e. book stores, coffee shops, bars, etc.). These comics wanted to try out new material and felt that commercial comedy clubs filled with TV executives and producers did not provide a nourishing space for experimentation. Comics like Andy Kindler, Janeane Garofalo, Bob Odenkirk, and Julia Sweeney came to emblemize the alternative scene (2015, 424). Then, in the early 2000s, in the aftermath of the 9/11 attacks on the World Trade Center, mainstream comedy's slump continued and permeated most stand-up comedy scenes. And now, according to Chattoo, from 2010 to the writing of this dissertation (2023), we are experiencing the "digital comedy boom" era with online video platforms and streaming services providing opportunities to a broad spectrum of comedians and audiences.

Back to the term "stand-up," its origins are somewhat elusive. The term is derived from the 1940s mafia-run comedy club time period. According to Nesterhoff, the mob created the term "stand-up comic" (Nesterhoff 2015, 85). He quotes an eighty-six-year-old comedian, Dick Curtis, to explain:

> The Outfit used to manage fighters. A stand-up fighter is a guy that is a puncher. A stand-up guy was a guy who was tough, and you could depend on. The Outfit managed fighters, and they managed clubs that booked comics, so the term found its way into the lexicon of nightclubs. A guy who just stood there and punched jokes—joke, joke, joke—he was a stand-up comic (2015, 85).

The notion of a stand-up comic as an aggressive male fighter is interesting in the series of analyses and sexist critiques of stand-up throughout the past few decades. Indeed, the history of stand-up is dominated by white cismen, but it is important to acknowledge that there have also been Black and female comics, less, but they still existed.[111] And their comedy was often where social issues were discussed and subversive comedy percolated.[112]

Stand-up, as we know it today, involves a lone speaker "offering a punchline-peppered monologue" to an audience in a nightclub (or other venue) that gathers for about an hour or so explicitly to laugh (Meier and Schmitt 2017, xxiii). It has come to be known as "one of the last remnants of rhetorical tradition in contemporary American culture" (Meier and Schmitt 2017, xxiii). Cultural studies scholar Stephanie Koziski clarifies that "Stand-up comedians function as cultural critics who 'jar their [audiences'] sensibilities by making [them] experience the shock of recognition' and by revealing 'the hidden underpinnings of their culture" (Koziski 1984, 57). One of my favorite definitions of stand-up is offered by Lawrence E. Mintz as "staged antagonism" (Mintz 1985, 77). Stand-up is also a dialogic performance event; it requires an audience (Brodie 100). Folklorist Ian Brodie writes that laughter and applause propel the text

[111] See Kohen (2014) for history of female comics and Hale (2018) for a history of Black feminist comics.

[112] Several comics discussed social inequities throughout the decades. Perhaps one of the first and most notable in contemporary history is Jackie "Moms" Mabley. Several historians regard Mabley as the first Black female comedian. At the height of the Jim Crow Era through the following forty years of her career, she used anachronistic references to the stereotypical figure of the mammy to deliver subversive political humor. According to scholar Abbey Morgan, "Mabley would use the limits of racial, gendered, and sexual representation as a way to reinvent Black female identity, speaking loudly, unabashedly, and acerbically within a public space not readily accepting Black female voices" (A. Morgan 2017, 41).

forward, and the genre is determined by the audience who "interpret, develop, and shape it as it progresses" (100).

And although there is not much research in the area of stand-up and its potential for social change, Chattoo, Meier and Brodie, and Gilbert, all explore the important cultural and social work that happens onstage. I want to be clear that I am not asserting that stand-up comedy is inherently subversive or always works in the service of justice-seeking projects. On the contrary, much of stand-up comedy reinscribes stereotypes and sparks laughter based on the superiority theory line of thinking. However, given the right conditions, stand-up comedy has contributed to social change and has the potential to continue doing so.

But what about social change? According to Meier and Schmitt, "Social change is simply not that simple. Social change is the result of complex interactions between orators, discourses, audiences, and events. No single oration, comedy routine or otherwise can result in social change" (Meier and Schmidt, 2017, xxii). Rather, there are rhetorical forms and strategies that contribute to the process of social change. "Stand-up carries unique potential to affect discourses for change by providing an alternative mode of expression while operating outside of the rules of serious discourse" (Meier and Schmitt, 2017, xxii). As Chattoo writes, stand-up as a performance form has lent itself to challenging social norms because it "is able to occupy a 'marginal safe place' in which normally 'subversive ideas' are granted license to be openly heard and discussed"(2016, 5). So, a stand-up set by itself does not change social injustices but contributes to the processes and discourses of change.

Comic Identity and Marginality

Since the personal turn in the 1950s, when comics began to perform their own material as themselves, comic identity has been central in stand-up comedy. More, the way that comics wield and position their own identities in relation to the audience often determines whether the comic "kills"—a favorite phrase for connecting with the audience and causing uproarious laughter—or flops. However, just because a comic is telling stories that draw from their own experience does not mean that they are playing their everyday selves on stage. Comics have a specific version of self that they play on the comedy stage, also referred to as the "comic persona."[113] A comic persona is a character played by the comic that stems from the comic's actual biography but encompasses many more social identities. Comic tone and humor ideology shape the persona, evolving from audience to audience (Medjesky 2017, 187).

According to former stand-up comic and communication studies scholar Joanna Gilbert, part of the success of a stand-up comic is their ability not only to construct their persona in relation to the audience but to construct their marginality. "Marginality," as Gilbert describes it, means belonging to a non-dominant group and connotes a sociological category. Despite lacking membership to the dominant culture often due to gender, race, class, sexual orientation, and/or other characteristics, the marginalized have the knowledge and insight of the insider with the critical attitude of the outsider. Her concept and part of the title of her book, "performing marginality" describes the means by which comics construct, contest, and negotiate their gendered, racialized, and otherwise marked identities in everyday life. Whether comics hold marginalized social identities or not, they still create their own marginalization within the context

[113] Christopher A. Medjesky reminds us that the term "comic persona" is not used universally. He offers several terms used by different scholars to describe what I am describing here. Scholars have used the following terms to describe a similar concept: rhetorical persona, character, persona, ironic persona (Medjesky, 2017, 199).

of the audience. Folklorist Ian Brodie terms this phenomenon "a priori" and "self-marginalization." A priori marginalization connotes an identity marginalized by society, such as comics who are Black, Jewish, Asian, women, Hispanic, etc. Self-marginalization, or created marginalization, refers to comedians who represent social groups who are not marginalized (i.e., middle-class white men) and still create an aspect of their identity as marginalized in relation to the audience for that particular set. Brodie offers Brad Stine, an American conservative and born-again Christian standup comic, as an example of explicit self-marginalization. He writes:

> In his set, Stine hit some familiar notes, "I'm a conservative, I'm a Christian, and I think the United States is the greatest country that has ever existed on the face of the earth!" he shouted, provoking one of four standing ovations. "And, because of those three belief systems, when I die, by law, I have to be stuffed and mounted and placed in the Smithsonian under the 'Why He Didn't Get a Sitcom' display" (Brodie 104-5).

So, although Stine is not part of a current or historically marginalized group, he creates his own marginalization as a comic who is a rarity and will never be chosen by a network or streaming service to star in a lucrative comedy show.

Additionally, some styles of humor have been linked directly to the a priori identities of the comic. For instance, many female and ethnic minority comics use self-deprecatory humor and stereotypical humor. Gilbert defines self-deprecatory humor as capitalizing on "the power of powerlessness" (1997, 138). Gilbert shows that through the use of self-deprecatory humor, the comic can critique societal ideals of appearance and behavior as well as the people who subscribe to them (1997, 141). She further explains that self-deprecatory humor can be safe while also being subversive. She writes that it is safe because it is not directed at criticizing the audience but the self; and subversive because the comedy stage offers a place to critique societal standards with impunity (1997, 160). Brodie adds that self-deprecatory humor arguing that it can

be used as a form of self-protection or autobiographical control. He offers the following example of comic Joy Behar speaking to her own self-deprecatory humor:

> It empowers you not to be victimized. One of the reasons people become comedians is so they can say these things about themselves first. For instance, growing up I had really, really kinky hair. Everybody used to tease me about it; they called me Brillo head. My fifth-grade teacher used to call me Brillo head. I was hurt by this, so finally I started to make jokes about my hair. I'd say, "I've got a Brillo head" first, before anyone could say it to me. This defuses it; it takes away their power to hurt me. (Brodie 2014, 95)

Behar uses her self-deprecatory humor to take control over a characteristic that has caused her pain in the past. She directly comments that it "takes away their power to hurt me." In a similar example, Jaye McBride, said the following joke at an AAF show about being trans: "[Referring to herself] People think 'She's either trans or a drag queen who's not putting in the effort.'" By joking that she looks trans or like an underachieving drag queen, McBride takes control of how she may be perceived and communicates that even if she is not perceived in a way that matches her gender identity, she does not care. She can laugh about it. Like Behar says, it can potentially take the power away from the audience and ground it in the joke teller.

Gilbert writes that female comics, like other marginal comics, "perform their marginality in an act simultaneously oppressive (by using demeaning stereotypes) and transgressive (by interrogating those very stereotypes through humorous discourse" (Gilbert 1997, 138). She explains that using stereotypes offers an opportunity to examine assumptions and dismantle the stereotype (1997, 151). She also qualifies that stereotypical humor can be used to objectify a person or reestablish hegemonic power structures. She says the type of work that joking about stereotypes can do depends on the context—who is employing the stereotype and what are the power relations (1997, 151)? Gilbert reminds us that the ways in which humor is interpreted are largely dependent on the audience, and that different audience members may laugh at the same

joke for different reasons. She offers an example of audience laughter at a joke about a female stereotype, with many women in the audience laughing because of the ridiculousness of the stereotype and men laughing because they believe that the sexist stereotype is true. Gilbert also suggests that comedy offers an opportunity to channel aggression at injustices. Citing Joseph Dorinson and Joseph Boskin, she explains that oppressed groups have three primary ways to respond to oppression—acceptance, avoidance, and aggression (1997, 158). She concedes that examining oppressive notions on the stand-up stage qualifies as aggression, albeit maybe not overt but in the form of cultural critique. And by critiquing culture, according to Gilbert, marginal humor can act as the Freudian concept of "mini rebellions" (Gilbert 1997, 158).

Ultimately, regardless of the content of jokes, performing marginality can be empowering—first by foregrounding difference and second by commodifying and ultimately profiting from that difference (1997, 165). Gilbert explains the potential empowerment of performing stand-up as a female comic (and by extension as a comic of other marginalized groups) when she writes:

> By the very act of standing on stage, speaking about any topic and getting paid, a female comic is empowered rhetorically and economically—by most standards, this is a "feminist" triumph. Does her behavior change existing power structures in any way? Perhaps not visibly—at least not immediately. No single joke is likely to precipitate the decline of prevailing ideologies. Still, […] jokes may be a place to begin. (Gilbert 1997, 167)

As we will see later, joke work and performance on stage can accomplish personal healing work for comics, especially around their stigmatized identities. This concept extends to stigmatized topics too.

Abortion Stigma

As I have shown throughout this dissertation, abortion is a deeply stigmatized health topic. Sociologist Erving Goffman describes stigma as a discrediting attribute that leads others to see them as untrustworthy, tainted, or incompetent. Stigma describes the "situation of the individual who is disqualified from full social acceptance" (Goffman 1963, 9). Further, when a stigma is known/visible, a person is discredited; when it remains unknown/invisible, the person is discreditable. For instance, race, ethnicity, physical disability, and gender are all visible stigmas, while mental illness, HIV status, and whether someone has had an abortion are all predominately concealable.

Goffman asserts that stigma is socially constructed, and an active social process based on social identities and associations. He also expounds that stigma is negotiated by the stigmatized and perceived by the "normals." He contends that social hierarchies and hegemonies controlled by the dominant class are the impetus for these systems of stigmatization. Stigma is used to create a difference or to distinguish from "the other." In revealing the intricate workings of stigma, Goffman establishes stigma as an active social process that must be met with intentional action to undo its harmful effects. One intervention or management strategy he suggests is the use of comedy, or as he writes, experiencing "the pleasure in tempting the devil" (Goffman 1963, 135).

Although Goffman focuses on stigma located in the individual and social identity group, stigma also permeates several health topics/procedures/diseases and all people associated with them. In their systematic review of abortion stigma literature, Franz Hanschmidt et al. clarify that sources of abortion stigma include significant others, medical institutions, the community, and society (Hanschmidt et al. 2016). Researchers highlight that most women who have had

abortions report self-judgment and a need for secrecy, as well as fear of social judgment (Hanschmidt et al. 2016, 170). Ellen M. H. Mitchell, Anuradha Kumar, and Leila Hessini detail that abortion stigma, in particular, "marks" women who seek to terminate a pregnancy as inferior according to traditional "ideals of womanhood" (i.e., culturally and historically specific notions that vary depending on the person's unique positionality within society) (Kumar, Hessini, and Mitchell 2009, 628). Additionally, they assert that abortion stigma is a "compound-stigma," as it builds upon other forms of discrimination and structural injustices, such as sexism, racism, and classism (Kumar, Hessini, and Mitchell 2009, 634). Allison Norris et al. expand the causes of abortion stigma to include "attributing personhood to the fetus, legal restrictions, the idea that abortion is dirty or unhealthy, and the use of stigma as a tool for antiabortion efforts"(Norris et al. 2011).

Most abortion stigma research focuses on understanding the experiences of those seeking and receiving abortions. While those perspectives are important, so are the perspectives of the professionals critical to abortion access, the people who provide them. Recognizing that abortion providers. Provider-specific abortion stigma can affect clinic staff in a multitude of ways. Lisa Harris, Michelle Debbink, Lisa Martin, and Jane Hassinger have done the most extensive research on abortion provider stigma. To determine the factors of stigma, they used narrative analysis from their 2014 intervention, the Provider Share Workshop (PSW). PSW provided a space for providers to share their experiences of stigma and gathered data for 315 U.S.-based abortion providers (Martin, Debbink, Hassinger, Youatt, and Harris 2014). From the results of the intervention, they concluded that improving human resources for abortion care must include stigma reduction efforts because, "Stigma is an important predictor of compassion satisfaction, burnout and compassion fatigue among abortion care providers" (L A Martin et al. 2014, 581).

From the PSW data and subsequent analysis, Martin et al. determined that worries about disclosure, internalized states, social judgement, social isolation, and discrimination were the primary factors of abortion provider stigma (L A Martin et al. 2018).

Providers have used humor to cope with their fear for safety, bond with one another, and discuss taboo topics such as abortion and contraception with patients. In Chapter One, I detail the ways providers use humor to mitigate fear. Here, I want to suggest that similar to how arts activists have used humor and storytelling to deal with fear, so do abortion providers and organizations such as AAF. Stand-up comedy in particular can be a meaningful way to challenge social stigma of abortion and support some of the people who carry the heaviest burden when it comes to that stigma—abortion providers. One of the main differences between some of these examples and Abortion Access Front is that AAF has quite literally made it a part of their mission, as a non-profit organization, to utilize humor to bolster abortion providers. They have organized their arts activism into a structure that adapts to the everchanging abortion access climate. The comics I spoke to deeply believe in AAF's mission and the power of stand-up to talk about difficult topics more generally. One comic said, "It is absolutely crucial to talk about and laugh about hard things on stage."

But why is humor a good way to confront abortion stigma? Comic Mehran Khaghani says:

> Humor is disarming. Instead of going to people with a message or campaigning for a politician, you are giving people warmth. Guards are down, and you get to communicate with someone without having to necessarily feel didactic. It's just a cleaner, clearer, more open channel of communication.
>
> The other thing that I love about humor, and what humor is an indicator of, is safety. If you are in a position to joke around with someone, it means that there isn't any explosion. There is nothing to worry about. So much of the conversation around abortion is keyed up like, "It's about the baby's life"—all these shitheads being so urgent and creating these

> irrational fears around it. Humor doesn't happen where there is irrational fear, or if it does it capitalizes on it, to make it go away.
>
> It's like if you were to taste a soup and be like, "Someone gets some lemon zest in there," it's just like, it's a flavor, it's an ingredient that's missing from the national abortion conversation. It's such a scarecrow conversation, and it doesn't need to be …. It is a procedure. It is something that tens of millions of women experience in this country. It is a perfectly valid life choice. It is [simple and safe] as procedures go, and I am someone who's been under the knife for multiple reasons. [It is] one of the less complicated medical procedures that a person can go through.
>
> Instead, there's such a barrier for people, in terms like just to grasp the ideas around it and to able to talk about it. If you ever just go in there and just like, "Oh, literally, this is no big deal." [chuckles] This is a wide-open conversation, and anyone can jump in.

In this quote, Khaghani summarizes most of the theory we have covered so far in a more poetic way. For Khaghani, using humor to discuss abortion works because it is disarming. Humor makes abortion feel like a safe and normal topic that we need not fear and is a "warm" way to communicate. He also mentions that stand-up can be a form of communication that is not "didactic," thereby an accessible way to gather information. He describes comedy as capable of combatting and resolving "irrational fear" because if you can joke about it, it isn't alarming. He even makes me laugh in his explanation of what humor can do when he calls antiabortion protesters "shitheads" and compares abortion-themed comedy to lemon zest in a soup. Additionally, he teaches me about abortion in his response when he says it is a simple, common, safe, and uncomplicated procedure.

AAF Comedy Shows

By reviewing comedy and arts activist literature, I have demonstrated how comedy can be an effective method for discussing socially complex topics like abortion, as well as the many ways AAF uses humor in their work. I have also discussed abortion stigma in general, and abortion provider stigma specifically. For this section, I operationalize what it means to "destigmatize"

abortion through comedy in the context of AAF's show. Destigmatizing abortion through the comedy show includes disarming abortion taboo, critiquing and exposing the many facets of the antiabortion movement, informing, educating, and priming the audience for activist action, and creating a space for healing as individuals and as a community. Ultimately, AAF harnesses comedy to mobilize local communities for direct service and shifts the abortion discourse from "pro-choice" to "pro-abortion."

Reprising my description I offered in my methodology section, the comedy show has three main components: (1) abortion organization tabling; (2) comedy line-up; (3) and the talkback with local providers and abortion organizations. AAF gives local clinics free tickets to attend the show, and the price for non-providers is usually around $15.00, depending on the location. AAF advertises the show ahead of time with local progressive organizations and tries to get mainstream media coverage. I use "tries" here because advertising in abortion-hostile states is often difficult and/or restricted due to abortion stigma. The venue is usually located in a known gathering spot for local progressive communities, musicians, and artists.

The line-up changes from town-to-town. The show usually features several stand-up comics in Lizz's network, privileging queer, trans, and disabled comics, as well as comics of color. The organization usually showcases at least one local comic. The multiple social identities these comics hold transcend fixed categories; however, if I had to categorize them, I would call them all "feminist-aligned" and/or "politically progressive" comics. AAF pays for comic transportation and room and board. The show typically lasts around two and a half hours, with an hour and a half for stand-up and about thirty to forty-five minutes for the talkback. Additional time is allocated for buying drinks, socializing, and visiting the tables.

The material I include here is from my fieldnotes from my first comedy show with AAF as a volunteer in Columbus (that I described in the Introduction to this chapter), and subsequent shows in towns across the country. My volunteer activities usually consisted of tabling but sometimes included transporting comics, picking up food, and running last-minute errands. I also use material from interviews with comics and activists. Notably, all the comics I spoke with, whether off the cuff or during an interview, were proud to be a part of AAF's work. In fact, many who had been invited on more than one tour excitedly shared stories about their experiences at clinics and about how they, too, learned about abortion access through their work with AAF.

The amount of explicit abortion material included in each show varies. Lizz's set is almost entirely about abortion. Lizz has encyclopedic knowledge of all-things-abortion and is always conversant on the latest and/or breaking news. Still, to prepare for her set, she studies the local news of each performance location and adapts her set accordingly. Lizz always peppers her sets with facts about abortion regulations and local politicians. But not all of the jokes of the night directly relate to abortion or reproductive rights. Some material may be more personal to the comic, but often still touches on other feminist themes, such as body standards. For instance, at a show in Minneapolis, Sarah Hartshorne said, "I was a plus-size model, then I quit and gained some weight and became a plus-size person—weird, those are not the same thing."

At the first show I attended in 2017, Lizz said to the audience, "We are comics; we can bring people together." In addition to attracting people from their individual fan bases, comics also engage people that may or may not be interested in abortion activism. Because of that, they may have the opportunity to convert new people to abortion activism rather than "preaching to the choir" (at a rally, per se). And although usually politically progressive-affiliated in some

way, AAF audiences can be quite diverse in class, and religion.[114] I should also mention that although I have observed some racial diversity, most of the audience members at the shows I attended were white.[115] And last, I need to mention that several colleagues have asked me about the palatability of AAF's approach for people who are "on the fence" about abortion. My response to this concern is that AAF is not speaking to them; they are not trying to "reach across the aisle." They are reaching more to the middle, or speaking to those who are sympathetic, but not active. They are also there to celebrate the community that already exists.

In addition to being fun, a stand-up comedy show can make difficult, taboo, or complex topics more accessible to an audience. It can disarm and prime an audience to listen and think about the topic. Some abortion jokes exemplify Chattoo's "gateway" effect of comedy (Chattoo 2016, 2). Chattoo explains that the concept refers to the ability of comedic portrayals of a serious topic to "open the door" to serious consideration. She explains that the gateway effect can initiate two major processes: (1) provide new exposure to complex issues and (2) provide an available knowledge framework (that is not fear-based or stigmatizing) for audiences to make sense of this issue in the future (Chattoo, 2016). [116]

There is a physiological component of laughter, too, that can make information about abortion easier to hear. Although many of us associate laughter with strictly intellectual or cerebral processes, Freud's relief theory reminds us that laughter is a process that encompasses the entire physical body. He writes: "The concepts of 'physical energy' and 'discharge,' and

[114] I have not mentioned gender because most of the audiences I have seen are majority women.

[115] Solange Azor discusses this as a limitation in her work on AAF, and it is a limitation that the organization is consistently working on remedying (Azor 2018b).

[116] Additionally, Chattoo expounds extensively in her book about how digital comedy media greatly increases reach. Although I will primarily discuss connecting during an in-person, live performance, digital comedy media is one of the primary ways AAF fulfills their mission.

treating physical energy as a quantity have become habitual in my thinking" (Freud 1905, 142). Focusing on the process of laughing as physical pleasure related to the energy-charge (often present concerning taboo topics or contradictions) as being "lifted" and "released" draws attention to the corporeal engagement of hearing a joke. As AAF member Amber said, the comedy "loosens the audience up" for the talkback, when they will hear the ways that they can help. Indeed, Gilbert too discusses the ability of stand-up to disarm and relax the audience into listening and understanding (Gilbert 1997). She adds that this happens particularly when comics include jokes that poke fun at the process of marginalization based on gender, race, ethnicity, and sexuality.

The marginal position of the comic, whether a priori or created, places her as an observer and interpreter for the public. She is not a traditional intellectual but a public or "organic intellectual."[117] The term "organic intellectual" evolves from Gramsci's "modern prince" concept and is used to describe an "agent of change and challenger of hegemony" (Duncan and Carter 2017, 139). Not all comics would be described as organic intellectuals. AAF comics certainly are, because they consistently challenge the heterosexist patriarchal values that underpin much of the antiabortion movement. In part, the context of a comedy show offers a space to question and critique societal norms and expose the hypocrisy of those in power.

The comic, as an organic intellectual, can also reveal links between abortion and other political issues. For instance, Joyelle Johnson, who identifies as straight, links antiabortion evangelicals with homophobia. She says, "Evangelicals think homosexuality is a choice—it's not, because I would choose it every day!" Her joke points out that antiabortion stances are usually linked to homophobic ones. She also offers that homosexuality is something she would

[117] In 1960, *Time* magazine dubbed stand-up comics "public intellectuals" and they have lived up to their name.

choose if she could, implying that it is more appealing to her than heterosexuality. Not only is she making a point about the political right, but she is also flipping their values, deeming homosexuality as preferable. Relatedly, Lizz talks about the links between abortion and, well, everything else. I hear her say some version of the following at most talkbacks. She says, "Abortion is about all of us. It is a human rights issue. And these antis, they are against people getting abortions, but they are also against you too—they are Islamophobic, homophobic, and racist."

AAF exposes the violence of antiabortion politicians and protests by sharing insights from their extensive research of the movement and their experiences at clinics nationwide. Not only is their engagement with anti subjects critical, but they also use humor to mock and parody antis, undermining the images and messages they spread. Carole-Ann Tyler describes mimicry as "one does ideology in order to undo it" (Tyler 1991, 53). Never has this notion been clearer to me than at the AAF show in Baton Rouge when comic Sarah Hartshorne created a pamphlet for antis. She created a trifold in the format of "sidewalk counselor" antiabortion literature. She distributed it outside of the comedy show where they were protesting and then integrated it into her set that night. By showing and explaining her process to the audience, Hartshorne also teaches the audience a way that they can respond to protesters. In fact, since this show, some activists have used Hartsthorne's pamphlet as a model and adapted it to their clinic contexts to distribute to their own regular antis. Even if antis do not take the brochure seriously, it neutralizes the fearful climate they attempt to create, and offers the escorts a good laugh too.

The comedy show educates the audience about abortion access in their community and primes them for action. In their essay "Sex Squad: engaging humour to reinvigorate sexual health education," Robert Gordon and David Gere demonstrate how storytelling and humor work

as effective apparatuses to spark honest and educational conversations about sexual health. Specifically, they describe how employing the participatory theatre methods of Augusto Boal's Forum Theatre and the fun of Pieter-Dirk Uys's first-person comedic storytelling creates an environment where students can confront their fears, laugh, relax, and become agents concerning a subject they might feel they have little power or agency over (Gordon and Gere 2016, 326). They emphasize that guiding students to use comedy consciously, with reflexivity, may enable them to "to critically analyze and challenge the systems of power they navigate every day, toward the goal of achieving greater sexual health" (Gordon and Gere 2016, 335). AAF comics do this through the comedy in their set and the talkback afterward. And they do all of this while centering abortion providers, the people who labor every day and rarely get the chance to be the focal point of conversations about abortion.

AAF shows are vehicles for education, filling a gap within media, which is rife with misinformation, and in some instances, is politically aligned with antis. Lizz Winstead explains that part of the reason she started AAF is that media coverage of abortion is "garbage" and has been siloed, just like abortion services have been siloed. The coverage usually focuses on abortion from a federal perspective when understanding access is all about state politics. She also explains that the media fails to reveal the hypocrisy and the money trails of antiabortion leaders and politicians. Through both jokes and stories told as part of the comic's sets and the conversations afterward, AAF informs the audience about abortion politics, corrects misinformation about abortion, and models pro-abortion language. For instance, in Columbus, Lizz told the audience about mandatory waiting periods and gestational limits in their state. During another show talkback, Lizz mentioned "TRAP Laws" (Targeted Regulation of Abortion Provider laws) and many people booed. Then when she asked people who actually knew what

TRAP laws were to raise their hands, very few people did. Lizz was then able to explain to them and detail how they affected abortion providers in their state. The comics of AAF confront misinformation when one comic tells the following joke: "Some people say that abortion reduces the chance of getting pregnant," by causing infertility. "Well, it doesn't, because I've had two [abortions]." In this joke, the comic informs the audience that the idea that abortion causes infertility is a myth while coming out about her own abortions.

Lizz and the other comics also model pro-abortion and inclusive language regarding abortion access. When referring to people who seek abortions, AAF makes a point to say "pregnant person," "abortion patient," or "women and people with uteruses" instead of "woman" or "pregnant women." They use more gender-inclusive terms to include trans men and people who identify as gender nonbinary. In the very first show I attended, Lizz told the audience not to call protesters "pro-life" but instead call them "antiabortion." She also encouraged the audience to refer to themselves as "pro-abortion" instead of "pro-choice" and, in turn, repeatedly referred to herself as "pro-abortion." For some audience members, the AAF show is one of the rare occasions they have heard the word "abortion" spoken multiple times. It may be the first time they learn that using language such as pro-abortion (rather than pro-choice) and antiabortion protester (rather than pro-life protester) does important rhetorical and cultural work to destigmatize abortion. Lizz mentions that using language like "safe, legal, and rare," which is commonly bandied about in pro-choice circles, is also stigmatizing.[118] This last point can also be linked to one of Lizz's jokes when she says, "When people ask me how many abortions I've had,

[118] For more on the problematic and stigmatizing aspects of this phrase, see Weitz (2014).

I say, 'I don't know. I don't save receipts.'" With this, Lizz aims to eliminate any stigma about the number of abortions someone has had.

In the early days of the Abortion Access Front, Lizz noticed that although the shows were good for starting conversations, they did not provide audiences with actions to take. AAF now have multiple opportunities for audience members to get involved at the performance venue as well as methods to keep their audiences engaged with abortion activist efforts throughout the year. In the Columbus example at the start of the chapter, NARAL solicited people to sign up for their next advocacy event, while Women Have Options asked for donations to help with practical support for patients. At the venue, AAF facilitated the ThankBank project and collected emails to share with local volunteer organizations. Once audience members are linked with AAF through email, they will start to receive news stories, podcasts, and consistent opportunities to volunteer and advocate for abortion.

One of the most meaningful aspects of the show is the potential for individual and community healing. Both comics and scholars have discussed the opportunities that personal storytelling can provide—especially when it is met with laughter—one of the signs of a joke's success (Seizer 2017; Meier and Schmitt 2017; Sangillo 2017; Mulubale, Rohleder, and Squire 2021; Auslander 1993). When transporting comics to a show in a Midwestern city, one of them asked about the other comic's family member, a person she knew caused some stress in the first person's life. The first comic said, "Well, I haven't done a bit about him yet, and that's how I know if I am working something out—if I can do it on stage."

Several comics choose to disclose their own abortions as part of their set. Falter expressed that by sharing their abortion stories, comics were taking control. She said:

I think you're taking it back. I think if you can laugh about your fucking abortion or laugh

> about that kind of thing, you're owning it and you're making it yours and you are saying, "Fuck the rest of you. This is my thing and I can interpret it and laugh about it. I can cry about it." I think it's so, so, so important to be able to laugh about the painful shit, in general.

And sometimes, abortion stories were shared without a comic framing. At an AAF-affiliated event, I observed a young comic share her abortion story on stage. You could tell by how she shared that she had not done it before. When I asked her about it afterward, she apologized and said, "I'm sorry. That wasn't the stuff that I planned to do. I just heard somebody else do it, and I got here, and I just felt I needed to do it. I know it wasn't that funny or whatever." I assured her that it was great. Even if it is not funny, many comics feel relief after sharing it, and inevitably, other people follow suit and talk about their abortions. At a show in DC, one comic said, "I talk about abortion—I had one. I don't regret it. I don't want women to feel ashamed for having an abortion." The audience cheered. Comics also discuss accompanying friends and family members for their abortions. Referring to accompanying a friend to her appointment, Mehran Khaghani said, "I've been a part of so many abortions. I love it!" And, of course, people experience healing through talking to others about their own abortions afterward, like Marisa did with me.

Ultimately, AAF's comedy show destigmatizes abortion by shifting abortion discourse and mobilizing supporters for independent clinics. When comics poke fun at the system that stigmatizes them and often come out as having abortions themselves, they give audiences an opportunity to (re)frame abortion in a positive way. By way of jokes and stories on the stand-up stage, AAF comics demonstrate how humor can help start (and shift) a conversation about abortion. For instance, the specific joke work AAF comics engage in not only educates audiences about abortion but also identifies the problematic power dynamics between legislators, providers, and patients. For example, when Lizz makes fun of Ohio legislators for recent gestational ban

bills, she teaches the audience about the antiabortion legislation in their own state. Simultaneously, she mocks legislators (mostly white cismen) who seek to control reproduction and identifies their faulty logic by comparing the fusion of egg and sperm cells with dead skin cells.

AAF does not solely reframe abortion through jokework, but through the format of their comedy show, they revolutionize what abortion education, support, and advocacy can look like. By focusing on the clinic-provider and community levels to expand health access, they are engaging in an important public health intervention. They use their wit, heart, courage, playfulness, and guts, and they have fun. They use their artistry to envision a more loving pro-abortion world, and they take concrete steps together with their communities to make it happen.

CONCLUSION

The patriarchy never takes a day off.

--Lizz Winstead

June 24th, 2022
Los Angeles, California

I feel like the world is crumbling around me, and I am sitting here, at my desk, behind on emails. My fingers feel like lead, reaching to stroke each key as I respond, uncharacteristically, with as few words as possible, "That's correct," "Meeting confirmed," "Best." I switch my attention from my phone to the kitchen to the computer, forgetting why. My dread is palpable, a smoldering fire. It ignites in the pit of my stomach and courses clumsily through my limbs.

Being an abortion researcher is filled with moments like these—moments when you, your colleagues, and most of the people you love dip in and out of Kübler-Ross's stages of grief like distracted teens (Kübler-Ross and Kessler 2005). There's denial, sadness, anger, and more. This happens with every abortion news catastrophe (of which there have been many in the past five years since I started this research). It is happening today—the day "the Roe-pocalypse arrived" (Abortion Access Front 2022).

I stare at the Zoom screen and see my beautiful colleagues who have become dear friends. Our phones are blowing up, and we ignore the constant buzzing, overwhelmed with it all. Alyssa is quiet, Alice is angry, Elise is despondent, Génesis is sullen, Kelsey is in denial, and we each appear on the brink of tears at various moments in the conversation. We are the supposed experts-in-training on the subject, and even we cannot fully comprehend the repercussions of the overturning of *Roe v. Wade*.

Today is a sad day for most feminists and people who care about fundamental human rights. But for us, it's different, because we know what happens when people don't get the abortions they want: they are more likely to experience serious complications from end of pregnancy (i.e., eclampsia and death), suffer anxiety and loss of self-esteem, and live below the Federal Poverty Level (Advancing New Standards in Reproductive Health 2019b). We know providers—their challenges and seemingly endless resiliency. And we knew this was coming.

Fear and Joy

Amidst the pandemonium in my email inbox on June 24th, 2022 was a note from Abortion Access Front. It was one of the few messages I felt I needed to read. The message announced the release of a new podcast episode to help process the day's news. In addition to notes about the episode, the email said:

> This episode is a space to primal scream, cry, plot, unite, and laugh your ass off. The floor has fallen out—that was *Roe*—but the Feminist Buzzkills have plans, and you're a part of them […]. Hilarious, amazing abortion evangelist Busy Philipps is in the house and bringing some much-needed pro-abortion joy! The world is heavy right now, in between all the raging and fighting against the patriarchy, so show yourself some extra love. You are not alone. We got you!
>
> ROLL CALL: Don't forget to sign up for Operation Save Abortion.[119] It's not a march; it's your training day. Follow @AbortionFront on all socials—we'll keep you one step ahead of the garbage womb raiders trying to seize your bodily autonomy.
>
> 'Cause you know us: when BS is poppin', we pop off! (Abortion Access Front 2022).

In this brief message, the comics and writers of Abortion Access Front do what they always do: affirm the range of emotional responses to the realities of abortion access, including feelings of sadness, anger, and fear; remind us that there is, in fact, "pro-abortion joy"; reassure us that we are not alone; and, calm us with the knowledge that they have a plan. Also, they make us laugh—or, at least, the line about "garbage womb raiders" and "popping-off" made me laugh. It was the first time I laughed all day.

Throughout this dissertation, I have discussed terror, and indirectly, I have explored experiences of fear. I have acknowledged fear as an individual, physiological, and social experience. Neuroscientist Thierry Steimer describes fear as a corporeal encounter in response to a known external danger or risk of harm (Steimer, 2002). Anthropologists Andrea Boscoboinik and Hana Horakova agree that fear is an unpleasant emotion that an individual may experience but clarifies that emotions are not individual constructions but cultural ones. They assert that fear is also a social experience and cannot be narrowed to an individual emotional condition. Rather than question what emotions are, they suggest we focus on what they do and mean, which

[119] To view the Operation Save Abortion resources, see Abortion Access Front, "Operation Save Abortion."

requires a social investigation (Boscoboinik and Horakova, 2014, 10). So, although some think of fear as residing in the mental realm of individuals, I prefer that we think of it as social and communal: essentially a collective memory of terror. As such, diminishing fear is not an individual project but a social one, mainly because when it comes to abortion, fear intertwines with stigma.

Visiting abortion clinics and especially countering Operation Save America, I did feel overwhelmed by fear. I was sweating and on edge. I was quiet and alert, closely watching my sibling activists and the antiabortion protesters. I worried that one of the antis might attack me. In fact, I was aggressively physically assaulted at different points. But I was also tapping into an underlying social fear. I was afraid of the harm that I knew OSA members and other antiabortion protesters perpetuate, and how they and their movement threaten people's bodily autonomy. I was uneasy about the powerful Christian heteropatriarchal forces these men on the microphone represent and how our country is changing based on the political influence of legislators who share their beliefs. And these fears did not live in my mind but in my entire body, affecting how I felt and moved (or did not move) in space.

Throughout this dissertation, I have also explored abortion stigma. I, a fiercely loud scholar-activist with a tattooed uterus on my arm, also recognize my own internalized stigma about my work. My stigma is primarily grounded in fear for my safety. After learning about how antis actively stalk, terrorize, and murder providers, I dreaded telling people on the road about my research, especially after my first OSA counter. After all, I realized I might never know who was an anti. I slipped up once at an Airbnb in Moab, Utah. When asked what my dissertation was about, instead of giving a more general answer (e.g., “art and public health"), which was my protocol for those types of situations, I said, "abortion access and stand-up comedy."

The host's face transformed from an easy smile to disgust and anger. It was as if I had spit in the coffee she was drinking. Her face reddened, and she said, "That's horrible. I can't believe you are studying that. How awful. There is nothing funny about abortion!" It was a tense moment, but not a lethal one. Still, later that night, I could not help but think it might not be wise to tell people about my research when I am staying with them alone in the middle of the desert with a lockless door. But this reality angered me because I knew that part of demystifying abortion was to talk about it normally with everyone I encountered. If I could not do it, how could I encourage others to? If I feel concerned about disclosing my connection to abortion with the public, what must providers feel?

More, I thought, what is the relationship between fear and stigma? Based on my time in the field, I know that fear perpetuates stigma. When it comes to abortion, although it is an incredibly safe procedure, providing abortion has also been linked to potentially dying (see the history in Part One) (National Academies of Sciences 2018). And as I have described, the everyday milieu of terror reinscribes this fear for providers. Historically, because of this fear, abortion clinics have been isolated from their communities, and many providers abstain from telling their loved ones where they work. Fear for provider safety prevents clinic staff from connecting with their communities and sometimes sharing their whole selves with their friends and families. Fear from the experience of entering the clinic and all of the obstacles that have led up to that point marks the abortion experience as difficult for many patients and, as such, not an experience they want to share. And the fear associated with the many negative repercussions of abortion stigma for anyone who talks about it in a positive or matter-of-fact tone relegates abortion as a topic we wish to avoid. After all, even I, the abortion-positive activist scholar, find

myself wanting to avoid disclosing my research topic in certain contexts. Fear pervades the topic of abortion and fuels its continued stigma.

Any association with abortion can make a person and their family vulnerable to antiabortion harassment at worst and having to explain the legitimacy of their connection at best, on account of which many have chosen to stay silent. Further, if fear often accompanies stigma, then destigmatizing interventions would also respond to fear. Stigma and fear have created multiple challenges for providers, activists, and advocates alike. It makes sense that decades of activists have made use of social and embodied humor; humor's direct corporeal effects and its capacity to bust stigma can make topics like abortion more discussable.

In a recent (2023) *drash* (Hebrew word for Jewish sermon*)*, my spiritual leader Rabbi Susan Goldberg reminded me that dealing with fear (and I would extend her idea to include stigma too) requires courage; and courage, like fear, is not a solo journey (Goldberg 2023). She said, "courage is collective;" we summon courage when we are intentionally dealing with fear and we usually do not do it alone. We face fear with our community, our beloveds, our friends, and our teachers. We choose courage, and we practice it. According to Goldberg, the practice of courage involves: dancing with uncertainty, clarifying values, building support, and engaging in continuous, daily actions (Goldberg 2023). She elucidates that social change does not happen because of one act by one person, but of the continuous, intentional, daily actions of many people, together. She says that choosing and experiencing courage in the face of fear brings us together and we form an "unshakable bond" (Goldberg 2023). And as I reflect on my time in the field, the people I met, and all that I learned, I know that the practice of courage is what I experienced with AAF and what I observed at independent abortion clinics across the country. In moments of fear and uncertainly, AAF activists collaborated to make something beautiful and

fun from the counter protests to the joy-affirming comedy shows. At clinics, providers supported their patients and one another in thoughtful ways daily despite the collective memory of terror.

Bursting into song with my sibling activists that day in Indianapolis, as described in the introduction, was an important experience on my journey. The humor we mustered in a time of such fear and despair helped sustain me in the movement and provided a road map for me as an activist. I know that if I am feeling hopeless and scared, I can witness the atrocities of OSA and do everything I can to nullify them with other activists. Along these lines, sibling activist Solange Azor writes that AAF brings people into allyship through laughter, primes them, and changes antiabortion-influenced mainstream narratives. AAF disrupts the gloom-and-doom narrative of the antis and inserts relief (Azor, 2018). AAF ushers in joy. And we cannot forget the joy. Along with the experience of fear described throughout this dissertation, I have also described moments of immense fun, happiness, and belonging. When people ask me what findings I was most surprised by in my fieldwork, I usually respond that despite the fear, security, and stigma surrounding abortion providers, abortion clinics are some of the warmest places I have ever experienced. They demonstrate the gold-standard of patient-centered care, and can serve as a model for all other medical professionals.

Similar to anthropologist Whitney Arey, I found that clinics enable experiences of what she terms "abortion biosociality," where "affective relationships are engendered based on shared medical experience, navigation of a stigmatized environment, and the ethic of care that is present in the arrangement of the clinic space"(Arey 2021, 306). Arey explains that this biosociality often results in an "assemblage of caring relationships" (Arey 2021, 306). The care provided in clinics can mitigate some of the external forces on abortion access (i.e., poverty, criminalization, and personal health issues), "increasing personal autonomy through an ethics of care" (Arey

2021, 311). Arey primarily focuses on how providers curate these possibilities for patients. I observed not only this, but also how they create biosocial relationships among themselves.

Many clinics have cultivated loving work communities prioritizing self and community care. Several providers told me that the flexibility and care they received working at their clinic were unparalleled in their other professional experiences. One said she could not be a single mom of a special needs child and work elsewhere. The staff fully supported her inconsistent scheduling needs. A provider shared that she could never gain the healthcare training and potential to advance in a medical career in any other setting. The clinic taught her every step of the process and helped her develop professionally. At almost every clinic I visited, at least one provider would tell me, unprompted, that their staff was like a "family." And additionally, others referenced the self-care parties, movie nights, pizza nights, and regular check-ins where staff shared their challenging cases and emotional difficulties at work, supported one another, and strategizes potential solutions together.

Prioritizing their own community care through social events was a key part of provider resilience. Michael Ungar defines resilience as the capacity of both individuals and their environments to interact in a way that enhances the individual's processes (Ungar 2013, 255). He explains that resilience is a social-ecological concept, relying on both the individual and their social ecology. In other words, an individual's skills and the structure and resources of one's environment factor into whether or how a person develops resiliency (Ungar 2013). By creating a fun environment in the context of fear, providers shape their work environments, and their work environments contribute to their resilience. Not only do we need to support these clinics, but as they close, we must learn from them: how to center patients, cultivate warm and fun work

environments, and find joy in some of the most difficult circumstances. We must learn from their resilience.

What to do When the Floor Collapses

I wrote most of this dissertation before June 24th, 2022, the day the U.S. Supreme Court struck down *Roe v. Wade*. In those early pages, I mentioned, citing several of my colleagues, that the overturning of *Roe* was likely based on the political success of the antiabortion movement. After June 24th, I had to CONTROL F "Roe" and change the tense accordingly. I have mentioned before that for many feminists in the pro-abortion movement, *Roe* was the floor. But we still need the floor to stand. So what now? Honestly, I do not know. Years deep in this movement, I still often feel lost in the mountains of work we must traverse for abortion equity. My best advice is based on years of research and, more specifically, years of learning from AAF—show up.

When I say, "show up," I am referring to the AAF concept of showing up that I described in Part Three: show up literally by attending abortion activist events and figuratively for yourself and others. In the context of how to get involved, I mean to know yourself, your skills, talents, and capacities, and then figure out how to direct them toward reproductive justice and pro-abortion work, even when, inevitably, your capacities change based on your season of life. Know yourself and take action. Ask the local activists in your community how to channel those skills, keeping in mind that centering the most marginalized in this work is paramount. Is there a clinic in your community? Is there an abortion fund? A reproductive justice organization? And if you are scared, connect with those around you and choose to practice courage.

In AAF's June 24th email, they mentioned that they had "a plan." The plan, of course, is what they call "Operation Save Abortion," a play on the antiabortion group name "Operation Save America" (formerly known as Operation Rescue), which I reference throughout this

dissertation (Abortion Access Front n.d.). The new main feature of AAF's activist arm, Operation Save Abortion, mobilizes activists to support abortion clinics and patients directly. It is yet another way to ensure the momentum from the shows and the recent news coverage channels into action. The kick-off to the project is currently available on their YouTube channel (Abortion Access Front n.d.). Operation Save Abortion was a full-day virtual training advertised like this: "It's not a march. It's your training day" (Abortion Access Front n.d.). Lizz describes the event as helping people figure out how to best show up and connecting them to resources. She says:

> With Operation Save Abortion, people will get plugged in with the amazing heroes and organizations already on the ground working to preserve abortion access in America. [...]. They'll learn about all the different ways they can channel their outrage into action, they'll come away knowing this fight requires every single one of us, and they'll know exactly where their special talents fit into that equation (C. A. Johnson 2022).

In addition to the filming of the kick-off training, the Operation Save Abortion website features several filmed panels with leading experts, from Reproductive Justice 101 to Clinic Support to Legislative Advocacy. AAF activists have produced an activity house party guide and encourage people—in both English and Spanish—to host gatherings using their guide. There is also an activity toolkit. Perhaps most important are two specific resources: the volunteer form and the activist calendar. The volunteer form asks about the location, skillset, availability, and aims of respondents. (They also vet respondents for the organization, which removes several barriers between willing volunteers and organizations that must be mindful of security.) Then, they link volunteers with those organizations. The activist calendar has all pro-abortion-related events on an Airtable calendar in one place. It allows one to filter by state.

Among many things AAF taught me is the reality that we need everyone in this movement at their full capacity. We need people in the streets, doctors, lawyers, graphic

designers, pizza parlor owners, uber drivers, academics, comics, and so on. “Full capacity” also means service in a way that feeds your soul and works for you because we need you for the long haul.

What I Learned About Myself

Los Angeles, California
November 15, 2019

On the final day of my last leg of clinic visits, in November 2019, I pull into my driveway, inhale, and slowly exhale. Perlita Avenue is so familiar, yet it almost appears new. Or maybe it's me that's new. Well, not new, but more awake. Awake to the impending doom of every piece of antiabortion legislation. Awake to the women who seek abortion care—the multiple hoops they jump through to navigate a shame cycle for years to come. Or not. For some, it's a blip—a pulse that activates them to tell a friend, a partner, a parent, or a legislator. Or not just to tell, but to shout—to, per the phrase coined by Amelia Bonow, "shout your abortion. “Awake to people who provide abortion care—many never mentioning their job, their passion, their expertise, the work that gives their life a great sense of meaning and purpose to their communities. Abortion work jolts them awake to start a day of mystery and sometimes chaos. It propels them through the gauntlet of haters; people who will never know their story or the story of their patients. People who claim to have the answers but do not hear, much less listen.

I have learned a lot in the past four months. I have driven from Los Angeles to Atlanta, Charlotte to Huntsville to Fargo, and many places in between—often in a figure-eight pattern. I have visited nineteen clinics, conducted over ninety-five interviews with abortion providers, escorted at six abortion clinics, and administered countless interviews with clinic escorts, abortion activists, pro-choice comics, and abortion researchers. I have learned a lot about abortion access in the United States. I have learned a lot about abortion provision and stigma. Thankfully, these were the research objectives: to learn about these concepts. But I have also learned something unexpected, something that did not appear in my IRB application. I learned about myself.

Steeped in academia, a field in which people seem to exist based on their competitive prowess, I often focus on the "no’s"—the rejections, the setbacks, the flaws, the failures. But this trip, although rife with various degrees of rejection and heartbreak, revealed (or developed) a part of me much more meaningful—the ability to hold, and we present with people. To hold pain, to hold sorrow, to hold anger, to hold fear: to practice courage. This trip presented the opportunity for me to hear the experiences of people in the trenches of the abortion wars—the ones who, day in and day out, do the work. But much more than hearing their stories, I was able to listen, perhaps better than I ever have before. Listening involves presence, empathy, and patience. I noticed this shift in me or perhaps in my self-awareness when several people I met along my journey outside of interview rooms poured out their stories to me or opened their own floodgates. I did not try and fix or prescribe; I did not encourage them to spreadsheet themselves to wellness (my usual go-to). I sat with them and listened.

In the process, I realized that part of listening is patience. Patience has always been a challenge for me. I needed to learn how to practice patience when hearing abortion stories and stories of abortion work, not to knee-jerk into my own emotional space but to ask questions and hold space. Also, to take notes. Near the end of my trip, I had a revelation about the research: that it had bestowed numerous gifts, including the contribution of self-awareness, reinforcing my ability to hear, listen, and hold. These attributes are precious to me. So, I meditated and prayed for the ability to have the patience to hold the pain gracefully and to funnel it into something that will help in this liberating work when the time is right. Today, post-*Roe*, as I complete the dissertation, I realize the time is now.

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