“PREGNANT? SCARED? OVERWHELMED? WE’RE HERE TO HELP:” CULTURES OF CARE IN CRISIS PREGNANCY CENTERS

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A thesis submitted to the
Faculty of the Graduate School of the
University of Colorado in partial fulfillment
of the requirement for the degree of Doctor of Philosophy
Department of Sociology
2019

This thesis entitled:

"PREGNANT? SCARED? OVERWHELMED? WE'RE HERE TO HELP:"
CULTURES OF CARE IN CRISIS PREGNANCY CENTERS

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The final copy of this thesis has been examined by the signatories, and we find that both the content and the form meet acceptable presentation standards of scholarly work in the above mentioned discipline.

IRB protocol #: 15-0385

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"PREGNANT? SCARED? OVERWHELMED? WE'RE HERE TO HELP:" CULTURES OF CARE IN CRISIS PREGNANCY CENTERS

Thesis directed by Dr. Janet Jacobs

Crisis Pregnancy Centers are non-profit, faith-based organizations that operate with the express intent to offer alternatives to abortion. These pregnancy centers comprise the largest component of the pro-life movement in the United States, yet little is know about the interpersonal dynamics that occur within centers and specifically, between staff and clients. Using observations from options counseling and ultrasound appointments, as well as data from interviews with staff and clients, this dissertation presents the first ethnographic data and scholarly analysis of client appointments in faith-based, "life-affirming" pregnancy centers. I focus on the construction, performance, and receipt of care at two pregnancy centers. These two centers provide distinct models of care that reveal important frames through which staff negotiate their gendered, religious identities and provide the context through which to understand how clients experience pregnancy centers. I add to a growing body of literature examining CPCs by contributing the first empirical data documenting the exchanges that occur within appointments at pregnancy centers. I also contribute to the literature that explores women's participation in evangelical Christianity by examining how staff reimagine effective evangelism and ministry in the pregnancy center context.

For Sage.

ACKNOWLEDGMENTS

My deepest gratitude to the clients and staff at Mountain Care and Urban Care who participated in this study. I am honored by your willingness to allow me to step into your lives and for your openness during this project. I have learned immensely from each of you.

To my family members—Mom, Dad, Kaleb, Keely, and our vast, beloved, extended family—thank you for your love, encouragement, and steadfast assurances. I could not have done this without your endless support. I am so fortunate to be wrapped in your hugs, to be the recipient of your advice, and for the sustenance you provide (physically, mentally, emotionally, and spiritually). Mom, your passions inspire me to do more in this world. Dad, you ground me and remind me of what is most important in this life. I love you all so much.

I am not sure how I managed to accumulate so many incredible friends in my life but, if I could, I would write volumes extolling the gifts you all have given me. The best part of graduate school has been the connections I have forged with each of you. Thanks to craigslist for bringing most of us together. To Alicia (my #1 co-trashpanda), you provide powerful inspiration for how to live in my values and push me to create a more just world. I have never laughed harder than with you. To Amanda, I cannot imagine my life without you. Our friendship has been one of the greatest joys of my life and it has been incredible to share the past decade with you. I look forward to so many more years of creative musings, growth, and therapeutic runs. Jake, you changed how I viewed the world and relationships. Molly, I would not have made it through my final year without you, our deep conversations, and our healing rides at Hall Ranch. Jennifer, my wise, generous friend, you have given me the most insightful advice over the past eight years and I am in awe of you. Britt, you are the model of how I want to exist in the world. Sunset whiskey

and wine talks in the North Country, the desert, or Skype never fail to fill me with joy and make me think about our connection to time differently. To all those who have held me in community (too numerous to list here), thank you for the hikes, climbs, happy hours, trips, laughter, and for listening to my confusions and inspirations.

I am deeply indebted to Dr. Janet Jacobs, my chair and advisor. Thank you for your intellectual guidance, compassionate advice, and for giving me a good kick when I needed it. I often reflect on our conversation at Innisfree and know I would not have completed this journey without you. Throughout my graduate career, you have shaped me as a scholar, pushed me to think deeper, and to consider multiple perspectives. In your *Feminist Theory* seminar, you provided a bit of 'sociological wisdom' that I constantly return to: learn to become comfortable in discomfort. I have come to experience sociology as something that builds our personal, professional, and collective capacities to hold complexity; and thus, being able to exist (at least somewhat comfortably) in discomfort is necessary for our abilities to persevere. Thank you.

Thank you to my dissertation committee members who generously shared their time, wisdom, and thoughtful advice. I am grateful for Dr. Stefanie Mollborn, ever a model of kindness and brilliance, for your unwavering faith in me and unflagging support. Your *Health Disparities* course has forever changed the way in which I examine the world around me. Thank you to Dr. Rachel Rinaldo for encouraging my growth as a feminist scholar and for your early, detailed reads of this work! I am so thankful for the questions you have asked and guidance you have provided. Thank you to Dr. Christiana Sue for your generous and considerate advice as you helped me to navigated challenges as a scholar and educator. You have deepened my sociological imagination and guided my professionalization. To Dr. Kimberly Kelly, I am so

deeply grateful for your compassionate feedback and support of my work. Our phone conversations were always enlightening, encouraging, and inspiring. It was an honor to have your insights help to guide this project; for your thorough review and advice for advancing my work; and for your gentle, firm critiques that pushed me to as a writer throughout this undertaking.

Additionally, I would like to thank the Sociology Department's office staff and Carrie Bagli, in particular. Carrie, thank you for your endless patience, extensive knowledge, and for always sharing your time. You and the other members of the office are the embodiment of grace as you keep the department running. To Moné and Thòng, your warm, early-morning welcomes always started my day off with a smile. Thank you for all the unseen labor you performed in the office.

The cohort of 2011 will always hold a special place in my heart. I am a proud and grateful colleague and I have relied upon each of you for guidance as we navigated this program together. A heartfelt thank you to my formal and informal advisors and writing partners in the department who helped to shape this work into something slightly less messy: Stephanie Bonnes, Amanda Barrientez, Elizabeth Bittel, Nikki Lambert, Jennifer Pace, Josh LaPree, and Cate Bowman. Thank you to Anjali, Ade, Phil, Kim, and Tracy for your academic support and friendship. Vanessa, you kept my spirit alive in so many ways. Thank you for nourishing me with homemade soups, German candies, and the best hugs. I would also like to acknowledge Alethea Tyler, whose enthusiasm and timely transcriptions, were a godessend.

Finally, thank you to the University of Colorado Boulder for the generous support of my scholarship. The Department of Sociology, the Beverly Sears Research Grant, and the Center to Advance Research and Teaching in the Social Sciences all helped to fund this project and were critical to the completion of this work.

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I. Introduction: Background and Focus

Pregnant? Scared? Overwhelmed? Often posing variations of these questions, pregnancy centers across the United States position themselves as caring resources that provide "life-affirming" help in what may otherwise be a frightening, lonely journey. Pregnancy centers—also known as Crisis Pregnancy Centers (CPCs), Pregnancy Resources Centers, Pregnancy Help Centers, Pregnancy Care Centers, and Pregnancy Medical Centers[1]—are non-profit, faith-based organizations created to provide free medical, material, emotional, and spiritual support to women making a decision about an unplanned pregnancy. Most pregnancy centers are evangelical Christian organizations and operate with the express intent to offer alternatives to abortion (Kelly 2012). Abortion continues to be understood and debated through religious frames (Avishai, Jafar, and Rinaldo 2015), and faith-based pregnancy centers represent the

[1] A brief note on terminology: In this dissertation I use the term "pregnancy center" in addition to "crisis pregnancy center" (CPC), the term preferred by most scholars. I choose to use "pregnancy center" for two reasons: (1) to reflect the preferred language of my participants; and (2) to reflect the language that *clients* are most likely to encounter in their search for pregnancy options. While this designation is used as a tool to distance centers from the negative accusations leveled against CPCs, it also reflects their internal dialogues. Staff report they consciously work to move women away from thinking about their pregnancy as a crisis and thus do not identify as *crisis* pregnancy centers. This mirrors advice provided by large networks, like Care Net. I think it is important to produce scholarship that reflects the lived realities of participants, but more importantly, I want to produce scholarship that uses the language and identifiers that clients are most likely to find when they search for pregnancy resources. When referring to the larger pregnancy center movement, I use both "pregnancy center movement" and crisis pregnancy center movement (CPC movement).

Additionally, the descriptor "pro-life" is incredibly political charged. The *Associated Press Stylebook* recommends instead the use of "antiabortion," as pro-life sets up an anti-life opponent. While I use both terms in this dissertation, I frequently use the term pro-life as it is the most commonly used, endemic descriptor.

Finally, it is important to acknowledge that not all pregnant people identify as women. While my sample includes one gender-fluid person, I typically refer to the pregnant people in this study as "women."

largest component of the United States' pro-life/antiabortion movement, outnumbering clinics that offer abortions 4 to 1 (Gaul and Bean 2018; Jones and Jerman 2017a).[2]

In a country in which nearly half of all pregnancies are unintended, in which unintended pregnancies are increasingly concentrated among low-income women, and in which 42% of those unintended pregnancies end in abortion (Finer and Zolna 2016), pregnancy centers hope to enable women to "choose life." In this way, pregnancy centers are part of the contentious public discourse surrounding abortion and, over the course of the past two decades, have been the site of increased public scrutiny, criticism, and legislative regulation. This visibility only heightened during my examination of Mountain Care and Urban Care,[3] two faith-based pregnancy centers situated in relatively liberal communities in the West.

I began my fieldwork in the summer of 2015, when the antiabortion Center for Medical Progress released surreptitiously recorded videos 'exposing' the practices of Planned Parenthood[4] and California passed the Reproductive FACT Act, which required pregnancy centers to disclose, in writing, information about their licensure and the availability of publicly-

[2] While there are approximately 1,700 abortion providers in the United States, clinics administer roughly 90 percent of all abortion procedures. In 2014, 788 clinics offered abortion services, though only 270 were abortion clinics (Jones and Jerman 2017a)

[3] I use pseudonyms for all people, organizations, and institutions in this dissertation.

[4] While the videos were intended to demonstrate that Planned Parenthood profits from the illegal sale of fetal tissue, an investigation by the US House of Representatives Oversight and Government Reform Committee found no evidence of wrongdoing (supported by the results of 12 state-initiated investigations).

funded abortion services.[5] These two events had my first fieldsite, Mountain Care, abuzz, as staff used each as a barometer for their work. At the national scale, these events laid the groundwork for abortion to become a vigorously debated topic in the presidential primary season leading up to the 2016 election. Later, abortion became a scapegoat, as liberal commentators blamed 'one-issue voters' for the election of Donald Trump.

As I continued my fieldwork, the summer of 2016 saw a landmark abortion decision. In June, the Supreme Court overturned Texas's House Bill 2 in *Whole Women's Health v. Hellerstedt*,[6] claiming this legislation created an undue burden for women seeking an abortion (Sanger 2017). Later that summer, individual states and cities began drafting highly contested legislation to regulate pregnancy centers. For example, Illinois Senate Bill 1564 amended the state's Health Care Right of Conscious Act. This bill required religiously affiliated healthcare providers to offer referrals and written information for all healthcare services, including those to which they object because of their religious beliefs. This required pregnancy centers to offer abortion referrals. Pregnancy centers in the state quickly sued and were granted temporary injunctive relief when the law came into effect, as they were not one of the groups named as plaintiffs in the initial case. Similarly, in 2017 Hawaii passed Senate Bill 501, requiring pregnancy centers to inform clients of the availability of abortion and funding for family

[5] According to the Harvard Law Review (2019): "In 2015, California passed the Reproductive Freedom, Accountability, Comprehensive Care, and Transparency Act (FACT Act). The Act required licensed facilities providing services including ultrasounds, contraception, pregnancy tests, and abortions to post notices informing patients of California's free and low-cost family planning services, prenatal care, and abortion. The notice could be "posted in a conspicuous place," printed and given to clients, or distributed digitally on arrival. Many unlicensed facilities providing ultrasounds, prenatal care, or pregnancy tests were required to disclose on-site and in advertising: "This facility is not licensed as a medical facility by the State of California and has no licensed medical provider who provides or directly supervises the provision of services." Both notices were required "in English and in the primary threshold languages for [state health care] beneficiaries as determined by the State Department of Health Care Services for the county.""

[6] *Whole Women's Health v. Hellerstedt* overturned Texas HB2 with required abortion providers to be licensed as ambulatory surgical centers and for physicians to have admitting privileges at a hospital within thirty miles.

planning services in the state. Then, just after I concluded my fieldwork, the Supreme Court decided another critical case. In June of 2018, *NIFLA v Becerra* overturned California's FACT Act, saying it amounted to compelled, commercial speech. This was widely heralded as a victory for pro-life pregnancy centers and laid the foundation for the repeal of other regulatory legislation that targeted pregnancy centers.

Within this timeframe, the public discourse surrounding pregnancy centers produced two dichotomous narratives. Supporters imparted glowing reviews that depicted pregnancy centers as stalwart advocates for women, important sources of care, and compassionate providers of free resources. Detractors presented a very different perspective, claiming pregnancy centers' deceptive, manipulative practices represented a threat to public health. These polarizing narratives are overly simplistic and I argue that pregnancy centers occupy a much more ambiguous space in women's reproductive healthcare. In this dissertation, I seek to add nuance to the public and scholarly conversations about pregnancy centers. Using observations from options counseling and ultrasound appointments, as well as data from interviews with staff and clients, I focus on the construction, performance, and receipt of care at Mountain Care and Urban Care. These two centers provide distinct models of care that reveal important frames through which staff negotiate their gendered, religious identities and provide the context through which to understand how clients experience pregnancy centers. I add to a growing body of literature examining CPCs by contributing the first empirical data documenting the exchanges that occur within appointments at pregnancy centers. I also seek to expand on the literature that explores women's participation in conservative religions. In examining how staff "live" their religion (Hall 1997), I use Orit Avishai's (2008) "doing religion" framework as a means to understand

staffs' narratives about and practice of "pro-woman care" as an intentional construction of identity. A significant portion of this identity work includes spiritual management in which staff consciously police the expression of their evangelism to effectively "minister" to women. Therefore, to illuminate the processes guiding staffs' identity work, I consider the ways in which Arlie Hochschild's (1979) concept of emotion work can be extended to include forms of moral management.

In this chapter, I first discuss pregnancy centers, situating them in the context of the broader pro-life movement. I then review the current scholarly literature on pregnancy centers, noting gaps that my research intends to fill. Next, I discuss the theoretical frameworks that undergird my work. Finally, I provide an overview of my dissertation.

II. Pregnancy Centers

A. Pregnancy Centers in the Pro-Life Movement

Studies of the pro-life movement have tended to focus on activism, highlighting male activists and fetus-centered politics that vilify abortion and the women who have them (Dworkin 1983; Ginsburg 1990, 1993, 1998; Jelen 1995; Petchesky 1987; Simonds 1996; Tan 2004). Scholarship has stressed the most radical elements and factions of the pro-life movement (Blanchard 1994; Diamond 1989; Ginsburg 1998; Maxwell and Jelen 1996; Youngman 2003), and thus produces an incomplete portrait of the pro-life movement as a whole. Today, the pro-life/antiabortion movement is a complex, multifaceted effort campaigning to reduce the number of abortions in the United States (Jacoby 1999; Luker 1984; Maxwell 2002).

While pro-life activism exists on a spectrum, Ziad Munson (2008) identifies four primary points of engagement: (1) political activism aimed at changing abortion laws; (2) direct action

aimed at healthcare providers; (3) education and outreach to shift public opinion; and (4) individual outreach to persuade pregnant women, themselves. These various streams rarely interact and are often critical of each other, yet each has changed the tenor of abortion conversations. Representing the individual outreach 'stream,' pregnancy centers comprise the oldest and most widespread pro-life campaign, encompassing more organizations and supporters than all other streams in the moment combined (Clowes n.d.; McIntire 2015; Munson 2008). While the movement's loudest voices tend to be street activists and legislative actors, Brian Clowes (n.d.) characterizes the pro-life movement's structure as an iceberg. The more visible components—protestors and lobbyists—are "the part of an iceberg you can see above the water," while pregnancy centers represent "the bulk of the iceberg below the surface, quietly doing their job behind the scenes, helping where it counts."

B. A Brief History of the CPC Movement

Conservative scholar Marvin Olasky (1992) locates the roots of the CPC movement in nineteenth century Christian programs and shelters for unmarried, pregnant women. These Christian social service agencies laid the foundation for the rise of modern crisis pregnancy centers in the late 1960s. In Hawaii, Robert Pearson founded the first dedicated, pro-life pregnancy center in 1967. The following year, Louise Summerhill established Birthright Pregnancy Center in Toronto—which would eventually grow into a large network of Catholic pregnancy centers in the United States (Clowes n.d.; Gaul and Bean 2018; Stacey 2015). These centers offered pregnancy tests and antiabortion counseling, largely in response to increasingly liberalized abortion laws (Chen 2013; Clowes n.d.; Stacey 2015). Throughout the late 1960s and early 1970s, the CPC movement was lead by Catholics. Catholic organizations formed

independent and church-based CPCs to "save and change lives" by offering pregnancy tests and counseling (Gaul and Bean 2018).

In the wake of the 1973 *Roe v. Wade* decision the movement began to coalesce. This landmark decision was by no means the start of pregnancy center activism but it marks a major shift in mobilization and the beginning of a more well-organized national movement (Luker 1984; Maxwell 2002; Munson 2008). In the late 1970s evangelical Christians began joining the movement en-masse, visibly bolstering its presence on the political landscape and shaping pro-life rhetoric (Gaul and Bean 2018; Maxwell 2002). In the 1990s three major evangelical pregnancy center "parent organizations"[7] emerged: Heartbeat International,[8] Care Net,[9] and the National Institute of Family and Life Advocates (NIFLA).[10] Heartbeat International and Care Net offer affiliates resources like counseling support and educational materials, while NIFLA primarily proffers legal support to pregnancy centers and facilitates centers' transitions to pro-life clinics (Gaul and Bean 2018). Beginning in the late 1990s, pregnancy centers began to adopt ultrasounds, prompting them as powerful tools in their ministry (NIFLA 2018).

The movement gained momentum under the George W. Bush Administration, which increased funding for abstinence-only education programs (Cohen 2015; Lin and Dailard 2002; Edsall 2006; Gibbs 2007; Hartshorn 2006; USHR 2004). *The Washington Post* estimates that in the early 2000s, sixty million dollars of federal grants went to pregnancy centers as part of abstinence-only education initiatives (Edsall 2006). Today, pregnancy centers continue to

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[7] Birthright International is another pregnancy center network, but primarily serves Catholic organizations.

[8] Formerly Alternatives to Abortion International founded in 1971; transitioned to Heartbeat International in 1992.

[9] Formerly the Christian Action Counsel founded in 1975; transitioned to Care Net in 1999.

[10] Established in 1993.

receive federal funding. Not only do they remain eligible for various federal grants, with the Trump Administration's recent changes to the Title X national family planning program, some crisis pregnancy centers have begun to successfully petition for Title X funding (Hasstedt 2019; Westwood 2019). In March of 2019, the Trump Administration awarded the Obria Group—a corporate chain of 21 pro-life pregnancy centers—$5.1 million in Title X family planning funds to be released over the course of three years (Obria 2019b; Vogel and Pear 2019). In addition, some pregnancy centers receive state funding. According to NARAL (2017) and the Guttmacher Institute (2019), 14 states directly fund pregnancy centers with taxpayer dollars. In 2018, these 14 states funneled roughly $40.5 million into pregnancy centers (Wilson 2018). Thirty-two states also make available "Choose Life" speciality license plates (Guttmacher 2019). In total, this program has raised over $26 million for CPCs (Choose Life America 2018).

C. Contemporary CPCs

The pregnancy center movement continues to grow and is working to change the face of healthcare. Centers are professionalizing, expanding their range of medical services, and forming corporate brands. Today, Mountain Care and Urban Care are among the estimated 2,750 pregnancy centers currently operating in the United States (Gaul and Bean 2018). Both of these non-profit centers are affiliated with evangelical 'umbrella organizations,' have intentionally cultivated professional offices, and offer a range of medical and material services. While both centers have distinct organizational cultures and offer divergent models of care, they are representative of the larger trends within the pregnancy center movement.

The pregnancy center movement is distinct from other pro-life movements in both its function and form. In this section, I discuss the ideal 'function' of the movement, before turning

to its feminized 'form.' Pregnancy centers focus on supporting pregnant women,[11] believing that with the proper material and emotional support women will "choose life." These community-based non-profits focus on individual women facing an unplanned pregnancy and offer free services like pregnancy tests, sonograms, options counseling, and material resources like diapers, wipes, and infant clothing (Kelly 2012; Munson 2008). With a positive pregnancy test, centers provide "pregnancy verification" forms, which can be used to help clients enroll in Medicaid and other governmental assistance programs, like SNAP and WIC. An increasing number of centers network with Christian adoption agencies and provide services like STI testing, some level of prenatal care, social service referrals, and parenting classes (Bryant and Swartz 2018; Fieldnotes 2017).

Pregnancy centers emphasize the importance of the ultrasound and increasing numbers of centers are adopting medical technologies. Some centers are not licensed medical providers, but an estimated 70 percent now provide ultrasounds and operate under the licensure of a physician (Gaul and Bean 2018; NIFLA 2018). However, pregnancy centers are not full spectrum healthcare providers. Because of their evangelical foundations, pregnancy centers do not offer contraception, abortions, or referrals for either. Instead, centers promote marriage as the family ideal, abstinence outside of marriage, and natural family planning within marriage (also known as fertility awareness or the 'rhythm method'). This religious orientation also means that in addition to seeking to intervene on pregnancy decisions, centers often frame their work through evangelical Christianity with the hope of converting clients (Kelly 2012). As Care Net (2018)

[11] Though throughout my fieldwork, I noted that services and campaigns targeting men became increasingly common. While this focus on men will likely expand, it takes a particular form in the CPC movement: men are positioned within the family and called upon to support women, fulfilling their roles as 'protectors,' 'breadwinners' and 'fathers.' Additionally, at both Urban Care and Mountain Care, men's emotions were centered and both men and women were understood to be "traumatized" by abortion.

explains, adding a religious component of care offers whole-person help and "these spiritual conversions can be key to helping a client truly transform their lives for the better." While some organizations openly declare their religious orientation, others have been accused of deceiving clients about their evangelical mission (Arthur et al. 2016; Rosen 2012). In sum, pregnancy centers aim to provide "life affirming" support to women experiencing unplanned pregnancies by offering medical services, options counseling, spiritual guidance, and material resources.

The movement not only functions to support women, its form is also uniquely feminized. At the organizational level, pregnancy centers are directed and staffed primarily by women, while being supported by an extensive network of female volunteers (Kelly 2012; Muson 2008). Women's leadership at the moment level has uniquely shaped the messaging of pregnancy centers. The CPC movement represents the "softer side" of the pro-life/antiabortion movement (Cannold 2002). Pregnancy centers frequently speak of changing hearts, rather than minds; and focus on cultivating a compassionate emotional context that derides graphic images and violent protests (Cannold 2002; Gibbs 2007). In emphasizing emotions, pregnancy centers frequently employ the language of "empowerment" and "choice" to describe their work. In a typical example, Care Net, a large network with which both Mountain Care and Urban Care are affiliated, explains that pregnancy centers seek to create "a culture where women and men faced with pregnancy decisions are transformed by the gospel of Jesus Christ and empowered to choose life for their unborn children and abundant life for their families" (Care Net 2019). The discourse of "empowerment" and "choice" aligns well with the movement's feminized image, reflects its evangelical roots, and represents an attempt to stay relevant amongst generations that are increasingly concerned with social justice. These narratives imply that women who choose

abortion are disempowered and suggest that the only reason women would want to terminate is because they do not feel supported in pregnancy or motherhood. In usurping pro-choice rhetoric, they position themselves as the more supportive advocates for women and organization that can offer 'choice' rather than options.

The appeal of this approach is evident: the CPC movement includes more organizations, activists, and volunteer hours than all other pro-life movements combined (Munson 2008). Today roughly 2,750 centers are supported by 67,400 volunteers, including 7,500 medical professionals who donate approximately 400,100 hours of sonogram service (Gaul and Bean 2018). This extensive support of CPCs has moderated and shifted the discourse in the broader pro-life movement to include a greater focus on women (Kelly 2009). Yet, despite their prominence within and effect on the pro-life movement, their long histories, strong base of supporters, and ubiquitous presence across the United States, there is a sparse scholarly record on pregnancy centers (Kelly 2012; Kimport et al. 2016; Munson 2008).

III. Research on Pregnancy Centers

As research emerges, a more full portrait of pregnancy centers is developing. Prior work has shed light on the history of crisis pregnancy centers as a distinct pro-life social movement (Kelly 2009, 2012; Munson 2008) and provides compelling analyses of movement strategies and activist motivations (Hussey 2013, 2014; Kelly 2012; Kelly 2014a, 2014b). Together, this body of work depicts the CPC movement as a discrete portion of the larger pro-life movement, a space for uniquely gendered activism, and reliant upon individual, interpersonal intervention strategies. Laura Hussey (2014) and Ziad Munson (2008) show how activists depict their approach, which focuses on women, as apolitical, 'softer,' and more practical than other pro-life strategies.

Building on this analysis, Kimberly Kelly (2012) argues that female evangelical activists capitalize on gender essentialism to legitimize their authority and strategies within pro-life activism. This research provides vital empirical data about pregnancy centers from a social movement perspective, helps to situate pregnancy centers amidst the larger antiabortion movement, and highlights how gender structures this religious movement.

In narrowing the scope of analysis to individual centers, other scholarship has reviewed the accuracy of medical information provided by pregnancy center websites (Bryant and Levi 2012; Bryant et al 2014; Bryant-Comstock et al. 2016) and assessed the counsel disseminated in-person and over the phone through a "secret shopper" approach (Bryant and Levi 2012). These studies have found that many centers provide medically inaccurate and misleading information to the women they serve and support the findings of congressional reports, pro-choice organizations, and popular media sources.[12] In documenting the dissemination of specious medical information, these studies argue that pregnancy centers may represent a threat to women's and adolescents' reproductive decision-making. Yet, pregnancy centers typically lack regulatory oversight. Because some centers are not licensed as medical practices and because most are often exempted from state regulations that apply to commercial enterprises, their practices fall under the classification of free speech (Bryant and Swartz 2018).

Recently, scholarly attention has turned to an examination of clients as a means to assess pregnancy centers' impact on pregnant women's experiences. Due to the difficulty of gaining research entrée, little is known about client motivations, experiences, and outcomes at faith-based pregnancy centers. A study investigating the intake records of a secular, "all-options"

[12] See for example: Gibbs 2007; McIntire 2015; USHR 2006; Winter 2015a, 2015b, 2015c.

pregnancy resource center in the midwest found that most clients sought parenting resources rather than pregnancy guidance (Kimport, Dockray, and Dodson 2016). While these findings cannot be extended to explicitly antiabortion or faith-based centers, it is likely that this center shares with CPCs a similar client base and that these data begin to shed light on client needs and motivations.

Additionally, Kimport, Kritz, and Roberts (2018) found that in southern Louisiana women experiencing a pregnancy rarely sought services at a CPC. In a survey of patients at an abortion clinic and three prenatal clinics, only six percent of their sample reported having visited a CPC for their current pregnancy. Those that did, explained that they used the CPC to obtain a free pregnancy test. In addition, many recognized the CPC as an antiabortion, Christian establishment, though, these clients reported positive experiences at the CPC. The researchers concluded that CPCs are not intervening in women's pregnancy decisions. These interpretations align well with Kimberly Kelly's (2014a) analysis of the CPC movement's lack of success in "preventing abortion, promoting traditional gender roles and families, and converting clients to evangelical Christianity" (420). However, Kelly argues this lack of efficacy is actually important to inspiring and reinforcing engagement in the movement, as an evangelical 'underdog' mentality prompts a sense of urgency to mobilize. In this way, Kimport et al.'s (2018) findings that report centers are not reaching many pregnant women, may also serve as motivation for increasing their efforts.

While there is little scholarly evidence of their efficacy, pregnancy centers boldly claim a broad reach. The conservative, pro-life Charlotte Lozier Institute collaborated with Care Net, NIFLA, and Heartbeat International to survey pregnancy centers across the United States. They

report that in 2017, pregnancy centers served two million clients and offered 679,600 pregnancy tests (Gaul and Bean 2018). According to Finer and Zolna (2016), in 2011 roughly 2.8 million pregnancies were unintended, meaning pregnancy centers are claiming to serve almost a quarter of women experiencing unplanned pregnancies in the United States. Furthermore, pregnancy centers claim to be effective. Care Net (2018), one of three major pregnancy center networks with 1,100 affiliated centers, asserts:

> After visiting a Care Net affiliate, 80% of women considering abortion choose life. In 2017 alone, Care Net-affiliated pregnancy centers saved 73,774 unborn lives! During the past ten years, 677,248 unborn children were saved from abortion…[and centers] provided more than one million free ultrasounds and 2.8 million free pregnancy tests.

While Care Net does not provide access to its data, nor any methodological discussion, these are statistics frequently cited at conferences, fundraisers, and boasted about on websites. These competing claims and the stigma surrounding unplanned pregnancy and abortion make it difficult to ascertain pregnancy centers' direct effect on client's decision-making.

More evident are the ways in which the CPC movement shapes public and political discourse about abortion. The movement is responsible for introducing and disseminating stigmatizing narratives about "post-abortion syndrome" that have been translated into state and federal policies regulating abortion (Kelly 2014b). These movement-level discourses are reproduced in interpersonal interactions within the pregnancy center context (Kimport 2019). Using 25 in-depth interviews with clients who visited a CPC, Katrina Kimport (2019) argues that CPC staff perpetuate medically inaccurate myths portraying abortion as dangerous and affirm parenting, often through a biblical framework. Yet she finds exposure to these discourses, alone, was not enough to produce internalized stigma. Counselors' actions and claims operated in interaction with clients' stated pregnancy intentions, their preexisting beliefs about abortion, and

their level of education to produce different outcomes: perpetuating abortion stigma, *de*-stigmatizing abortion, or resisting stigmatizing narratives. This important research highlights the significance of social context in evaluating pregnancy centers' efficacy, yet relies solely upon self-reported experiences that may be subject to recall bias.

This body of research yields important data and contributes invaluable sociological insights into the role and function of pregnancy centers at the movement level and individual level. In particular, the work of Kelly (2012, 2014a, 2014b), and Munson (2008), reveal that these religious social movements cannot be understood without careful attention to the ways in which gender structures forms of activism. Therefore, gender and religion need to be a central categories of analysis at multiple levels in order to accurately assess pregnancy centers. Additionally, research has begun to shed light on the client experience, noting that pregnancy centers may not be very effective in reducing the number of abortions or reaching women considering abortion (Kelly 2014a; Kimport et al. 2018; Kimport 2019). At the same time, this body of literature includes notable gaps. Importantly, little is known about the interpersonal dynamics within centers and specifically, between staff and clients. Previous research has not explored how staff construct and preform care within the pregnancy center context. Similarly, outside of Kimport's (2019) work, little is known about how clients receive and experience care. My study seeks to build on this work and to contribute empirical data illuminating the context, form, delivery, and influence of pregnancy-related care in two pregnancy centers.

The primary purpose of this dissertation is to use an ethnographic approach to examine the cultures of care within two pregnancy centers and to explore how both staff and clients experience CPC care. My research presents the first ethnographic data and scholarly analysis of

client appointments in faith-based, "life-affirming" pregnancy centers. Through observations and in-depth interviews with both clients and staff, this dissertation seeks to clarify how staffs' gendered, religious identities are negotiated in client care at two pregnancy centers in a politically liberal context. In particular, this study examines how pro-life staff in faith-based organizations attempt to manage the expression of their religious ideology in order to perform what they characterize as "pro-choice work." This analysis is paired with a consideration of the client experience at Mountain Care and Urban Care. Previous scholarship has only examined staff narratives and client experiences in isolation. My analysis bridges staff narratives, their performances of care, and client experiences. In this study, I provide new empirical data that adds nuance to the understanding of the exchanges that occur within the walls of a pregnancy center.

In this dissertation, I examine two pregnancy centers at the organizational, interactional, and individual level. I analyze the ways in which organizational narratives influence how staff understand and perform care in these pregnancy centers, thus providing the context through which to better grasp client experiences. In this way, both narratives and performance are central to staffs' gendered, religious identities. I treat gender as an identity that is constantly constructed through interactions and a structure that creates meanings and expectations at the individual, interactional, and organizational levels (Risman 2004). Thus, I focus heavily on the ways in which staffs' identities are negotiated within a gendered, religious organization and frame my study in identity theory. Below I review significant contributions to the sociological understanding of identity formation, with a particular focus on identity work; emotions; and gendered, religious identities.

IV. Theoretical Framework

A. Identity Theory

Grounded in symbolic interactionism, identity theory examines the meanings people attach to the multiple roles they perform in society (Stryker and Burke 2000; Stryker and Serpe 1982). Identity theory holds that individuals have access to a variety of identities, though these identities hold different meanings and relevancy in different situations. Snow and Anderson (1987) distinguish between social identities, personal identities, and self concept. Social identities refer to designations ascribed to 'others' that situate them as social objects, whereas personal identities are self-designations. In contrast, one's self-concept denotes what a person holds to be true about themselves. The authors explain personal identities can reveal the (in)consistency between social identities and self concept (Snow and Anderson 1987).

In studying the relationship between the multitude of social and personal identities, research has produced two interrelated theoretical orientations. The first, a structural approach, examines the relationships between identities and larger social structures (Stryker 1980; Stryker and Serpe 1982); and the second, a cognitive approach, focuses on the various internal dynamics of identity formation (Burke 1991; Burke and Stets 1999; Stets and Burke 2000). Yet, as Stryker and Burke (2000) explain, these two 'strands' of theory are inextricably intertwined as "the relation of social structures to identities influence the process of self-verification, while the process of self-verification creates and sustains social structures" (284). In this way, social and personal identities are *both* collective and internal; they are embedded in social context and are internalized cognitive schemas. In other words, the concept of identity links the self and society.

Yet, identity is not a stable, fixed concept, nor are all identities equally meaningful. Identities exist within a salience hierarchy that is a result of the interplay between social context and internalized meanings (Stryker and Serpe 1982). Social structures provide identity roles (Stryker 1980; Stryker and Serpe 1982), while internalized self-meanings help to give certain identities salience (Stryker 1968). Identity salience reflects the probability that an identity will be invoked across situations or across individuals in a particular situation (Stryker and Burke 2000; Stryker and Serpe 1982). Individuals' behaviors are ultimately shaped by how their salient identities interact in various situations, in interpersonal interactions, and with their other personal characteristics (Schwalbe and Mason-Schrock 1996; Stets 2005; Stryker and Serpe 1982). In other words, salience is shaped by social structure, interactions, and internal processes. In the pregnancy center context, gender and religion emerge and intertwine as the most salient identities for staff.

Identity formation is linked across all levels of human social life. Scholarship has explored how identities are produced at the macro-level of cultures and institutions (DiMaggio 1997), the meso-level of organizations (Alexander 1992; Gubrium and Holstein 2001; Schneider and Ingram 1993), and the micro-level of personal identity (Gergen 1994). In this dissertation, I am primarily interested in how organizations influence processes of personal identity construction because, as Gubrium and Holstein (2001) assert, organizations are "explicitly in the business of structuring and reconfiguring personal identity" (2). More specifically, I examine how pregnancy centers 'translate' components of institutional identities (gender and religion) into personal identities. Therefore, I explore the ways in which organizational narratives reflect and repudiate institutional narratives about gender and religion to structure staffs' personal

identities in the pregnancy center context. Additionally, I analyze how staff construct, negotiate, and utilize salient identities to maintain a stable sense of self amidst the sometimes contradictory aspects of their work. In doing so, I understand identity formation as part of an ongoing, iterative process produced through interpersonal interactions that occur within a particular social and emotional context (Schwalbe and Mason-Schrock 1996). My work is thus framed by concepts of identity work, emotion work, and the production of gendered and religious identities.

1. Identity Work

Identities define, locate, and differentiate the self, ultimately contributing to a stable self-concept, or what a person holds to be true about themselves (Charmez 1994; Turner 1976). Yet, identities are actively and constantly constructed, a type of 'work' one does to maintain a sense of meaning and self worth. Identity work refers to the range of narratives and performances in which individuals engage to construct, present, maintain, or repair personal identities in ways that are congruent with their self-concept (Snow and Anderson 1987).

In examining narratives, individuals craft identities and a sense of self through the stories they tell about themselves (Irvine 1999). Narratives express and establish identities for the self and other (Bruner 1990; McAdams 1996), and in this way become verbal and interactional assertions, amendments, or alterations to current identities (Ibarra 1999; Kreiner et al. 2006; Pratt et al. 2006). Narratives can also express and accomplish identity goals and aspirations for a future self (Ibarra and Barbulescu 2010). In constructing both a present and future self, narratives are the 'work' individuals do to establish themselves. Narratives are dynamic stories of experiences, feelings, hopes, memories, and imagined futures that articulate a sense of self (McCarthy et al. 2000; Polletta et al. 2011). At the same time, narratives are constrained by

larger social structures and cultural context, and thus can become powerful windows through which to examine inequalities and social stratification (Loseke 2007; Pugh 2013).

The interplay between agency and structure in narrative identity work is particularly apparent in examinations of stigmatized social identities (Goffman 1963; Snow and Anderson 1987) and in work that examines the loss of function, attributes, or social roles (Charmez 1994). For example, Snow and Anderson (1987) explain how identity 'talk' is the primary avenue through which the homeless population generates, asserts, and sustains personal identities in the face of an imposed stigmatized social identity. These 'identity dilemmas' present threats to a sense of self and often reveal implicit inequalities in society, highlighting how those with power can leverage identities to maintain their favorable position in a social hierarchy (Cast 2003; Schwalbe et al. 2000). Successfully negotiating these dilemmas enables the maintenance of a positive internal identity, sometimes congruent with a positive external identity and, at other times, incongruent with a negative social identity (Irvine 1999; Snow and Anderson 1987; Vinitzky−Seroussi and Zussman 1996). Herein, constructed narratives serve a dual purpose: to present an intentional, curated identity to others, while providing meaning, maintaining, and restoring a favorable sense of self (Irvine 1999). This becomes particularly relevant in the pregnancy center context as staff construct particular narratives around abortion and the women who have abortions. As McAdams (1995) claims, narratives may very well "be *the* way through which human beings make sense of their own lives and the lives of others" (207, emphasis in original).

Though narratives are by no means the only way in which individuals construct and perform identities; and in addition to the discursive, the material needs also be considered.

Identity work simultaneously involves the intentional employment of the material: signifiers, strategies, and bodily comportment. These performances evoke and confirm meanings about the self for the self and others (Schwalbe and Mason-Schrock 1996). Holland and colleagues (1998) assert that behaviors actively construct meaningful identities within the frames of meaning provided by cultural context—context matters. In this way, scholars highlight the ways in which gendered, sexual, religious, and racial identities (among others) are performed in context, as evidenced through tastes, beliefs, language, skills, rituals, and embodiment (Alexander 2006; Avishi 2008; Beauboeuf-Lafontant 2009; Butler 1988, 1990, 1999; Griffith 1997; Tehranian 2000; Warren 2001; Young 1980). These performances serve as symbolic resources employed in identity construction and are frequently used in conjunction with narratives. For example, Kathy Charmez (1994) explores how chronically ill men relied upon both narratives and performances to reassert and preserve their masculinity. In addition to narratively reframing their condition, some chronically ill men carefully controlled how they performed work and meticulously hid signs of their illness to maintain a masculine sense of self and avoid a stigmatized identity. Examining identity as, in part, a performance locates it in acts or practices, rather than merely in consciousness and non-material social facts.

In this dissertation, I examine both the identity narratives employed by staff as well as how they perform care as a means of managing their identities. The construction of the self is important to both staff and the cultures of care created in pregnancy centers. This identity work is laden with emotions and staffs' roles in the pregnancy center require a great deal of emotional labor (Hochschild 1979). Therefore, understanding the relationships between narratives, performances, and emotions is crucial to understanding staffs' identity projects.

2. Identities and Emotions

Central to the examination of narrative and performative constructions of identity are emotions (Pugh 2013, Illouz 2008). Contrary to the assumption that emotions are 'natural,' biological human responses, emotions are socially constructed and understood to be, in part, symbolic actions or social performances that involve both cognitive and physical processes (Averill 1986; Gordon 1981; Hochschild 1983; Loseke and Kusenbach 2008; Sharp and Kidder 2013; Thoits 1989). As Schwalbe and colleagues (2000) explain, the way we feel about things is largely dependent on the meanings we learn to give to those things. Thus, emotions play a critical role in the reflexive and interactional construction of the self (Denzin 1985; Dilorio and Nusbaumer 1993; Stets and Carter 2012).

Emotions are described as "language forms" for how they communicate and 'signal' components of identity and society (Perinbanayagam 1992). Individuals are socialized into emotion cultures that rely upon a shared understanding of feelings and provide 'rules' about how to name, manage, experience, and express them appropriately (Gordon 1981; Hochschild 1979; 1990, 2003). "Feeling rules" guide affect while "display rules" guide the expression of emotions (Hochschild 1979; 1990, 2003). In this way, narratives are shaped and constrained by the emotions individuals think they should feel and display. Yet, often there are discrepancies between internal feelings and external expectations, or between the emotions one is feeling and what they believe they should be feeling. These discrepancies can result in negative self evaluations and negative emotions, particularly if they represent a violation of an intimate, group-based identity (I am a particular kind of person) rather than a less intimate role-based identity (I perform these roles) (Burke 1991; Burke and Stets 1999; Stets and Tushima 2001). In

this way, individuals engage in emotion work to suppress or alter emotions deemed inappropriate and to maintain a consistent sense of self. In sum, emotion work describes the internal process of altering feelings or emotions to better align with the feeling rules and display rules of a particular situation (Hochschild 2003). Doing pregnancy center work requires staff to perform emotional labor. In doing this work, staff often negotiate conflicting aspects of their identities to maintain a moral sense of self. I explore these processes within this dissertation and focus on how staff construct moral selves and manage their emotions and spirituality as part of their gendered, religious identity projects.

3. Gendered, Religious Identities

The primary identity project I explore in this dissertation surrounds staffs' gendered, religious identities. Staffs' conservative religious identities cannot be understood outside of their position as women, and the staff in both pregnancy centers were subject to socialization that was simultaneously gendered and religious as they learned how to become "ministers" of "pro-woman care." Sociologists have long advanced theories about gender and religion, and beginning in the 1970s feminist scholars began to develop critical gendered analyses of religion (Daly 1973; 1975; Ruther 1975). Expanding upon studies that examine why women express more religious commitment or how women may be oppressed in patriarchal religions, contemporary scholars have turned toward an examination of the more complex ways in which women negotiate gender in their religious practice and an understanding of gender as a structure rather than a variable (Avishai, Jafar, and Rinaldo 2015). In this way, my dissertation is framed by theories which see both gender and religion as socially constructed identities into which individuals are socialized. Individuals learn to "do gender" and "do religion" (Avishai 2008;

West and Zimmerman 1987). Below, I briefly outline key sociological perspectives on gendered identity construction before summarizing key ways in which scholars have examined women's religious participation as an identity expression.

Rejecting biological determinism, sociologists examine the varied ways in which gendered identities are constructed and how individuals are socialized into largely dichotomous, 'traditional' gender roles, typically based on their biological sex. Gender socialization begins before birth (Smith 2005) and continues throughout the life-course via a variety of agents of socialization (Carter 2014). This line of inquiry reveals how gender is implicated in social processes, practices, organizations, and institutions; and how one learns to do gender in interactions that signal the practices, stylings, talk, and acts appropriate to men or women (West and Zimmerman 1987). Rather than something that exists within individuals, gender is a phenomenon that is externally produced and reproduced by social processes and performances (Butler 1999) and is a form of 'social embodiment' (Connell 2001). In this way, gender is both bodily and social. Importantly, context shapes how gender is invoked (Connell 1995) and gender intersects with multiple other identities to profoundly influence one's gendered beliefs and gendered experiences (Collins 1990; 2000). This approach treats gender as dynamic and constituted in relation to other identities and structures (Choo and Ferree 2010; Collins 1990; McCall 2005). In this study, I examine how conservative religious identification intertwines with gender in the pregnancy center context. Following the call of scholars like David Hall (1997), Robert Orsi (1997), and Mary Jo Neitz (2004), I consider the ways in which narratives become lived practices of a religious identity.

Early feminist examinations of religion concentrated on exploring how the explicit and implicit gendered messages in scripture that shaped women's subordination (Daly 1973, 1975, 1982, 1986; Ruther 1975, 1983) and others identified the ways in which conservative religions proffer patriarchal gender ideologies (Afary 1997; Braude 2004; Epstein 2007; Gallagher 2003; Ross 1991). Scholarship shows how, in these patriarchal renderings, gender is understood to be binary, biological, and immutable. Furthermore, the 'natural' differences between men and women give them different roles in the family; ideally, men are the breadwinning family-head, while women maintain the domestic household (Gallegher and Smith 1999). Scholarship has thus attempted to explain women's participation and commitment to seemingly oppressive religious ideologies (Davidman 1991, 2003; Jacobs 2002; Isasi-Díaz and Toaragno 1988; Manning 1999; Rodriguez 1994; Woodhead 2008). Emerging from this effort is a complex portrayal of gendered, religious power structures and how gendered identities are reproduced or challenged in the context of religious communities and practices. In particular, scholarship has moved away from conceptualizing religious identity merely in terms of belief to also consider practice, demonstrating the ways in which religious identities are revealed in both what people say and what people do. This focus on practice is important as "proclaiming particular beliefs does not constitute religious identity for Catholics and Jews in the way that it does for Protestants" and that religious "practices are more likely than beliefs to be gendered in observable ways" (Neitz 2004, 399-400).

In this way, scholars have examined the ways in which religious identities are constructed outside of the beliefs proffered by religious institutions and the ways in which practices reveal important gendered dynamics within religion. For example, Janet Jacobs (2002) and Lynn

Davidman (2003) examine how Jewish identities are constructed in powerful ways outside of synagogues. In research that examines evangelical women's role in the family, scholars have noted a discrepancy between ideology and practice, finding that conservative gendered beliefs are not always observed in daily life (Bartkowski 2000, 2001; Edgell 2005; Gallager 2003; Gallagher and Smith 1999; Manning 1999). In studying heterosexual, evangelical couples, Sally Gallagher and Christian Smith (1999) refer to this as "symbolic traditionalism and pragmatic egalitarianism." The authors argue that couples' traditional attitudes towards gender roles prop up hegemonic masculinity, but are largely a symbolic means by which to maintain a distinct evangelical identity. In their actual family practices, couples were much more egalitarian.

Women are no longer understood to be passive victims to conservative religious ideology. Instead, scholarship has highlighted women's agency and demonstrates the ways in which women use religious practices and reinterpretations of religious narratives to resolve issues of modernity and identity (Brasher 1998; Davidman 1991; Göle 1996; Griffith 1997; Jacobs 2002; Stacey and Gerard 1990). For example, Nilüfer Göle (1996) examines modernity and gendered religious practice in the veiling movement in Turkey. Göle argues Muslim women assert a modern identity and practice agency by choosing to veil and use it as a visible, public symbol of their faithful identities. In examining contemporary evangelical women, Marie Griffith (1997) shows the way in which women utilize prayer as a means for grappling with the anxieties of modern womanhood. She argues evangelical women reimagine relationships with God to come to terms with the suffering they encounter in life and the dysfunction and lack of intimacy experienced in their interpersonal relationships. Griffith and other scholars have noted that the rise of 'biblical feminists' in the evangelical tradition have challenged patriarchal interpretations

of wifely submission, contending that the Bible mandates "mutual submission" within marriage (Bartkowski 2001). As a whole, this body of work moves away from understanding women as complaint 'doormats' (Stacey and Gerard 1990) and instead explores the ways in which women strategically or subversively negotiate the boundaries and dictates of conservative faith traditions to meet the practical demands of everyday life (Aune 2008, 2015; Bartkowski and Read 2003; Brusco 1995; Chen 2005; Gallagher 2003, 2004). By focusing on gender and the discrepancies between ideology and practice, this scholarship has illuminated the complicated ways in which conservative religions are sites of gender negotiation for women.

Other scholars have examined how women are neither compliant or strategic in their religious practices. Kelly Chong (2006) demonstrates that Korean evangelical women can simultaneously draw upon conservative evangelism as a source of comfort while reinforcing patriarchal norms. Orit Avishai (2008) blends agency and complicity by arguing Orthodox Jewish women "do religion" in order to achieve a religious identity. Avishai contends women express agency as they comply with, rather than challenge, strict religious norms. In both Avishai and Chong's work, women experience some ambivalence around patriarchal systems, but also reaffirm their identities in a larger community and in the family. As Chong (2006) explains, Korean women's attraction to evangelicalism is rooted in part to their attachment to the family system to which they feel a deep sense of moral obligation and which, "despite its oppressiveness, still offers women the best form of security required in a rapidly changing world" (719). In this way, evangelicalism serves to maintain an oppressive gender order by providing women a socially acceptable means to grapple with their oppression and internal ambivalence, while continuing to 'redomesticate' them within the family. Both Chong and

Avishai, characterize women's religious participation as a complex response to multiple, conflicting gendered desires.

In addition to examining gendered identity negotiations in the private and nonsecular spheres, some scholars have moved to consider gendered religious roles in the public sphere. In particular, research has explored women's role in religious movements (Kelly 2012; Mahmood 2005; Moghadam 2012; Rinaldo 2008). Especially relevant to this study are Kelly's (2012) insights from her examination of gender in the evangelical CPC movement. The CPC movement is unique among evangelical social movements in the acceptance of female leadership and authority. Yet, this acceptance is not without ambivalence and women rely upon conservative gender ideologies to legitimize their positions in this movement. In this way, Kelly argues that seemingly repressive religious traditions can also provide women the means by which to define and lead evangelical pro-life activism.

In this dissertation, I use Kelly's initial framing, to explore the processes by which women negotiate their gendered, religions identities within centers and through interactions with clients. Kelly (2012) explores how women shape the frames of the CPC movement, but also how individual staff in local projects reject movement rhetoric surrounding adoption, marriage, and the role of men. The findings I present in this project support and extend Kelly's work to consider the ways in which staff renegotiate evangelism in their work. This allows for the examination of how evangelical Christianity is reimagined through organizational narratives of "pro-woman ministry" and is iterated through client care. I show how this informs staffs' identity projects and reveal the ways in which staff "live" their religion through interactions with clients (Hall 1997). For staff, performing care through everyday bodily and emotional practices

become a means by which they express and experience the sacred. Lived religion is a useful concept to understand staffs' conception of care as ministry because it distinguishes "the actual experience of religious persons from the prescribed religion of institutionally defined beliefs and practices" (McGuire 2008, 2). My analysis of client appointments calls attention to the way in which staffs' practices align with and diverge from institutional prescriptions. Staff "do religion" through doing care and "do religion" differently through the construction of a feminized evangelism. In this way, staffs' practices cannot be reduced to 'compliant' or 'subversive.' In showing how staff define evangelism in the pregnancy center context, I contribute to the nuanced analyses extended by previous scholarship examining women's religious identities.

V. Dissertation Overview

In this chapter, I have provided an overview of pregnancy centers and reviewed the extant scholarly research examining CPCs. I have noted gaps in the research and highlighted the contributions of my own study. In addition, I have discussed how identity theory frames my approach to this dissertation and highlighted scholarship on gendered, religious identities. In the following chapter, I describe my study design, fieldsites, data collection, and analysis. Additionally, I discuss my positionality, ethical considerations, and the limitations of my research.

I examine narratives in Chapters 3 and 4. Chapter Three focuses on organizational narratives about abortion, clients, and care. These narratives are central to the construction of pregnancy center work as a 'ministry' and provide the basis for understanding staffs' gendered, religious identities. These organizational frames are willingly adopted and repeated by staff, but they do not always map neatly upon their passionate, pro-life worldview. In Chapter Four, I

discuss how pregnancy centers work to 'reposition hearts.' I rely upon both scripting theory and the concept of emotional labor to highlight how Mountain Care and Urban Care employ a *pro-woman care script* that guides how staff think and feel about their work, clients, abortion, and appropriate religious expression. I argue this common script is central to how staff negotiate their gendered, religious identities.

In Chapters 5 and 6, I analyze how staff perform care in "easy" and "difficult" appointments. In these chapters, I illuminate the process whereby identity 'talk' is translated into the performance of caring actions. Mountain Care and Urban Care present two distinct models of care; while there are important similarities between these centers, I explore how these two models produce fundamentally different cultures of care. Chapter Five examines Mountain Care's "medical model of care" which centers around the ultrasound. I review the history of ultrasounds in the pregnancy center movement and show how the *pro-woman care script* guides the performance of ultrasound care. I argue that through the heavily guided ultrasounds at Mountain Care staff perform their religious identities and construct a particular experience of pregnancy. In Chapter Six, I explore how Urban Care's "social work model of care" is structured to facilitate moral reflection in clients. At Urban Care counseling is the focal point of client appointments and staff enact gendered, religious identities through narrative therapy techniques that frame what staff deem to be appropriate emotional reflection. In both Chapter 5 and 6, I argue that these performances enable staff to understand themselves as good, moral Christian women.

In Chapter Seven I offer my concluding thoughts on this project. In this chapter, I put my two fieldsites 'in-conversation' with each other and discuss some of the key findings and

contributions of my work. I end this dissertation by outlining potential directions for future research.

Chapter 2: Methods, Data Collection, and Analysis

I. Methodological Approach

A. Ethnography

In this project, feminist ethnographic methods reveal a rich portrait of the cultures of care within two pregnancy centers and of the women who work and seek services there. As an ethnographer, I seek to understand how the women I study create meaning in their lives. Thus, I practiced "firsthand participation in some initially unfamiliar social word" in order to produce an account of staff and client experiences in pregnancy centers (Emerson, Fretz, and Shaw 1995). In paying careful attention to how staff in pregnancy centers make sense of and give meaning to their work, interact with each other and clients, and negotiate their identities, I work to uncover the processes whereby staff and clients construct "webs of meaning" that produce their lived experiences (Geertz 1973). In doing so, I work to situate "people in place" and to understand the experiences of individuals within a specific social context (Zussman 2004).

Qualitative methods are particularly well-suited for documenting the nuances of experiences through the use of thick description to vividly document social relations in practice. In this dissertation project, I employed a qualitative method which utilized an inductive approach, purposive sampling, and the use of memos and matrices to focus my analytic attention during research and writing (Miles, Huberman, and Saldaña 1994). I used participant observation and in-depth interviews to produce data revealing how staff and clients construct meaning. Additionally, I drew upon textual analysis of internal documents and pamphlets intended for a public audience. I situated my analysis within preexisting theoretical frameworks (Burawoy 1998) and contextualized participant accounts within larger structural forces. In this

way, I build on existing theoretical concepts and frames—like Hochschild's emotional labor and Avishai's doing religion—to further develop an understanding of the social word.

B. Critical Feminist Perspective

The ethnographic approach I use in this research is distinctly shaped by feminist epistemologies. Feminist analyses have insisted upon "the significance and particularity of the context of theory" (Alcoff and Potter 2013) which has lead feminist theorists to understand knowledge claims as "situated" (Haraway 1988), partial (Clifford 1986), and derived from a "positioned subjectivity" (Meadow 2013). The data and analysis presented in these pages is particular to a specific context and is filtered through my own positionality. As such, my research adds another chapter to a constantly evolving book of knowledge.

As a feminist concerned with issues of inequality, throughout my data collection and analysis I paid "particular attention to the interplay between gender and other forms of power and difference" (Hesse-Biber and Leavy 2007: 192). As Brooke Ackerly and Jaquie True (2010) explain, a feminist research ethic privileges an attentiveness to the power of epistemology, boundaries, relationships, and the researcher's own positionality throughout the research process. This research is informed by five guiding principles of feminist methodologies. First, I attempt to ground my analysis in women's lived experiences (Ramazanoglu and Holland 2002). Second, I strive to truthfully represent the diversity of women's experiences within pregnancy centers. Third, I endeavored to engage with participants respectfully, honestly, and empathetically. Within this approach, I shared information about the research process and findings with my participants (Reinharz and Davidman 1992), and solicited the feedback of the staff at Urban Care

to validate my analysis.[13] Fourth, throughout the research process I was attentive to relationships and their power differentials—including between participants and myself—in order to reflexively reflect on how these relationships have effected both process and findings (Ackerly and True 2010). Finally, this research, in addition to contributing to academic knowledge, is driven by a desire to support the development of a more socially just world (Ackerly and True 2010; DeVault 1996). As such, this research is informed by my own values. I believe that women's reproductive health is of great individual and social significance—an embodied issue that has implications for knowledge, healthcare, and democracy. As I use a gendered lens with the intent to "transform, and not simply explain, the social order," this project reflects goals of great importance to me (Ackerly and True 2010, 2). Throughout this dissertation I have worked to recognize and communicate these values in a way that, I hope, produces valuable research. I present evidence that has, at times, made me uncomfortable; I raise questions around some of my research practices; and I present arguments that reveal contradictory nuances in pregnancy centers. It is my hope that in acknowledging and recognizing these difficulties, this transparency will produce more sincere scholarship (Harding 2002).

II. Project Development and Fieldsites

A. Project Development

In the summer of 2015 I reached out to the Executive Director of Mountain Care in a 'cold' email. I wrote to her about my interest in studying pregnancy centers and how I felt it was important to highlight the experiences of the clients using their services. Anne responded within

[13] As Mountain Care had transitioned to a new organization (complete with a new staff) by the time I began data analysis in earnest, I did not share results or solicit feedback from them.

hours. Expressing curiosity about my project, she agreed to meet with me in person to tell me more about Mountain Care and to learn more about my project and research approach.

My first in-person meeting with Anne lasted over 90 minutes. Anne began our meeting by providing a tour of Mountain Care's main office before we settled into the conference room to discuss my project. By the end of our conversation, Anne expressed enthusiasm for my proposal and agreed to present my request to the rest of the staff at their next meeting. She explained that my approach, which highlighted the experience of clients, resonated with her. Additionally, she expressed her view that pregnancy centers were misrepresented in the media and she wanted to be part of a story that helped to "set the record straight." Anne explained Mountain Care "had nothing to hide" and reported her conviction that once people understood what "we *actually* do," they would see how pregnancy centers provide caring help to women. This became a common narrative employed by staff as they welcomed me to their centers.

After receiving Anne's initial approval, I wrote and received approval from the University of Colorado Boulder's Institutional Review Board to conduct observations and interviews with staff and clients aged 14 and above. Then, I met with Mountain Care's staff of six women at the beginning of a weekly, all-staff meeting to answer questions and address any concerns they had about my research. I brought donuts to share, gave a brief oral presentation, and then opened the floor to questions. Staff asked me why I was interested in studying pregnancy centers, how I intended to protect clients' confidentiality, and personal questions about my family, faith, and feelings about the recent Planned Parenthood controversy.[14]

[14] In 2015 the Center for Medical Progress—an anti-abortion organization—released several surreptitiously recorded videos of meetings with Planned Parenthood representatives. While the videos were intended to demonstrate that Planned Parenthood profits from the illegal sale of fetal tissue, an investigation by the US House of Representatives Oversight and Government Reform Committee found no evidence of wrongdoing (supported by the results of 12 state-initiated investigations).

In this meeting most of the staff were friendly and encouraged me with smiles. This conversation gave me the sense that their primary concerns included client confidentiality, the length of my project (they appreciated that I had proposed a long-term project), and my personal biography—they wanted to vet my trustworthiness. To my surprise and relief, throughout my fieldwork I was *never* asked by staff, volunteers, or clients if I was pro-life. My thoughts on "choice" and "the life issue" were strictly avoided. I believe this is a result of three interconnected phenomena: (1) pregnancy centers intentionally position themselves as apolitical and, thus, do not bring up what they perceive is a political stance that detracts from their actual work; (2) throughout my fieldwork, staff rhetorically distanced themselves from others in the pro-life movement, not wanting to be associated with the "crazies" or to be perceived as judgmental; and (3) staff wanted me to be equally apolitical and consistently referred to me as a "neutral" or "objective" researcher.

After reviewing my proposal, Anne and the staff invited me to begin research at Mountain Care the following week. I initiated fieldwork in September of 2015. In August of 2016 Mountain Care transitioned to Sunnyside Health and began renovations to enable them to operate as a comprehensive medical center. Sunnyside Health remains a steadfast antiabortion service provider but has expanded their services in partnership with a large, conservative, religious non-profit and a women's clinic to provide obstetric, gynecological, and infertility care for female clients. This means that Sunnyside Health contracts with medical professionals to provide some pre- and peri-natal OBGYN services, to offer STD/STI testing and treatment, and to offer "Abortion Pill Reversal" services. While this transition makes Sunnyside Health unique

among pregnancy centers, it is also representative of a growing trend towards professionalization and increasing medicalization among these organizations.

When Mountain Care became Sunnyside Health there were fundamental shifts in the organization and, as a result, I could no longer continue my research with them. Not only did their expanded services make them less representative of pregnancy centers in the region, but they also experienced a complete staff turnover and ceased to offer client services for an extended period during building renovations. Because of these changes, I began to seek a second fieldsite. The ease at which I gained entry at Mountain Care gave me unrealistic expectations for accessing a second site. Between September of 2016 and November of 2016, I made contact with four pregnancy centers. I spoke at length about my research with the directors of two centers and then never heard back from them. At another, Mary's Choice, I scheduled three separate in-person meetings with the director, each lasting approximately two hours. This site seemed promising enough for me to apply for IRB approval to add Mary's Choice to my project. Then communication suddenly stopped. I sent two follow-up emails to no response; not wanting to feel coercive, I sent a final email thanking them for their time and asking that they reach out to me if they would like to continue our conversation about my project. I received no response. While I believe this silence was due primarily to the difficult transitions happening in the personal life of the center director, I do not know why my attempts to begin research at Mary's Choice failed. Finally, just before Thanksgiving 2016, I reached out to Urban Care, feeling dejected and unhopeful. To my surprise, Imogene, the Executive Director, responded and agreed to meet in person. This meeting began a four-month long process of gaining entrée to Urban Care that entailed emails, phone calls, in-person meetings, and finally, a five-week pilot study.

Through this experience, Susan A. Ostrander's (1993) remarks rang true: "gaining entrée is the first source of valuable data in any field research project" (11).

At the end of February 2017, I began a five-week pilot study at Urban Care by attending their five-day, bi-annual staff and volunteer training. During this five-week period my movements at Urban Care were strictly controlled. I was only granted permission to observe client appointments on specific days with a center director (as opposed to other staff or volunteers). At the end of this period, I met again with the site directors and Imogene and we exchanged feedback about the research process. After some back and forth, Urban Care granted me permission to conduct observations two days a week, rotating each week between three of their high-traffic offices (out of eight total offices). I conducted fieldwork at Urban Care two days a week until July 2017 when I asked for and was granted permission to expand my observations to four days a week. I concluded my fieldwork at Urban Care in December of 2017.

At Urban Care, I was allowed to observe appointments with directors, staff, and volunteers who had opted into my study. Additionally, I was permitted to observe appointments for material services, options counseling, pregnancy tests, and ultrasounds. I was not allowed to observe STI appointments, abortion-pill reversal appointments, or individual or group post-abortion counseling sessions, as staff deemed these appointments too sensitive and worried an additional presence would be disruptive.[15]

[15] A form requesting clients contact me for an interview was provided to clients seeking STI testing. However, I am not sure how consistently these forms were distributed and no clients contacted me.

B. Fieldsite One: Mountain Care[16]

Founded in the 1970s, Mountain Care is a "life affirming organization…that seeks to protect the life of the unborn within our community" (Mountain Care History 2015). Mountain Care is a faith-based non-profit with four locations. Mountain Care is affiliated with two crisis pregnancy center networks: CareNet and Heartbeat International. While their public image (website and publications) minimizes their religious foundation, Mountain Care's internal documents, including their mission statement, statement of principles, and training manuals, emphasize Christianity and the importance of sharing the "love of Christ" with clients. A resource packet for volunteers prompts them to respond to inquiries about their pro-life mission with: "We are not a political organization. We believe in life—that of the mother and the child. We are non-profit and non-denominational."[17] This minimization was successful: only two clients reported knowing Mountain Care was a faith-based organization before their first visit.

Mountain Care is supported by a vast network of volunteers and community partners. Early in my fieldwork, Mountain Care merged with a well-networked, local chapter of a Catholic social service agency. Championed by Anne, this was a unique merger that brought together an evangelical pregnancy center and a Catholic organization to increase the resources and reach of Mountain Care. Large-scale transitions did not occur until after I concluded my fieldwork at Mountain Care and I observed only superficial signs of the merger. For example, in October of 2015, staff hung a crucifix in the lobby to mark the occasion and would often remark they were eagerly anticipating offering additional services, like STI testing.

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[16] In this section I describe Mountain Care Pregnancy Center as it was during my data collection and before its transition to Sunnyside Health.

[17] Positioning themselves apolitical, as an organization Mountain Care does not picket or participate in political marches or rallies, like the March for Life (although individual staff and volunteers may, and many do).

Mountain Care is run by a staff of four full-time employees and two part-time employees. This staff includes two registered nurses (RNs)[18] who perform ultrasounds and discuss pregnancy options with clients. Staff and volunteers are predominately white, middle-class, Christian women.[19] At Mountain Care only women can meet with female clients and only mothers serve as mentors, as staff understand mothers to be better equipped to host discussions about pregnancy, motherhood, and infant development with clients.

Mountain Care's four centers are strategically located in closely-linked cities and suburbs across the region. One center is situated across the street from a high school. Another office is down the street from a large university and across the street from a Planned Parenthood. The third center is located in an urban area across the street from another Planned Parenthood.[20] Mountain Care's fourth office is located on the campus of a large, public university. This office does not offer client services but is a student-lead branch designed to create a campus awareness for Mountain Care, to promote 'healthy' intimate relationships among college students, and to advocate for parenting on campus by lobbing for campus-wide initiatives like adding baby-changing tables to public restrooms and offering free or low-cost childcare during final exams.

Mountain Care's three client service offices offer urine pregnancy tests, ultrasounds, options counseling with a registered nurse, mentoring, and post-abortion lay-counseling. Staff report that providing these services free of charge ensures that Mountain Care does not benefit

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[18] One additional RN, Miranda, volunteers her services on a part-time basis.

[19] Mountain Care's one staff member of color, a bilingual Latinx woman, was the staff accountant and also mentored a handful of clients. She was "let go" near the mid-point of my research. Staff were not forthcoming in discussing the circumstances around her termination and I did not push them for details as I did not want to jeopardize the rapport I had built with staff. All other staff and volunteers I encountered were white women.

[20] This location was added with the merger. While the center was officially linked with Mountain Care, it retained independent leadership, staff, client services, and branding. It was not until the conclusion of my fieldwork that transitions towards cohesion began to take place.

financially from any client decisions, a contrast staff often draw between their organization and Planned Parenthood. Registered nurses at these sites provide referrals to medical centers and Medicaid offices if women continue their pregnancy, but do not recommend nor provide referrals for abortion providers.[21] Similarly, Mountain Care does not offer referrals for contraceptives, many of which they consider abortifacients, and only provide information on "natural family planning" or fertility awareness methods. Pregnant women and new mothers are also offered mentoring services through the Earn While You Learn (EWYL) program.[22] Through EWYL, women can earn "Baby Bucks" for attending mentoring sessions, and can use Baby Bucks to 'purchase' access to diapers, wipes, infant clothing, and donated children's items located in the Resource Room at Mountain Care's main office. Additionally, Baby Bucks allow access to the food closet, in which program participants can select up to three grocery bags of food products per visit. Anne explains that using a system of Baby Bucks empowers clients to feel as if they have earned these items rather than feeling as if they are receiving charity. While they primarily operate within centers, Mountain Care also actively tries to solicit invitations from county middle- and high schools to "share the message of abstinence" with students (Mountain Care History 2015).

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[21] Staff are trained to state they do not recommend or refer for abortion services but to frame their position carefully. Under "General Phone Tips": "If a client asks if we refer for abortions or who we could recommend for an abortion, never start with "we don't refer for abortion." Although we don't, saying that would be the end of your call! A better response may be something like: "we are not an abortion referral agency, but we can discuss all your choices and options with you. All of our services are free and confidential. Would you like to come in today or set up an appointment?" Remind the client she has time to make her decision" (Mountain Care Volunteer Binder 2015).

[22] Earn While You Learn (EWYL) is a program which pairs clients with mentors (both staff and volunteer) who guide them through a curriculum which consists of videos and worksheets that cover "important information" from pregnancy to early childhood. According to the EWYL website, their curriculum is used in CPCs throughout the United States. This is a Christian-based resource that specifically targets "abortion-vulnerable clients," promotes heterosexual marriage and emphasizes a long-term relationship with God (EWYL 2015). Mentors at Mountain Care personalize the curriculum to meet client's individual needs; for each completed lesson, a client earns 10 Baby Bucks to be used in the Resource Room.

I conducted research at Mountain Care's main branch and largest, most resourced office.[23] This office is located in a growing suburban community of about 25,000. This branch is located in a relatively racially and socioeconomically diverse suburb—the city is roughly 18 percent non-white and 12.5 percent of the population falls below the poverty line (US Census Bureau 2010)—situated between two major metropolitan areas. It is across the street from a high school where 35 percent of the students are considered economically disadvantaged; 31 percent qualify for free or reduced lunch; and 48 percent of students are youth of color, most of whom identify as Hispanic (School Self-Report 2018; National Education Policy Center 2015; U.S. News and World Report 2015). Staff explained this location was selected for its "high visibility," and this office attracts a diverse clientele, several of whom have been students at the nearby high school. This location, near a high school serving a disproportionate number of youth of color, is significant because while teen pregnancy, birth, and abortion rates have continued in a downward trend, Hispanic teens (aged 15-19) become pregnant at twice the rate of white youth, and black teens experience pregnancies at two-and-half times the rate of white teens (Kost, Maddow-Zimet, Arpaia 2017). Furthermore, research has established that women who are young, unmarried, black or Hispanic, or economically disadvantaged have higher rates of abortion (Jones et al. 2002; Jones and Kavanagh 2011; Finer and Zolna 2014). While Mountain Care did not state that this location was chosen for its proximity to this high school, pro-choice

[23] I visited all of Mountain Care's locations. However, the campus location did not meet directly with clients (they were referred to client services offices), so I did not conduct any observations on campus. Additionally, during my second week of data collection I visited Mountain Care-West. At this time the RN and sole employee in this office expressed she was suspicious of my research and was unwilling to allow me to conduct observations in her office. She explained I would not gain much from waiting in the small lobby and told me to spend my time at the central office. Finally, Mountain Care-East was 'officially' linked with Mountain Care, but it retained independent leadership, staff, client services, and branding. It was not until the conclusion of my fieldwork that transitions towards cohesion began to take place; thus, I did not conduct observations there.

advocates have noted the placement of pregnancy centers in areas considered to present a 'high abortion risk' (Grant 2013).

C. Fieldsite Two: Urban Care

Urban Care was founded in the 1980s and is a faith-based organization whose mission is "to care for area women and men in pregnancy-related crises and offer them a meaningful alternative to abortion" (Urban Care website 2018). The "About" section on the Urban Care website explicitly states they are a Christian, faith-based organization and treat their work as a ministry. The written materials they offer clients (including those that are internally published) usually include a mention of God, a bible verse, or other religious 'markers.' Despite this—and the heavy emphasis on Christianity and one's relationship with God in training and during staff meetings—the clients I interviewed did not realize that Urban Care was a faith-based organization.

Urban Care's organizational history is one of expansion and professionalization. In 1997, Urban Care opened a medical office to provide ultrasound services with the understanding that the "ultrasound is one more tool that helps women to choose life" (Urban Care website 2018). Today, with a staff of roughly 25, Urban Care operates seven 'brick-and-mortar' offices and one Mobile Testing Clinic. Urban Care's eight centers are spread across tightly-linked cities and suburbs. While their mobile testing clinic moves strategically throughout the region—to be present on college campuses, across the street from high schools, and in church parking lots—five of their centers are located in commercial office buildings and one is located in a Catholic Chapel on a university campus.

Urban Care offers a range of free services including: a 24-hour helpline, pregnancy tests, options counseling, ultrasounds, material services, STI testing and treatment, referrals for adoption, abortion-pill reversal services, men's counseling, post-abortion counseling, and a "life-skills" youth curriculum intended for use in schools and church youth groups. Unlike at Mountain Care, material services at Urban Care are offered as a layette, free of charge and obligation as a one-time "gift."[24] This broad range of services reflects Urban Care's intention to "[follow] the example of Christian love…to meet emotional, physical and spiritual needs, enabling and encouraging women and men to choose life every day" (Urban Care website 2018).

Urban Care has a large administrative staff and a highly educated staff of directors who meet directly with clients. During my fieldwork, each client services director held a master's degree in counseling, education, or social work—many of which were obtained in seminary or at Christian universities. These directors, trained staff, and volunteers who offer lay-counseling are termed "Client Advocates." Client Advocates have the most contact with clients, performing options counseling and remaining with them through an ultrasound conducted by medical personnel. Whereas at Mountain Care, RNs directed client appointments—providing everything from options counseling to medical services—at Urban Care, medical staff played a more limited role in client care. A physician assistant (PA), sonographer, or retired OBGYN (who occasionally volunteered to perform ultrasounds and also served as the Medical Director)

[24] Material services clients met with Client Advocates briefly to discuss their needs, life, and motherhood. Appointment ranged from 15 to 30 minutes. Clients did not have to take any classes, meet with a mentor, or earn any form of currency they could trade for goods. To receive this one-time-per-child gift, a client was officially required to bring in 'proof' of their child—the child or a birth certificate (although I witnessed several times where no one checked for 'proof'). Staff often talked about how these appointments were their favorites because of how much they loved showering mothers with kindness and love.

facilitated the "medical portion" of a client's appointment (including ultrasounds and STI testing and treatment), though clients had brief and limited interactions with the medical staff.

Reflecting trends in the broader CPC movement, Urban Care's staff predominately consists of white, middle-class women; though there are notable exceptions: two male administrators, a male client-services director (for men only), a number of bilingual staff (Spanish and English), and several staff, volunteers, and interns of color. Urban Care demonstrated a higher level of racial consciousness than Mountain Care, speaking about the need to specifically recruit more staff and volunteers of color. Staff reported recognizing a significant portion of their clients are women of color and framed their consideration of race as a means to better "meet clients where they're at" and to avoid acting as "white saviors."

Urban Care is supported by a wide network of community donors who contribute roughly $2,000,000 in revenue and in-kind donations every year (Urban Care Annual Report 2016). They are also supported by over 100 volunteers and present their "Healthy Relationships" curriculum in "classes, school assemblies, parent seminars, and community workshops" to roughly 1,700 people, annually.

I spent the most time in Urban Care's busiest offices: Midtown, Riverside, and Meadowview. Midtown is located in the downtown area of a growing city. The metro-area's population exceeds half a million residents, 46 percent of whom identify as people of color (US Census Data 2010). Roughly 14 percent of the population falls below the poverty line (US Census Data 2010). Riverside is located in a commercial office building in a Hispanic neighborhood of a suburb of 360,000. Slightly more racially diverse, 54 percent of the population identifies as non-white and 12 percent of the population falls below the poverty line

(US Census Data 2010). Meadowview is located in a commercial office building in a suburb of 150,000. This suburb is 70 percent white and, while the median household income is lower than the communities housing Midtown and Riverside, only 8.6% of residents fall below the poverty line (US Census Data 2010). All three locations serve a diverse clientele representing a range of ages, social classes, and races.

III. Data Collection

Throughout this project I engaged in participant observation. First, I spent nine months at Mountain Care observing client appointments (the irony of that timeframe does not escape me) and then I spent 10 months at Urban Care. Throughout my fieldwork, I recruited and interviewed clients. Interviews with clients ranged from 2 to 4 hours and clients were compensated with cash for their time.[25] Near the end of my fieldwork at both sites, I privately recruited and interviewed staff. With the exception of one staff member at Urban Care, who declined to participate because of scheduling reasons, all staff members I approached agreed to be interviewed. Staff interviews ranged from 1 to 3.5 hours. While I typically bought coffee or a meal for a staff-participant during our interview, staff were not otherwise compensated. Additionally, throughout my fieldwork I gathered documents for textual analysis. I collected both internal documents and documents intended for a public audience. Internal documents include training manuals, client records, anonymized client data, and centers' annual reports. Documents available for the public include their websites; brochures and pamphlets produced by pregnancy center networks; and self-published materials on pregnancy, fetal development,

[25] The first client I interviewed was compensated with $20; subsequent clients were compensated with $30.

decision making, adoption, abortion, dating, abstinence, and fertility awareness methods, among other topics.

I also observed events, trainings, and fundraisers. At Mountain Care I attended an annual fundraising gala, a Thanksgiving dinner hosted for clients, and a "Ladies Tea" fundraiser. At Urban Care, I attended the training required for all staff and volunteers, as well as the training for "Healthy Relationships" facilitators. These events and trainings often occurred outside the centers but reveal important ideological frames (re)produced by staff, supporters, and clients alike. In addition, I attended the Evangelicals for Life National Conference in January of 2016 to more fully immerse myself in the culture of the pro-life movement and to get a sense of the relationship between the pregnancy centers in my study and the CPC movement more broadly. In total, I collected data over the course of three years and spent just over 1,700 hours at my fieldsites. In what follows, I describe my fieldwork in each center and then provide a brief overview of the intake process and appointment structure at each center (detailed 'walk-throughs' of pregnancy-related appointments can be found in Chapters 5 and 6). Finally, I discuss my interview process for both clients and staff.

A. Participant Observation at Mountain Care

1. Fieldwork

I was given access to Mountain Care's online scheduling system (eKyros[26]) which allowed me access to information about client appointments. During my first month of fieldwork, I established a regular schedule at Mountain Care's central office, conducting

[26] eKyros is a company that provides software specifically for "the Pregnancy Resource (PRC) ministry" specifically to support "the challenging demands of Christ-centered PRCs around the globe, allowing them to spend more time on their core mission of saving LIVES" (eKyros 2018).

observations 3 times a week for 2 to 5 hours each day. This allowed me to get a baseline understanding of the level of activity at Mountain Care. Staff were comfortable with my presence and I was free to come and go as I pleased. In subsequent months, I used the online scheduling system to tailor my fieldwork to overlap with client appointments, in order to optimize the likelihood of observing client and staff interactions. Ultimately, my fieldwork schedule was based on scheduled client appointments and my own availability. On a typical day, I would "hang out" in the small lobby while clients came in for appointments throughout the day. I was open about my role as a graduate student researcher and spoke directly to clients, staff, and volunteers about my research.

New clients at Mountain Care were given a research form to complete with their intake documents (see "Recruitment Form" in Appendix A). This form provided clients a brief explanation of my research study and requested their consent to allow me to observe their: (1) meeting with the nurse; (2) their ultrasound(s); (3) their mentoring sessions; and (4) to contact them for an interview. With the client's consent, the nurse would retrieve me when she began the appointment. For clients who provided written consent to mentoring session observations, I would also obtain verbal consent from the mentor and verbally confirm consent with the client for each mentoring meeting.

During all observations—of options counseling, ultrasounds, and mentoring sessions—I sat quietly in the corner of the room. While I tried to remove myself from the interactions between the nurse or mentor and the client, sometimes clients would involve me in the appointment with questions about my research or by making eye contact with me as an attempt to address their answers to both the nurse and me. In these moments, I would provide brief

answers or non-verbal reassurances (smiling, nodding). While Loftland et al. (2006) advises limiting conspicuous note-taking, I used written note-taking as a means to distinguish myself as a researcher both in and out of appointments and to record important data. While this was occasionally the source of pointed curiosity and may have made some participants uncomfortable, my note-taking became an important means of establishing professional boundaries with staff. While I was in appointments or mentoring sessions, I constantly recorded written notes about clients, staff, the interactions that occurred, the content of videos (only used in mentoring sessions), and my personal reactions. I payed particular attention to verbal and non-verbal conversations, noting body language, physical appearance, and other indicators of status. In my notes I differentiated between direct quotes and thematic dialogue. I developed a systematic shorthand that enabled to me record important words, phrases, reactions, and most conversations verbatim. Additionally, immediately after appointments, I wrote a brief analysis of the appointments and noted any themes, patterns, or impressions that emerged. While all fieldnotes were handwritten during appointments, later (usually the same day) I would review and then type my fieldnotes. In these 'memos,' I systematically organized my notes, added relevant observations and reflections, and began to develop initial codes that helped me to formulate interview questions (a process I discuss later in this chapter).

2. Intake and Appointment Overview at Mountain Care

Mountain Care's central office is a small, stand-alone brick building. Set back from a busy street, it shares a driveway with a Methodist church. Opening the heavy class door etched with Mountain Care's logo and adorned with stickers promising a "Safe Space," clients walk into a welcoming lobby filled with an inviting, overstuffed sofa covered in throw pillows and two

straight-backed chairs. Bright art adorns the walls, soft music plays, and a small chalkboard is filled with handwritten responses to: "How do you define love?" and "How do you feel today?"

From behind a large desk at the far end of the room, Danielle, the young volunteer coordinator and de facto receptionist, greets everyone with a smile as she asks what brings them in today. Clients usually respond verbally with "an appointment" or "a pregnancy test," and Danielle gathers the necessary paperwork from a cabinet under a crucifix. Clients are handed four documents including: (1) a document explaining Mountain Care's services;[27] (2) a notice of privacy practices indicating compliance with HIPPA regulations;[28] (3) an intake form;[29] and (4) my research consent form. After pointing out where to sign these documents, Danielle makes a point to highlight my paperwork and introduces me as a researcher. I generally rise from my seat in the corner of the room to shake the client's hand before she settles into the sofa, surrounded by glossy pamphlets, to complete the clipboard of intake documents.

Once complete, Danielle collects the paperwork and brings it back to the registered nurse on duty. Within minutes either Celeste or Miranda enter the lobby to greet the client; Celeste always dons a white lab coat to meet with clients, while Miranda prefers bright scrubs. They are

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[27] This document describes Mountain Care as "a non-profit organization providing free services and education enabling clients to make real choices about pregnancy, sexual health, and healing from past choices in a safe, non-judgemental environment." The document explains that clients will be offered services, free of charge, by a staff nurse who is a mandatory reporter. Emboldened in the middle of the page is a statement that Mountain Care "***does not provide prenatal care, adoption services nor provide or refer for abortion***, so you can rest assured that we are not profiting financially from any decision you make" (emphasis in original). Clients are asked to turn off any devices with recording capabilities and sign to indicate their understanding of this document.

[28] This document simply explains how a client's protected health information (PHI) is safeguarded, used, disclosed, and how a client can access it in accordance to the Health Insurance Portability and Accountability Privacy Act.

[29] This document asks clients for: (1) their personal contact information; (2) demographic information (birth date; sex; ethnicity; language; occupation; church); (3) questions about outside sources of assistance, living arrangements, parent's marital status, and the age at which they became sexually active; (4) medical questions about their sexual health status; (5) "Spiritual" questions: What is your relationship with God?; Are you a Christian?; Have you been baptized? (which is separate from the "religion" section); (6) pregnancy history questions; and (7) partner information.

friendly and warm, introducing themselves and welcoming the client back to the counseling room. If a client brought a support person, Celeste or Miranda will usually explain that they prefer to first meet alone with the client.[30] If a client has consented to my observations, the nurse motions for me to follow and the three of us walk past the Resource Room full of baby clothing and sign declaring "We support every 'Individual Choice' that doesn't take away someone else's choice," to the counseling room.

At Mountain Care, pregnancy-related appointments have three distinct phases: (1) an initial consult with the nurse; (2) an ultrasound; and (3) options counseling. A client's initial conversation with the nurse is generally brief. Here, in a small, cozy counseling room awash in calming pastels, a nurse asks the client why she is here, briefly inquires about the options she is considering, and provides a self-administered urine pregnancy test. These conversations tend to be brief, but can last up to half an hour depending on the client's responses.

Upon 'diagnosing' a positive pregnancy test, the nurse proposes an ultrasound, framing it as a "decision-making tool" that will provide "a more accurate due date." The nurse explains that Mountain Care provides "limited ultrasounds" in which she will check for three things: (1) that the pregnancy is developing in the uterus; (2) that there is a measurable heartbeat; and (3) measurements that will help determine gestational age. After the client signs a consent form indicating she understands and consents to a limited ultrasound, the nurse poses a standard set of medical questions, jotting down the client's responses on a clipboard. Finally, if the client came

[30] While meeting with a client alone first to ensure she does not feel coerced or manipulated is standard operating procedure, I saw this violated a number of times by the nurses—primarily with married couples. When I asked Miranda about the policy, she told me why it was in place and then said "unless they are married" as if a woman's partner could not be coercive or abusive.

with a support person, the nurse will ask her if she would like that person to be present during the ultrasound. Then, the client and nurse move to the ultrasound room.

As I explain in Chapter 5, the highly personalized, guided ultrasounds at Mountain Care are the focal point of appointments and typically last 25-30 minutes. After the ultrasound, the nurse concludes the appointment with a conversation. Depending on how the nurse assessed the client's stated intentions and feelings during her intake and ultrasound, the nurse may initiate a more in-depth options talk that provides details about fetal development and, for "abortion-minded" clients, centers around an explanation of the risks and harms of abortion. The nurse explains that Mountain Care is not a prenatal provider and encourages the client to seek out medical care as soon as possible, though she frequently invites clients back to receive a second ultrasound with their partner. The nurse then tells the client about the other services offered by Mountain Care—mentoring, parenting classes, the Resource Room, lactation counseling, and post-abortion support—and offers to sign the client up for anything in which she expresses interest. At the end of her appointment, a client will be given a confirmation of pregnancy form (for insurance purposes), prenatal vitamins, and a tour of the "Resource Room" containing baby clothes, diapers, wipes, and formula. Usually, over an hour later, the client steps out the door laden with forms, informational packets, and ultrasound pictures.

B. Participant Observation at Urban Care

1. Fieldwork

The research process at Urban care differed in significant ways. Urban Care did not use an online scheduling system, preferring to write appointments in a physical calendar and fax client information between offices. Unlike at Mountain Care, I was never fully an 'insider' at

Urban Care. The staff were warm and friendly but maintained a sense of professionalism and did not approach me to engage in lengthy, personal discussions. Where at Mountain Care I was treated as a spectacle, a source of entertainment, and a potential convert, at Urban Care I was largely ignored and had less informal interactions with staff. Ultimately, I was regarded as a professional researcher for whom they "wanted to be prepared." Thus, my movements at Urban Care were carefully coordinated by the Client Services Coordinator, Fiona, and approved by the Executive Director, Imogene, and each site director. Fiona determined my schedule and rotated my observations between their busiest offices: Midtown, Riverside, and Meadowview. Because I could not arrange my schedule to align with client appointments, there were days at Urban Care where I would spend six hours alone in the lobby and others where five different clients would be seen. This allowed me to experience Urban Care's variable schedule but also served as a means to control my experiences and interactions.

On a typical day at Urban Care I would "hang out" in the lobby at Midtown or Riverside (at Meadowview I was given a private office to use between client appointments). Clients were not given my research form with their intake documents. Rather, Client Advocates presented my research with a standardized script when they first met privately with a client.[31] Therefore, clients were unaware of my status as a researcher until they met with a Client Advocate. I used a different consent form at Urban Care that reflected the preferred language of staff and was

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[31] This was a stipulation made by Urban Care in one of our initial meetings. They expressed this preference—to provide my research consent form directly and privately—as a means to (1) avoid any potential researcher coercion; (2) to allow Client Advocates to assess the appropriateness of me sitting in on a client's appointment; and (3) so that clients who many not be familiar with an ultrasound procedure could ask any questions of Client Advocates before consenting to my observations.

The introductory script was created by Urban Care staff at my request, so that I could attempt to standardize the recruitment process. While all staff were presented with the script and familiar with my research, I really have no idea how my research was presented to clients as my research was introduced to clients behind closed doors. See "Urban Care Intake Script" and "Urban Care Intake Document" in Appendix A.

altered to accurately reflect the services they offered. Client Advocates—staff or volunteers who met directly with clients for counseling—reserved the right not to introduce my research for any reason. Staff explained that some situations may be too delicate, or that introducing my research project may disrupt the flow of the appointment. As Client Advocates privately presented my research forms to clients, I do not know how many clients were approached for participation, nor do I now how many refused participation. If clients consented to observations, a Client Advocate would retrieve me from the lobby.

I conducted in-appointment observations in the same manner as I had done at Mountain Care. I sat quietly in the corner of rooms, constantly taking hand-written notes describing client and staff interactions, the structure of the appointment, and my own reactions. I recorded most exchanges verbatim and after the appointment I wrote a brief analysis, noting emergent patterns and themes. In Urban Care appointments, staff carefully avoided including me in client interactions. If a client attempted to engage me in conversation, Client Advocates would immediately steer the conversation away from me and back to the client.

2. Intake and Appointment Overview at Urban Care

Across Urban Care's multiple locations, the client experience was structured remarkably similarly. In contrast to the lobby at Mountain Care, the receptions at Urban Care's locations are reminiscent of a doctor's office. Lobbies are fairly spartan and for the most part silent. Instead of a cozy couch, straight-backed office chairs line the walls. Brightly colored art covers the walls at each center, but rather than informational pamphlets or Christian literature, popular homemaking and sports magazines cover the coffee tables and children's toys are neatly tucked away in a corner.

As clients enter the lobby they are greeted directly by a smiling Client Advocate, usually dressed casually in jeans and a blouse, who asks: "Are you here for our services today?" Rather than engaging the client in conversation, the Client Advocate retrieves a clipboard of paperwork, either in English or Spanish, instructing the client to complete the documents which include: (1) a form inquiring about the services needed and basic demographic information; (2) a sheet explaining service limitations;[32] and (3) a HIPAA Notice of Privacy Practices. Client Advocates then request a photo identification to copy for their records and offer the client water. Upon her return with water, a Client Advocate generally examines the first "Request for Services" form to determine the reason for the client's visit. Based on her written responses, a client is then offered additional paperwork which could include a "Pregnancy Test Form" or a "Direct/Material Assistant Form." A client is typically given 10 minutes to complete this paperwork.

After a client completes her paperwork, a Client Advocate comes to the lobby to collect the clipboard. Generally, she takes a few, private minutes in her office to review this paperwork before meeting with the client. Then she returns to the lobby and asks the client (by name) to follow her to a counseling room. Urban Care's counseling rooms are filled with three chairs—the same upholstered, oak office chairs lining the waiting room.[33] The Client Advocate will position herself kitty corner from the client in order to make direct eye contact but the rooms are large enough for her to maintain some distance from the other woman. If, at this time, a client

[32] This document explains Urban Care's support does not replace professional counseling services or a primary medical provider. Furthermore, the document states "We **do not** perform or refer for abortion" (Urban Care "Limitation of Services" 2016) and explains that Urban Care staff are mandatory reporters. Clients must sign to indicate they understand this document.

[33] The one exception is at Meadowview, which uses the copy, cozy chairs with which you might furnish your own home.

consents to my observation of her appointment, the Client Advocate will return to the lobby to invite me into the counseling room, usually handing me the client's consent form as we walk.

Like at Mountain Care, there are three distinct phases to pregnancy-related appointments at Urban Care: (1) initial options counseling; (2) an ultrasound; and (3) a post-ultrasound check-in. Yet, in contrast to the ultrasound-focused appointments at Mountain Care, Urban Care places the most emphasis on the initial options counseling with a Client Advocate, which typically lasts 30 minutes. Client Advocates are not medical professionals, but are trained as lay counselors and most frequently begin appointments by asking, "how do you feel about being here today?" Before any discussion of a pregnancy test, clients are generally told some variation of, "Here at Urban Care, we like to discuss all your options: parenting, adoption, and abortion," before asking clients what they know about and how they feel about each option.[34] The tone of these conversations is personal and curious. Client Advocates ask lots of "feeling" questions and questions about a client's life beyond her potential pregnancy. After 'getting to know' the client and discussing her pregnancy options, Client Advocates turn the conversation toward a pregnancy test.

Explaining that Urban Care offers self-administered urine pregnancy tests, a Client Advocate hands the client a white, paper bag with a plastic cup, instructing her to collect her own urine in the bathroom (in the office at Midtown and in shared building restrooms outside of the office at Riverside and Meadowview). Clients return to the counseling room within a few minutes with their sample, where they are instructed to dip the pregnancy test themselves and set it in a small, paper-towel lined plastic basket. While they both wait for the pregnancy test to

[34] Even if a client states she has no interest in one option, Client Advocates are trained to bring it up; though individual Client Advocates exercise some autonomy in these situations.

show a result, the Client Advocate requests permission to followup with the client after her appointment. After gathering the client's contact information, the Client Advocate will glance at the pregnancy test sitting on the side table. Pronouncing it ready, she will ask the client to read it, saying, "two lines is positive; one is negative." Once a client has read her results, the Client Advocate will confirm the results before asking "how does seeing those results make you feel?" After their discussion, the Client Advocate fills out a 'Confirmation of Pregnancy' form and asks the client if she would like an ultrasound, framing it as a tool that provides "more accurate dates" and that will give her information she needs to make an 'informed decision' about her pregnancy.

Ultrasounds are conducted by appointment only, and while there are some exceptions, generally clients are unable to receive an ultrasound the same day they come in for their initial options counseling and pregnancy test. If the client requests an ultrasound, the Client Advocate gets out her 'pregnancy wheel' to approximate gestational age based on a client's last menstrual period. Based on that information, the Client Advocate will retrieve a large binder and schedule an ultrasound (clients' pregnancies must date at least seven weeks for Urban Care to perform an ultrasound). Urban Care's medical providers rotate between three offices and the mobile clinic to provide ultrasounds (and STI testing) at least one day a week at each office. Ultrasound appointments take a similar form: clients first meet with a Client Advocate to discuss how they are feeling about an ultrasound and if there have been any health or life changes since the last time they met, then the Client Advocate briefly explains the ultrasound procedure before accompanying the client to the ultrasound room.

As I detail in Chapter 6, ultrasounds at Urban Care are brief and professional, usually lasting less than 10 minutes. After, the client and her advocate return to the counseling room to

conclude the appointment. The Client Advocate uses this time to check-in with the client about her ultrasound experience and her plans to move forward. The Client Advocate then reviews a thick resource packet which lists everything from healthcare providers who accept Medicaid to organizations that provide maternity clothing and diapers free of charge.[35] As the client gathers all the documents she has been given throughout her hour-long appointment, the Client Advocate smiles and reminds her she will be in touch and they walk together out to the lobby.

C. In-Depth Interviews

In addition to participant observation, I conducted semi-structured, in-depth interviews with clients and staff. Interview data were important to balance my observations in appointments with staff and clients' self-described experiences and sense-making. Guided by feminist methodologies, my interview design allowed participants to use their own words to identify important aspects to their experiences in pregnancy centers. In privileging participants narratives, interviews reveal how participants make sense of their experiences (Fine et al. 2000). In treating these experiences as forms of 'situated knowledge' interviews reveal important processes and frames (Collins 2000; Haraway 1988). Therefore, the participants' own constructions illuminate important gendered dynamics of pregnancy centers.

Interview participants were recruited via convenience and snowball sampling (Loftland et al. 2006). In total, I conducted 29 client interviews (12 with Mountain Care clients and 17 with Urban Care clients) and 10 staff interviews (4 with Mountain Care staff and 6 with Urban Care staff) which provided approximately 80 hours of audio data which were later transcribed. One-on-one interviews were guided by a list of issues, topics, and potential open-ended questions, but

[35] Abortion providers are not included in this packet.

I treated these interviews as flexible, allowing the participant to privilege topics they thought were important (Loftland et al. 2006; Rubin and Rubin 2012; Strauss and Corbin 1998).

Each client who indicated that I could contact them was emailed, texted, or called within a few hours of their appointment. Those who consented to partake in an interview met with me at a time and location that was convenient for them. These interviews were conducted outside of Mountain Care and Urban Care. While most clients preferred to meet in a coffee shop, I met with clients in their homes, at libraries, parks, or diners. At the beginning of our meeting, I provided a written consent form while verbally explaining the purpose of the study and how I work to protect their confidentiality. To protect client's confidentiality in audio-recordings, particularly given the sensitive nature of the topics we discussed, they were only required to provide their verbal consent to interviews and audio-recordings (as opposed to written consent). Clients were compensated with cash at the end of each interview.

These semistructured interviews were loosely organized around a set of inquiries regarding client's unplanned pregnancy (or assumed pregnancy) and their experience at a Mountain Care or Urban Care.[36] I first asked client-participants questions about their identity and background to establish rapport (Schwerdtfeger 2009), before moving on to ask questions about their ideas and beliefs about motherhood, abortion, adoption, and sexuality. I then asked about their experience(s) at Mountain Care or Urban Care, focusing my inquires on if and how their appointments shaped their experience of pregnancy and their decision-making. Throughout the interview, I asked follow-up questions unique to individual interviews. Finally, I concluded

[36] Please see "Client Interview Guide" in Appendix B.

each interview by asking clients to identify their personal strengths and ways in which those strengths might assist them in any challenges they identified in our interview.

Near the end of my fieldwork at each site, I approached staff for interviews.[37] I only asked staff members who had direct contact with clients and each center's executive director for interviews. Staff were emailed, called, or asked directly to meet with me outside of the center for an in-person interview. Generally, we met at a convenient coffee shop or restaurant. I would treat (or try to treat) staff to coffee or a meal. Staff were not otherwise compensated for their interviews. Staff provided both verbal and signed consent before we began our interviews.

At the time of staff interviews, I had already built significant rapport with each participant and found I was able to ask (and staff were willing to respond at length to) questions that might have otherwise felt uncomfortable or been considered 'suspicious.' While I created and utilized an interview guide,[38] I approached staff interviews with flexibility and they flowed like conversations, directing the interview to themes and experiences staff felt were important. Interview questions centered around staff-participant's personal biography, including their experience working in a pregnancy center; their thoughts, feelings, and beliefs about abortion, motherhood, adoption, and reproductive choice; and their responses to common critiques of pregnancy centers. To conclude interviews, I asked staff to speak to their personal strengths and to describe what brought them joy in their work.

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[37] I only interviewed staff. I chose not to interview volunteers for two reasons: (1) I established strong rapport with staff members, but because of the variability of the volunteers' schedules I had less contact with them and, at Urban Care, sat in on fewer volunteer-led appointments; and (2) staff had the most contact with clients in pregnancy-related appointments, making interviews with staff important for understanding the typical client's experience. While only interviewing staff limited the number of participants eligible for interviews, these interviews provided rich insights into each center's organizational culture and enabled me to conclude my fieldwork in a reasonable timeframe.

[38] Please see "Staff Interview Guide" in Appendix B.

After each interview, I wrote or audio-recorded post-interview notes. These notes captured my initial impressions about the interview and participant. Additionally, I recorded important data that was not captured by my audio recorder (including any conversation we had before or after the interview, important contextual notes, and my interpretation of their body language throughout the interview). I reviewed and transcribed these notes, including them at the beginning of each interview transcription to provide important context as I began data analysis (Loftland et al. 2006).

D. Staff and Client Participants

Staff at both centers are predominantly white, middle class women, active in their respective, Christian churches. Staff frequently prayed together, spoke openly of their faith, and, at Mountain Care, often attended a bible study held each Monday over lunch.

Staff at Mountain Care are white, monolingual, and married (except for Celeste, a nurse who is widowed). Here, staff are in their 50s and 60s with adult children. Danielle, the volunteer coordinator is a notable exception in her 20s and not yet a mother. Staff at Mountain Care hold degrees in higher education—from an associate's degree to bachelor's degrees in nursing, international affairs, and art. At Urban Care most staff are white and all whom I interviewed are white.[39] Here, staff range from their late 20s to 60s, but most staff who meet directly with clients are in their 30s and 40s. Many staff members are mothers and, during my fieldwork, two pregnant site directors quit to become stay-at-home moms. Unlike at Mountain Care, at Urban Care being a mother is not a requirement for staff to meet directly with clients; in fact, the executive director, a site director, and a handful of volunteers and members of the

[39] Urban Care employee a few staff of color and has multiple volunteers and interns of color. Additionally, three employees are bilingual (Spanish and English).

administrative staff did not have children. Additionally, staff at Urban Care are highly educated and, as I mentioned previously, all directors hold master's degrees. Urban Care also has an active internship program for students pursuing their master's degrees.

At Mountain Care and Urban Care there are clear demographic differences between staff and clients. In offering free services, these centers draw women of lower socioeconomic status. Due to the tight coupling of race and economic status, the centers I studied served a disproportionate number of women of color, many of whom were under-insured at the time of their appointment or who did not want to use their parents' insurance to access medical care. While some clients come from middle class backgrounds, many are economically marginalized and represent the working class or the working poor, and the majority of clients are on Medicaid or are uninsured (two participants receive health insurance through their employers and were seeking more "confidential" services and four are insured under their parents).

I interviewed female clients (and one gender-fluid client) who ranged in age from 18 to 37. Sixty-five percent of my sample identifies as non-white. Additionally, while most clients (64 percent) have had some college experience, some have not completed high school and five hold graduate degrees (2 MAs, 2 MDs, and 1 PhD). Five clients identify as bisexual, while all others identify as heterosexual. Clients described highly chaotic lives, rife with abuse, mental illness, and instability and sought services at Mountain Care and Urban Care for a variety of reasons—receiving everything from material services and mentoring, to options counseling and ultrasounds. Two clients were not pregnant and sought material services, three clients received

negative pregnancy tests, and of the 24 clients who were pregnant, one stated her intention to choose adoption and three terminated their pregnancies through induced abortions.[40]

IV. Data Analysis

In my data collection and analysis I employed a generic, inductive method. Throughout my fieldwork, I transcribed all my my handwritten fieldnotes. In doing so, I not only re-recorded my descriptions, I created reflective, analytic memos to document themes and connect seemingly disparate ideas and occurrences (Davies 1999). I structured these memos to include: (1) a brief introduction to contextualize my notes and my emotional state or reactions; (2) my fieldnotes and observations from the day; (3) emergent themes, patterns, and analysis; and (4) a methods section in which I reflected on 'what worked' and what needed to be revised in my approaches. Memos were organized temporally and thematically color coded (i.e.: red memos contained important ultrasound observations, blue contained important options counseling information, and yellow, methodological considerations). This process acted as a form of meta-analysis in which I moved from highly descriptive data logging to analyzing my findings and connecting these findings to theory. As a form of "initial coding," I identified a range of general themes (Charmez 2000). Then, focused coding enabled me to further narrow my initial ideas and analytic themes to emphasize a smaller number of common themes and areas of interest presenting in my data (Loftland et al. 2006). These focused codes helped to guide subsequent observations and interviews.

I engaged in a similar analytic process for interviews. All interviews were audio-recorded (with consent) and transcribed. I personally transcribed 27 interviews and all my

[40] See "Table 1: Research Participants" for details.

interview notes. I received funding for the remaining interviews to be transcribed by a professional transcription service and undergraduate research assistant.[41] Upon receiving completed transcripts, I listened to the audio files while reviewing transcripts to become more deeply familiar with them (noting tone, correcting errors, and annotating transcripts).

After transcribing my first six interviews, I developed initial codes by reading through each transcript to highlight and annotate interesting emerging themes. This process of "open coding" (Emerson, Fretz, and Shaw 1995) revealed themes that shifted my focus in subsequent interviews and shaped my data analysis. As I coded interviews, I organized my data into descriptive and analytic categories. Descriptive categories included observations and quotes that represent how participants understand themselves; analytic categories were paired with these descriptive categories to lend a sociological perspective to participants' sense-making. After all data had been transcribed, I began to further develop and expand my initial codes in the process of focused coding. I manually coded all interview transcripts organizing them into broad themes with multiple sub-themes. I then used the analytic notations made in each category to develop and build the data chapters of their dissertation.

V. Limitations and Ethics

This dissertation is based on an ethnographic study of two pregnancy centers. Ethnographic work provides a rich understanding of how processes emerge from particular contexts. In this way, I am able to contribute empirical data to further scholarly understandings of how care is constructed and used to cultivate and nourish emotions in staff and clients. The

[41] Both the professional transcription service and the undergraduate student signed a confidentiality form to protect the personal information and identities of participants in interviews. Transcribers deleted interview transcripts and audio-files upon confirming my receipt of the completed transcripts.

claims of my study are not intended to be generalizable to all pregnancy centers or the CPC movement at large, but rather to document nuances in localized projects. Therefore, the data and findings presented in this dissertation should be considered with a full understanding of the boundaries and limitations shaping them. In this section, I discuss how my sampling methods and my own positionality shape this research.

The demographics of my sample reflect those of a particular geographic region and may not be generalizable to other parts of the country. Additionally, my sample is limited to two organizations situated within politically liberal suburban and urban communities. While the staff at Mountain Care and Urban Care reported similarities between their organizations and other pregnancy centers, they were also careful to highlight differences, including their long histories, their positions within politically liberal communities, and their professionalism. The narratives of staff in these pregnancy centers are likely unique to this geographic and political context.[42] Additionally, pregnancy centers are notoriously difficult spaces to gain entry (Kimport et al. 2016) and both centers were willing to allow a graduate student researcher unprecedented access to their organizations and clients. Opting into my research makes these organizations highly unique. I surmise there are a number of important differences in leadership, organizational culture, practices, and knowledge between centers that welcome researchers and those that do not.

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[42] The Rocky Mountain West is a particularly fruitful site for the examination of how women navigate choice in unintended pregnancies as this region's polarized political views are reflected in the resources available for women facing unplanned pregnancies. As of 2011, there are 42 abortion providers in the state, 24 of which are clinics (Guttmacher Institute 2014) and at least 39 CPCs (State Senate Resolution 15-003). Furthermore, Mountain Care and Urban Care are situated in one of only 9 states that do not have a gestational limit in pregnancy termination and is home to one of the three providers which offer late-term abortions. However, public funding is available for abortion only in cases of life endangerment, rape, or incest and state law requires written parental notification for minors seeking abortions (McIntire 2015).

I recruited client and staff participants for interviews directly from Mountain Care and Urban Care, thus, this is a self-selected sample. Using an intake document to recruit clients gave staff members the opportunity to select participants for me. At Mountain Care they may have thrown out or changed responses on intake documents; at Urban Care, staff may not have presented my consent form to clients. In this way, both organizations may have restricted my sample. I attempted to control for this by building strong rapport with staff, but it represents a significant limitation. Additionally, clients were presented with consent forms that indicated I was an outside researcher, but clients may have associated me with the pregnancy center and opted into or out of interviews because of that link. For those participants who agreed to be interviewed, I attempted to control for this limitation by verbally reminding the client that I do not work for Mountain Care or Urban Care, that I am not obligated to report my findings to them, and their interview is confidential. Both my association with Mountain Care and Urban Care and the stigma associated with teen pregnancy, unwed pregnancy, and abortion may have shaped participants' actions in appointments and their responses in interviews in an attempt project a particular image. Yet, the amount of time I spent at each center allowed me to gain rapport with staff, observe patterns, and reach a level of data saturation that enabled me to engage fully with the data.

Further sampling limitations arise from the intimate nature of my research. In this project, I asked permission to witness incredibly intense moments in women's lives. It is possible that women experiencing the most struggle with their pregnancy or decision-making may have been unwilling to allow yet another stranger into their lives. Similarly, in interviews, I asked participants to discuss private and potentially stigmatizing subjects. I do not assume all of

my interviewees entrusted me with their most intimate thoughts and experiences. In an attempt to address this limitation and encourage women to be forthcoming in interviews, I specifically structured my interview guide to build trust with participants and I constantly tried to validate participants without attaching value to their decisions or circumstances. I noticed participants' initial nervousness seemed to dissipate as the interview progressed and I was often surprised with their openness in interviews. After the interview was completed, many participants thanked me for listening to them and described the interview as "nice" or "fun." Others drew positive comparisons to therapy.

Finally, my own positionality has shaped this study—presenting limitations and opening doors to unfamiliar spaces and conversations. Conducting research from a feminist perspective demands accountability and reflexivity throughout the research process. As a researcher who studies people whose lives and experiences are not her own, I have often questioned the balance between voyeurism, research, and creating space for women to discuss often silenced, shamed experiences. In this project, I placed myself in a position to try to deeply understand people with whom I do not agree and people with whom I do not share common experiences. I am a white, liberal, pro-choice feminist without a salient religious identity who volunteers with an abortion provider (and did so throughout my fieldwork). I do not have children (nor do I want children), I have health insurance, and before I started this project I had not had an ultrasound. I share some characteristics with my participants and others represent significant differences.

One of the strategies I adopted in the field was to define myself as a curious, professional researcher—an 'outsider' who was 'in'—to build rapport with staff and volunteers. This strategy seemed to be effective with staff. Early in my fieldwork at Mountain Care, staff began

advocating on my behalf, either because they liked me or because they saw my presence as lending a sort of scientific legitimacy to their work. There were a few times when a client had not provided consent for my observations and the nurse would "put a plug in" for me. On two occasions a client had provided consent enabling me to observe her abdominal ultrasound but not her transvaginal ultrasound. I witnessed the nurse asked the client if she was sure, explaining that they needed a third person to be in the room. Both moments made me highly uncomfortable and felt coercive. Yet, I observed those appointments. I made the choice to do so for three reasons: (1) I verbally asked for consent directly from the client, reassuring her it was ok to say no or to ask me to leave at any point so that I genuinely felt that her consent was granted; (2) I worried leaving the appointment after the nurse had "put a plug in" for me and the client granted verbal consent would make the nurse feel as if I was undermining her authority or questioning her judgement, something I was concerned would threaten my rapport with the staff; and (3) I thought the data was important. There were many days of fieldwork where I would not observe appointments and months where I did not recruit a single interview participant. I made the choice to enter into ethically grey areas in order to gather data that might otherwise be unattainable and that reveled important dynamics between staff and clients.

While establishing myself, visually and verbally, as a 'professional researcher' helped to establish rapport with staff, it also served to emphasize differences between some clients and myself. Not only did my class position, education, and racial privilege distinguish me from many clients, but I was not visibly pregnant during this research, I am not a mother, and I am insured. Furthermore, despite asking clients about their beliefs and opinions, I did not share my own. This likely lead some clients to make assumptions about where I stood on issues of

abortion, motherhood, and healthcare. While these characteristics and beliefs can create distance between participants and myself (or artificial bonds), it is my hope that my professionalism and empathy reassured participants and created a space that allowed them to speak freely to me.

It was a strange and and sometimes terrifying experience to study the 'other side'; even more so, when the 'other side' became complex individuals that I respected and liked—a shifting of boundaries that necessitated constant, critical reflection about how my own identity and relationships to the women I studied shaped my construction of knowledge in this project (Narayan 1993). Herein, I continue to struggle with trying to find a relational balance that feels ethical and effective, that respects the trust women showed me and my own scientific imperatives. I think at best, this research resembles a 'partial feminist ethnography' (Abu-Lughod 1990; Jacobs 2004; Stacey 1988), in which I did not remove my own emotions from my research, but rather used them as an important moral compass and methodological tool that guided my relationships in the field and how I represent others in my work. In this way, I have deeply reflected on my own subjectivity and potential for unintended bias throughout this process (Baca Zinn 1979). Although I cannot use this research to make generalized statements about all pregnancy centers, I believe my study contributes to a better understanding of faith-based pregnancy centers and how their organizational cultures shape the construction, performance, and receipt of care.

Chapter 3: "A Ministry for Their Hearts:" Staff Narratives on Abortion and Constructing Care as Ministry

I. Introduction

Pregnancy centers position themselves as a "life-affirming" alternative to abortion. In a country in which nearly half of the 6.1 million pregnancies are unintended, in which unintended pregnancies are increasingly concentrated among low-income women, and in which 42% of those unintended pregnancies end in abortion, it is imperative to understand pregnancy centers against the broader backdrop of abortion in the United States (Finer and Zolna 2016).

Abortion has a long history, originating first as an herbal approach that used toxic herbs in an attempt to induce miscarriage. Reliable surgical procedures emerged in the late 1800s and became safe after advances in antiseptic techniques in the early 1900s (Luker 1984; Petchesky 1984; Watson 2018). In an examination of the legal history of abortion, Kristin Luker (1984) notes that the practice of abortion was relatively unregulated in the United States until 1900, at which time "every state in the Union had passed a law forbidding the use of drugs or instruments to produce abortion at *any* state of pregnancy" (15). Luker locates this shift toward regulation in the concerted, calculated efforts of physicians to establish their professional status as scientists and their moral rigor as practitioners in order to amass clients. However, by the late 1950s, medical professionals and lay activists began to mobilize to change these laws. Individual states began to decriminalize abortion in the late 1960s and in 1973 the Supreme Court decision *Roe v. Wade* legalized abortion at the federal level.

While abortion regulations vary greatly from state to state, women have a legal right to surgical abortions or, for early pregnancies, a "medical abortion" using a series of FDA-approved pills. Together, these procedures comprise one of the safest and most common out-patient

procedures in the United States, posing no greater risk of death than running a marathon (Raymond et al. 2014), and representing significantly less risk than carrying a pregnancy to term (Raymond and Grimes 2012).[43] This safety is imperative, as roughly 1 in 4 women will have an abortion by age 45 (Jones and Jerman 2017b). While abortion rates have been steadily declining in the United States and are now at the lowest rate ever observed in the United States (Jones and Jerman 2014), induced abortion continues to be a common medical procedure, particularly for low-income women. Data reveals that 75 percent of abortion patients identified as poor or low-income and that a disproportionate number of abortion patients are women of color (Jerman, Jones, and Onda 2016).

The prevalence of abortion is widely established. Yet despite its legalization and prevalence, abortion remains a highly contentious public issue and the central issue with which pregnancy centers engage. As conservative, faith-based organizations that provide care with the express intent to "provide meaningful alternatives to abortion,"[44] pregnancy centers develop and maintain narratives around abortion, clients, and what it means to care. These narratives endow care-work with rich meaning and represent "equipment for living," or resources through which staff make sense of their work and themselves (Burke 1984). Staff provide a narrative of care that is profoundly shaped by their interpretation of religion, their understanding of abortion, and their identities as women. This care is constructed as a ministry and is deeply informed by staff members' individual experiences and collective story-telling. In this way, staff in pregnancy

[43] The safety of these procedures has been extensively documented and is among the safest out-patient procedures performed in the United States (Gerdts et al. 2016; Raymond and Grimes 2012; Raymond et al. 2014; Upadhyay et al. 2015). The risk of mortality from childbirth in the United States is 14 times higher than the risk of induced abortion and the risk of all maternal morbidities is significantly higher (Raymond et al. 2014)

[44] Selection from Urban Care's mission statement.

centers become “anchored in narratives” that reflect their belief systems and provide meaning for their work (Harter 2009).

This chapter examines the construction of care in two pregnancy centers in the Mountain West. Through a narrative analysis of data from interviews with staff and three years of participant observation, I explore how staffs’ gendered, religious identities interact with the regulatory discourses of Mountain Care and Urban Care to produce a distinct ministry of care. I first describe how staff employ ‘anchoring narratives’ which reveal how conservative religious ideologies motivate their engagement in pregnancy centers. This section details the worldview of staff, and I highlight how staffs’ religious beliefs intersect with their gendered identities to help them maintain strict pro-life views amidst the emotional complexity of their work. I argue that staffs’ religiosity cannot be separated from their gendered identities, in that their experiences as women frame their practice of religion. In the next section, I utilize Orit Avishai’s (2008) ‘doing religion’ framework to make sense of the way in which staff construct their work as a ministry. I ague this is a form of gendered, religious identity work with significant implications for staff, organizational imperatives, and clients. In delineating how staff understand abortion and how pregnancy centers construct ministry, this chapter provides the foundation for Chapter Four’s examination of how staff negotiate their gendered, religious identities in the context of the regulatory narratives of care promoted in each organization and within the broader pro-life movement. Together, these two chapters explore how staff ‘talk’ about their work and provide the necessary framework for exploring the different ways in which staff ‘do religion’ and perform care in Chapters 5 and 6.

In describing the narrative contours of pregnancy center care, I deepen the sociological understanding of pregnancy centers and present new empirical data on the scholarship on lived religion and the construction of religious identities. Pregnancy centers serve some of our nation's most vulnerable populations (uninsured, low-income, pregnant women) and are redefining the boundaries of formal care and gendered, religious practice. In carefully examining how this care is constructed, I contribute to scholarly conversations about how women negotiate religious identities, as well as to the growing literature examining the role of pregnancy centers in women's lives—both for those working within these spaces as well as for the women they serve.

II. Understanding Pro-Life Staff

As research shows, deeply held religious beliefs and a conservative worldview are the primary forces driving engagement in the CPC movement (Kelly 2012; Munson 2008). While Ziad Munson (2008) argues the pro-life movement is composed of individuals who "get involved in the movement before they develop meaningful pro-life beliefs," and goes on to assert movement action is "simultaneously and irreducibly both religious practice and social movement practice" (5; 9), the women at Mountain Care and Urban Care complicate this process of mobilization. Not only do staff report that their pro-life perspectives motivated their engagement with pregnancy center work, but staff do not characterize their work as activism.[45]

[45] All but one respondent repudiated the label "activist," which they largely associated with activities such as picketing, sidewalk counseling, and participating in organized marches. The one staff member who identified with that label explained: "I never thought about this as activism before! But heck yeah, in a weird way, but yeah. I feel like you get to be an activist for someone, their voice. And I love the idea that they get to choose. I want to be an activist for that."

Staff describe deeply felt, personal pro-life world views grounded in their own gendered experiences with pregnancy, abortion, and evangelical Christianity as motivation for involvement at a pregnancy center. Like many respondents, before Danielle (26, white) joined Mountain Care, she did not know pregnancy centers existed but she disagreed with abortion: "I knew that I was pro-life, but I had never been a part of anything pro-life before… I didn't even know there even was a movement! I knew that I didn't believe in abortion. I had always known that." Danielle moved from an evangelical, campus-based ministry to Mountain Care, and saw this transition as a broadening of her religious work (and noted this new position also came with a higher salary and better hours). Working for Mountain Care enabled her to 'bring the church' to women in need and ultimately "to help women choose life." Danielle and others entered into pregnancy center work as an extension and expression of their pre-existing religious identities. For the staff at Urban Care and Mountain Care their work is not activism, but rather a personal commitment to living out their faith and helping women. Fiona (58, white) characterizes her work as a religious calling that originated with her unplanned teen pregnancy, explaining: "it was always something that I feel that God was calling me to; and it was to help women…make healthy sexual choices."

Yet, similar to Munson's (2008) claims that activists views change as they become mobilized, staff articulate specific ways in which their views on abortion, clients, and ministry are shaped by the organizations in which they work. Mountain Care and Urban Care help staff and volunteers to define abortion and the appropriate means by which to, in Anne's words, "wage battle in the abortion war." In what follows, I present the results of this "repositioning" for staffs' understanding of abortion. This perspective provides the context through which to

understand why they construct particular ministries of care. These beliefs are the foundation from which staff are motivated to enter into the pro-life movement and interact with the regulatory discourses in each center to shape how Urban Care and Mountain Care build caring ministries. Abortion 'talk' in Mountain Care and Urban Care follows a similar narrative arc in which salient themes emerge to tell a story about abortion that centers on 'life,' morality, choice, crisis, and trauma. In the following sections, I discuss how evangelical Christianity frames staff members' worldview and how staffs' gendered identities inform empathetic feelings about women who choose abortion.

A. Abortion, Religion, and Science

Staff hold an unambiguous understanding of abortion. Anne (62, white), the Executive Director of Mountain Care, succinctly summarizes this perspective: "Abortion is taking a life." Anne, like the other staff members, bases her assertion on a clear understanding of 'life' and when it begins:

> I believe life begins at conception—I don't even have to believe that, *science* says a new life begins at conception. A new, unique life is formed at the minute the sperm enters the egg and the DNAs come together! There's a unique individual that is formed at conception—that's a unique life!

Citing "science" as the basis for her belief, Anne weaves together a narrative blending science and religion to legitimize her conviction that life begins at conception and abortion ends that life.[46] In the United States, religion and science are often discussed as antithetical poles. Yet, in the pregnancy center context, the two are placed in dialogue with each other to reinforce staffs' perspective on abortion. Evelyn (27, white), a director at Urban Care, begins discussing abortion

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[46] Government agencies and medical organizations define pregnancy as the implantation of a fertilized egg in the uterine lining, not conception. In other words, the scientific, medical, and legal consensus holds uterine implantation is when pregnancy begins (ACOG 2018).

by reciting Bible verses. Ultimately, the Bible informs her "true, deep belief that there's a plan for human life," but she laughs as she continues, "but then, science—the other side of the coin! A heartbeat can start at 21 days gestational age, and that's amazing!"[47] A list of other "scientific facts" roll off Evelyn's tongue; these "facts"—brain activity, 'gender,' having "every single thing they need to become a fully formed human at the instant of conception"—confirm her faith-based belief in "life."

Anne and Evelyn are not unique in their integration of Christianity and science. Staff consistently use science as secondary proof of biblical concepts, yet faith remains the primary frame through which staff view abortion. Staff narratives around "life" frequently reference the Bible and are deeply informed by their Christian convictions. According to Fiona, life begins at conception and even if pregnant women do not hold this belief, their bodies reflect the divine truth that "God put in our hearts a mother's instinct. So even if we are trying to tell ourselves it's just a clump of cells—there's nothing there—we're feeling *something* in our womb…We *know* something is up with our own bodies." Fiona relies on faith to frame her understanding of life; it is what gives meaning and feeling to the "clump of cells" developing in a woman's uterus. Similarly, Evelyn emphasized the importance of "life" as personhood, that it is more than merely multiplying cells. These beliefs are confirmed through staffs' experiences with fetal ultrasound technology. Evelyn explains:

> It has its own life…It's just very hard for me to hear people say it's just a ball of tissue…I think it goes back to my religious background…it's a baby. Its almost been reinforced as I've watched ultrasounds.

[47] According to ACOG (2018) cardiac activity can be detected with ultrasound around six weeks of pregnancy, or roughly 42 days gestational age.

Similarly, Danielle describes that seeing a sonogram is powerful and a moment that reveals a 'baby' for staff and clients, "I think it just brings home that it's a human. They can see the heartbeat. I think they are like 'holy crap! That's mine. That's in me. My baby.' I think a picture is worth a thousand words." For staff, the developing entity in a uterus represents a "human life" full of hopeful potential because of their religious convictions, a belief that is confirmed and reinforced through scientific developments like fetal imagery and knowledge of fetal development.

Staff strategically evoke science and technology as a means to establish their moral authority. This scientific rhetoric is selectively employed to lend a sense of objectivity to their beliefs. Staff reference technology, like ultrasounds and pregnancy apps, and publications on fetal development as proof of "life." Yet these interpretations reveal "life" because it aligns with staffs' preexisting biblical framework for understanding pregnancy.

B. Abortion in Absolutes

Away from clients, in the private spaces of pregnancy centers, staff frequently turn to scripture as a grounding reminder of God's omniscience and their understanding of abortion. In informal conversations and more formal interviews, staff often reference God's plan for the "unborn" through Jeremiah 1:5: "Before I formed you in the womb I knew you, before you were born I set you apart."

Trained to frame the "status of the unborn" through the bible, staff view fetuses as "unborn children," a planned creation of a God who does not make mistakes. Urban Care's training manual (2017) states that the consistent pro-life stance holds an "unborn child is not merely part of the mother, but an individual with a future ordained by God. The unborn child is

not a potential human, but rather a human with potential." These "unborn children" are "weak" and "defenseless," thus, in need of protection from harm, specifically abortion.

For staff, abortion is clearly morally wrong. Geraldine (64, white), a soft-spoken counselor at Urban Care, describes her "heartbreak" over abortion: "We are getting rid of children silently in the womb; we are just saying this child shouldn't live." With this certitude, there are no moral exceptions to abortion; no justifications though which abortion can make moral sense. While staff empathize with "abortion-vulnerable" or "abortion-minded" clients' feelings of fear or challenging circumstances, their beliefs hold abortion is always morally wrong. Therefore, Mountain Care and Urban Care do not make moral exceptions for pregnancies resulting from rape or incest. Anne holds firmly to a consistent pro-life stance: "I believe that life, is life, is life; and we don't get to choose. I think you create moral dilemmas when you start deciding about whose life is of value and whose isn't." Celeste (61, white), a nurse at Mountain Care, explains that meeting with clients experiencing a pregnancy resulting from rape is hard but, "that baby is half hers. Why destroy that and once again, bring more violence and trauma to something bad that's already happened? I think those are terrible things, but you can't make it go away." She goes on to support these claims:

> I think there's a lot more healing, especially if somebody who's raped chooses to place the baby for adoption. Then she can know she did the right thing, that she didn't end another life. She didn't allow one kind of violence to turn into two kinds of violence.

Imogene (41, white), Urban Care's Executive Director, echoes Celeste's comments:

> I do not feel it's justified with rape. Because of the trauma that a woman has already gone through from being raped, it is a secondary trauma. Incest is hard for me. Incest is terrible…So then to add abortion on top of it? Doesn't seem right. None of it seems right…I'm not saying you should raise this baby from incest, but I think you should not hurt yourself anymore.

Imogene goes on to say that this discussion is almost irrelevant because there are so few pregnancies that result from rape or incest, but, "if I want to get in my battle mode, then I'm going, 'don't try and minimize that 98% of abortions are out of convenience!' [Abortions] that are not in the rape or incest category, because it's usually those two that people use—as if those justify it." Anne explains that Mountain Care does not offer referrals for or recommend abortion because, "abortion isn't healthcare," and today, "there's no medical indication to have an abortion." Staff at both Mountain Care and Urban Care emphasize that abortion is almost never medically needed. Anne offers a common, though not universal, view:

> When would it be medically necessary for women to have an abortion? There isn't a reason. The old reasons have been addressed—old reasons like it will jeopardize the woman's health. They've been able to manage women's health during pregnancy regardless of what's going on with her body. Medicine has come a long way.

From staffs' perspective, abortion is always a choice, always takes a life, and is therefore always wrong. Because staff hold this absolutist position, "choice" discursively frames how staff understand abortion and clients. In this way, staff believe clients choose abortion and must be held accountable to a morally-laden choice.

C. Narratives of Choice and Consequence

As a whole, staff members characterize abortion as a "convenient" *choice*. As Geraldine reports, abortion is a decision women make "out of convenience. Because most of the time it's *not* a necessity and it's *not* because their life is threatened or anything else." Fiona expands this idea: "I think you always have a choice. They might not be great choices, but you always have a choice…it probably sounds a little harsh, but I think it's a cop-out to say 'I have no choice.'" Even amidst difficult life circumstances—joblessness, homelessness, a lack of family support—staff draw attention to choice. Staff use identical phrasing to illustrate their belief that society

tells women lies that "abortion is an easy solution to their problem." Believing that we exist in a culture that does not value "personal responsibility," staff emphasize what they believes is an appropriate ethic of personal responsibility. Fiona explains:

> I think people have a right to choose, but they have to take responsibility for their choices… understand what that really means for yourself, for your daughters, for your granddaughters…We all have a choice and it's a sobering thing, and we have to take responsibility for it.

For staff, personal responsibility is rooted in sexual responsibility—the words they use to describe abstinence and marital faithfulness. Fiona explains that people must take responsibility for their actions—locating her authority on the matter in her unplanned pregnancy at 17. Grappling with the implications of her own sexual decision-making, Fiona completed the paperwork for an abortion before deciding to take responsibility for her actions and become a mother at 18. Fiona believes that if women do not want to face the complexities of choice, then they should not "engage in the behavior that got you pregnant." Similarly, Celeste reports she is not "judgmental," but that people need to face the consequences of sex: "it's not *just* sex and abortion…there's consequences. It's hard. You can't take away consequences." Anne reflects a similar narrative:

> You hear the arguments, 'Well, why should I be punished? My birth control failed.' Well, everything we do has consequences! I mean we make choices and choices have consequences—good and bad. So if I make a choice to have sex, one result of sex is I could get pregnant, I could get an STD. I mean those are just the consequences of making that decision, and so I think we should be prepared for that. And I don't think taking a life is the right solution to that consequence.

Anne highlights that pregnancy and motherhood is not 'punishment' but rather a consequence of the decision to have sex. Staff do not believe this consequence is borne by women, alone. Staff would frequently reference men and their responsibility, often characterizing men as "forgotten" in conversations about abortion. Yet, staff often avoided engaging in conversations that

acknowledged that the consequences of sex are very different for men and women. Similarly, staff did not speculate on the ways in which race structures "choice" and "consequence," and only offered a one-dimensional view of how class functions to create economic barriers for low-income women to continue desired pregnancies.

Urban Care and Mountain Care's staff feel particularly strongly that religious clients twist their faith to make sense of an irresponsible abortion decision. Despite framing God as loving and forgiving, staff often felt a decision to have an abortion by a woman of faith was particularly myopic and an affront to all religious faiths. In making sense of these decisions, Celeste explains abortion is particularly difficult for women of faith and recounts her experiences with Christian and Muslim clients:

> People try to tell themselves 'God will forgive me.' Or I had a girl a couple weeks ago: 'Well, God will help me through anything.' I said, 'He'll also help you through having the baby and raising it!" I've had them tell me, 'I'm just not going to tell God.' It's just the little lies we tell ourselves to do what we know is not right. We just don't want to have to deal with the consequences of the choices we've made.

These narratives of "choice" and "consequence" call into question the moral legitimacy and decision-making of women who terminate their pregnancies. Staff are clear that these women—the "abortion-vulnerable," "abortion-minded," and "post-abortive" women—are exercising their agency in an immoral and irresponsible way: to 'forget' their partners, deem a life inconvenient, and end it. As Anne points out, this is the wrong solution to a perceived problem. Staff see women as the gatekeepers to life's threshold and frame abortion as an immoral "choice" borne out of crisis, which allows them to question other women's capacity to make judgments and to frame their own perspective as caring, beneficent, and accurate. Furthermore, as the narratives above highlight, women considering abortion are subtly marked as

selfish and "inferior to ideals of womanhood" because they rupture staffs' understanding of feminine sexual responsibility. This perspective limits female sexuality to heterosexual, procreative marriages and valorizes an instinctive nurturance that upholds motherhood as virtuous (Kumar et al. 2009, 628).

D. Shared Gender Identity, Forgiveness, Trauma, and Empathy

For staff it is clear that abortion is immoral and is always a bad choice. In framing abortion as an unconscionable choice to take a human life, staff frequently cite religion and science as the foundation of this worldview. Yet throughout my fieldwork, staff were careful to distinguish between the act of abortion and the women who choose it; allowing for, as Jillian (39, white) suggests, the separation of "the sin from the sinner." This boundary work is informed by an organizational culture in which Christian notions of forgiveness and salvation are intertwined with staffs' personal and emotional experiences with pregnancy, miscarriage, (in)fertility, and abortion. This blurring of boundaries results in a construction of abortion as always immoral, but more complicated feelings about women who choose or are considering abortion. Through this lens, women are understood to be imperfect. They have made the wrong choice, often because they felt pigeonholed or were ignorant of abortion's consequences. Yet, according to staff, these women—particularly those who attribute their suffering to prior abortion(s)—are deserving of loving empathy and forgiveness.

The staff at Mountain Care and Urban Care describe histories rife with their own struggles around miscarriage, infertility, and motherhood. Staff surmise that these experiences allow them to connect with clients through a shared understanding of gendered experiences, particularly trauma; or as Blanche (64, white) puts it: "understand women as women." Staffs'

religious views and personal biographies inform their picture of a merciful God and their understanding of how to do God's work. Hope (38, white) explains that Urban Care's Client Advocates embody empathy and forgiveness in their work because it emulates God: "I don't know what God you believe in, but my God forgives." She further explains this belief is a result of witnessing the trauma of abortion and women's need for healing and forgiveness. In line with this view emphasizing women's trauma and God's forgiveness, Celeste states that "aborted babies are in heaven with God, and that's not a bad thing…my heart is really for the women who make those choices because I have seen the damage that can happen." Celeste goes on to explain how it is important for these women to talk about their abortions, not so that abortion stigma is reduced, but so that these women can be forgiven by God and can forgive themselves.

Each staff member I interviewed emphasized the importance of forgiveness for abortion, which some characterized as a sin that was no different than any other sin. Geraldine summarizes the sentiments expressed by many: "I don't believe that this is outside of God's forgiveness. I don't believe that this is an unforgivable sin or anything like that. I think there is healing and we've seen that!" This image of a loving, forgiving God helps staff align their rigid beliefs about abortion with their empathy for women who make that choice. While for many, these images of God and 'post-abortive women' have been shaped by their work and the subsequent 'testimony' of other women, for some staff, their beliefs about abortion and the women who have them are deeply informed by personal experience.

After being raped at gunpoint by an abusive partner, Blanche became pregnant and recalls doctors telling her an abortion, "will solve your problem." Blanche recounts that choice was made in ignorance and "hardened her heart." She explains: "it took me longer to overcome

the abortion than it ever did the rape, the rapes. That was harder for me because I *chose* that. I didn't choose to be raped." In addition, Blanche blames her abortion for placing her on a path of self-destructive behavior. After the abortion she began pursuing relationships with 'bad men,' eventually terminating two other pregnancies. Shortly before she had her third abortion, Blanche "gave her life to Jesus," making her final abortion a turning point in her life:

> I do remember my last one, thinking: Oh God if somebody…would just come in and say… 'we could make this work,' I will get off this table. And I didn't, and nobody said anything to me… That almost killed me, I think. That third abortion just about ripped my heart out.

Because of her own experiences with abortion, Blanche emphasizes the importance of empathy and forgiveness as she gives testimony in local churches, at pregnancy center events, and facilitates post-abortion counseling and post-abortion healing groups at Mountain Care to "help women receive healing."

Jillian offers another example of the way in which personal trauma has informed her work at Urban Care. Jillian had an abortion when she was a junior in college. When she found out she was pregnant, Jillian remembers feeling "so scared and terrified that I just wanted somebody to tell me what to do." She recalls that her mom "flew out and took me to the abortion clinic. So I felt like that was her support: 'whatever you want to do to get *rid* of this, I will support you.'" Jillian lived for years with what she characterizes as shame and guilt over that 'secret' decision. When Jillian met her now-husband Mark, he reintroduced her to God. She began attending church with him and recalls one powerful sermon "during the Sanctity of Human Life Sunday in January…they did this big push for sanctity of human life and post-abortion group that they were starting. And I remember sitting there like, wanting to sink into

the floor and disappear….Mark looked at me and was like, 'you have to go through this group before we get married!'" This Bible-based, post-abortion group was her pathway to healing.

Jillian reports that her experience helps her connect with clients in a more authentic way: "I know firsthand what that is like—to be in that place when the *fear* takes over. And the impact of that decision—no matter what a client chooses, there is gonna be a lifelong impact—and I feel like I really understand that." Jillian uses her story to give testimony in church and to guide her counseling at Urban Care as she strives to 'plant seeds of hope' in clients.

The abortion stories recounted by Blanche, Jillian, and others in the movement are often retold in pregnancy centers where they 'bravely' share their narrative of having made a bad decision with which they struggled until accepting Jesus and ultimately feeling forgiven. While neither Urban Care nor Mountain Care believes women need a relationship with Christ to receive healing, they are confident that Jesus still facilitates 'forgiveness.' Blanche explains, "there's still hope and healing and help for women without Christ—even though I think it comes *through* Him to help them. Cuz most women don't forgive themselves." Geraldine notes that Urban Care has created a non-Bible based post-abortion counseling program for precisely this reason: to indirectly facilitate healing through God.

These narratives of forgiveness and loving Christianity help staff make sense of a decision with which they disagree. While both centers primarily use these narratives to build empathy for other women, these accounts serve to help staff understand themselves as loving Christians and to feel as if their own thoughts and actions are forgivable. It is a structuring of religiosity that enables staff to maintain their moral identities. This is an emotional response distinct from other segments of the pro-life movement. Unlike the other 'streams' (Munson

2008), the CPC movement is highly feminized, with women leading and supporting the movement at all levels (Kelly 2012). As Kimberly Kelly (2012) explains, this shared gender identity lies at the heart of staff's approach to care and serves to legitimize CPC strategies. Staff 'have been there' or feel as if they genuinely understand the choices a woman faces, and these feelings deeply inform how they conceptualize God, their religious practice, and how they feel they should care for women. In the following section, I examine how these beliefs intersect with organizational narratives of ministry to structure the meaning of care in pregnancy centers.

III. Doing Religion Differently: Constructing Care as Ministry

A. Care as Religious Practice

The women employed at Urban Care[48] and Mountain Care understand their work as a loving expression of their faith. "I see it as a ministry," Blanche says while sipping coffee on a sunny spring day. Smiling and leaning forward, she explains, "ministry, to me, is you go to the *heart* of people. Doesn't mean anything about Jesus…Ministries are relational—it's not just about offering a service…we talk about people's hearts." Staff uniformly describe their work as a form of ministry, yet take care to articulate a ministry founded upon, "loving and blessing *women*," often contrasting their actions with a more "traditional" form of evangelical Christian ministry based on proselytizing or other pro-life work 'saving lives.'

The women of Mountain Care and Urban Care are "doing religion" as a means of creating and performing their religious identities (Avishai 2008). For staff, the performance of care is a religious practice and the forms that care takes denote religious rituals and are a means

[48] Urban Care also employs three men, one in an administrative position, one in an outreach position, and a men's counselor.

of living their faith. Following Orit Avishai (2008), who examines how agentic religious observance is articulated and performed, in this section I explore how staff actively construct pregnancy center care as a ministry in order to cultivate a cohesive sense of self amidst the often contentious boundaries between deeply felt religious imperatives and the complex emotional reality of their work.

Avishai's (2008) "doing religion" frame is a particularly useful lens through which to analyze pregnancy center work. According to Avishai, religion is a constructed performance that arises out of social interaction within the context of regulatory discourses and structures. This necessitates careful consideration of cultural context, the development and everyday performance of religious identities, and how these performances can be consciously or semi-consciously done in the pursuit of religious goals. The pregnancy center is a particular context, complete with specific regulatory discourses, that shapes how staff talk about and perform care in the pursuit of their pro-life mission. In doing religion, staff construct care as a ministry in pursuit of religious goals: it enables the cultivation of a good, feminine Christian self who does good work.

In paying careful attention to how organizational structures shape the meaning of religion, pregnancy centers make a unique contribution to scholarship examining lived religion. Pregnancy centers offer a window for examining how evangelical women practice their faith in ways that challenge and support institutionally defined beliefs and practices. In this way, we can understand the ways in which staff negotiate evangelicalism, organizational practice, and personal beliefs as a means of constructing and performing a religious self that assimilates some institutionally defined beliefs, while rejecting others. In understanding religion as a dynamic,

lived practice linked to specific social contexts, scholarship tends to examine religious performance in secular spaces (Hall 1997). The pregnancy center setting creates a distinct overlap of secular and nonsecular spaces and acts as a unique means by which to expand scholarly understandings of lived religion. Pregnancy centers are faith-based organizations that attempt to perform religion within secular interactions with clients. Founded in evangelical Christianity, Mountain Care and Urban Care expressly hire staff who believe in and are willing to adhere to tenants of their faith,[49] yet shape their services for secular others and limit blatant proselytizing. Clients often do not share the meaning, language and artifacts of staffs' religious practice and at these centers they consciously avoid overtly sharing these ideas with clients. In this way, pregnancy centers attempt to construct a culture that is both religious and nonreligious and reveals new dynamics in the performance of religious identities.

In the following section, I explain how two pregnancy centers articulate a 'ministry of care' to serve women. I show how staff in pregnancy centers construct their work as a ministry that requires specific action and comportment. This ministry is guided by the regulatory discourses of Mountain Care and Urban Care that instruct staff how to 'do religion' and thus, do care through various actions and comportment. Staff are willing subjects to the regulatory discourse of each pregnancy center—they opt-into these caring practices and embrace them as important components of their religious identities. Yet, as I highlight in the following chapter, the adoption of these practices takes some reframing and realignment to maintain a cohesive identity. In this chapter and the next, I argue that this is a form of religious identity work, in

[49] CareNet requires its affiliates (like Mountain Care and Urban Care) to adhere to a "Statement of Faith" containing seven components of belief, including a belief in one omnipotent God, and the infallible authority of the Christian Bible (see: https://cdn2.hubspot.net/hub/367552/file-2184386775-pdf/Statement-of-Faith-2-08-C.pdf?t=1539009851830)

which the staff at Mountain Care and Urban Care actively produce the meaning of care to shape and reinforce their religiosity. How staff construct and understand care is an ongoing identity project with implications for the self, the organizations in which they work, and the clients they serve.

B. Constructing Ministry

Knowing that staff and volunteers enter pregnancy centers with passionate pro-life beliefs, staff-facilitators at Urban Care's biannual training emphasize the "goal of the training is to become ministers, not manipulators." After completing an exercise delineating between ministry and manipulation, Bob—one of three male staff members—rises from a round-table of trainees to summarize his interpretation of this approach. He asks others to remember the words of St. Francis of Assisi, who stated "preach the Gospel at all times. And, when necessary, use words." There are murmurs of assent and head nods from the staff and volunteers, who learn throughout their training that their faith should extoll them to "act like Jesus, the perfect model of an effective and compassionate helper," and to "speak the truth in love," rather than to convert clients to Christianity or prescribe action. Evelyn thoughtfully summarizes what this "ministry" means in action:

> It's not necessarily a ministry for the faith—a ministry to bring people to the Lord...I see it more as a ministry for their *hearts*…not necessarily 'you have to know the Lord.' More just, 'I care about you. You're worth being heard and cared for.'

Staff rely upon the trope of a heart-centered ministry to emphasize the importance and efficacy of feminized emotion work, like "listening and loving," to help "a woman to make a life-affirming decision." Danielle understands this as "the softer-side of care" in which women seek more than medical or material services—a perspective which aligns well with the broader

movement's focus on individual relationships and emphasis on care (Munson 2008). In his examination of pro-life activism, Ziad Munson (2008), highlights how those drawn to the "individual outreach" approach of CPCs believe that "with the proper support and guidance" women will choose to carry their pregnancies to term (113). This is a perspective embodied by staff at Urban Care and Mountain Care. Celeste represents a common refrain: "I think for most people, if they have the right kind of support, they would not want to make *that* choice…God enables us to get through things, and sometimes going through really hard times makes you stronger. If you had the right support, you could do it."

At Mountain Care and Urban Care 'proper support' entails providing "compassionate care" through free medical services, emotional support (in the form of lay options and post-abortion counseling), and material services (like diapers, wipes, and baby clothing). Yet it is not merely the provision of these services but how they are delivered. Staff emphasize the need to support clients in a compassionate, relational, educational manner—often contrasting their services with those provided at secular healthcare facilities and abortion providers, in particular. Therefore, to care for clients is to build relationships; and each center pays particular attention to the ways in which they communicate. Communication with clients is of utmost importance in staff trainings, ongoing in-service trainings, and during staff meetings. They pay attention to what their environments communicate and carefully cultivate welcoming, professional spaces. They give great consideration to how staff listen and speak to clients, stressing three areas: (1) spoken word; (2) body posture and gestures; and (3) vocal tone and inflection. Staff dedicate themselves to examining not just what they say but how they say it. At Urban Care, an entire day of training is devoted to communication skills and Mountain Care's volunteer handbook is

filled with scripts to be used to promote, "empathetic communication with the abortion-minded woman."[50] It is through skillful communication that Mountain Care and Urban Care believe effective care can be delivered. Their institutional narratives define "compassionate care," and are peppered with phrases like "tender confrontation," "unconditional love," and "speaking the truth in love." Unpacking these phrases begins to reveal the particular ways in which care filters through client services.

For staff, "compassionate care" means creating an atmosphere of trust and care through "unconditional love" in order to "tenderly confront" clients. This 'compassionate care' gives staff the opportunity to "reflect" a client's understanding of abortion and to give clients "the opportunity to hear the justifications, contradictions, rationalizations, excuses and potentially false or misleading information in their own words and actions" (Urban Care's training manual 2017). In other words, staff attempt to create—through words, actions, and physical environment—a space that feels intimate and supportive in order to evoke and cultivate emotional and moral subjectivity in clients. Rather than directly intervening in clients' pregnancy decisions by telling clients the 'Truth' (about abortion and their lives), they aim to co-construct with clients a lived experience of the 'real' by "speaking the truth in love." Imogene explains that "speaking the truth in love" means to empathize with clients but to present them with the "reality of abortion"—a reality that is imbued with important physical ramifications and

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[50] For example, Mountain Care's volunteer handbook (2016) states:

> If a client asks if we refer for abortions or who we could recommend for an abortion, never start with "we don't refer for abortion." Although we don't, saying that would be the end of your call! A better response may be something like: "we are not an abortion referral agency, but we can discuss all your choices and options with you. All of our services are free and confidential. Would you like to come in today or set up an appointment?" Remind the client she has time to make her decision.

This is listed under "Communication Skills." Staff inform me this is an example of 'empathetic communication' in crisis intervention and, in their view, is *not* manipulative.

deep emotional considerations. Staff are trained to ask clients questions that call forth particular emotions because, as Hope explains: "feelings last longer than logic." Additionally, as Fiona states: "it's not as simple as just having the procedure done and then it's over. It's part of your journey forever."

Staff frame this technique as "asking the hard questions." Evelyn reports:

> I think I know I've cared for her well when I ask the hard questions…Asking the hard things like, 'Okay, so you want to get an abortion. How do you think that's going to go for you? Have you thought about the procedure?' I'm not saying that because I'm trying to make her decide what *I* want her to decide. It is important that *she* thinks about that. If she's going to do that, you would think about that with any procedure you were doing. So *she* needs to think about that. She *needs* to be asked those hard questions. 'How do you think you're going to *feel* afterwards?'…Caring for them well is sometimes hard, like asking hard stuff.

Like Evelyn, staff emphasize feelings in appointments. Care is feeling-centric; logic and reason are cold responses to short-term circumstances and what is really important is abortion's emotional reality. At each center, staff repeat a variation of the phrase: "don't make a long-term decision because of short-term circumstances." Jillian explains this means validating how challenging circumstances complicate a decision but, more importantly:

> Asking questions that have her looking inward—not necessarily at the circumstance that are surrounding her: job, money. But what is your heart, what is your spirit saying about this? How do you feel about this in the deepest core of who you are? Because circumstances can change.

Thus, their caring work is not only about providing information but also about guiding appropriate emotional processing. While staff maintain that this prioritizes client decision-making, it also ensures a client asks of herself the "right" questions. Celeste explains:

> I see it as helping them make the decision to do what they really want to do…The people who come to us are the ones who really are in a pickle. They think they have to have an abortion. And so my hope is, by giving them that support and the information they need, then they can make the decision that they really *want* to make. You know? And I always…tell them it's their decision. It's not mine.

Because staff see clients as forced to make an abortion decision they do not want, care becomes about creating a space to affirm motherhood, laud pregnancy, and help women avoid the complicated emotions surrounding an abortion experience. As staff understand abortion to be a life and death issue which results in deep emotional trauma, the hardships surrounding 'external circumstances' like poverty, educational and occupational opportunities, health concerns, homelessness, and relationships are deemed temporary and less critical.

Staff passionately wish to save women from themselves—from their own ignorance around abortion, from their denial of emotions, from abortion's inevitable emotional fallout. Staff firmly reject direct intervention, insisting the most effective and loving way to caretake is to convince women to save themselves. Staff often reported they cannot change minds, as Celeste proclaims, "you can't talk anybody into anything, anyway. You can get them to change their mind and then they're going to go outside and go back to whoever talked them into having an abortion and they're going to change their mind again!" So rather than work to change their minds, staff seek to change how women feel about the options they have in front of them, particularly for those women who they perceive to be "in a pickle" and unsure about their future.

It is through this form of care that centers hope to cultivate an emotional subjectivity in clients that encourages them to interrogate their own moral decision-making. According to Anne and Imogene, caring for clients requires them to, "let go of our need to change a client's behavior," and to give her the opportunity to think about her life choices and decision-making by "speaking the truth in love." During appointments, staff "tenderly confront" a client's rationalizations, making a point to return to her emotions and encouraging her to prioritize her feelings by listening to her heart. Dialectically framing this as a selfless act, staff put aside a

concern for the 'unborn child' to prioritize saving a woman from the grief and trauma of abortion. Celeste remarks, "we want what's best. And I really don't feel- I don't feel that abortion is best for anybody." Celeste and others genuinely care about their clients but they can also experience a tension between wanting a client to make an 'informed decision' and knowing the best decision. Importantly, this requires staff to navigate a fine line between pointing out ("reflecting") a client's ambivalence and creating an emotional climate that raises doubts about a decision to terminate a pregnancy.

C. Avoiding Manipulation

At both centers, staff consciously navigate the tension between care and manipulation; Anne reports Mountain Care's biggest challenge is overcoming their "bias" that abortion is "not a good choice for you." Similarly, Imogene explains: "we do a lot of training because if you're a passionate person who wants women to choose life, how do you put that aside to hear: what is their fear? And to know that they'll come to their decision. It's not on you." To overcome that bias and to "lovingly encourage clients to make good choices," Anne asserts, "we really train people to be good listeners, to be good lay counselors, to offer information in a more factual way, but to challenge people's answers, too…to help them dig deeper into why they're making the decisions they're making." At Urban Care, Jillian and Hope conduct a seminar on the difference between ministry and manipulation. They guide trainees through several exercises to help them identify and define any possible 'secret' agendas that inhibit a connection with clients and that assist in distinguishing "the difference between your job, God's job, and the client's job."

Recognizing their own strong feelings about abortion, staff work to avoid the manipulation and coercion they deride and of which they have been accused by outside critiques

(see for example: Gibbs 2007; NARAL 2015; Rosen 2012; Waxman 2006). Staff insist they do not want to manipulate clients; not only does manipulation make clients feel awful but, as Geraldine explains, "manipulating isn't going to do any good anyway! So give it up. Plus, it makes *me* feel terrible." To avoid manipulation at Urban Care they uphold four pre-requisites of care: (1) the motive must be love; (2) the goal must be to benefit the client; (3) the context must be one of trust; and (4) the nature of the feedback should be specific (Urban Care's training manual 2017). In other words, the purpose of care (rather than its specific form) determines if it is ministry or manipulation. Imogene summarizes this approach by claiming, "it's a heart-check thing—what's my intention?"

By comparison, Mountain Care's staff are not trained to follow any specific ministry guidelines but rely upon reflections in weekly staff meetings to hold each other accountable. Here, staff are primarily concerned with education, which is, as Anne reports, "presenting information in a factual way," and focusing their efforts on "not *getting* her to do anything." At Mountain Care, staff construct a ministry based on an assumption that staff share a common understanding of the difference between manipulation and truthful, caring ministry.

Maintaining this care can be challenging. Both centers recognize the difficulty in avoiding manipulation and are highly sensitive to critiques that characterize their practices as deceptive and paint them as 'fake clinics.'[51] In interviews and in informal conversations, staff emphasize the importance of training in maintaining unbiased compassion. Additionally, both centers carefully regulate care providers. Staff occasionally report stories of volunteers they

[51] In fact, my research took place amidst a "Expose Fake Clinics" media campaign by Lady Parts Justice League, who self-describe as "abortion defenders [who] use original rapid response media to fire back at the relentless attacks on report rights" (LPJL 2018). Urban Care staff reacted by joining national pregnancy center webinars, creating an action plan for increasing their positive web presence, and responding to criticisms and protests.

"pray out" because they are "too judgmental" or fail to put their pro-life agenda aside. Blanche states, "if you're going to be judgmental in any way, shape, or form; or coercive in any way, shape, or form, this isn't the place for you to volunteer. This isn't the place for you to be." Evelyn recounts a story of a volunteer Client Advocate she had to reprimand for praying with a client who did not ask for prayer. She knows not to assign 'abortion-vulnerable' clients to another Client Advocate she believes is, "too uncomfortable with abortion to give her information." Imogene asserts there are other places in the pro-life movement for those women because, "everyone has a place. God uses every person along that pro-life spectrum and they have a place. It just might not be shoulder to shoulder with me." Geraldine, the post-abortion counselor at Urban Care, reports she stays away from the client services side of care (interacting directly with clients in the midst of pregnancy) because of her experience working with traumatized women: "I feel like I would move into the manipulation: 'no, you can't do this, let me bring in 10 women that you can talk to!'" Ultimately, staff know their organizations are not perfect: "we make mistakes" but "our hearts are in the right place."

At Mountain Care and Urban Care, staff characterize attempts to "get her to do something," as manipulative. They recognize outright deception, coercion, and evangelism as counter to their caring practices. To avoid manipulation and instead promote ministry, both centers emphasize staff and volunteer training in which they regulate behavior by teaching staff the appropriate means of ministering to clients. Additionally, centers rely upon individual-level regulation—in the form of supervision, prayer, and self-management—to ensure staff interact with clients in ways that align with their vision of ministry.

IV. Conclusion

In this chapter I have described how staff use religion and science to frame their understanding of abortion as taking a life and always immoral. Yet, I also show how staff rely upon their own gendered experiences to make sense of their complex feelings about the women who have abortions. While staffs' religious views undergird both narratives, their gender-identities provide the most salient frame for understanding clients and their own work.

Staffs' gendered, religious identities deeply inform the ways in which they construct their care-work as a ministry. Staff understand abortion as an emotionally traumatic experience and thus, Urban Care and Mountain Care frame ministry as empathetically caring for women's hearts. In this way, ministry is centered on the examination of emotion and the cultivation of feeling. In constructing this ministry as an effective religious practice that only women can do, staff see themselves as good Christian women, doing God's work. While I have presented a description of a cohesive ministry, this practice takes intentional cultivation to bring staffs' passionate, pro-life worldview into alignment with organizational definitions of care.

Each organization recognizes that they often have to reposition hearts, so that staff and volunteers minister to clients in a particular way—one deemed the most effective at encouraging a "life affirming decision." These adjustments—which as Imogene points out require staff to set aside their own passionate feelings about 'choosing life'—are guided by a *pro-woman care script*. This script serves not only to shift perspectives but also to elicit from staff appropriate emotions and, ultimately, to guide the provision of care. In the next chapter I describe the common *pro-woman care script* employed at Urban Care and Mountain Care. In highlighting

the use of this script, I show how staff work to negotiate their identities amidst the tensions between their worldview and their work.

Chapter 4: "Pro-woman Care:" Organizational Scripts, Emotional Labor, and Religious Identity Work

I. Introduction

In the previous chapter I discussed how staff view abortion and subsequently construct their work as a ministry. Through organizational discourses about ministry, Urban Care and Mountain Care carefully construct the meaning of care. Yet these institutionalized narratives do not always map neatly onto staffs' religious beliefs or the pro-life views that initially inspired their employment at these pregnancy centers. In this chapter, I explore how a *pro-woman care script* serves as regulatory discourse through which staff bring their beliefs, feelings, and religious practice in-line with an organizational construction of ministry. In doing so, I explore how staff navigate gendered, religious identity work through "pro-women" pregnancy center ministries.

I first use Simon and Gagnon's scripting theory to analyze the ways in which staff frame their work as "pro-woman" care. I argue this script has three components which function to frame abortion as trauma, interpret clients as in crisis, and uses evangelical Christian schemas as the foundation of effective care work. I then explain how these scripts concurrently prescribe feeling rules for staff. Using Hochschild's concept of emotional labor, I describe how these scripts require staff to bring their internal and external affective expressions in line with a *pro-woman care script*. At the same time, I extend this concept to consider the way in which staff must also engage in moral labor by regulating the expression of their faith and reimagining effective Christian ministries. To do so, I highlight how staff reject important tenants of evangelism to bring their practice of religion and their religious identities in line with a broader

organizational narrative about ministry. This is a means by which staff construct their faithful identities as women and do lived religion. Finally, I describe how a *pro-woman care script* also functions to legitimize staffs' approach to pro-life ministry.

II. The *Pro-Woman Care Script*

In an intentionally secular framing, Mountain Care and Urban Care characterize themselves as, "pro-women social service agencies." Throughout my tenure in each center, the term "pro-women" acts as a touchstone of care, a standard by which staff measure their services and through which they identify as good, moral actors. Jillian, a director at Urban Care, explains that a "pro-woman" approach dictates a standard of care that requires staff to set aside their personal feelings on abortion to "meet a woman where she's at" to enable her to make a "life-affirming decision." More specifically, Jillian states:

> That means that we care for her; and no matter where she is, no matter what decision she makes… I would say that I'm more pro-life because I *do* understand that abortion is killing a child and I think that's wrong. But, I feel like we are missing out if we don't focus on the woman. I f we are all pro-life and we're just talking about the baby and saving the life, then we are missing the big picture. Because we need to be there with *her*, we need to be listening to *her* and walking alongside *her*; no matter what decision she makes. Because she's the one whose life is about to change, she's the one who's in the thick of it. And if she doesn't feel loved and cared for she can't make a decision to love and care for herself or the baby that's growing inside of her…we need to minister to *her* and that's how life-changing decisions get made, when *she* feels cared for, loved, and she's got somebody to walk alongside her in the journey.

Variations of Jillian's thoughts create a common script staff repetitively employ to describe the care they provide for clients. I term this the *pro-women care script.* The *pro-woman care script* is an organizational narrative used to train staff on how to think about abortion, clients, and care. In other words, the *pro-woman care script* is a form of regulatory discourse employed by Urban Care and Mountain Care to bring staffs' pro-life views in alignment with the organizational construction of ministry. Both centers construct their 'pro-woman' ministries as loving,

Christian, and effective, but recognize the need to instill, with persistent instruction, the attitudes, ideas, and habits that they believe will enable staff to become effective ministers. This script guides staff behaviors (Simon and Gagnon 1986) and elicits feelings from staff (Hochschild 1979).

Throughout my fieldwork, staffs' interactions with clients seemed to follow unwritten scripts. Similarly, staff rely upon a common script to make sense of their interactions with clients. Originally developed by Simon and Gagnon (1986) to describe sexual behavior, social scripting theory holds that internalized scripts guide normative patterns of behavior and emotion. Like the scripts actors utilize in performance, social scripts instruct members of a group how to act appropriately and what meanings to attach to those behaviors. These social scripts operate on three levels—cultural, interpersonal, and intrapsychic—to produce a presentation of self. Scripts that operate on a cultural level provide collective meaning, while those which operate on an interpersonal level apply those cultural meanings to exchanges between individuals in a specific social context. Finally, internalized, intrapsychic scripts guide the inner management of emotional responses (Simon and Gagnon 1986). Scripting that occurs on these three levels provides the 'guidelines' for appropriate behavior. While Simon and Gangon (1986) explore how sexual scripts enable the development of sexualities, scripting theory also provides an explanation for how staffs' comportment and identities are carefully constructed from institutional narratives and interpersonal interactions in the pregnancy center context.

Components of the script that I explore below determine caring action and staffs' qualitative experience of providing care. This script dictates how and when to provide care, and how much care clients deserve. These scripts reflect the positionality of the predominantly

white, middle-class, Christian staff at each center and are used to understand clients and guide the care they provide for women, particularly those considering abortion. Staff-facilitators introduce scripts in training and they are continually reinforced through organizational practices and structures. These learned, interpersonal scripts help staff and volunteers to understand what 'pro-woman' ministry means and to manage their own complicated, and sometimes conflicting, feelings around abortion and clients. As staff see their work as a form of ministry, I argue that this approach is a form of religious identity work, in which a *pro-woman care script* creates an imperative to bring staffs' authentic, pro-life worldview in-line with perceived organizational 'feeling rules.' In this way, staffs' clear moral perspective on abortion merges with their more complicated feelings around abortion and those who choose it, often requiring staff to suppress their strong, personal religious beliefs in order to effectively "meet a client where she's at."

In this section I explore the three primary components of this *pro-woman care script* which (1) construct abortion as trauma; (2) empathetically frame clients as in need of care; and (3) legitimize evangelical schemas of care. In doing so, I describe each component and discuss subsequent implications for the organizational construction of care. Ultimately this *pro-woman care script* functions to create and affirm the organizational 'feeling rules' (Hochschild 1979) in Mountain Care and Urban Care, informing how care is constructed and eliciting specific emotional labor from staff.

A. Abortion as Trauma

As staff narratives in Chapter Three highlight, the *pro-woman care script* frames abortion as a trauma which re-victimizes women who are already suffering. The *pro-women care script* turns from the broader pro-life movement's fetal-centric discourse to center on women and how

abortion harms women. This is an intentional strategy to increase pro-life efficacy (Munson 2008) that has produced in staff authentic feelings of empathy for clients. Hope, a director at Urban Care, reveals how this script operates. Hope was initially motivated to join Urban Care to "save babies." However, she now works to honor a broader sanctity of life, and describes a "preciousness to life" that extends to both baby and woman in which "one doesn't trump the other, but one is as important as the other." Hope emphasizes that her acrimony towards abortion arises from witnessing trauma in her work:

> I adhere to my own truth of the sanctity of life. I don't want abortion, I don't want it. Not because I think of it like I used to—like murder—but because I think of it like I do now. I've seen it hurt so many people! I've seen it destroy relationships! I've seen it destroy women. I've seen it destroy men. Over and over again.

Staff narratives, highlighted in the previous chapter, reflect that a 'consistent' pro-life view holds abortion is taking a life and always morally wrong. Yet while Hope and others view abortion as "murder"—a view which first inspired her involvement in pregnancy center work—she insists the more pressing atrocity is the trauma inflicted upon women. Locating this transition in her work at Urban Care, Hope demonstrates the efficacy of institutional narratives about abortion. Abortion destroys women and, according to Celeste, it has permanent ramifications because it is a "decision that's going to affect them for the rest of their life!" Celeste reports her work at Mountain Care has made her, "hate abortion more…because we have so many hurting women because of it. The trauma of it, the pain of it, the loss of it, the confusion around it, the depression." She angrily throws her arms to the sky and asks, "are we really helping women? Is *that* how we care for women?!"

Unsurprisingly, Urban Care's post-abortion counselor, Geraldine, spoke at length to the multiple and continued traumas of abortion which "effect all areas of our life," inflicting

physical, mental, emotional, and spiritual distress. Describing her work counseling or facilitating healing groups with "post-abortive women," Geraldine reports that after an abortion women experience "a moment of 'oh my gosh! What did I just do?' And a real emptiness…a real sadness that comes in…because they're grieving the loss of not being pregnant anymore, of not having a baby." Geraldine's heart breaks over the "lost babies," yet she pushes that heartbreak aside to focus instead on the woman in pain. While not trained as a trauma counselor, Geraldine considers much of the healing she facilitates to revolve around "trauma work" which gives "a narrative to the emotions that are just tucked away," or emotions a client may be feeling but may not associate with their abortion.

Institutional discourse frames abortion as traumatic. A *pro-woman care script* constructs abortion as a symbol of women's suffering and care as "loving women" to enable them to make a choice to avoid that suffering. This script provides the so-called "softer-side of care," and, according to Anne, this means appointments are "about women. I'm not even looking at your baby…even though I know she's carrying one. I'm looking at *her* heart. I'm looking at how *her* life is going." In other words, this script provides the framework through which pregnancy centers conceptualize care as women-centric and a means to avoid and treat abortion's trauma. Framing care in this way, staff are expected to display and feel particular affects. Staff narratives reflect deep sadness and anger about abortion because of the consequences for women. In Geraldine's words, abortion is a "very sad, sad thing." Yet, this sadness and anger is directed at abortion and rather than shaming or condemning clients, staff are trained to feel compassion and to offer 'love' because they understand clients as hurting or traumatized and believe abortion is not outside of God's forgiveness. This script functions to align staffs' antipathy to abortion with

organizational narratives that promote empathy for women and a merciful God. In addition to scripting abortion, the *pro-woman care script* also provides the means by which to understand clients.

B. Clients in Need and Crisis Intervention

The second element of a *pro-woman care script* pivots on the construction of a vulnerable client deserving of sympathy and care. Urban Care's training—which includes a five day intensive, at least four 'on-the-job' shifts for volunteers, and requires ongoing, annual in-service trainings—heavily emphasizes understanding a client, specifically, "the Abortion-Vulnerable Woman," because, "before we believe we have anything to say to a woman, we must know who she is and the forces, thoughts, and pressures that are behind her decision-making processes" (Urban Care training manual 2017). In both centers 'understanding' and 'knowing' a client are fundamental to care.

Clients are understood to view abortion through a different moral framework. Clients are cast as tormented protagonists, assumed to perceive abortion rationally as "killing" and irrationally as "self-preservation" (Urban Care training manual 2017). In our interview, Imogene ties together her clear understanding of abortion with her empathy towards clients:

> The Bible is clear; God is really clear that it is really not okay to take the life of an unborn. And it hurts women! …So how do we, as Christians, as people who are hoping and desiring that someone makes a choice for life, how do we meet them in the fact that they feel like their life is gonna end!? They are *so* scared. It's not that they're a bad person. It's not they don't think killing is wrong.

Imogene explains pregnancy centers "meet" women in understanding them as "scared" and feeling as if their very existence is under threat. Told that clients experience an unplanned pregnancy as a decision between "my life or the baby's," staff review an illustration of a woman in the bottom of a stone pit gazing up at the word 'abortion' written in the sky above. This

woman acts as a symbol of the 'abortion-vulnerable' client—she is depicted deep in this pit, operating with tunnel vision and unable see beyond her immediate crisis to make a good, virtuous decision. In training, Jillian emphasizes that the pit feels dark and frightening, reminding trainees that "abortion seems the only way out of the pit. The intensity of her feelings, circumstances, and pressures make it impossible for her to envision any other options." Staff and volunteers are told that 'abortion-minded clients' are unable to see past their "narrow sense of self," and instead view abortion as an easy solution to a perceived problem. This sketch and narration constructs a desperate, vulnerable client who cannot see clearly and whose judgment is therefore suspect. Staff narrowly frame women considering abortion as "frightened," "fragile," "in-crisis," and incredibly disempowered and vulnerable. Clients considering abortion are not 'bad people' but rather scared victims frantically seeking resolution.

Knowing that staff and volunteers often come from different social locations, the facilitators of Urban Care's training spend significant time cultivating empathy for this symbolic client. Trainees study the "Profile of A Woman With An Unplanned Pregnancy," and move through exercises which call upon them to relive a moment in their own lives where they have felt scared, out of control, or made a bad decision. Hope and Jillian attempt to impress upon trainees that clients shoulder "overwhelming pressures" that may be difficult for staff and volunteers to understand. They explain these pressures are both internal and external. Internal pressures include the woman's feelings, goals, dreams, and self-esteem. While external factors include other people in their lives, circumstances (like finances), culture (living in a pro-abortion society), and even her church.

In framing clients in this manner, staff simultaneously position themselves as bearers of a more accurate vision. This has significant implications for the ways in which staff construct care. Staff view their responsibility as pro-woman caregivers to help clients "slow down" and to engage in "tender confrontation." "I *always* tell them, 'slow down!'" says Evelyn, who believes this allows clients "to see outside of the scope of crisis and also invite[s] them into, 'what does this look like down the road?'" At Mountain Care, Celeste reports, "the *main* thing that I try to get them to do is slow down in making their decision…you have plenty of time to make the decision for surgical abortion, so don't make it in haste." Anne explains that slowing clients down is important because it helps clients to make informed decisions:

> It's really about informed choices. Here's all the information, give yourself permission to think about the next year or two years from now…I think one of the things we help with, is to slow down and enable her to think of the long term effect of that decision. In a year from now, can you see yourself with a little baby? In a year from now, can you see yourself visiting your child, being a part of parenting your child, but not full time? In a year from now, can you envision yourself without that child? And that child's gone, and how would you feel? …You take longer picking out a pair of shoes than you do making a decision about your pregnancy! Come on! This is a life changing decision no matter which one you make.

Slowing clients down enables them to consider their future as well as to recognize the supports that would enable them to carry a pregnancy to term and mother. Danielle points out that slowing down allows for pregnancy centers "to surround women with support services and care so that when faced with a pregnancy that feels really overwhelming becomes of crippling circumstances like poverty…you feel like there are people and resources that can support you through it."

The *pro-woman care script* emphasizes the importance of slowing women down so that staff can tenderly confront clients' decision making and clients can then make the best decision

possible—one which aligns the head, heart, and spirit.[52] In slowing down, a client can crawl out of the pit of crisis to evaluate other options. Notably, this script relies on a construction of a "scared" client who cannot accurately "see," evaluate, and understand her own life. As a whole, staff construct a distraught and frantic client deserving of their compassionate care. Through highlighting feelings such as fear and the desire for love, staff cultivate empathy for clients.

In framing a client in these ways—in crisis and unable to 'see' accurately, uneducated, or miseducated about their options—staff legitimize not only their authority on the subject of abortion but also a style of care which aims to intervene in crisis and rests upon 'speaking the *truth* of abortion in love.' To 'speak the truth in love,' staff use what they term "tender confrontation." Staff report tender confrontation merely helps to reveal truths a client already holds. Ministry, through the reflective listening of 'tender confrontation' is care that inspires moral reflection, not mere information. In fact, Imogene differentiates between the ministry Urban Care provides and merely supplying information:

> If information changed minds, we wouldn't be having this conversation. Information is out there. Back in 1982 they didn't have readily available ultrasounds; they didn't know it was a baby. Now they know it's a baby…if it was as simple as just giving them all the information, we wouldn't have an organization. So I think that's…the continual ministry.

Imogene believes clients know they are carrying a baby, so therefore, ministry becomes about reflecting that 'truth' back to clients as well as enabling them to see outside of their own crisis, to see resources as well as their own strengths and abilities to cope with difficulty. As this style of confrontation is considered to be gentle, this also aligns with the ideas staff hold about their loving, Christian ministry.

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[52] Please note that what is absent in these conversations is any acknowledgment of how delaying an abortion decision increases risk, cost, and difficulty in finding a provider.

Mountain Care deviates slightly from this approach. At Mountain Care, staff tend to believe their ministry combats perceived ignorance. Clients are often assumed to be "uneducated" about the realities of abortion. Blanche states her primary mission at Mountain Care is education:

> I will educate them! I'm all about educating women to not make choices out of ignorance. God says, "My people perish for lack of knowledge." He doesn't say through abortion. He doesn't say through murder. He says *knowledge* is powerful; and we can make healthier choices when we're knowledgeable… This is her choice but she could make a more educated choice when she's knowledgeable about how this might look.

For the staff at Mountain Care, education is part of "whole women's care." Because they do not believe clients receive adequate education about their bodies, sex, and relationships in schools, at "Planned Parenthood," or at home, they approach clients as uninformed *and* in crisis. Danielle describes this educational care as "honoring [women] in a dignified way. And helping them to see their value, and their value of their body, and their choices. That's really our mission, is to help women thrive—especially women that may not be thriving."

At both centers, staff emphasize that abortion should be addressed even with clients who state they plan to continue their pregnancy because clients in crisis are vulnerable to abortion's allure at every turn. Additionally, as Imogene points out, "that's part of making sure she understands all of her options." But nowhere is broaching abortion more vital than with clients who have experienced previous abortions. Urban Care's training manual (2017) explains why:

> We have a unique opportunity at the Pregnancy Center to talk with women about Post-Abortion Stress…This is information a woman may not hear about as society does not readily acknowledge the loss of a baby or the reality of Post-Abortion Stress. We have a responsibility to share this information in order to help women grieve the loss of their aborted children and reconcile their relationship with God…When a woman reveals that she has had an abortion(s), she has provided you with a teachable moment and an opportunity to share information about Post Abortion Stress.

'Post-abortive' women are deceived by society about the reality of their experience. In both centers, these clients are "suffering in silence" because of their miseducation; suffering that is

compounded if they are experiencing another pregnancy. Despite remaining a highly contested diagnosis[53] (also see Kelly 2014), for the staff in pregnancy centers, Post-Abortion Stress (PAS) is very real. Staff link PAS—as a form of Post-Traumatic Stress Syndrome—to a host of self-destructive behaviors (like substance use and sexual experiences with multiple partners) and clinical diagnoses (like depression and anxiety). Because Urban Care and Mountain Care frame these women as having made a poor decision out of fear and without knowledge of the consequences, they report proper care entails sharing this information.

Ultimately, organizational narratives envision a vulnerable client in crisis. She is both disempowered and susceptible to social messages that incorrectly portray abortion as an easy solution to her problematic pregnancy. In this way, staff approach their work as a loving intervention, helping women to understanding their pregnancies not as crises, but moments of growth. Anne reports, "there's lots of good that comes from this, what seems like a bad thing in your life…this is a character-building and astounding opportunity for you." In the way, Anne explains she wants the clients of Mountain Care "to consider other options." Care is about giving clients information, support, and the "permission to explore…the full spectrum of what's available." This allows staff to maintain a moral sense of self. Their work is a caring, crisis intervention and they see themselves as beneficent caregivers who do not tell vulnerable women what to do, but rather empower them to see beyond their panicked tunnel vision to make a decision they really want to make.

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[53] In a longitudinal, cohort study assessing 956 women's risk for post-traumatic stress symptoms after an abortion, M. Antonia Biggs et al. (2016) found that abortion does not increase the likelihood of post-traumatic stress. Furthermore, the authors note that women reporting post-traumatic stress after an abortion pointed to a range of other traumatic life experiences as the source of their stress, such as sexual and physical assaults (only 7 percent of their sample attributes their symptoms to their abortion).

C. Evangelical Schemas

The third key component of the *pro-woman care script* is a foundation grounded in evangelical Christianity. Scholars and others frequently characterize the CPC movement as an evangelical movement and most pregnancy centers are founded and managed by evangelical Christians (Kelly 2012). While staff describe deeply personal relationships with Christ, both Mountain Care and Urban Care reject the 'limiting label' of 'evangelical' to describe their organizations, preferring instead the designation "faith-based."[54] While this is more than a difference in semantics, I argue the style of care these faith-based centers provide is deeply rooted in an evangelical worldview.

To make sense of why Urban Care and Mountain Care minister to women in the way they do, I turn to Michael Emerson and Christian Smith's (2000) *Divided by Faith.* Emerson and Smith examine white, evangelical Christians' ideological commitment to justice and equality amidst a theological paradigm of individualism. While the authors explore this tension through the lens of race, their analysis of the evangelical "toolkit" (Swidler 1986) is significant for understanding how evangelical Christians comprehend structural inequalities more broadly. The authors contend that evangelicals maintain a worldview based on "accountable freewill individualism," "relationalism," and "antistructuralism." These three tenants profoundly shape the narratives around care in these faith-based pregnancy centers and appeal to their supporters (even those who do not consider themselves to be evangelical).

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[54] Staff prefer the organizational label "faith-based" and explain their staff, volunteers, and supporters include adherents of non-evangelical denominations, like Catholics. Additionally, individual staff self-identify as 'disciples of Christ,' or as having 'a deep, personal relationship with Christ' or as 'Bible-based Christians.'

The foundational assumption of accountable freewill individualism holds that individuals "exist independent of structures and institutions, have freewill, and are individually accountable for their actions" (Emerson and Smith 2000, 76). In this worldview, systemic inequalities are downplayed as individuals are responsible for their freely chosen actions. Relationalism speaks to the significance of interpersonal relationships for evangelicals. Originating from the theological understanding that salvation arises from a personal relationship with God, it deeply influences beliefs about how people should relate to one another. Antistructuralism refers to the deep reluctance of evangelicals to give credence to the power of social structural influences. Herein accountable freewill individualism merges with antistructuralism to maintain that the power of institutions and groups is overestimated. Rather, in this view, the individual is accountable for their beliefs, behaviors, and circumstances. These three 'tools' work within the pregnancy center context to construct a client and to create ideas about what it means to care for those clients.

Broadly speaking, the evangelical worldview shapes a *pro-woman care script* which emphasizes building relationships with clients and justifies care work focused on the individual in need and her ability to overcome her circumstances. Urban Care reminds staff that each client has an SOS: clients are "Scared and full of emotions! Face Overwhelming pressures! And have Strengths that need to be emphasized!" Hope describes this as "speaking life" into clients so that when clients are operating with "tunnel vision," staff can "[reflect] some of their strength to them. Reflecting where they've come from, reflecting where they've had strength in the past… reflecting life to others by just saying: 'you matter…your time matters, who you are matters, your story matters.' I think that in and of itself speaks life." In this way, Hope and other staff

validate clients by focusing on their individual strengths rather than the persistence of structural inequalities many of their low-income, uninsured clients of color likely face.

Staff emphasize that women make the permanent decision to abort because of "short-term circumstances." The list they review in training includes internal pressures (for example a desire to go to college or fear of parental reaction) and external circumstances (such as pressure from family members, joblessness, and homelessness). Importantly, while these 'overwhelming pressures' are valid concerns, they do not justify the choice to have an abortion because they are 'short-term circumstances' clients can choose to overcome. Staff are not blind to structural inequalities but diminish their power in their narratives of care. Rather than seeing clients' lives as framed by structural inequalities, staff weave a "pro-woman" narrative that emphasizes the hope of individualism: while this moment in a client's life may be hard, they should not make a short-sighted decision because they are strong and their lives can change. In fact, Anne recounts how pregnancy can be a turning point in a client's life:

> I can't tell you how many girls were totally a disaster and had no direction and vision for their life and were just floating along; and you could read the writing on the wall, where they were headed. And then they got pregnant—and not all of them, some of them didn't do well, but a lot of them went, 'Okay, now I got somebody to live for,' and all of a sudden they had purpose, and direction, and vision, and they were like okay… We need to tell women, 'This is not the worst thing that ever happened to you, and with good guidance and care and support, this can be a catalyst for great things for you!'

Anne believes that to care for women means to help them see their pregnancies as a "catalyst for great things," a means by which women can overcome their current life circumstances. This narrative, in which staff frame a "pro-woman" attitude as one which promotes an ethic of personal responsibility and foregrounds a woman's individual strengths and resiliency is understood to be a hopeful, supportive, and "life-affirming" approach. Staff emphatically insist women are not limited by their circumstances, a narrative which reflects the anti-structural and

individualistic orientation in each center. Yet, this narrative also rationalizes and legitimizes the social status quo by implying those who are disadvantaged simply lack the willpower to change their lives. This discourse similarly reflects and normalizes as "loving" and "healthy" the beliefs, practices, and norms of staff and volunteers which promote particular forms of intimacy (heterosexual marriages as the ideal family foundation), a formulaic life plan (a standard path of education, marriage, and children as successful and healthy) and economic success (a purposeful, meaningful job and private home).

Staff believe the most effective manner of sharing this worldview is through relationships. In Chapter Three, Blanche described the ministry of a pregnancy center as "relational," an approach pregnancy centers construct as both 'God-given' and effective. Staff continually emphasize the importance of building relationships with clients. Blanche explains Mountain Care is "a medical clinic but we have our structure set up so that we can care for women and be in relationship with her." Danielle affirms this by emphasizing how they are different from conventional care: "there's relationships here…I only go see my doctor when I'm sick or I have questions that I can't answer versus friendship and relationship…I perceive that there are friendships here." According to Celeste, relationships are central to pregnancy center care because "you change people's mind with a relationship and with a conversation." As a nurse who meets directly with clients, she explains, "I try to make it a caring relationship with them so that they know that their best interests are important to me." In this way, care becomes an act of building relationships with clients so that staff can guide them on the appropriate pathway to success.

Ultimately, an evangelical worldview shapes the organizational narratives of Mountain Care and Urban Care to produce an 'abortion-vulnerable' client who (more often than not) faces an unplanned, crisis pregnancy that is a result of her own irresponsible actions. She is to be approached relationally with kindness and empathy, yet she is to be held accountable for her morally-laden choice though tender confrontation which "speaks the truth in love" by asking her the hard questions. Moreover, she is understood to be the author of her own story, an individual who holds the power to change her circumstances.

III. Emotional Labor

In the previous section I described the *pro-woman care scripts* employed in the pregnancy center context and analyzed the scripts' prescribed emotions. These scripts are adopted by staff and inform the ways in which staff construct care and how they feel, however, these organizational discourses do not always map neatly onto staffs' personal emotions and beliefs. In this section, I examine how the particular organizational feeling rules created by a *pro-woman care script* creates an imperative to bring staffs' authentic feelings about abortion and clients in-line with the regulatory discourse in each center.

A. Feeling Rules

"Better a patient [woman] than a warrior, a [woman] who controls [her] temper than one who takes the city" (Proverbs 16:32; brackets in original). This adapted, Biblical quote lies emboldened on the page under "Practice Exercises for Tender Confrontation" in Urban Care's Training Manual. This verse aptly summarizes the feeling rules created by the *pro-woman care script* in Mountain Care and Urban Care. Scholarship by sociologists Arlie Hochschild (1979, 1983) and others (Bendelow and Williams 1998; Schott 1979; Thoits 1989) shed a light on the

processes whereby scripts prescribing emotional affect become internalized. Hochschild's (1979) "feeling rules" and "emotional labor" are particularly important conceptual tools for understanding how this occurs through the provision of 'pro-woman' care in pregnancy centers. Influenced by Goffman's dramaturgical approach, Hochschild (1979) asserts:

> Rules seem to govern how people try or try not to feel in ways 'appropriate to the situation.' Such a notion suggests how profoundly the individual is "social" and "socialized" to try to pay tribute to official definitions of situations, with no less than their feelings (552).

Further, Hochschild (1979) claims that when one's feelings do not align with those which are expected, emotion work—much like Goffman's deep acting—is required to 'consciously' and 'deliberately' shape feelings (559). In this way, individuals attempt to exhibit the appearance of appropriate emotion through surface acting and attempt to cultivate authentic internal feelings through deep acting. This emotional labor may involve "enhancing, faking, or suppressing emotions" (Grandey 2000: 95) and may be an explicit or implicit expectation. Importantly, this is labor which takes effort. While emotional labor may provide organizational benefits, Hochschild (1979, 1983) also points out how stressful the commodification of emotions can be for employees, potentially resulting in burnout.

Scholarship on emotional management tends to center on the workplace (Enrenreich 2001; Grandey 2000; Hochschild 1979, 1983; Meerabeau and Page 1998), demonstrating emotions and emotional labor have important individual and organizational outcomes (Arvey et al. 1998; Grandey 2000). Like other workplaces, pregnancy centers expect from staff and volunteers particular emotional stylings that require both surface and deep acting to regulate their emotions at work. In "regulating the arousal and cognitions that define emotions" (Grandey 2000, 98), staff control the expression of emotions at work and cultivate 'appropriate' internal

feelings. In an extension of Hochschild's original concept, while staff in pregnancy centers report some pernicious effects of this emotional labor, my research demonstrates that adhering to organizational feeling rules simultaneously affirms a positive sense of self. Emotional labor in the pregnancy center context produces positive affect in that it confirms staffs' religious identities. Performing this emotional labor makes them feel like good Christians.

The *pro-woman care script* determines appropriate "feeling rules" which dictate surface and deep acting. At Mountain Care and Urban Care, the three components of the script which I outline above, require the performance and feeling of sadness about abortion, non-judgmental empathy for clients, and appropriate religiosity. In the following two sections, I first examine the feeling rules requiring sadness and empathy, and then turn to a discussion of moral management, exploring the ways in which staff learn to feel and display appropriate religiosity.

1. Sadness and Empathy

The CPC movement is emotionally distinct from other "streams" in the pro-life movement (Munson 2008). This is an intentional strategy that distinguishes pregnancy centers as the apolitical, softer-side of the pro-life movement. Earlier, I discussed how staff construct abortion as a devastating trauma. Rather than expressing anger, indignation, and pain over abortion, the *pro-woman care script* instead evokes feelings of profound sadness. Staff are trained to direct this sorrow towards abortion. Knowing staff generally enter this line of work because they feel strongly about abortion, the centers guide them—through 'empathy-building exercises'—towards expressions of heartbreak and sadness over abortion. Abortion is a "heartbreaking tragedy," "hurtful," and "devastating." As Geraldine says: "It's sad, just so sad. She's *so scared* she's gonna lose her life. Abortion is just a tragedy." With a resigned sigh,

Imogene explains abortion is a "tragedy…that women have to be in a place where they have to make a decision—for lack of better wording—to kill something that's growing inside of them, something that's a part of them." Herein, Imogene reflects an institutionalized sadness about abortion and the circumstances in which women feel they must make an awful decision. In this way, Mountain Care and Urban Care implore staff to feel sad about abortion and attempt to cultivate feelings of empathy toward women faced with an unplanned, crisis pregnancy.

In training, staff are taught to approach clients with empathy. Staff are asked to put themselves in "her shoes"—a woman who believes her "life" is at stake, not in the physical sense but in many other ways. Training works to forge connection on the basis of common humanity, between staff and clients—two groups often separated by significant class, race, and social distance. In doing so, staff are asked to remember a time they felt alone, fearful, or without options—an important exercise because some staff have not experienced an unintended pregnancy. Staff are encouraged to connect with clients as emotional beings. Evelyn explains that although she has never experienced pregnancy nor felt the pressure to abort, she connects with clients on a deep emotional level because she is "a human being…I know what it's like to not feel value or worth or to feel loved and seek that in a way that might not be healthy." Stressing that "everyone has sinned and fallen short," Jillian tells trainees, "you are not so different than clients." So while clients may be considering an option with which staff strongly disagree, they are asked to set aside their personal feelings to empathize with the client; and, as Evelyn attempts, "to bring myself back to: 'I might not agree, but it's her life that she's living.'" Hope says this approach is what sets Urban Care apart from other pregnancy centers, which she believes take a more authoritarian approach to "save, not serve, clients."

Empathetic connection to clients is reinforced through various organizational practices and informal staff conversations. At the beginning of each day, staff set aside time to pray for clients and the strength to "treat them with kindness and love" (prayer at Urban Care) or for God to "grant us the wisdom to show her your grace" (prayer at Mountain Care). Staff create "prayer requests" for particularly challenging clients, urging others in the center and within their prayer-chain to ask God for guidance to care for the woman they see. At Urban Care staff are required to participate in regular supervisions, to meet every two weeks with the counseling supervisor for personal counseling sessions (she acts as a "counselor for the counselors"), and to participate in guided group counseling meetings. The purpose of these sessions is to allow staff an opportunity to process their work and to challenge their practice. Evelyne explains that these sessions allow staff to question, in a safe space, if they "went too far with a client" and to reflect on "better ways to minister." It is a formal structuring of staffs' emotional responses to clients. Evelyn attributes her growth as a counselor to these group sessions, which allow other staff members to offer emotional support and professional critique. She explains the purpose is to "help better ourselves, to be open to the criticism and critique…and build healthy emotional response." In other words, these group sessions not only serve as an emotional outlet, but facilitate the appropriate emotional response to clients, teaching staff not just what to say to clients but how to feel in those moments. While Anne is confident she trains her staff to be "good listeners," Mountain Care does not have in place any formal structures for this style of self-care and emotional training. Staff often meet informally to process 'difficult' clients and they meet in weekly all-staff meetings in which prayer-filled conversations around clients emerge (though

they are not the focus or purpose of those meetings). These meetings enable staff to express and validate emotional challenges but rarely served as a corrective response to reported interactions.

2. Moral Management

In both centers there exists a clear institutional understanding of appropriate religiosity in which faith-filled staff openly express, share, and practice their faith with each other, yet strive to maintain secular interactions with clients. This is an intentional, institutionalized management strategy enacted by staff where they recognize and control the expressions of their faith as a means to be more effective at their jobs. Appropriate religiosity requires them to suppress their strong, personal religious beliefs in order to "meet a client where she's at." While staff describe fervent pro-life beliefs and a deep sense of connection with God, they also explain how those beliefs can be obstacles to interacting with clients and thus, the need to manage their religiosity. Staff frequently report pregnancy center work requires one to put aside their personal faith. Rather than merely a form of emotional management, I argue this also involves moral management in which staff are required to regulate the expression of their moral value system and its prescribed conduct. For staff this primarily involves the policing of proselytizing and the rituals of Christian practice; a management of morality that has significant emotional consequences.

Appropriate religiosity means understanding that the center is not necessarily the place to evangelize. Anne explains:

> We're gonna care for women with the love of Jesus and if that creates a curiosity about why we do what we do, great! But that's not what we're here for—we're not here to *turn* all these people…Why we exist is to care for women. It's not to evangelize.

In this vein, neither Mountain Care nor Urban Care provides clients with tracts.[55] Hope—who holds a deep, personal faith herself—feels strongly that appointments should not be used to proselytize:

> *Hope*: So there are some pregnancy centers that use the opportunity to talk to someone about their crisis to share the gospel. Which, the bible tells us: preach the gospel at all times—like that's our job as Christians. But that's where I think Urban Care can be distinct in a lot of ways, different…that's why we spend a whole morning of our training to say, this isn't the *context* to say, 'we've talked about your crisis pregnancy, now I'm gonna share the gospel with you and then I'm gonna pray with you, and then I'm gonna hope that you become a believer.'
>
> *Kendra*: Why is this not the space for that?
>
> *Hope*: Because this is the wrong *context*. People don't come in asking for the gospel, they come in for a pregnancy test! For us to take advantage of that in that moment, to say, oh we're also gonna bait and switch you into believing in Jesus, feels like we are missing the heart of the women.

Hope sees her work as requiring her to refute, in some ways, her "job" as a Christian. She and others manage the evangelism requirement of their faith in this context, deeming it inappropriate. Yet rather than viewing themselves as 'bad' Christians, they instead reimagine an appropriate evangelism as care work and planting seeds.

In the pregnancy center context, staff characterize their care for pregnant women and their counsel as "planting seeds." Imogene explains these seeds potentially create the space for a woman to reconsider an abortion and maybe, eventually grow to 'transform' her relationship with Christ. According to the staff, all they can do is plant seeds in clients, because this is a ministry focused on a particular moment of crisis intervention while one's faith journey is a life-long endeavor. In this way, the *pro-woman care script* provides a means through which staff reinterpret religious imperatives requiring them to "preach the gospel at all times." At Mountain

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[55] A tract, according to Hope "is a little piece of paper that talks about the gospel. Something on it that talks about 'believe in Jesus and you'll be saved.'"

Care and Urban Care effective ministry requires 'preaching' in kindness and action rather than proclamations of Biblical convictions.

Evangelical ideology holds that one's primary role as a faithful "disciple" is to evangelize, thus, many staff must regulate their proselytizing—learning to "minister" in loving actions rather than words. Not only does this shift the expression of their faith, but it also requires a modification of their internal feelings. In framing this approach as "more loving" and "more Christian," staff report that this feels good. This is a conscious practice that becomes apparent as staff relate stories of re-evaluating and re-aligning their emotions around this ministry. At the same time, staff members struggle to bring their actions and emotions in-line with Mountain Care's appropriate religiosity. Blanche, for example, recounts a story of conflict over her display of bibles at Mountain Care and another pregnancy center. Blanche tearfully reported a profound religious conversion that "saved her life" after three abortions. As a result of her own experiences, she feels strongly that the Bible can be a powerful tool in other women's lives; and yet, she works in an organization that disciplines her faith by restricting the ways in which she can share it:

> I have Bibles sitting out, you know, in my reception area. They're not out in the open. They're sitting on this little shelf. If people want to pick them up, they can. That's their choice. And I see people picking them up all the time, asking us if they can have them…It's their choice. I'm not shoving it down their throats... I know Anne kinda follows that same line of thinking, to put the Bibles away; but now [with the merger with a Catholic organization] I think that's going to change a little bit…because I think that Jesus is a big piece for a lot of people, that he brings healing, he brings hope, he brings stability. He's a huge piece of people's lives.

Not sharing testimony with clients is "hard" for Blanche, but she reconciles this difficulty by reconceptualizing effective faith work, explaining she finds peace in forming relationships with clients and helping women, not by inspiring conversions.

Regulating the expression of faith requires constant vigilance. Staff like Blanche often rely upon prayer as an emotional tool that helps them navigate their work. Staff pray on behalf of clients but, more importantly, for themselves. In both centers, prayer acts as a means to provide comfort to staff and to re-focus them. Evelyn reveals "sometimes I go in my office and I'll pray…because I'm like okay, this is gonna be a hard one. It'll be hard to listen or focus, or my client's gonna smell really bad today. And I need to focus." After particularly challenging clients, Mountain Care and Urban Care staff often meet informally with each other to process through prayer. Each center utilizes "prayer warriors" or anonymous "prayer chains" in which they ask their supporters to offer prayer for clients and for the work they are doing—sometimes in celebration and other times for guidance. Prayer also serves as a physical ritual to console staff when they feel a lack of control as Danielle describes:

> I have a little box at work that I write down prayers and I fold them up and put them in my box. When a client comes in and I feel heavy for them or like they have a specific need like housing or whatever, I'll just put it in my box and I'll date it, and I'll put it away. That's a very tangible way that I feel like my faith comes out at work. Like, prayer for them. There's so much that we can't do for someone. I just like to pray for them.

While there are lots of prayers about clients, prayer is rarely shared with clients. Staff at Urban Care regularly check-in with their volunteer Client Advocates to remind them prayer is for self-support and to only pray with clients when the client requests it. Both Hope and Jillian tell me that, in the approximately seven years they have worked at Urban Care, they have only prayed with two clients. At Mountain Care, staff occasionally tell clients near the end of their appointment, "I'll pray for you," but rarely share the ritual with clients. Enacting appropriate religiosity therefore privatizes prayer.

While there are many similarities between the boundaries of appropriate religiosity at both centers, there are also distinct differences in each environment with respect to how staff approach spirituality in conversation with clients. At Urban Care, a strict 'secular veil' consciously and conspicuously separates faith-filled organizational practices from interactions with clients. Relegating their Bibles and faith-based brochures and publications to a supply closet, only popular magazines like *Home and Garden* and *Sports Illustrated* fill client-spaces like lobbies (with one notable exception: *Before You Decide*, a publication by the faith-based CPC network, CareNet). While staff at Urban Care occasionally wear crosses and some display visible Christian tattoos, their 'front stage' space lacks symbols of faith readily accessible to clients.

The boundaries drawn at Mountain Care are messier. Mountain Care makes faith-based documents and brochures on abortion, adoption, pregnancy, and sexual health openly available to clients—they line the walls of counseling and ultrasound rooms and are strewn across the coffee tables in the lounges. Christian literature and Bibles occupy every room, often Christian music softly plays in the lobby, and a crucifix hangs above the reception desk. In client appointments, staff carefully guard their 'God talk' but more liberally question clients about their faith and their sexual choices. The nurses at Mountain Care also more frequently offer their own prayers to clients as a source of comfort. The divergence in these practices reflects slightly different understandings of 'appropriate religiosity,' which, as I discuss in subsequent chapters, starkly influences how care is performed in each center.

In this section, I examined the ways in which a the components of *pro-woman care script* —which constructs abortion as trauma, understands clients as women in crisis, and relies upon

evangelical constructions of care—functions to create organizational feeling rules to evoke from staff feelings of sadness and empathy. Additionally, I argue this script impels moral management. I show how a p*ro-women care script* encourages appropriate displays of religiosity. While this regulation is experienced as conscious labor by staff, it also serves to positively reinforce their identities as good Christians. In other words, emotional and moral labor helps staff to reimagine a Christian ministry in which doing the hard work of "loving" difficult women is simultaneously doing good work. While requiring the regulation of outward displays of emotions and faith, this labor concurrently evokes internal identity work, in which staff reframe their understanding of ministry to maintain a cohesive religious identity. Next, I turn my attention to the strategies staff employ to externally negotiate these identities amidst a sense of outsiderness. In what follows, I examine how staff legitimize this practice of pro-woman care.

IV. Legitimizing Care

Christian Smith (1998) holds that evangelical Christianity thrives on feelings of embattlement, that orthodox evangelicalism endures because of the perceived challenges of the modern, fallen society. Not only does this reaffirm their religious identities, but it inspires "engaged orthodoxy" in which evangelicals feel duty-bound to act out God's will and change society. Kimberly Kelly (2014b) demonstrates how this "evangelical underdog" narrative functions at the moment level to inspire increased participation in pregnancy center work. Embattlement and marginalization emerged as a salient feeling in both centers, reflecting the collective memory in each center rather than their daily reality. Staff use this feeling to legitimize their form of "engaged orthodoxy" in the pregnancy center context. My findings align

well with Kelly's (2014a) analysis of movement frames which position CPCs as victims of pro-choice "attacks" and secular, "fallen" world. I expand this analysis to demonstrate how staff also position themselves against others within the pro-life movement and ultimately use these embattled identities to legitimize their approach to care.

Staff constantly communicate feelings of outsiderness—they face derision from other factions of the pro-life movement and criticism from the pro-choice movement. They conclude that this condemnation is unfounded and exists because of ignorance. Imogene claims Urban Care's detractors simply "don't know what pregnancy centers do!" Staff like Evelyne wish these folks "would just come talk to me or talk to us. Come in! The doors are open! Walk on in! We can have a conversation about what we do." Nearly every staff member expresses feeling as if they are under attack. Amid this embattled, threatened state, staff work to position themselves as legitimate providers of ethical, 'whole-woman' care.

Mountain Care and Urban Care achieve a sense of legitimacy by using three specific strategies to establish their own sense of authority on abortion and position their form of care as virtuous: (1) centers rhetorically distinguish themselves from pro-life others; (2) centers frame their work as "more pro-choice" than their pro-choice counterparts; and (3) centers reference their perseverance in a "morally broken" society.

A. Distancing from Pro-Life Others

"We're not the crazies!" Anne exuberantly exclaims. Imogene adds nuance to this perspective when she highlights the "long spectrum" of pro-life activism, explaining on one end, "you've got the wackos that are killing the abortion providers," and on the other, "you've got the devoted prayer warriors who are not talking with anyone except for God. And then you've got

pregnancy centers right in the middle that toe that line." Staff often juxtapose their work with the actions of "others" in the pro-life movement. In fact, Imogene and Anne prefer their organizations avoid the label 'pro-life,' because they believe it has negative connotations. Imogene clarifies, "I don't want someone to hear pro-life and think, I can't tell them I had my abortion." She goes on to list several other 'negative' associations with the pro-life label including being considered judgmental and overly concerned with babies.

These "othering" strategies (Fine 1994) primarily serve to create distance between pregnancy centers and extremists but also function to legitimize their style of engagement against a backdrop of more passive pro-life activism. Danielle explains that the confrontational style of extremists—those "crazy people who like yell at women when they walk into Planned Parenthood and show them pictures of aborted babies. [Who] say that if you had an abortion you're going to hell"—is hateful and ineffective. Institutionally, Mountain Care does not participate in any picketing or pro-life organizing to avoid a 'too' pro-life stigma. Yet, these organizations also defend themselves against criticism from, as Imogene characterizes it, the more "conservative portions, who say: 'how dare you talk about [abortion]?'" An inquiry to which she replies, "how dare you don't! …get your head out of the sand!" Jillian emphasizes this point by saying, "if we didn't talk about abortion, we'd be manipulating women!" Evelyne notes talking about her job is actually "harder with my religious friends" who negatively judge her for speaking about abortion with clients.

Highly aware of critiques of pregnancy centers as manipulative, staff also engage in "defensive othering" (Schwalbe et al. 2000) in which they tentatively support media

denunciations of other pregnancy centers in order to position their work as moral. Staff report other centers may manipulate women, like Evelyn who states:

> I mean, a lot do! They might say that they're not going to sway you, but like you get there and- I've heard that a lot from my clients. I've had a lot of clients come in with past experiences at pregnancy centers where they felt very manipulated. I think I want to validate that…I also want to say that there's so many that don't! There's so many that don't manipulate…you got to do your research.

In this way, Evelyn distances Urban Care from other pregnancy centers to reinforce the legitimacy of Urban Care and how much they care for women.

Staff affirm the appropriateness and rightness of their work in the pro-life movement through positioning their care as moderately poised between two extremes and by framing it as more loving, rational, and realistic. In identifying and "othering" distinct groups within the pro-life movement and even other pregnancy centers, staff validate their own 'good' work. This "othering" is a form of emotional management that works to evoke an internal sense of goodness and rightness, while simultaneously crafting a 'soft,' feminized public image. Staff are concerned with validating their work in this way for clients and outsiders but, more importantly, for themselves.

B. Pro-Choice Centers?

Staff carefully consider the labels they affix to their organizations. Like Anne, who initially characterizes Mountain care as pro-life but quickly amends her statement, "I think we're actually more pro-choice. I think we are advocating for more choices!" Staff rely upon a rhetoric of "informed choice" to describe the counsel they provide women facing an unplanned pregnancy. 'Informed choice' stands in stark contrast to what staff consider to be the "pro-abortion" stance of the pro-choice movement. Celeste clarifies this position:

> Pro-abortion means that you believe that abortion is right. It bothers me that *they* call themselves "pro-choice" because I believe *we* are pro-choice. My personal view is pro-life but I think what I do in my job is pro-choice. And Planned Parenthood…they *want* people to have an abortion! You go there and that's what you're funneled into. They don't ask you if you have thought about what you want to do…they are assuming you go there because you're going to have an abortion. I've had my clients tell me that they were not given any option beyond that…And I don't believe that *that's* pro-choice.

Celeste articulates a pro-choice position as a desire for "every woman to know exactly what choices are available to her *and* that she has the resources to make any of those choices work for her."

Staff consistently paint the pro-choice movement as full of profit-driven liars. A statement on each clients' intake documents at Mountain Care reminds clients that Mountain Care does not profit from any decision they make; something staff believe makes their services less biased and more sound than abortion providers.[56] Staff portray their pro-choice counterparts as misguided. Celeste tells me they "genuinely believe they are helping women" but in reality pander to the "abortion-industrial complex" that tells women abortion is an easy solution to their problems. Staff contrast that version of 'choice' with their approach—a more informed choice, that considers the "reality" of abortion. Here, staff frame their work as more 'pro-choice' than their pro-choice counterparts. Staff believe their understanding of 'choice' to be more nuanced and caring, thus legitimizing their role as an essential counterweight to a profit-driven abortion industry.

C. Perseverance

"The proof is that we've been here since 197X, so there's a need for what we do…people should have options and that's one of the reasons why we've successfully been in this

[56] CareNet—"a nonprofit organization that supports one of the largest networks of pregnancy centers in North America"—requires all its affiliates to offer "services free-of-charge at all times" (CareNet 2018).

community…Being in a community for more than 40 years says we're a place for women to come to!" Anne authoritatively points to Mountain Care's history as 'proof of concept.' Both Urban Care and Mountain Care have long histories in the Mountain West, a source of pride and validation for staff. Hope reports Urban Care is "one of the biggest pregnancy centers in the country! We have a lot of offices, a lot of ultrasound machines, a ton of donors, and we have a pretty big staff for a non-profit. And I feel like there's a reason for that." That reason, according to Hope, is serving clients well based on "research informed practice," "annual reports that show success," and "listening to clients." With over 35 years of experience, Urban Care has carefully crafted organizational practices around abortion. Hope explains:

> Like with our abortion handout, we are asking questions informed by over 35 years of doing this work. None of the questions on there are *me* saying, this is a good question. It's a post-abortive woman who said: 'I wish someone would've asked me this question. I wish someone would have told me there was a physical risk.' …That's another reason why Urban Care gets it; because we are using information from *actual* people, who have actually walked this road. Because we love them well and they come back and talk to us because we didn't shut the door on them, because we didn't make them feel so judged that they couldn't come back. Because we have women coming back to us saying: 'I had an abortion…and I'm so glad you asked me those questions. I'm sorry I didn't listen.' That's their words!

Yet, staff experience their existence as a struggle. Located in what staff characterize as predominantly liberal communities, Anne draws a contrast between pregnancy centers located in the "Bible belt" with "all the support and help they could ever need," with the struggles of Mountain Care: "it's not easy to be here. But that's all the more why we need to be here." Blanche explains "it's like pulling teeth here because of the—I don't want to say it, but because the liberal population. I think they think we're taking a woman's choice away from her. When it's actually the opposite!" Staff rely upon a discourse of victimization when recounting their experiences in the larger community, frequently recounting personal incidents to support these narratives. At a community festival, Danielle recalls:

> People walked by and yelled at us! Like they won't come up and talk to us, but they'll yell from 10 feet away: 'Don't trust these people! They lie to women, they deceive women, they force them to keep the babies,' and they like walk on by. And this happens consistently. Like often enough, that it's not unusual.

Some years ago Mountain Care was "victim" to an undercover investigation carried out by a local college student who surreptitiously scheduled an appointment at Mountain Care. Staff claim that the female blogger was not able to level any deep criticisms—because as Danielle points out, "thankfully we don't do *that* as a center"—but this incident contributes to the collective memory of Mountain Care. Staff believe their work is challenging but necessary and the fact that they persevere through trials—criticism, unsupportive communities, the emotional toll of their work—is a testament to the good work they do and that they are "on God's side." Pregnancy centers' staff feel both under attack and righteous, an experience that contributes to their overall sense of legitimacy.

V. Conclusion

Pregnancy centers respond to what they perceived to be the 'abortion problem' by constructing "pro-women ministries" intended to provide "life affirming alternatives to abortion." Both Mountain Care and Urban Care rely upon a rhetoric of "pro-woman" care to characterize the work they do as distinct from others in the pro-life movement and their counterparts in the pro-choice movement. Each center describes pro-woman care as providing the medical, emotional, and spiritual care and social resources they believe women need in order to feel like motherhood or adoption are plausible choices. Additionally, they perceive their work to be part of ensuring a woman experiencing an unplanned pregnancy is making an informed decision about her options. In this way, each center discusses the physical and emotional risks of abortion and works to provide a 'heart-centered' ministry that ensures a woman fully understands

the traumatic repercussions of abortion. For both organizations, this is a means of ministering to others and living out their faith. Yet, this form of ministry must be carefully cultivated in staff.

The findings presented in this chapter demonstrate the ways in which staff rely upon a *pro-woman care script* to align their personal religious beliefs and pro-life views with organizational constructions of ministry. These organizational forms of ministry do not always coincide with the understanding of abortion, clients, or the personal religious practices that compel staff to work in these pregnancy centers. To manage these discrepancies and to realign staffs' views with organizational practices, Mountain Care and Urban Care rely upon a *pro-woman care script*. This script functions to: (1) frame abortion as trauma; (2) imagine a vulnerable client in crisis; and (3) use evangelical schemas to shape the approach to care. I argue that this approach is a form of religious identity work, in which a *pro-woman care script* creates an imperative to bring staffs' authentic, pro-life worldview in-line with perceived organizational 'feeling rules.' Therefore, pro-woman care requires significant emotional and moral labor from staff. Staff also rely upon these scripts to justify their form of care and to legitimize the work they do amidst the larger pro-life movement and secular pro-choice movement.

These scripted narratives have significant implications for staffs' religious identities and the performance of caring labor in pregnancy centers. These scripts help staff to maintain a cohesive religious identity in which they can both hate abortion and feel empathy for women considering what they know to be a heinous action. These scripts enable staff to view their work as hard but good, and thus themselves as virtuous, Christian women who are more realistic, display more kindness, and are more pro-choice than 'others.'

Despite having similar narratives of care, Mountain Care and Urban Care each interpret this 'pro-woman' frame in distinct ways, leading to different performances of care. Mountain Care practices a "medical model of care" in which informed decision-making revolves around ultrasound care. In contrast, Urban Care prefers a "social work model of care" in which they foreground counseling. In the following chapters, I turn to examine how 'talk' moves to practice. In Chapter 5, I examine the performance of care at Mountain Care, while in Chapter 6, I analyze Urban Care's model.

Chapter 5: "Gummy Bears" and Teddy Grahams": The Ultrasound and the Social Construction of Reality in Client Appointments at Mountain Care

I. Introduction

"You can do it! We want to get you the tools to do it," implores Celeste as she reaches forward to gently place her hand on Caroline's knee. Less than seven weeks pregnant and unsure if she wants to continue her pregnancy, Caroline (23, white) is visiting Mountain Care for her second appointment. Encouraged by Celeste to return to Mountain Care for an ultrasound to help in her decision-making, Caroline lays quietly on the vinyl exam table in the darkened ultrasound room as Celeste performs a trans-vaginal ultrasound.

At Mountain Care, appointments like Caroline's are termed "difficult," because these clients are considering abortion. Staff informally designate appointments as 'difficult' or 'easy.' In easy appointments, staff care for women who wish to continue their pregnancies and for whom they can easily find various ultrasound 'landmarks.' Difficult appointments are those in which women are undecided, want an abortion, or those in which staff believe women are or are likely to miscarry a desired pregnancy. During my time at Mountain Care, I observe both 'easy' and 'difficult' appointments. Easy appointments characterize the majority of client visits; yet, for staff, difficult appointments are the most memorable and meaningful. These designations not only reflect the emotional labor involved in translating a *pro-woman care script* into practice, but also the moral significance staff attach to their work, in which doing hard work is doing good and important work.

In this chapter, I use ethnographic data collected from nine months of participant observation and interviews with clients and staff at Mountain Care to detail how staff enact the

pro-woman care script detailed in the previous chapter. In Chapter Three, I analyzed the ways in which care is a social and religious construction that reflects and frames staffs' values and understanding of the world. In this chapter, I depict how those values become actions. While my previous chapter examines how staff talk about care, this chapter describes and analyzes how care is performed in client appointments at Mountain Care.[57] To do so, I first explain Mountain Care's "medical model of care," noting how this medicalized approach reflects broader trends in the CPC movement and revolves around ultrasound care. I then analyze the ultrasound as a form of biopower. Next, I depict typical 'easy' and 'difficult' pregnancy-related appointments, analyzing each for how they reveal complexities in the *pro-woman care script* and serve as a means to socially construct reality for both clients and staff. Finally, I discuss the significance of these performances for staff, explaining how 'pro-woman care' is a means of 'doing religion.'

II. A Medical Model of Care

Mountain Care's central office is situated just across a busy arterial from Mountain View High School—a racially diverse high school serving roughly 1100 students. Some days Mountain Care's lobby teems with clients scheduled in back-to-back appointments and donors dropping off baby bottles filled with loose change or packs of diapers; on others days, it remains silent. Staff laugh as they describe their schedules as unpredictable as the local weather.

The clients I observe seeking services at Mountain Care are disproportionately women of color, and the vast majority of clients are uninsured. Though I observe and interview women ranging in age from 17 to 39, many of these women are in their 20s and unmarried. During my time at Mountain Care, I witness staff care for women without high school degrees, women

[57] The following chapter will examine how care is performed in client appointments at Urban Care.

completing college degrees, and women who hold advanced graduate degrees. Christians, atheists, Muslims, and spiritual believers pass through their doors. While the women I interview explain a range of motivations that propel them to Mountain Care, I most frequently hear them cite free services—particularly the opportunity to receive a free ultrasound—as the primary impetus.

At Mountain Care, the ultrasound is a key component of their "medical model of care." Characterizing their approach as unique among pregnancy centers, staff explain that their medical model promotes "whole women care" in which clients' physical, emotional, and spiritual needs are approached with dignity and objectivity. While staff understand their work as a ministry, they employ a medicalized framework to introduce, moralize, and legitimize their care as virtuous. Their organizational interpretation of ministry therefore dictates the use and delivery of medical technology, which, at Mountain Care includes urine pregnancy tests and ultrasound services. In this way, medical technologies intertwine with religiosity to create a unique form of care in which staff provide medical and material services as a means of living out their faith and ministering to women.

As Mountain Care's *pro-woman care script* conceptualizes a vulnerable client considering a traumatic abortion, staff perform care in ways that emphasize the trauma of abortion, the humanity of the fetus, and structure choice as a moral undertaking. Staff explain that they provide care that empowers clients to make healthy decisions. Nowhere is this "tender confrontation" more clear than in the darkened ultrasound room, where staff perform highly personable ultrasounds as a means to inspire connection. Mountain Care, like pregnancy centers across the United States, has adopted ultrasound technology as central to their ministry. Yet,

rather than something that makes them unique,[58] the provision of ultrasounds is a key strategy that reflects broader trends in the CPC movement at large.

A. Ultrasounds and the 'Medical Turn' in Pregnancy Center Care

As detailed in the introductory chapter, pregnancy centers have a long, complicated history and currently occupy a contentious place in the public consciousness. In reaction to criticisms about graphic videos, unwanted evangelism, and outright coercion (Solow 2003), some pregnancy centers underwent "medical conversion" (FRC 2009, 2012), adopting what Anne refers to as the "medical model of care." Motivated by a desire to capitalize on the social respect granted to medical authority and to "go head to head with Planned Parenthood" (Anne), the CPC movement is steadily adopting medical services—primarily urine pregnancy tests and ultrasounds—as standard practice. Simultaneously, in a calculated shift away from religious rhetoric, pregnancy centers have begun to employ biomedical discourse to make their message more compelling and legitimate (Pollack Petchesky 1984). In a 2009 report, the Family Research Council (FRC)[59] extolls the growth of "medically oriented pregnancy centers," and predicts this trend towards medicalization will become the new norm for pregnancy centers (25). The FRC bases these assertions on data collected by CareNet which reveal that the number of CareNet affiliates which offer ultrasound tripled between 2003 and 2006 (FRC 2009). While

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[58] What *may* make Mountain Care unique is that options counseling and ultrasounds are provided by Registered Nurses, a practice Anne promotes as important to their objectivity and legitimacy.

[59] The Family Research Council (FRC) is a conservative, Christian nonprofit based in Washington DC. It acts as an activist group, with an affiliated lobbying organization. Its stated "vision" is "a culture in which all human life is valued, families flourish, and religious liberty thrives" (FRC 2018) and "to advance faith, family and freedom in public policy and the culture from a Christian worldview" (FRC 2009).

[60] Some centers also offer STI testing and some level of prenatal care.

pregnancy centers are shifting to provide a range of medical services,[60] their primary focus remains the limited obstetrical ultrasound.[61]

Portraying ultrasound technology as a "window to life," pregnancy center networks began urging their affiliates to employ ultrasounds as a key part of their work around the turn of the twenty-first century. In 1998, the National Institute of Family and Life Advocates (NIFLA)[62] launched The Life Choice Project (TLC) as a "comprehensive medical conversion program" to support pregnancy centers with key resources in their conversion to "medical clinic status" (NIFLA 2018). As the leading provider of legal information and support to pregnancy centers, NIFLA explains how pregnancy centers can provide ultrasound services as medical clinics:

> A center must be a licensed medical clinic under the laws of the state in which it operates. Unless dictated otherwise by state statutory regulations, a "medical clinic" is a facility which provides medical services under the supervision and direction of a licensed physician…[In most states] the only legal requirement to be a clinic is to have a physician (MD or DO) who is licensed to practice medicine in the state serve as the Medical Director and supervise all of the medical services being offered. The legality of the center providing medical services flows from the legality of this physician to practice medicine under his or her medical license…A PMC [Pregnancy Medical Center] continues to provide crisis intervention counseling for women. By "converting to a medical clinic" a center is not changing its mission. Rather, it is enhancing the mission by attracting, reaching and serving at risk women with the professional medical services that are needed…The provision of ultrasound services is the practice of medicine (NIFLA 2019b: "Frequently Asked Questions").

Conversions are expensive, with ultrasound machines, printers, staff training, and annual maintenance costing tens of thousands of dollars. The adoption of ultrasound technology is

[61] A limited ultrasound establishes a uterine pregnancy, confirms fetal cardiac activity, and verifies gestational age.

[62] The National Institute of Family and Life Advocates (NIFLA) is a non-profit organization providing "life-affirming PRCs [pregnancy resource centers] with legal counsel, education, and training" (NIFLA 2018a).

enabled, in part, with funding provided by Focus on the Family's[63] Option Ultrasound Program (OUP) initiated in 2004 and NIFLA's TLC. The OUP offers grants to urban pregnancy centers "targeted by large abortion providers," to assist in the purchase of an ultrasound machine, sonography training for medical staff or volunteers, and "medical conversion funds" (Focus on the Family 2018).[64] This funding has effectively enabled the widespread medicalization of pregnancy centers. According to NIFLA, nearly 1,200 of their members have transitioned to "life-affirming medical clinics" (NIFLA 2018a). There is widespread movement support for these expensive conversions because the CPC movement regards ultrasound technology as an emotional aid—a tool to promote bonding between 'mother' and 'child.' Focus on the Family, NIFLA, pregnancy center networks, and their affiliates cite the power of images and sounds provided by ultrasound as a vital component in women's decision-making, purporting a woman is more likely to choose life when she can see her 'unborn child.' NIFLA claims, "more than 80 percent of abortion-minded mothers choose life after they see their unborn baby via ultrasound" (NIFLA 2018a), and Focus on the Family asserts their Option Ultrasound Program has saved "an estimated 425,000 precious moms and their babies!" since 2004 (Focus on the Family 2019).

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[63] Focus on the Family is a conservative, evangelical Christian non-profit, that provides "help and resources for couples to build healthy marriages that reflect God's design, and for parents to raise their children according to morals and values grounded in biblical principles" (Focus on the Family 2019). Focus on the Family values evangelism; natural, immutable differences between men and women; a view of marriage as "intended by God to be a thriving, lifelong relationship between and man and a woman;" and value the "sanctity of human life…from conception to natural death" ("Our Values" 2019).

[64] In order to qualify for support a pregnancy center must serve a "metro city population of 300,000 or more" (which pairs well with Heartbeat International and CareNet's Urban Initiative Project targeting low-income African American women) and is required to meet other external criteria including having a four-year university with a student body of at least 15,000, and "four or more public abortion providers" (Focus on the Family 2018).

Ultrasounds are now a routine diagnostic tool utilized in United States pregnancy care. Yet, the emotional function of the ultrasound is not well understood. Current literature reports nebulous psychological effects, including an unclear relationship between ultrasounds, maternal attachment, and attitudes toward the pregnancy or fetus (Baillie et al. 1999; Garcia et al. 2008; Rustico et al. 2005; Taylor 2008). For example, Baillie and colleagues (1999) report that attachment increases linearly throughout a pregnancy regardless of technological intervention and that attitudinal shifts towards the pregnancy or fetus can be attributed to a "lengthy and reassuring consultation" rather than the viewing of an ultrasound (155). Similarly, research contradicts movement claims that viewing an ultrasound inspires a decision to continue a pregnancy. In a quantitative study examining the influence of viewing ultrasound images on abortion decisions at a large, urban abortion provider, researchers found that among patients who opted to view their ultrasound image, 98.4 percent continued with their pregnancy termination. This indicates 'seeing' does not alter decision-making for the majority of women, at least for those receiving services at an abortion provider (Gatter et al. 2014). What this research suggests, is that the "window to life" is not the ultrasound itself, but rather the multiple layers of interpretation and explanation in the ultrasound experience (Boucher 2004). In this way, the ultrasound acts as technology which shapes pregnancy as a biosocial experience (Mitchell 2001), or one which a pregnant person experiences physiological changes that are inextricably intertwined with social meaning.

Pregnancy centers, as both medical and faith-based institutions, use ultrasound technology to create particular experiences for clients and staff. Given both the trend toward increasing medicalization in the CPC movement and the guided-ultrasound's potential to

construct a woman's experience of pregnancy, it is important to carefully consider the implications of the use of ultrasounds in pregnancy centers. In the following section, I use Foucault's concept of biopower to analyze the ways in which ultrasounds shape both the individual and social experience of pregnancy.

III. Ultrasounds and Biopower

Pregnancy is a biosocial experience: physical transformations, shaped and molded by social phenomenon (Mitchell 2001). Ultrasounds and the images they produce are "one of the most common rituals of pregnancy" and play an important role in constructing the embodied and social experience of pregnancy in the highly visual culture of the United States (Mitchell 2001, 3). To understand how ultrasounds have become culturally meaningful and produce ideas about fetuses, women, and reproductive politics, Michel Foucault's concept of biopower (1990) and feminist interpretations of the ultrasound as a disciplinary technology are particularly useful lenses through which to examine the ultrasound experience at Mountain Care. Viewing the ultrasound as biopower reveals how this medical technology manages the pregnant body while simultaneously creating a fetal subject. In revealing and entering into "the order of knowledge and power" the fetus—an entity which, historically, was enveloped in a woman's body and obscured from view—the ultrasound becomes a means by which both the fetus and woman are subject to disciplinary power.

The public and private roles of fetal imagery have been the focus of feminist scholarship since its introduction in the 1960s.[65] This intersectional research examines how and why

[65] See for example: Boucher 2004; Haraway 1997; Mitchell 2001; Palmer 2009; Pollack Petchesky 1987; Rodrigues 2014; Taylor 2008; Sanger 2017; and Weir 2006.

ultrasounds become imbued with deep, emotional meaning and the various ways to utilize ultrasounds in pregnancy. How an ultrasound is perceived is highly contextual, depending on the conditions of the appointment, the relationship between the viewer and the image, and the significance ascribed by and to the viewer and images (Mitchell 2001; Palmer 2009; Pollack Petchesky 1987; Taylor 2008). By examining context, it becomes clear that the ultrasound acts as more than mere medical technology revealing 'objective' truths; it is a personal and political tool housing the ideas, aspirations, and visions of those who use it and those upon whom it is used (Pollack Petchesky 1987). Ultimately, this scholarship recognizes ultrasound technology as a tool used to control the behavior of pregnant women (Rodrigues 2014, 52) and a tool through which its users construct reality. In this section, I first explain Foucault's concept of biopower and then explore the ways in which ultrasounds produce fetal knowledge and render women's bodies docile. Finally, I examine how the ultrasound, as a disciplinary technology, takes particular forms in the antiabortion/pro-life movement.

A. Biopower

At its core, Foucault's biopower refers to the social control over physical bodies through 'techniques of power' that allow for the regulation of individuals and populations. Foucault claims various institutions create regulatory controls and disciplinary measures to subjugate human bodies to both individual bodily management and population control. In this way, power operates on two axes: the "anatamo-politics" of the individual body and the "biopolitics" of the population. It is in utilizing both poles that the body is subjected to surveillance, control, examination, and the subtle "micro power concerned with the body" (Foucault 1990, 146). In the first axis, the individual body is treated as a machine to be rendered more docile through

discipline, thus optimizing its capabilities and utility. The second biopolitical pole refers to the "interventions and regulatory controls" that occur on a population level, those which manage "propagation, births and mortality, the level of health, life expectations and longevity" (139). In the nineteenth century, these two axes converged to form a unique iteration of power focused on managing life. Power came to represent the preservation and investment in life because "it was the taking charge of life, more than the threat of death, that gave power its access *even to the body*" (143, emphasis mine). According to Foucault, modern power is diffuse and encoded in social and behavioral practices to which citizens willingly comply. No longer merely repressive, Foucault (1991) saw power as productive, a force which produces reality and "rituals of truth" (194). This conception of power allows for the ultrasound to be considered a technique of control which operates on both the individual and population level as a technological ritual which produces 'truth' and promotes normative bodily conduct. Not only does the ultrasound shape the embodied experience of pregnancy but it is simultaneously used as a tool to control population health through the screening for fetal anomalies and monitoring of healthy and risky pregnancies (Mitchell 2001). Importantly, this biopower operates through hegemony, in which women not only consent to, but desire their own corporeal management.

Pregnant women in the United States consider ultrasounds a healthy, medical decision (Mitchell 2001) and often want to 'see' their baby for reassurance or connection (Gudex et al. 2006; Santalahti et al. 1998; Stephens et al. 2000). Janelle Taylor (2008) reports that "while it is true that the exam is often fraught with anxiety over the possibility of a "positive" diagnosis of fetal anomaly or death, it is also true that many women look forward to and enjoy ultrasound, and even actively seek it out" (121). This desire guarantees, in Foucault's (1990) words,

"relations of domination and effects of hegemony" in which women *want* to participate in their own management (141). Even in 'low risk' pregnancies, ultrasounds are considered a routine, necessary, and desirable part of pregnancy care (ACOG 2017),[66] despite a lack of evidence supporting advantageous perinatal morbidity and mortality outcomes (Hemingway 1991; Goldberg 2000). While ultrasound technology is a useful diagnostic tool utilized by the medical community, the ultrasound's primary power lies in the cultural meaning embedded in the images it produces (Pollack Petchesky 1987; Taylor 1998); it is important because it reveals *your "baby"* and its health. In this way, both the experience of an ultrasound—which often renders women's bodies invisible or as barriers to see through—and the 'knowledge' of a fetus it produces, are means by which to enact power over and through women's bodies, means by which to subjugate pregnant bodies to hegemonic control. As technology which helps to transform the experience of pregnancy into a measured and controllable experience, the imagery produced by ultrasound tends to be exploited in two distinct ways: (1) to unveil and produce a 'baby'—a separate, human individual with distinct characteristics (Mitchell 2001; Rodriguez 2014); and (2) to control women's conduct by initiating an emotional bond with her 'baby' (Taylor 2008; Rodriguez 2014).

B. Producing the Fetus and Docile Women

Ultrasounds are commonly considered 'neutral' technology, capable of providing a 'window' into the uterus (Mitchell 2001). In seeing through the pregnant body to make visible a 'baby,' ultrasounds are perceived to confirm the status of the fetus as an autonomous human.

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[66] Medically, ultrasounds may be used as part of prenatal diagnosis and as a key part of pregnancy management (including for abortion, pregnancy, and labor). Ultrasounds are often used to determine fetal gestational age, the number of embryos or fetuses in utero, fetal viability, placental health, amniotic fluid levels, and—later in the pregnancy—fetal positioning.

Rosalind Pollack Petchesky (1987) argues this is significant because visibility allows for the treatment of "a fetus as if it were outside a woman's body" (272). Rather than an objective display, this is a highly political act because it personifies a fetus, allowing for the fetishization of the fetus as an independent individual (Duden 1993; Pollack Petchesky 1987). Similarly, the ultrasound is not neutral because it requires 'expert' interpretation to make sense of the grainy images produced, an interpretation which, in part, is a reflection of the viewer's values (Pollack Petchesky 1987). As Lorna Wier (1998a; 1998b) highlights, the discourse around ultrasound imagery is not impartial. Weir's research demonstrates how a fetus becomes a "baby" to appeal to social recognition, inviting those who view fetal imagery to accept a fixed understanding of this 'objective' technology and to see a social 'baby' complete with all the associated trappings (Wier 1998a; 1998b). While fetuses gain personhood through an ultrasound, women tend to become managed bodies in support of a pregnancy.

In-utero images 'reveal' a fetal 'baby' by obscuring the pregnant woman (Mills 2011; Pollack Petchesky 1987; Rodrigues 2014; Rothman 1987). An ultrasound is used to visually display that a woman's body is no longer her own; graphic evidence which providers use to support their prenatal care recommendations for various behavior modifications regarding food consumption and substance use (Field et al. 1985; Lumley 1990; Mitchell 2001; Reading and Cox 1982; Reading et al. 1982, 1988; Taylor 1998). As Sara Rodrigues (2014) explains, this is a means by which to discipline reproductive bodies under the auspices of protecting future generations: women's bodies are to be managed to "optimize the quality of future populations" (59).

Within the ultrasound experience, women become "subjects whose relation to their own embodiment is rendered newly problematic by new technologies of visualization" (Taylor 2008, 29). Traditional, physiological markers of pregnancy have been supplanted by a "technological quickening," in which the visual provided by ultrasound is used to confirm pregnancy, assure health, and stimulate parental bonding (Mitchell 2001; Taylor 1998). Herein, women become unreliable sources of knowledge about their own bodily experiences, justifying increased technological interventions in pregnancy care. Insofar as pregnancy is constructed as a medical condition requiring technological intervention, protection, and maternal behavioral modifications, pregnant women become a population to be controlled. Sara Rodrigues (2014) summarizes the implications of this intervention: "politically and culturally, the regulation of the behavior of pregnant women protects and preserves their capacity for reproduction, which is an important factor in the measure of their value" (60). For pregnant women considering an elective abortion, this construction of a fetus and pregnancy undermines their agency and provides only one pathway by which to make sense of their decision-making: as a moral, emotional, life-or-death choice—a construction emphasized by the CPC movement.

C. Ultrasounds in the CPC Movement

Rather than considering the ultrasound a political or religious tool, the CPC movement frames the ultrasound as neutral. The movement evokes the perceived medical-technical authority of the ultrasound to invoke a sense of legitimacy and objectivity for their claims. The CPC movement relies upon in-utero images as a kinder, gentler, more scientific way to 'reveal' the 'miracle of life' (Boucher 2004). The visual culture of the CPC movement fetishizes fetuses by investing deep feelings into an imagined fetal person. With the widely available images

produced by sonograms, antiabortion activists and their supporters claim these images produce evidence to restrict abortion access and to increase gestational-age-based restrictions based on visible fetal development (Palmer 2009). Opponents of abortion claim that ultrasound images likely dissuade women from choosing abortion, whereas abortion-rights activists claim ultrasound viewing may create an excessive emotional burden for women (Kimport et al. 2012). This is particularly important in the pregnancy center context, in which ultrasounds make it possible to impart religious world-views through medical services.

Due to the difficulty of gaining access to these spaces, scholarship has not yet examined the ultrasound experience within pregnancy centers. The data and analysis presented below represent the first ethnographic account of ultrasound care in a pregnancy center. Existing scholarly research has not yet established a baseline from which to assess the representativeness of the experiences I describe below and I do not claim these experiences are representative of every center—in fact, the ultrasound experience at Mountain Care was distinct from that at Urban Care. However, the ultrasounds provided at Mountain Care represent one iteration of how pregnancy center care is enacted according to their interpretation of pro-woman care. In the following section, I detail how this care is delivered at Mountain Care, paying particular attention to the ways in which their performance of care aligns with or contradicts their construction of care through *pro-woman care scripts*.

IV. Ultrasounds and Pro-Woman Care at Mountain Care

Mountain Care, like most pregnancy centers with ultrasounds services, provides early, limited obstetrical ultrasounds. It is standard practice for prenatal care providers to offer an ultrasound between 18-22 weeks of pregnancy. First trimester ultrasounds are not standard

practice, as it is too early to see with sufficient detail fetal organs and limbs (ACOG 2017). Yet, the vast majority of ultrasounds conducted at Mountain Care occur within the first trimester. While the nurses at Mountain Care always begin with a trans-abdominal ultrasound—coating a woman's abdomen with jelly and passing a transducer over her body to create a sonogram—clients are often so early in their pregnancies that the nurses cannot obtain images with identifiable 'landmarks.' Rather than inviting a client to return at a later date, nurses commonly request to perform a transvaginal ultrasound to provide clearer imagery. This is a far more invasive ultrasound in which a condom-sheathed probe is inserted, by the practitioner or client, into the client's vagina. Upon seeing the long probe many clients became uncomfortable. The nurses would soothe a client's nerves by explaining, "it's just like a big tampon," reassuring her that the whole probe does not enter her body.

Because of the gestational age, the pixilated, 2D images flickering on the screen in front of clients rarely look like a baby; instead, these images require authoritarian interpretation by one of the three registered nurses[67] to guide a particular visioning of the ultrasound. Cloaked in white lab coats or brightly colored scrubs, the nurses of Mountain Care interpret—as experts—the grey-scale images on the monitor. The earliness of most client's pregnancies and the trappings of medical authority, provide Celeste, Miranda, and Bonnie more leeway to interpret an ultrasound *for* the client, rather than with her. To confirm the meaningfulness of the landmarks they emphasize during the ultrasound, printouts of the scans are paired with pamphlets displaying photographs of fetal development and nurses often recommend a pregnancy-tracking smartphone app.

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[67] Two of the RNs are employees and one is a part-time volunteer at Mountain Care.

Ultrasounds are the focal point of appointments at Mountain Care. While most appointments begin in the counseling room, the bulk of a client's appointment revolves around the ultrasound and clients generally spend the most time in the ultrasound room. I observe ultrasounds by all three nurses at Mountain Care; though I primarily sit-in on those performed by Celeste and Miranda, who both work in the central office.[68] After a few weeks of field work, Celeste and Miranda welcomed my presence in client appointments, explaining they were excited to share their work. As Mountain Care policy requires a third person in the ultrasound appointment (with the explicit purpose of avoiding coercion), when clients did not complete my study form (or even if they marked "Yes" for abdominal ultrasounds but "No" for transvaginal ultrasound observations), Celeste or Miranda would "double check" with them, speaking positively about my study and often saying "we need another person in there anyways!"[69]

Before a client enters the ultrasound room, the RN already knows the client's stated intentions—they have had a conversation in-person or on the phone about the client's plans and feelings about the pregnancy. This is generally a brief discussion held before a urine pregnancy test and subsequent ultrasound. If a client is unsure of her pregnancy options, it is typical for a more extended discussion to occur after the ultrasound. Staff limit the initial intake counseling because, as Bonnie explains, the ultrasound provides "information they need to make a decision." While this 'information' includes pregnancy viability and gestational dates, staff also

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[68] Bonnie works in a smaller office in a nearby city, but when Celeste left for vacation, I observed Bonnie perform two ultrasounds at Mountain Care Central.

[69] As I discussed in Chapter Two, this practice made me highly uncomfortable. While I would also check with the client, assuring her I only wanted to observe if she was ok with it, this practice opened up space for clients to feel coerced into my observations. Additionally, my silent presence as a "researcher" could have unintentionally lent legitimacy to the practices at Mountain Care. Yet, with a client's reassurances, I sat in on these ultrasounds to avoid the perceived awkwardness of undermining my gatekeepers' authority and because of my desire to collect data in rarely presented opportunities.

subtly use the ultrasound as a means to invoke emotions. At Mountain Care I frequently observe 'easy' appointments; 'difficult' appointments occur less frequently (or at least I am allowed to observe them less frequently), but provide rich data and serve to reveal important slippages within the performance of a *pro-woman care scrip*t.[70]

In "easy" appointments, a client has stated her intention or desire to continue the pregnancy. While staff may characterize some of these women as "abortion vulnerable" in conversation or within their online client portal—meaning they may face circumstances staff believe could potentially lead them to desire an abortion—these women are actively seeking an ultrasound. Difficult appointments are characterized by an unsure client or a client considering abortion. Below, I describe and analyze typical "easy" and "difficult" appointments.

A. "Easy" Appointments

Hannah, a white woman in her mid-twenties, makes small talk as she walks with Celeste back to the counseling room, "I'm surprised there are no protesters here! Back [home], abortion is a big thing—maybe because it's more liberal here?"[71] Celeste replies in agreement and then explains, "well, we don't offer abortions here." "Oh! I don't want one!" Hannah exclaims. Both she and Celeste laugh, while Celeste tucks her clipboard under her arm and guides Hannah to the back saying, "we are in the business of saving lives here."

A few minutes later, Celeste invites me back to the ultrasound room. I enter the small, square room dominated by a vinyl exam table. Celeste has closed the blinds and turned off the

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[70] I am unsure if this is because of selection bias (women who are more certain of their decision are more likely to opt-in to my study) or because Mountain Care serves a disproportionate number of women who desire to continue their pregnancies.

[71] I did not interview Hannah, thus cannot provide demographic information like self-reported race and age.

overhead lights; the space is bathed in a soft, rosy glow cast by a small lamp while a scented candle flickers on a side table. The ultrasound machine hums in front of a tall, wooden cabinet containing various ultrasound accouterments (warmed jelly, condoms for the probe, and other odds and ends). Hannah perches on the edge of the paper-covered exam table, while Celeste fills out paperwork at a small desk covered in pamphlets, menstrual charts, and a small, black-velvet box containing first-trimester, pro-life fetal models.[72] Before I take a seat at one of the two soft-pink wingback chairs, I close the door, noting an "Abstinence Only" poster taped above a "Sexual Exposure Chart" on the back of the door.

Hannah is excited to be here; after a 16-hour drive she wants to ensure everything is 'ok' with her pregnancy and is "hoping to take pictures home!" She recently moved to the area to be closer to her fiancé, and her degree in environmental science and policy has landed her a part-time consulting job. However, like many clients, she is currently uninsured and was drawn to Mountain Care by the promise of a free ultrasound. After a brief medical history review, Celeste begins an abdominal ultrasound, calling it "the rockstar treatment." Celeste is bubbly, announcing she rarely gets to do ultrasounds on clients at 13 weeks (Hannah measures 13 weeks 4 days), but "they are so fun! You get to see so much!" Directly in-line with Hannah's vision, a large, flat-screen monitor mounted to the wall flickers to life as Celeste begins, transmitting the images produced by the ultrasound machine.

Celeste informs Hannah that she will be conducting a limited ultrasound, where she looks for "three things: a pregnancy in the uterus, a heartbeat, and measurements consistent with your

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[72] The models used at Mountain Care are the Touch of Life Caucasian Fetal Models, available through Heritage House (an online anti-abortion/pro-life retailer) and Amazon. They look far more like white, mini-babies, than fetuses.

dates." "There's baby!" exclaims Celeste. "Hi baby," greets Celeste as she points out "his head, hands, little face" and the umbilical cord, ribs, spinal chord, and bones developing in the face, elbows, and knees. Celeste turns the ultrasound monitor towards Hannah, and points to the screen "there's the heart fluttering! Ohhh! Did you see him move?" Celeste quickly corrects herself, informing Hannah that it is too early to see the baby's sex: "it's not that it's not there, you just can't see it yet," but explains she tends to use male pronouns because it is "easier."

Celeste begins to print ultrasound pictures which she collects and shows to Hannah—still on the table—pointing out the 'landmarks' she found during the ultrasound. Both women smile and coo over the grey-scale images before Celeste carefully tucks them into a white envelope. She hands the envelope to Hannah along with a bottle of prenatal vitamins and a confirmation of pregnancy form, instructing her to bring it to the Medicaid office. Acknowledging Hannah's previous abortion for medical reasons, Celeste says, "let us know if there is a problem with the baby—we can help you with those decisions." She places her hand lightly on Hannah's shoulder as she continues to tell her that some women struggle to bond with their babies after an abortion and that she may feel more anxiety before or after birth, "although it doesn't seem like you're having those problems, know that we're always here if you'd like any help dealing with those emotions."

Celeste hands Hannah a few paper towels, instructing her to wipe the jelly off her abdomen before guiding her out of the ultrasound room. As Celeste escorts Hannah back to the lobby, she pauses by the Resource Room to "put a plug in" for the parenting classes and mentorship program offered by Mountain Care. She explains that through the mentoring program, "you can earn Baby Bucks to spend on diapers, wipes, or these cute, little clothes!"

Back in the lobby, Celeste introduces Hannah to Danielle, the volunteer coordinator and de-facto receptionist, saying "she can help determine the best programs to hook you up with!"

Hannah's ultrasound is one of the first I observe. In my fieldnotes that day I write:

> *Wow, I was really affected by the ultrasound today. It was amazing how much the nurse's story of 'life' and 'baby' influenced how I viewed the images on the ultrasound. All of a sudden I saw 'life.' It is easier for me to see how pregnancies become imbued with intense emotions through ultrasounds. The nurse was very practiced and created an emotional environment where even I felt a bond between me and this 'thing.' I became excited for the client; I smiled; I felt joy. Though the fetus is the size of a baby carrot, it looked like a baby through her words.*

Lisa Mitchell's (2001) analysis of the ultrasound acting as a site of 'fetal production' took on a new meaning that day. Through the ritual of ultrasound, I began to witness the social construction of reality. Women, quite early in their pregnancies, often enter through Mountain Care's glass doors defining their pregnancies in terms of their own bodily experiences: Sarah explains she is feeling nauseous all day; Genevieve's breasts are painfully swollen; Katerina missed her period. Yet, these women leave impregnated with a *baby* and, later in interviews, talk about their pregnancies in terms of fetality. Faith (26, white) explains her motivation for seeking out an ultrasound:

> What really jumped out about Mountain Care was they did the free ultrasounds…I wanted to make sure that it was a viable pregnancy. And I wanted to make sure that it was alive in there and was healthy…instead of just, 'oh ya, you are pregnant; your body is saying you are pregnant, so we are assuming you are.'

Similarly, like other clients, Katie (34, white) did not trust her bodily experience and wanted an ultrasound "to make it real" explaining: "you don't need an ultrasound—if you're pregnant, you're pregnant…but I wanted some sort of proof. And I wanted to see…for peace of mind! To make it real…to be honest, I just wanted to see it!" She now "obsessively" looks at her ultrasound pictures as a source of connection: "I just love, *love* looking at that picture and

connecting with something visual. Because we are such visual creatures…like I see my belly, I get it, there's a baby in there, but this picture fills in the blanks!"

For Faith, Katie, and many others, their ultrasounds made their pregnancies "more real," and helped them to form a deeper connection with something that felt intangible. As Katie reports, "my ultrasound day gave me visual proof that allowed me to really commit to having two feet into my pregnancy." However, this connection was not a result of mere images, but rather the experience of a guided ultrasound in which staff carefully cultivated an emotional environment emphasizing connection to images representing an imagined other.

Faith, the only participant in my sample considering adoption, describes the importance of the guided ultrasound experience:

> I didn't expect it to be as cool as it was. I was thinking that I'd be very detached from it all because of what my opinions were on everything. You know, I thought, 'ehhhhh, it's going to be whatever—they're going to gather whatever information they need—like the measurements.' But it was weird, once she started showing me, like 'it's moving!' And I got, I guess I got a little bit emotional. Like, wow! That's really weird! Like that's like a tiny thing—a human that's moving around in there. Like I can't feel it moving around, but it's a full thing; like you could see arms and like a foot—we saw a foot! And you know, you could see it like wiggling around doing its like weird, full-person thing. So it was really cool and it was kinda emotional.

Faith was not expecting to 'see' or recognize anything in her ultrasound. Faith had viewed other people's ultrasound printouts, which, to her, looked "like little blobs." So she was surprised when her own ultrasound revealed "a human that's moving around." Furthermore, Faith reported a sense of emotional detachment to her pregnancy. As she was considering adoption, Faith was puzzled by the comments of her friends and family, who admonished that her "maternal instincts" would prevent her from following through with her plans. She explained that she felt neutral about the "thing" inside of her and annoyed by morning sickness that was not limited to mornings. Because of this, Faith expected to feel disinterested and detached in her ultrasound.

Yet, throughout her ultrasound and later in her interview, Faith expressed a sense of amazement, often using the phrases "weird" and "wild," as she made sense of all the changes happening in her own body that she could not physically feel. Furthermore, Faith did not use the term 'baby' to refer to the entity developing in her uterus until the very end of her ultrasound, preferring instead the moniker "thing" or "it." It was when Celeste began *showing* Faith the ultrasound that her experience took on meaning and "thing" transitioned to "baby." In Faith's ultrasound, Celeste eagerly pointed out various landmarks—like the head, brain, and a foot—in an animated voice. Celeste carefully guided Faith's visualization, asking, "do you see the heart beating?" When she showed Faith her ultrasound printouts, Celeste excitedly imparted a sense of fetal personhood: "It's amazing! Most people don't realize that by the end of the first trimester everything is in there—everything a baby needs as an adult."

Miranda cultivates a similar emotional environment as she makes Josephina's[73] pregnancy 'real.' Josephina, a young, Hispanic woman, and her partner returned to Mountain Care for a second ultrasound after Miranda was unable to date the first and worried the pregnancy was miscarrying.[74] Conducting a transvaginal ultrasound, Miranda excitedly points out the yolk sac, amniotic fluid, and "the cute baby!" She laughs and says, "sorry, I'm getting excited for you!" She points to the screen and, in a buoyant voice, says, "oh see, he looks like a little *gummy bear*!" Josephina's partner whispers, "that's a picture of life." Miranda tells the couple "everything looks good!" and high-fives them both. The relief is palpable as the couple

[73] I did not interview Josephina and thus do not have demographic information like age or racial identity.

[74] Mirada explained that she was unable to find markers typically associated with the estimated gestational date based on Josephina's last menstrual period, making her worry that Josephina was miscarrying during her first ultrasound.

jokes and laughs with Miranda. Embracing a newfound sense of certainty, they announce they can now make plans to schedule an appointment with "a real doctor," and Josephina can begin to buy baby clothes.

This transformation—from ambiguity to certainty—is intentional. Staff at Mountain Care use ultrasound appointments to intentionally cultivate connection, orally constructing a 'tiny human' as real, fascinating, adorable, and vulnerable. In appointments, I frequently hear Celeste and Miranda use appealing, encouraging voices to refer to fetal images as "gummy bears" and "teddy grahams." The warmth in their voices and the time they take to point out barely visible markers of fetal development fills the ultrasound room with an excited, friendly energy. Celeste and Miranda often directly address the fetus with a "hi baby!" when they first find fetal tissue on their ultrasound screens. Autonomy, awareness, and cognition are imparted as they describe fetuses as 'sleeping,' 'shy,' 'jumping,' 'waving,' or 'sucking their thumb.' They frequently point out characteristics or movement, then ask "do you see that?" or "did you feel that?" In one exchange with a client, Miranda exclaimed: "Oh! He just jumped—did you feel that?" The client looked with amazement at her flat belly, covered it with her hands, and laughed, "No! Holy cow, that's weird!" Her pregnancy was dated at 7 weeks 4 days, at which point the tissue developing inside of her "weighs less than an aspirin" and weeks before fetal movements can be felt (quickening can range from 13-25 weeks) (American Pregnancy Association 2018[75]).

Clients welcome and enjoy these ultrasounds which 'show' them a cute, fascinating, alert 'baby.' Many Mountain Care clients enjoy the sense of connection provided by an ultrasound.

[75] This is the same source Mountain Care staff recommend to clients for pregnancy information.

Brittany (21, white) recalls her first ultrasound at Mountain Care as a "really special" moment—in part because she could see movement, but importantly because "the woman who did the ultrasound, she was just so sweet. She talked through everything, was really excited about everything. She was really great!" Brittany emphasized that it was the care she received, rather than the information provided by the ultrasound, that was memorable and significant. She tells me she left feeling "comforted," "more confident," and "relieved." Later, she contrasted her experience at Mountain Care with the ultrasound she received as a part of her routine prenatal care with a medical doctor:

> I think a medical doctor- is really just kinda in and out, fast: 'ok heartbeat's ok, everything's ok. See you in 4 weeks.' Mountain Care is more like: 'what questions do you have, how are you feeling emotionally, what other supports do you need?' Even the ultrasound was completely different! One was just really fast—this is this and this—and then the Mountain Care one was just super! Like, 'this is where everything is; and look at this picture; and let's pause on this; and this is cute!' And like it was a totally different experience. One was just super medical, super- in and out. And one was just really involved, really…more emotional, more resources, it was totally different.

In intertwining the 'reality' of ultrasound images with guided emotional responses, staff construct fetal subjectivity and the feeling rules of clients' pregnancies—an experience that clients, like Brittany, overwhelmingly describe as positive. For staff, these ultrasounds feel easy, light, and are often described as fun. The nurses are animated during these ultrasounds—they smile, speak more quickly, and constantly point out aspects of the ultrasound images they find interesting. Through these ultrasounds, staff believe they provide 'pro-woman' medical care; revealing scientific 'truths' in a supportive manner that emphasizes the relationship between 'mother' and 'child'—a technique staff refer to as the 'softer side of care.' Importantly, the social construction of reality in ultrasound appointments also extends to clients considering terminating their pregnancies, or "difficult" appointments.

B. Difficult Appointments

"It doesn't look like a baby, but that's what it is," Celeste calmly tells Caroline and her roommate as she moves her cursor over the ultrasound screen. This appointment feels distinctly different from easy appointments; no one is smiling, Caroline is quiet, and her hands grip the blue vinyl exam table as Celeste performs a trans-vaginal ultrasound. Watching Caroline and Celeste—who dates the pregnancy at 6 weeks, 4 days—my 'gaze' feels powerful and uncomfortable, as if I am witnessing a very private, painful struggle.

Wearing her white lab coat over a knee-length, floral dress, Celeste explains she is looking for a "pregnancy" and needs to "prove that the baby is in the uterus." While she can see Caroline's pregnancy through an abdominal ultrasound, the images are "not good enough" and necessitate a transvaginal ultrasound. Celeste switches between "the pregnancy" and "the baby" as she guides Caroline through the images on the screen. She points out the yolk sac, telling Caroline, "it's so cool! The yolk sac nourishes your baby! I'm going to print this picture out for you—if you want," printing the image before Caroline can form a response. The room is silent as Celeste struggles to find any heart movement. She tells Caroline this may be because she is so early in the pregnancy or it may mean that Caroline is miscarrying, saying, "that is important information that we need to know." Caroline remains silent, as her eyes follow the cursor on the large screen in front of her. Celeste continues to move the probe inside of Caroline's body and then points out a barely discernible motion flickering on the screen, announcing: "ah, there's the heartbeat." Having collected all the data she needs to confirm an intrauterine pregnancy, Celeste concludes the ultrasound by telling Caroline her due date. Gathering the photographs she printed, Celeste instructs Caroline to dress and meet us in the counseling room.

When Caroline arrives in the counseling room, she sits on the love-seat diagonal to Celeste's matching club chair. Celeste leans forward, ultrasound image in hand, and points out "the baby." As Celeste reviews fetal development, she explains, "at this point your baby is just a cute little teddy graham," and reminds Caroline, "the heart begins beating 21 days after conception—the heart has been beating in your baby for one to one-in-a-half weeks! Isn't that amazing? It all happens so early!" She tells her the "baby's" blood type may be different than her own, and doctors could test for that difference, concluding "it's amazing that all this happens so early!" Then, Celeste begins to review abortion procedures, telling Caroline, "I'm not encouraging you to have an abortion by giving you this information—because I know you want to keep it. But you need this information to make a decision." Celeste hands Caroline a booklet entitled "Before You Decide," a CareNet publication that briefly reviews pregnancy, fetal development, emergency contraception, and abortion procedures and risks. Tears begin streaming down Caroline's face as she listens to Celeste—who slips between "embryo" and "baby," and between facts and falsehoods—explain how an abortion "kills the baby."

First, Celeste reviews "the abortion pill" procedures, explaining the FDA only recommends a medical abortion up to seven weeks but "abortion providers will give it up to nine weeks—I recommend against that because there is a greater chance of having surgery. If you end up having an abortion, I wouldn't recommend the pill." She explains that RU46 is provided up to 49 days after your last period, it "kills the baby, then starts contractions to expel the embryo and all that." Celeste looks into Caroline's eyes and, speaking about the medication-induced abortion, says, "the vast majority of people, in my experience, said they wouldn't do it again; that it was painful, hard, that they bled for up to a month." Furthermore, she continues, the

abortion pill is unsettling because, "you don't know when the abortion is going to start." She goes on to explain there are "procedures to reverse the first pill—they're not 100%" but because "some women regret their decision" she was relieved doctors were starting to think about it and informs Caroline of a hotline she can call.

Celeste then beings to explain a surgical abortion. Caroline silently sheds a few tears that go unacknowledged by Celeste. Celeste uses the correct, medical terminology to discuss a first-trimester abortion procedure, yet also provides frightening, misleading details like "the doctor will perform a 'blind procedure' that uses suction 29-30 times higher than a vacuum," something, she warns, that can be triggering in future dental appointments or while cleaning her home. In a single breath, Celeste says "it's a very safe procedure; one of the safest. But things do happen," describing risks such as: "difficulties getting pregnant in the future;" "risk of infection," "changes in breasts…where the cells that are grown are more vulnerable to cancer after abortion." The risk of cancer seems severe for Celeste, as she explains, "if you abort you are more likely to get cancer in 10 years."[76] Yet, Celeste implores, "my concern with abortion is the emotional complications." Establishing her authority as an experienced expert, she reports, "I've seen a lot of this in a lot of pregnancies: women want to carry, deep down, but they are persuaded by others. Those are the people who have problems." The problems, according to Celeste, include: feelings of anger or depression (particularly around the due date); trouble bonding with future babies ("in your subconscious mind you may be thinking: you aborted one

[76] Both Celeste's claims that abortion may cause "difficulties getting pregnant in the future" and increase the risk of breast cancer are misleading and inaccurate (Beral et al. 2004). See the Rosen (2012) for an overview.

baby, not another—how can you love this one?"); and not enjoying sex with her partner.[77] She reminds Caroline "we can help you work through it," implying that if she terminates her pregnancy, Mountain Care has resources to guide her through the subsequent 'grieving process.'

"You've got three weeks to make a decision—about a month. Don't rush," Celeste softly states. She tells Caroline, "85 percent of women who've had an abortion said they wouldn't have had the abortion if they would have had the support of one person. We want to be that one person…If you decide to stay with the pregnancy, we have mentors that will help you. There is support!" She reminds Caroline, "you can do it. We want to get you the tools to do it."

Finally, Celeste steers the conversation toward parenting. While Celeste took care to describe two abortion procedures and their risks in detail, the information she provides on parenting consists of a single, thin pamphlet and a thirty-second discussion about a single-mothers group at Mountain Care. Celeste goes on to say, "if you decide to continue we can talk about adoption," but there is no conversation about adoption in this appointment. This is a typical absence in difficult appointments. Staff rarely broach adoption unless a client expresses interest in it, believing clients consider adoption the hardest option.

As Celeste wraps up the appointment, she tells Caroline, "my job is not to force you into a decision, but to give you all the information." She hands her yet another glossy brochure on fetal development and explains, "at 6-7 weeks the baby is about 1/3 of an inch. Next week we

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[77]Again, these claims are not supported by current mental health literature (Charles et al. 2008; Major et al. 2009; Robinson et al. 2009; Stotland 1992); though research does demonstrate that the *context* of a woman's abortion decision matters (American Psychological Association 2008; Broen et al. 2005). While the American Psychological Association's Task Force on Mental Health and Abortion (2008) conclude the act of elective termination does not increase the risk of experiencing mental health issues, they note several other factors that reduce a woman's emotional resiliency after an abortion such as: low self-esteem, low levels of social support, perceived stigma and need for secrecy (see also Adler et al. 1992; Mueller and Major 1989; Major et al. 1990; and Major and Gramzow 1999).

could see fingers and elbows on the ultrasound! And at eight weeks it starts moving." In a concerned voice, she explains, "it's important to know that, too, if you have an abortion." After a moment of silence, Celeste leans back in her chair before remarking, "there is a lot going on—it's not just a clump of tissue." Speaking in a soft, comforting voice, she explains that she goes into such detail because this information is part of informed consent and she wants Caroline to be prepared: "in ten years you could regret your abortion when you come across information on fetal development in a women's magazine while you are getting your hair cut at a salon." Finally, she places a hand on Caroline's knee and gently says, "the decision is yours to make."

Celeste asks Caroline if she has any questions. Caroline, wiping the tears from her eyes says, "no, I just have to think and figure things out. I have a few weeks." Caroline goes on to explain she is still a full-time student, really excited about what she is studying. She is not sure she can handle the hardships of young, single-motherhood. Celeste nods her head empathetically and shares, "I got an email from a client—her son is six and a half right now. And she was sitting where you were. None of my clients have ever regretted the decision to continue, but I do know many people who have regretted their abortions." Her voice is sincere rather than condescending, and Caroline seems to be hanging on to every word: leaning forward, nodding her head, taking pamphlets, and sharing deeply personal stories about her life. Caroline explains her boyfriend is in rehab and knows she is pregnant, but her parents do not—she fears they will be disappointed, mad, and sad. Celeste sympathizes, "that sounds hard. But having the abortion doesn't erase time—you are already a mother to your baby in your mind."

Celeste concludes Caroline's appointment saying, "I'm done with you medically. It's important for you to get prenatal care around ten weeks," as she hands her a bottle of prenatal

vitamins. "I'll be praying that the decision will be real clear for you," she continues. Caroline and her friend rise, saying "thank you!" On her way out the door, Caroline's friend thanks Celeste again, telling her, "you were perfect!"

Caroline's ultrasound appointment is typical of "difficult appointments" with 'abortion-minded' or 'abortion-vulnerable' women unsure of their decision. In these appointments, staff enact a *pro-woman care script* by approaching a client as scared, vulnerable woman; by emphasizing the trauma of abortion; and by operating within evangelical schemas of relational care in which staff create a relationship with clients and between clients and 'the unborn.' Staff work to consciously cultivate connection through ultrasound images and a kind, caring affect. As Miranda explains to an 'abortion-minded' client, these "bonding moments" help a pregnancy to "become real…and it goes from the head to the heart." In Caroline's appointment, Celeste enacts the *pro-woman care script* by making her ultrasound images come alive. She points out a cute, rapidly-developing 'teddy graham' that has all the characteristics of a human being. With a kind, soothing voice, Celeste takes the time to ask questions and to provide a highly personal ultrasound, throughout which she builds rapport with Caroline—making her appointment feel warm and relational. She also focuses on saving Caroline from the trauma of abortion by speaking at length to the emotional and physical risks of an abortion, using her voice and the information she selects to construct abortion as a profoundly distressing experience. Celeste expresses concern that Caroline feels scared, forced, and pressured into a fear-based abortion decision by others in her life (for Celeste, abortion can never be an empowered decision). Finally, Celeste emphasizes there is time to make a decision, reminding Caroline that, ultimately, it is her individual choice. It is this emotionally-laden care that resonates with Caroline.

A few weeks later, as I share tea with Caroline, she reflects on her recent abortion and her experience at Mountain Care. Caroline explains that what was most significant about her appointment at Mountain Care was a "feeling….it's just like: 'come to me, you're safe, and it's ok.'" She explains further:

> Mountain Care was soooo awesome! Talking with Celeste was really comforting, and I didn't feel like she was pushing me either way at all. I was kinda like trying to figure her out while I'm sitting there, like, 'what do you want me to do?'…I think maybe she kinda got the vibes from me that I wanted to keep it just because she gave me those [prenatal vitamins]…but it was so supportive. I was just amazed at how somebody can be just transparent about support, whether it's what they want or not.

Caroline goes on to explain what felt so supportive: "I think it was her voice? Like it was calming! Even my roommate was like, 'oh my god, if this ever happens to me, I'm going there. That lady was so awesome; this place is so great!' So I think it's just how she presents herself." She then explains how much the environment mattered, too—the comfortable couches, art, and plants that make everything feel welcoming. Other clients remark that the length of appointments makes them feel cared for—an hour spent with a kind provider who listens rather than a few minutes with a harried physician. For example, Yvette (18, Hispanic) expressed her surprise that Celeste's interest extended beyond her pregnancy, "she actually asked questions about my life! I spent like 45-freaking-minutes with her just talking about like my boy problems!" All these factors—the nurses, the environment, the personal nature of the appointment—create for clients a sense of care rather than manipulation.

Caroline's ultrasound promoted a deep and desired reflection, she reports, "I wanted to experience it and like feel all this stuff." While she is still making sense of a very difficult termination decision, she goes on to explain:

> I'm glad I took the time to weigh out both options and as hard as it is to have these pictures in my head and to think about that ultrasound—it's hard to have that and now I don't—but I'm happy that I went through that to fully make the decision.

Caroline reports that both the time she took to make a decision and the ultrasound itself created feelings of "attachment" and a desire for connection. Amidst this complicated emotional context, Caroline understood her ultrasound to reveal a new reality and potential future. She experienced Celeste as comforting, caring, and neutral, understanding her attachment to an imagined baby and future to be the natural outcome of an ultrasound. Yet, ultimately, practical factors like wanting to finish her education, economic security, emotional stability, and a desire to provide a better life for her children, lead her to terminate her pregnancy.

I witness a number of other 'challenging' appointments at Mountain Care. These appointments are memorable because they reveal the ways in which staff attempt to navigate a thin line between pointing out a client's ambivalence and contributing to her uncertainty. The ambiguity of this boundary was particularly apparent as Miranda negotiated a difficult appointment that originated with a phone call from a client. After answering the phone, Miranda explains, in a soft, soothing voice, "we don't provide abortions, but we do offer free ultrasounds." After a brief pause, Miranda follows by warning the client, "you may miscarry—let's find out if it's viable before you go through the expense and heartbreak of an abortion."[78] Miranda continues, "are you sure? You sound like you could really use- [pause]. We do that for

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[78] Please note, informing clients they "may miscarry" so an abortion may be unnecessary, is part of the *pro-woman care script* used at Mountain Care to save clients—who are unsure of their pregnancy intentions—from the trauma of an abortion (also seen in Caroline's appointment). While staff viewed miscarriage as a tragedy, they framed it as less traumatic than an abortion because miscarriages are not actively chosen. Staff would frequently follow up with offers for a free ultrasound, claiming it would provide information an abortion provider would need, too. This is significant because it may delay or interfere with women's access to abortion services (Rosen 2012)—and is particularly important for women who are uninsured or for whom abortion services represent a significant economic burden (abortion access decreases and cost increases as a pregnancy develops). Furthermore, ultrasound is routine in abortion care services and regardless of whether a woman obtained a previous ultrasound, an abortion provider will conduct a current ultrasound.

free!" After asking how far along the client believes she is, Miranda says, "five weeks? Ok, remember you have time to make a decision,"[79] before softy remarking, "you sound really sad." She then inquires about the client's children and the 'father of the baby,' briefly summarizing the support Mountain Care offers to both her and the man involved. Miranda concludes the phone call with "we will be open until 4:00 pm and if you can come in today, we can do that ultrasound. Why don't you come in and we can talk?"

A few hours later a young, Hispanic woman with a small child walks into the lobby. Miranda, dressed in bright turquoise scrubs, greets her with a broad smile and says, "I'm so glad you decided to come in today!" Miranda brings her immediately to the ultrasound room and asks if it would be ok to leave her son with another staff member to play. The client nods and follows Miranda to the ultrasound room. As I sit in the room with Miranda and Tiana,[80] Tiana tearfully questions her pregnancy—wondering how she got pregnant after she took emergency contraception following unprotected sex—and explains how stressed she is as a single mother working full time as a bartender. While her partner is excited about the prospect of having a child, he told Tiana the decision is her's alone. She remains undecided. Tiana is nervous about the additional life stressors another child adds and feels "weird" about having children with two different fathers. Miranda nods her head sympathetically, but keeps her questions brief and quickly introduces the ultrasound, saying, "I know you want an ultrasound; hopefully, you can get some clarity today." After announcing her urine pregnancy test is positive, Miranda then

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[79] This is a delay tactic used to "slow women down." While staff tell me this helps a woman to 'see outside of her crisis' to make an informed, sure decision; rarely, is any context about the pricing and availability of abortion services offered. Again, this is significant, because as a pregnancy develops, the risks associated with an abortion increase, as does the price; furthermore, access to a provider decreases substantially.

[80] I did not interview Tiana, thus cannot provide demographic information like self-reported race and age.

explains she performs a "limited ultrasound. I want to see how old baby is; where baby is; and if baby is viable. I'm not looking for any abnormalities." Knowing Tiana experienced an ultrasound with her first child, Miranda's use of the term 'baby' serves as a reminder that the ultrasound reveals a *child*. The use of 'baby' connects the ultrasound imagery to Tiana's experience in her first pregnancy and to her relationship with her young son.

According to Tiana's last mensural period, Miranda dates her 7 weeks, 3 days pregnant. She begins the abdominal ultrasound saying, "first, I'm going to look around and get pictures I need for the doctor. Then we will look for the baby! If you have any questions-" she trails off, "some people want to know, some don't." Without asking if Tiana would like to see her ultrasound, or if she would like to know what she is viewing, Miranda points out the uterus, gestation sac, yolk sac, and the "baby," announcing, "I can see the heart beating!" Miranda states she needs a transvaginal ultrasound to get the 'best' pictures and most accurate dates. Once she begins the transvaginal ultrasound, Miranda excitedly points out "the baby!" who is "moving a lot." She shows Tiana the heartbeat, saying "so baby's heart rate is great!" Then Miranda turns the ultrasound monitor—which she claims provides a more clear picture than the television screen—towards Tiana and says, "I can see his heart rate, I can see leg buds, the umbilical cord, and this is the amniotic sac around the baby!" As she does so, Miranda saves "cute" pictures to later print out for Tiana. Tiana turns her head toward Miranda and smiles, "it's good it's in the right place."

Later, with Tiana now dressed and sitting on the exam table, Miranda hands her the ultrasound pictures she printed off. Tiana stares at the images for a long time, a slight smile on her face. Miranda asks, "what do you think about what you saw?" Her voice heavy with

emotion, Tiana says, "it's exciting. I guess it's real now." Miranda smiles and nods, knowingly. She tells Tiana she is happy to do another ultrasound with her partner present. Then, grabbing the black velvet box from the desk, she tells Tiana her due date and says, "your baby is just a little smaller than this one," as she points to the smallest fetal model. "It is a boy or girl already. It has a heartbeat, and it's all there—stomach, lungs, everything! It just has to grow." Tiana leans forward, arms and legs crossed, to examine the fetal model. She smiles as Miranda hands her pamphlets and a verification of pregnancy form. As Miranda wraps up the appointment, she advises, "I think it would be really beneficial for you to come back with Marcus [her partner]. It becomes real—like with you. It goes from the head to the heart. Would you like to make an appointment with Marcus?" Tiana declines, saying she needs to go over her schedule. Miranda hands her a bottle of prenatal vitamins and then walks her to the lobby where another staff member brings out her son, and they leave together.

Miranda knows Tiana is unsure about the future of her pregnancy and is considering abortion. Yet, throughout the appointment, she refers to Tiana's pregnancy as a "baby" and treats her as if she is going to carry to term—printing out "cute" pictures and pointing out various markers of development she believes marks the fetus as human. Tiana arrived crying and left smiling. As I take my seat in the lobby, I wonder if this appointment changed her mind, if it added layers of emotional turmoil to an already difficult decision, or if it validated a desire for which she does not feel support. Pregnancy centers occupy a complex, 'in-between' space. Mountain Care represents a space wherein low-income, uninsured women can receive desired care—emotional support that can validate their decision to take on the challenges of motherhood and physical care that confirms a pregnancy and clears a pathway to obtain Medicaid. At the

same time, Mountain Care is also a place in which difficult decisions become laden with heightened emotional and moral complexity as women unsure of their decision or desiring an abortion, have a particular reality constructed for them through a guided ultrasound.

Difficult appointments are characterized by more counseling than 'easy' appointments. Nurses speak in kind, soothing voices about fetal development and the risks of abortion, telling clients they merely want them to be "informed." The quiet in the ultrasound room contrasts the light, small-talk in 'easy' appointments, making the room feel tense. Staff are never overtly judgmental, nor do staff explicitly tell clients what to do; yet, they never ask a woman if she would like to view her ultrasound (it is immediately projected and visible to her) or if she would like markers pointed out, and they slip between 'baby' and 'fetus' throughout her appointment. Staff do not proselytize in appointments, limiting evangelism to brief conversations initiated with "what's your relationship with God?" or statements like, "I'll pray for you," as they conclude appointments. Staff genuinely believe they present "information in a factual way." Staff passionately explain that ultrasounds are windows that allow them to reveal the 'miracle of life' and are unable to see their own personal agendas in how they cultivate a connection to a pregnancy—through their voices, the words they use, and the information they highlight—to actively construct a reality rather than reveal objective truths.[81]

While I interpret 'difficult' appointments to be manipulative, the clients I interview about their appointments describe them in overwhelmingly positive terms. Appointments like Caroline's and Tiana's are 'difficult,' but the most meaningful for staff and volunteers—these

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[81] The one notable exception at Mountain Care is the use of the term "baby." Staff often remark they attempt to avoid using "baby" with undecided clients, preferring instead medical terminology. Yet, staff also explain this use of language is difficult—they so clearly see babies in ultrasounds—and they frequently slip between 'baby' and the terms 'embryo,' and 'fetus.'

types of appointments are, according to Anne, "the reason we do what we do." Staff highlight these appointments at fundraisers, discuss them in meetings, and frequently refer to them in conversation with each other and with me, celebrating them as moments in which they saved two lives—the life of the woman and her unborn child. Herein it becomes apparent that staffs' religious identities intertwine with their work and that providing pro-woman care is a way in which they do religion. In the next and final section of this chapter I discuss how doing pro-woman care maintains engagement in the CPC movement because staffs' religious identities are reaffirmed through the hard work of difficult appointments and validated through their success stories and the visualization of ultrasounds.

V. Conclusion: Constructing Reality and Doing Religion Through Pro-Woman Care

Staffs' religious identities are constituted through interactions—with clients, other staff members, and outsiders—that occur in the pregnancy center context. It is through caring for clients that staff at Mountain Care construct and perform feminized, religious identities set apart from secular and non-secular 'others.' It is also through performing care that staff cultivate and negotiate their own religious identities; it is through care that staff 'do religion.' In this way, the ministry of 'pro-woman care' is both an expression of faith (something they do) and a construction of their own faithful identities (who they are), bound by the norms and symbolic boundaries constructed in the pregnancy center context. Staff learn, negotiate, and practice "appropriate religiosity" as they perform 'pro-woman care' to achieve the identity status of good Christian. Like Avishai (2008), I argue performing care is not merely strategic action (to intervene on abortion decisions) but importantly, the performance of an identity.

A. Gendered Religious Identities

Staff consciously interpret scripture to make their work a feminized ministry. In Chapter Three, I discussed how staff emphasize an image of a kind, loving, forgiving God and talk about the importance of acting like Jesus. At Mountain Care this ministry is constructed and performed as a gendered religious project that emphasizes feminized care practices like empathetic listening and emotional intelligence. Staff frame their practice of care as an extension of their gendered religious identities: their ministry is the best way for women to care for other women. Womanhood intersects with evangelical Christianity, wherein care for others is an appropriately feminine expression of faith. Staff understand themselves as legitimate caregivers based on a shared gender-identity with clients (see also Kelly 2012). Only women are allowed to meet with female clients at Mountain Care, and only mothers are allowed to mentor clients. While staff draw upon their gendered experiences to inform the care they provide, rarely do they reference their reproductive histories when meeting with clients. This is a conscious strategy they believe allows them to understand clients as women, yet keep the focus of the appointment on clients. Instead staff rely upon the implicit belief that a shared gender identity allows them to relate to clients across racial, class, and age divides.

As this gendered ministry emphasizes receptivity and listening, staff believe that the most effective response to abortion is practical, empathetic action aimed at helping women. This interpretation of appropriate religiosity dictates that appointments focus on the woman's pregnancy rather than on her salvation, a notable departure from larger CPC Network

imperatives which emphasize evangelism.[82] Staff reframe network dictates to promote what they believe is a more appropriate form of providing witness. In practice, while staff inquire about a client's religious beliefs or relationship to God (verbally and on intake documents), these queries are limited and tend to be brief; generally ending with a staff member repeating a version of: "I ask, because for some women there is a spiritual component to abortion." Staff do not pray with clients, hand out bibles, or distribute tracts at Mountain Care—something they regard as coercive. Instead, like Celeste, staff gently promise clients, "I'll pray for you," or "I'll pray your decision will become clear." Staff do not preach the gospel in appointments, but rather construct care itself as evangelism. In this way, staff do not confront women with their convictions, but promote an ethic of 'education' and 'informed consent.' Staff utilize and make available to clients faith-based 'informational' pamphlets on pregnancy, adoption, abortion, sexuality, and dating. Never mentioning these pamphlets originate from faith-based sources like CareNet, staff reference them as presenting "vetted," "up-to-date" facts on fetal development, abortion procedures, and sexual health. Because these pamphlets cite medical journals and research institutes, staff consider them accurate and unbiased; failing to critically analyze the manner in which these facts are selected or recited. Similarly, staff fail to extend a critical lens to the focal point of their ministry: ultrasound care.

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[82] For example, CareNet, one of the three major CPC Networks and a network with which Mountain Care is affiliated, holds evangelism as the primary mission of the pregnancy center. The first point in CareNet's "Pregnancy Center Standards of Affiliation" (2017) holds:

> The primary mission of the pregnancy center is to share the compassion, hope, and help of Jesus Christ — both in word and deed — with those facing pregnancy decisions. The pregnancy center is equally committed to sharing the Gospel of salvation through Jesus Christ with those it serves. Commensurate with these purposes, all board, staff, and regular volunteers (and any non-regular volunteers who interact with clients) of the pregnancy center have made a profession of faith to trust Jesus Christ as their Savior and Lord.

B. Ultrasound Care

While Ann Oakley (1984) famously argues that the ultrasound is an extension of the medical gaze, in pregnancy centers, the ultrasound becomes an extension of the religious gaze. In both 'easy' and 'difficult' appointments, staff 'do religion' through ultrasound care. Mountain Care's visual culture relies upon ultrasound and in-utero imagery, a departure from the violent, graphic images favored by other streams of the pro-life movement. This is a conscious choice staff make to affirm their ministry as kind, loving, and 'pro-woman.' Staff believe ultrasounds reveal crucial moral information, yet frame them as educational. In appointments, it becomes apparent that ultrasounds are not merely educational tools, but rather religious acts that contribute to the construction of a human life for both clients and staff. Nurses at Mountain Care explain that the ultrasounds they perform are diagnostic; yet, in their execution, they become a hybrid practice (Taylor 1998), a mixture of clinical care and social ritual. Hybridity is operationalized in three essential ways in the pregnancy center context: (1) tightly controlled experiences; (2) cultivating a connection to a baby; and (3) making the ultrasound a symbolic family occasion.

Staff at Mountain Care guide the ultrasound experience every step of the way. Nurses position themselves as powerful, knowledgeable experts in the way they dress and speak. They don the traditional trappings of medical authority by wearing scrubs and, often, white lab coats. This power goes unacknowledged, and the gap between provider and client widens as nurses assume client consent. At Mountain Care, women are not asked if they would like to view their ultrasound—as soon as the nurse turns on the machine it transmits images to the television screen hanging in front of the exam table. Staff report that women do not have to watch these

ultrasounds, but staff never engage in any explicit conversation with clients or ask for the client's consent. Nor do staff ask for a client's consent to point out developmental landmarks. While they occasionally mention "some women want to know, some don't," staff do not ask "would you like me to point out markers on your ultrasound?" Instead, staffs' religious beliefs—which dictate life begins at conception—filter through the performance of guided ultrasounds in which they identify autonomous, miraculous babies in pregnancies as early as five weeks. In the pregnancy center context, ultrasounds are understood and used as tools, but it is staff who reveal the 'Truth.' Staff clearly see "life" and "babies" in ultrasounds, and thus they guide experiences in ways they believe are educational, reveal life, and promote an ethic of connection. In effect, staff make sense of the imagery for clients—pointing out development that would otherwise remain unclear. In this way, staff verbally and visually construct a baby. Mountain Care's clients thus describe their ultrasound as the moment when their pregnancy "became real."

This guided experience cultivates a sense of connection to an independent "baby." While Mountain Care staff attempt to use "neutral language" and avoid "baby," ultrasound appointments almost always identify or reference a baby. Importantly, this baby is cute—a little "teddy graham" or "gummy bear." While it is common for pregnancy guides to compare the size of a developing pregnancy to food items and edibles (often aspirin, lima beans, and fruit like oranges and grapefruits), Mountain Care's use of gummy bears and teddy grahams is significant. Not only are gummy bears and teddy grahams petite, cute food items, but they are sweets that bring to mind childhood and care for children. These are treats marketed towards the parents of children. They are food items bought for children as a way to express care and love for a child. In comparing the entity inside a woman's body to a teddy graham or gummy bear (as opposed to

a quarter or a baby carrot), staff at Mountain Care subtly evoke pleasant, sweet imagery associated with parenting children and the pleasures of childhood. Additionally, nurses speak directly to the baby and do so with soft, kind, excited voices. Even in "difficult appointments" with uncertain clients, staff slip between 'baby' and 'fetus,' when describing an ultrasound to the client. These babies are autonomous actors—often described actively waving, sucking their thumbs, or jumping. These babies are also special and are deserving of photographic memento, or "baby's first picture!" Nurses print numerous sonogram images throughout the appointment, referring to these as "pictures"—even if clients decline these prints, they state they will be kept in their client files, "in case you change your mind." For example, I witness Miranda, without client permission, print some images with the phrase "Hi Mom!" emblazoned across the top.

Finally, Mountain Care ultrasounds are also family occasions. Staff encourage clients to invite back their partners or support people, or prompt clients to return with their partners for another ultrasound. There is no formal limit to the number of people able to sit in on the ultrasound (some ultrasound providers have strict limits). In one appointment, four family members and one family member on video chat were packed into the small ultrasound room. In these appointments, 'babies' are contextualized as part of the family. Staff refer to them as children, grandchildren, siblings, and cousins. This shift is a social cue, subtly preparing clients for how to 'do' family. Staff also inquire if clients would like to bring home photos to share with others, believing 'seeing' is an essential means of cultivating connection other family members and garnering more social support for the pregnant client.

The ultrasounds at Mountain Care clearly represent the hybrid practice articulated by Janelle Taylor (1998), who describes how ultrasound images hold meaning as medical practice,

social ritual, emotional reassurance, and entertainment. Mountain Care's staff use ultrasounds to provide clients with a confirmation of pregnancy form that helps the uninsured obtain medicaid coverage, and use sonographic imagery as a means to develop a sense of connection between 'mother' and 'child'. Pro-woman care thus becomes about evoking appropriate maternal emotions in clients through a guided ultrasound. Yet in this setting, the ultrasound also occupies another domain of meaning, that of religious tool. Ultrasounds continuously reveal for staff the 'miracle of life' and reaffirm their own religious identities. In this way, the ultrasound itself (particularly in difficult appointments) not only cultivates emotions in clients, but also renews and inspires, in staff, continued engagement in the CPC movement.

In this chapter, I discussed Mountain Care's medical model of care which centers on the ultrasound appointment. I reviewed the history of ultrasounds in the pregnancy center movement and examined the ways in which they are used in "easy" and "difficult" appointments at Mountain Care. I concluded by arguing ultrasound care is a means by which staff enact their religious beliefs through the use of medical technology—an act that is consequential for both clients and staff. In the following chapter, I turn my focus to Urban Care's "social work model of care."

Chapter 6: "What is Your *Heart* Telling You?": Facilitating Moral Reflection at Urban Care

I. Introduction

In the previous chapter, I argue that the heavily guided ultrasounds provided at Mountain Care create an emotional context in which staff cultivate a connection to an imagined child and reaffirm their own religious beliefs. Mountain Care's medical model foregrounds the visual experience of a guided ultrasound. Combining social, emotional, medical, and religious meaning, the ultrasound is a particularly powerful medium through which to evoke feeling. Simultaneously, the ultrasound renders visible an imbalance of power between staff and clients and the strategies used by staff to construct clients' realities. The legitimacy imbued in the ultrasound as medical technology and the authority granted to those who wear white lab coats, creates a hierarchy of knowledge and power at Mountain Care. Mountain Care's medical model of care is structured to promote a visual relationship between 'mother' and 'child,' a form of care in which staff truly believe they are providing beneficent support that advances the welfare of clients and prevents harm.

I did not encounter the same visual culture at Urban Care. Instead, while Urban Care's staff share similar goals—to save women from the perceived trauma of abortion—their methods are distinctly different. Urban Care's "social work model of care" provides an interpretation of pro-woman care that emphasizes counseling. Urban Care did not try to actively cultivate a connection to an imagined child through ultrasound imagery; instead, using narrative therapy techniques, staff attempt to facilitate moral reflection in clients. At Urban Care, both easy and difficult appointments are structured to give priority to options counseling with a trained Client

Advocate, while ultrasounds, provided by "medical staff," are deemphasized. Because of this configuration of care, the majority of a client's appointment occurs in the counseling room with a Client Advocate who uses questions, rather than visuals, to evoke careful contemplation in clients. While I was often impressed with the manner in which Urban Care prioritized clients' consent and how they understood clients to be situated in complex contexts, I simultaneously found myself wondering if, in the tradition of Judith Stacey (1988), the intimacy shared in the Urban Care counseling rooms might represent an opening for a "deeper, more dangerous form of exploitation" (22). Urban Care presents a model through which the boundaries between 'ministry' and manipulation in the pregnancy center context become more complex, blurry, and mutable.

In this chapter, I use ethnographic data collected from 10 months of participant observation at Urban Care and data from in-depth interviews with staff and clients to describe and analyze the ways in which pro-woman care is enacted in pregnancy-related appointments at Urban Care. In what follows, I first describe the three sites at which I conducted observations and Urban Care's institutional model of care, noting key departures from Mountain Care. I then examine the role of counseling in pregnancy center care. In doing so, I argue options counseling is a means by which staff perform gendered, evangelical identities and emotionally manage women. Then, I turn my attention to the use of the ultrasound at Urban Care, noting that while it does not play a central role in their model of care, it remains an important tool in their ministry. I next describe and analyze how staff perform care in "easy" and "difficult" appointments. Finally, I examine the ways in which this distinct style of care facilitates moral refection and evokes emotional subjectivity in clients, while reinforcing moral meaning for staff.

II. Urban Care and a Social Work Model of Care

A. Urban Care

I observed pregnancy-related appointments at three of Urban Care's busiest offices—Midtown, Riverside, and Meadowview—all located in bustling metro areas. Unlike Mountain Care, Urban Care maintains highly secular lobbies. Bright watercolors hang on the walls and potted plants sit beside popular magazines, like *Sports Illustrated* and *Good Housekeeping*. There are children's toys and Disney videotapes sitting atop small televisions in each lobby. The lobbies are lined with stiff, straight-backed chairs like those in a physician's office and lack the glossy brochures on pregnancy, STIs, and abstinence education that were scattered across the tables of Mountain Care's lobby. The single faith-based publication, *Before You Decide,*[83] is tucked in with the other magazines. In lieu of evangelical literature distributed by pregnancy center networks, Urban Care's lobbies host a few flyers that highlight community resources like affordable dental care, hiring events, and youth programs.

Urban Care's Midtown office is located in a historic building that shares a block with hipster coffee shops, clothing boutiques, and trendy restaurants. This donated office space acts as a hub for their eight locations and hosts the administrative staff, a large ultrasound room, three counseling rooms (one dedicated to post-abortion counseling and men's counseling), and serves as the primary storage space for donated material resources. Riverside is situated in a suburban office in a predominantly Latinx neighborhood. Sharing the office building with other

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[83] *Before You Decide* is a CareNet publication available for purchase by CareSource—CareNet's online "Resource Center" where pregnancy centers can purchase "life-affirming resources." CareSource describes *Before You Decide* as:

> Created for millennials by millennials, *Before You Decide* magazine is the only life-empowering resource your "at-risk" clients will need! Organized in a Q&A format that mimics the pages of popular magazines, the updated BYD includes expanded information, compelling graphics, and documented research to help your clients make informed pregnancy decisions (CareSource 2019).

businesses, Riverside's office is considerably smaller but frequently welcomes clients. Here, a full-time director occupies a large corner office (that doubles as a counseling room on busy days) positioned between a small ultrasound room and a sunlit counseling room. Volunteers at Riverside make the resource room their home, settling in at a desk nestled between layettes and office supplies. In a suburb across town, Meadowview's office sits next to a busy highway in a two-story commercial office building that also hosts a security firm, accountants, and a new gym. While less busy than Midtown or Riverside, Meadowview has a spacious office which is home to a full-time director, a small resource room where volunteers work, another office used by the sonographer (which doubles as a counseling room on busy days and often served as my 'office'), a cozy counseling room, and an ultrasound room.

Similar to Mountain Care, the clients I observed seeking services at Urban Care were frequently uninsured and many were struggling financially. Clients were almost always female and disproportionately women of color (according to Urban Care's internal data for 2017, roughly 66 percent of clients self-identified as women of color—a proportion closely matching my own observations—and a percentage that is out-of-step with a city the U.S. Census Bureau estimates is 65 percent white). Although Urban Care serves teens through post-menopausal women,[84] their clients tend to be women in their early 20s. During my fieldwork, I observed women across an educational spectrum—from those without a high school degree to those with advanced degrees—seeking services at Urban Care, though most do not have a college degree. These characteristics stand in stark contrast to the predominantly white, middle-class staff, most of whom hold advanced degrees. This divide does not go unacknowledged at Urban Care, where

[84] Staff tell me they see older clients for post-abortion counseling years after the client's abortion.

a model of institutional empathy trains staff and volunteers how to *feel* and *perform* empathy for women in other social locations. In the following section, I describe how this distinct model of care structures appointments at Urban Care before discussing the role of counseling within the broader pregnancy center movement.

B. A Social Work Model of Care and Options Counseling

Urban Care follows an institutional framework they term a "social work model of care." This model emphasizes options counseling and foregrounds the non-medicalized relationships between Client Advocates and clients, resulting in appoints that are structured very differently from those at Mountain Care. While medical services—pregnancy tests, ultrasounds, STI testing—are an important part of Urban Care's ministry, the "medical portion" of client services is a discrete part of a counseling-based appointment.

In practice, this structuring results in the majority of a client's appointment taking place in the counseling room with a Client Advocate. Client Advocates do not perform any medical services outside of distributing (and sometimes interpreting) urine pregnancy tests. Client Advocates are trained staff members[85] or volunteers who have undergone the five-day intensive training and several on-the-job trainings with directors. In these initial appointments, Client Advocates adhere to an organizational policy requiring staff to first meet with clients one-on-one

[85] When clients meet with staff they most frequently meet with a center director. At Urban Care every center director held a master's degree, in fields ranging from counseling to education.

to ensure her privacy.[86] Furthermore, it is standard practice to turn on a small white-noise machine outside of each room before entering the counseling space (though forgetting or neglecting to do so, is not uncommon). The quiet intimacy of the counseling room provides a space for staff to create a highly personal experience that does not feel rushed. Here, in softly lit rooms, Client Advocates focus on building relationships with clients and the conversations they host are longer, broader, and more in-depth than those I observed at Mountain Care.

There are four distinctly ordered aspects to Urban Care's options counseling appointments: (1) "getting to know" clients; (2) discussing a client's options; (3) a urine pregnancy test; and (4) concluding appointments by reviewing a community resource booklet. Client Advocates spend considerable time "getting to know" clients and discussing pregnancy options before offering a pregnancy test (Urban Care requires clients take an in-house, urine pregnancy test before receiving an ultrasound). Client Advocates are instructed to ask questions that focus on the context in which a woman is making her decision, because, as Hope explains, "we need to address *that* before we can focus on her pregnancy." While the initial questions asked—about schooling, jobs, intimate relationships, and family—are similar to those at Mountain Care, staff at Urban Care spend far more time posing follow-up questions and

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[86] This policy also held for my observations; I was only allowed into client appointments *after* a Client Advocate's initial meeting with a client—this initial meeting could last 30 seconds to 5 minutes. To minimize any sense of obligation to participate in my study, this was when Client Advocates introduced my study (if they thought it was appropriate).

I observed three exceptions to this organizational policy. In these instances the client's support person (boyfriend, mother, or interpreter) were allowed into the initial appointment "to help translate."

Staff often framed this as a means by which to assess if women were being pressured into an abortion decision (being pressured into motherhood was not discussed), a good practice of a number of reasons, although research shows few women report coercion from others as a reason for seeking abortion (Biggs et al. 2013; Finer et al. 2005).

validating client emotions. In fact, one of the most frequent questions asked in appointments is: "how do you feel about that?"

During a slow day at Meadowview, the director, Jillian, utilizes role-play as a training exercise with an intern to demonstrate, "what a typical client interaction *should* look like." Jillian emphasizes the need to connect with clients to "reassure them and build trust in you." She gently suggests starting with small talk about school and work. She then explains that with clients who report a traumatic history, she would ask the "important questions very casually. Like, 'I see you've been abused, tell me about that.'" Jillian explains how important it is to ask followup questions such as "why, who, how much, etcetera," to demonstrate genuine concern for clients and to gain a more clear understanding of the context in which clients will be making their decisions. As she moves between playing a Client Advocate and client in several different scenarios, she illustrates how to cultivate a more "egalitarian relationship." Jillian tells the intern (a seminary student who is working towards her master's degree in counseling) to use the client's language; to speak in a soft, curious voice; and to pay careful attention to her body language: "if her arms are crossed and she leans back, she may be uncomfortable—ask her about that. You can say, 'it seems like that makes you really uncomfortable, can you tell me about that?'" Jillian cautions the intern that clients may be "hard" or may say "awful things" that contradict her own beliefs; however, she implores the intern to remember that "this appointment is *not* about you; it's about *her*."

After this initial series of questions, Client Advocates move on to the options counseling portion of the appointment. Often, Client Advocates preface this conversation by explaining that

they want to discuss all three options: abortion, adoption and parenting.[87] Client Advocates are trained to say "we want to discuss all of your options," even with clients who have stated their intention to carry a pregnancy to term and mother. This is with the express intention of guiding reflection and inviting clients into conversations that may reveal "hidden contradictions," or situations in which a woman would consider an abortion. Similar to narrative therapy models advanced by counselors and social workers (see Freedman and Combs 1996 and Morgan 2000), Client Advocates attempt to center client's voices during counseling sessions and to see clients as people separate from their problems. To promote a client-centered appointment, staff are trained to employ a question-based listening model (and sometimes utilize a hard-copy of a decision-making guide) to help them approach clients with 'compassion' and 'objectivity.' In appointments, staff do not talk about their own histories of pregnancy, motherhood, abortion, adoption, or struggles with fertility as a means to connect with clients or impart a sense of authority. While these experiences are not explicitly shared with clients they inform their counseling practice, as Fiona explains, "God uses my story to help form my words."

Staff report that Urban Care's social work model of care emphasizes the importance of listening to a woman's story and inviting her into a different viewpoint, a technique referred to as "tender confrontation" that allows staff to "speak the truth in love." The intention underlying Urban Care's social work model is to promote in clients a perception of themselves as active decision-makers. Staff frame this as an empowering technique informed by decades of pregnancy center work. Hope reflects on this question-based model, asserting "we are asking

[87] There is some variation in how this conversation is approached. Some Client Advocates (most frequently volunteers) ask "what options are you considering?" If a client responds by stating her intention to carry a pregnancy to term and mother, Client Advocates generally follow up with a reminder that if her situation would change, Urban Care is a place where she can discuss all her options. Other Client Advocates push a deeper options discussion by asking what a client knows about adoption and abortion.

questions informed by over 35 years of doing this work. None of the questions on there are *me* saying this is a good question. It's a post-abortive woman who said: 'I wish someone would've asked me this question.'" Yet, these invitations also reflect the organizational values of Urban Care and, occasionally, individual staff members. Evelyn explains that she asks clients particular questions because "it is important that *she* thinks about that." As Urban Care sees an abortion decision as mothering decision to which great moral and emotional responsibility is attached, in asking "important" questions clients are simultaneously subjected to moral and emotional management. The questions that are asked and how they are posed reveals the values and gendered worldview of staff. As I explore later in this chapter, the counseling in "difficult" appointments divulge beliefs about motherhood and abortion. While the staff at Urban Care work to conduct counseling in caring, client-centered manner, their practices also highlight the pro-life convictions undergirding the pregnancy center movement more broadly. Below, I first examine counseling in the CPC movement; then I argue that options counseling is a means by which staff perform gendered, evangelical identities as they negotiate the boundaries between the secular and the religious; and finally, I explain how these performances serve to manage women as 'mothers.'

1. Counseling in the CPC Movement

In Chapter Three, I discuss how staff frame their work in pregnancy centers as a "ministry" and how this is an appropriately gendered form of ministry. While large Protestant networks, like CareNet, Heartbeat International, and their affiliates, emphasize the ultrasound as a powerful tool in pregnancy center ministry, counseling around unplanned pregnancies remains the understated foundation of their work. Importantly, counseling also represents a way for

centers to maintain their woman-centric focus—a key aspect to their construction of ministry—amidst a movement criticized for its emphasis on the fetus.

Pregnancy centers, pregnancy center networks, and supportive evangelical organizations (like NIFLA and Focus on the Family) are largely concerned with establishing ethical standards of practice around medical services, paying scant attention to establishing similar standards of practice in options counseling. Even NIFLA, which provides legal counsel, education, and training to member "life-affirming pregnancy centers," offers only this advice: "Counselors and Client Advocates should be thoroughly trained to present medical facts and should not give their opinions outside of these facts." Instead, NIFLA and others focus their attention on assisting pregnancy centers in making the transition to medical centers, training practitioners in the provision of ultrasound services, and responding to "fake clinic" claims.

While large pregnancy center networks require their affiliates to adhere to "Standards of Affiliation," "Philosophies of Care," or a "Commitment of Care and Competence," each of which implores centers to provide "truthful," "honest" information, there is little standardization of lay-counseling practices among centers and each establishes its own interpretation of network dictates and the training requirements for staff and volunteers. Additionally, in June 2018, *NIFLA v Becerra* struck down California's Reproductive Freedom, Accountability, Comprehensive Care and Transparency Act (FACT Act) enacted to regulate pregnancy centers.[88]

[88] The FACT Act required licensed and unlicensed pro-life centers that offer pregnancy-related services to provide on-site, written notices. Licensed clinics were required to notify women that California provides free or low-cost health services, including abortion, and to provide a phone number. Unlicensed clinics were required to notify women that the center they were visiting was not licensed to provide medical services. The stated purpose of the FACT Act was to ensure women were aware of health care services provided by the state and to ensure women knew they were receiving health care from licensed professionals (*NIFLA v. Becerra* 2018). In June of 2018, the U.S. Supreme Court ruled the FACT Act constituted compelled speech and violated pregnancy center's first amendment rights. According to the majority opinion expressed by Judges Kennedy, Roberts, Alito, and Gorsuch, "Government must not be allowed to force persons to express a message contrary to their deepest convictions" (*NIFLA v. Becerra* 2018, 2379).

This ruling effectively established that pregnancy center services are classified as free speech, protected by the first amendment. In this way, pregnancy center practices—from medical services to options counseling—largely lack federal and state regulatory oversight, beholden only to their internal organizational guides. Without federal supervision or clear, comprehensive network guidelines, individual pregnancy centers are left to determine and manage counseling practices.

A number of programs exist to train lay-counselors in the pregnancy center setting. CareNet collaborated with the American Association of Christian Counselors (AACC) to offer an opt-in, DVD-based training program for lay-counselors through Light University, the AACC's education division that offers a variety of online, Christian, continuing education programs and trainings. Similarly, International Life Services offers a "Pro-Life Counselor-in-Training Program" which pairs a series of DVDs with a textbook developed by Sister Paula Vandegaer, L.C.S.W. to provide "very specialized training" for pregnancy center staff and volunteers. "Equipped to Serve" is the curriculum developed by former pregnancy center Executive Director Cyndi Philkill. Based on Adult Learning Theory, "Equipped To Serve" provides training manuals filled with exercises "designed to equip you—the volunteer—to care for women and their unborn children…[and] to provide materials that will enable you to be ministers, not manipulators, and to understand the difference." Additionally, nearly one-third of pregnancy centers in the United States use the Earn While You Learn (EWYL) curriculum (EWYL 2017). The EWYL program was developed to "educate young mothers" about pregnancy, relationships, parenting, and "life skills" (which include "finances, abstinence, and careers") (EWYL 2017). While this program is typically employed in mentoring programs rather than initial client

appointments, EWYL claims to bolster pregnancy centers' ability to attract 'abortion-minded' clients and provides for counselors and client advocates important answers to client fears:

> When counselors are working to convince clients the baby is alive, the fears of the future also need to be addressed. EWYL gives answers to those fears. The "I can't be a mother" can be addressed with, "We can help you learn how" and the "I can't make it alone" can lead to a response of, "we will be here to help you." EWYL provides the tools that the young clients know they need—and it helps them choose life because they see a possible road forward (EWYL 2017).

In this way, EWYL also informs the options counseling practices of pregnancy centers across the United States.

These manuals are designed for self-study or in-person, guided workshops. Each program focuses largely on developing and refining evangelical lay-counseling skills in the pregnancy center setting. While these training programs discuss the legal status of abortion in the United States, they do not provide information on adoption or abortion procedures, nor do they discuss parenting resources or STI information; leaving the framing of these topics to the discretion of each center.[89] This lack of standardization and differences in origin and scope of training, means that the structure and content of counseling sessions can differ drastically from one center to another, and even between one counselor and another (Munson 2008). Yet, each of these counseling training programs rests on a shared foundation of gendered, evangelical practice.

2. Counseling as Gendered, Evangelical Practice

Throughout my fieldwork I observed how evangelical Christianity functions to infuse divine purpose into lay-counseling. A "life-affirming," evangelical approach is common among these training materials, which emphasize the theological roots of a 'pro-life ministry,' the

[89] Pregnancy Center Networks and evangelical support organizations (like Focus on the Family) also sell pamphlets, brochures, and magazines to their affiliates to use as trusted sources of information on pregnancy options, fetal development, and sexual intimacy.

sanctity of life, the development of listening skills, relational approaches to crisis intervention, and serve to define the appropriate ways to evangelize. Importantly, evangelical Christianity relies upon gender essentialism to frame pro-life activism as uniquely feminine (Luker 1984), and women as naturally well suited to perform the caring labor of pregnancy center ministry. Thus, pregnancy centers are highly feminized spaces, organized and supported primarily by women (Kelly 2012; Munson 2008). In an "Equipped to Serve" newsletter Cyndi Philkill (2014) celebrates this feminized practice:

> One of the joys of this ministry is that God has provided a way for women to use their gifts and abilities within this ministry in ways that have not been readily available to them in the wider context of the church and Christian community. Gifts of teaching, leadership, pastoring, organization are being exercised freely in the many positions available to women in the context of the Pregnancy Center.

As feminized spaces within a conservative religious framework, pregnancy centers are sites of multiple negotiations of gender and religiosity.

Scholars have long grappled with the perplexing question of why women—particularly well-educated, middle-class women—participate in religious systems that seemingly subjugate them to oppressive gender ideologies.[90] In particular, scholarship has moved from understanding women as universally oppressed in conservative religious practice (Daly 1986), to examining the ways in which women can use the "repertoire of their faith tradition in strategic, creative and sometimes subversive ways to meet the practical demands of everyday life" (Bartkowski and Read 2003, 73). In this tradition, research on evangelical women focuses on the complicated ways in which evangelicalism can serve as "a strategic form of women's collective action" to empower women in the public sphere (Brusco 1986), within the family (Griffith 1997; Stacey and Gerard 1990), and inside religious spaces (Brasher 1998). These are practices that facilitate

[90] See for example: Avishai 2008; Brasher 1998; Chong 2006; Griffith 1997; Kelly 2012; Stacey and Gerard 1990.

gendered identity formation and diverse evangelical women draw from their dynamic religious 'toolkit' (Swidler 1986) to negotiate identities in a myriad of ways (Bartkowski and Read 2003; Ingersoll 2002, 2003). Yet among evangelical women, this identity work is contested and constantly renegotiated (Bartkowski 2001; Bartkowski and Read 2003) as they often confront the contradiction between remaining devoted to evangelicalism while resisting or strategically complying with its conservative gender imperatives (Gallaghar 2004; Gallagher and Smith 1999; Griffith 1997; Ingersoll 2003).

The complex ways in which evangelical traditions function are further explicated in Kelly Chong's (2006) study of Korean women's participation in conservative, evangelical practice. Chong examines the ways in which evangelical religiosity intertwines with existing social-structural systems, to produce complex and contradictory experiences for some evangelical women. The women in Chong's study recognized their patriarchal oppression while consenting to it in order to construct cohesive, religious identities. In this way, women's evangelical practice can represent a duality: upholding conservative, oppressive gender ideals while simultaneously using it for strategic ends. This analysis by Chong moves past frames which dichotomize women's religious agency as either subversive or subordinate, empowering or accommodating, and includes the importance of structural and cultural context. In this vein of research, Orit Avishai (2008) proposes a nuanced approach to understanding women in conservative religions. Rather than juxtaposing agency and compliance, Avishai maintains that "observance is best explained by the notion of religious conduct as a mode of being, a performance of religious identity, or a path to achieving orthodox subjecthood the context of threatened symbolic boundaries between orthodox and secular…identities" (410). In this way,

Avishai argues religious observance may not be strategic but rather a performance of identity for religious ends. The emergence of this research demonstrates that gendered religious identities can expand and shift to accommodate contrasting ideologies and construct counterintuitive performances. Kimberly Kelly's (2012) research explores how this occurs within the CPC movement.

Within the highly gendered pregnancy center movement, women simultaneously uphold gender essentialism through feminized care practices while challenging conservative gender roles as empowered, authoritative movement leaders (Kelly 2012). This has important implications within pregnancy centers and within the broader pro-life movement. Kelly (2012) argues that the gender essentialism characterizing evangelical pregnancy centers is a unique source of authority for conservative women that "legitimates autonomous, sex-segregated spaces, prompts gender identification across religious and political divides, and places explicit limits on men's power" (204). In this way, pregnancy centers act as spaces in which female staff and supporters draw upon essentialist frames to justify their strategic, women-centered approaches aimed at preventing abortion and actively redraw relationships between women and men. Ultimately, this is a means by which women express their faith as they effectively restructure it (Kelly 2012). Counseling is one of the primary mechanisms through which women enact feminized, evangelical identities while challenging the patriarchal order. Central to conservative, evangelical ideologies are beliefs about motherhood. In the following section, I discuss how ideas about motherhood and abortion are reflected in staffs' counseling practices and serve as a means by which staff manage women as mothers.

3. Counseling and the Management of 'Mothers'

Evangelical Christians attach a high value to motherhood (Gallagher 2003), a gendered frame that is evident in the movement more broadly. Kristin Luker (1984) argues that abortion is upsetting to pro-life activists because it disrupts their social understanding of traditional gendered relationships and motherhood. In making pregnancy discretionary, motherhood is "demoted from a sacred calling to a job" and frees women to act more like men, that is to "compete equally with men without the burden of an unplanned pregnancy," while simultaneously disrupting traditional beliefs that men and women have naturally separate but equal roles in life (Luker 1984, 205). In this way, Luker asserts that "the meaning of *women's* lives" is the heart of the abortion debate (174). Yet, since Luker's ground-breaking work, the pro-life movement has experienced pronounced gender liberalization (Shields 2012) and now draws upon feminist frames to express an anti-abortion ideology.[91] This shift is apparent in how staff at Urban care conceptualize motherhood.

In contrast to the view of motherhood as the most fulfilling, unique role a woman can have—which was purported by the staff at Mountain Care and which is typical of pro-life activists (Luker 1984)—the staff at Urban Care hold a vision of motherhood that is more complex and reflects the positionality of staff (a significant proportion of whom are not mothers). While staff uphold motherhood as "fulfilling" and a "blessing," they frequently emphasize its difficulties, describing motherhood as one of the most challenging journeys a woman could undertake. Staff discuss motherhood in terms of children—it is about the joy of children and the

[91] At both Urban Care and Mountain Care this liberalization was reflected in staff discourse. Staff frequently spoke of their work in terms of women, using phrases like "pro-woman," "whole-women's care," "the beauty and strength of women's bodies," and ensuring they focused on how abortion traumatizes *women* and how their work provides true choice.

pleasure in molding a new life—rather than as a fulfillment of one's full potential as a woman. In other words, motherhood is understood to be important because it cultivates a sense of self in relationship and service to others. In this way, motherhood is understood to be a self-sacrificing role that prioritizes the wellbeing of others. Mothers are expected to care and love others and to make hard decisions for the benefit of others; in essence, to be selfless. Motherhood is time and energy intensive, but should be prioritized for the welfare of a child and family. Motherhood is something that happens to your body (immediately upon conception), and something you do as a woman.

If the essence of motherhood is to be selfless, a woman considering abortion is incredibly selfish. Staff at Urban Care reflect this ideology by asking questions that highlight a woman's responsibility to others. They ask questions that lead women to consider how they exercise power in the context of their relationships and obligations to others, effectively reminding women that they hold the power to determine if someone will or will not become a father, grandparent, or sibling. In this way, options counseling serves to remind women of the duties of motherhood and their obligations to others.

In conceptualizing a pregnant woman as a mother, an abortion decision's immorality is intensified. Legal scholar Carol Sanger (2017) explains, "abortion is not just a killing but a killing by the victim's *mother,*" increasing its inherent selfishness and cruelty (17). Whether or not the decision to have an abortion was arrived at with a partner or family member,[92] in the pubic consciousness and legal code the ethical accountability for an abortion remains solely in the woman's hands. Because the stakes are so high, staff feel a moral imperative to "ask the hard

[92] Scholarship has demonstrated abortion decisions are often made in partnership or in consult with others and rarely made alone (Chibber et al. 2012; Finer et al. 2005; Kumar et al. 2004)

questions" in order to ensure that a woman thinks carefully about the decision before her and takes responsibility for whichever option she selects. This entails staff asking questions about how a client will feel in the future, how she would feel if her circumstances shift, and if she will feel regret. As I show later, these trends are particularly evident in "difficult" appointments.

While counseling is at the center of Urban Care's model of care, medical services remain important and many clients come to Urban Care seeking a free ultrasound. The ultrasounds performed at Urban Care differ from those I observed at Mountain Care. In the following section, I describe the ultrasound experience at Urban Care, noting the ways in which their social work model of care emphasizes client consent and leads to a distinct ultrasound experience.

C. Ultrasounds and the Social Work Model of Care

Urban Care offers free ultrasounds at their Midtown, Riverside, and Meadowview locations, and frequently conduct early, first-trimester ultrasounds. In order to receive an ultrasound, clients must establish a positive pregnancy through an in-house, "self-diagnosed" pregnancy test[93] and meet with a Client Advocate for intake and options counseling. Clients are often unable to schedule same-day ultrasounds, as Urban Care's medical staff rotate between offices. While ostensibly because of scheduling needs, the practice of breaking up client appointments also serves to reinforce Urban Care's model of 'slow care' which protracts women's decision making. Two staff members—Olivia, a physician assistant, and Stephanie, a sonographer—perform the vast majority of ultrasounds. Occasionally, Urban Care's Medical Director and a retired physician, conducts ultrasounds as a volunteer.

[93] Urban Care's protocol requires clients to read (diagnose) their own pregnancy tests. However, Client Advocates do not always follow this procedure, and it is not uncommon for Client Advocates to read client's urine pregnancy tests and then confirm the results with the client. For example, when working with an "easy" client, Jillian read her pregnancy test and said: "it is two lines, so it's positive. Do you want to see?"

While a client's initial counseling session with a Client Advocate may span 30 minutes to an hour, the medical portion of her appointment is much shorter. First, in the counseling room, a Client Advocate will ask if a client has ever had an ultrasound and then explain what to expect. Client Advocates usher clients to a separate ultrasound room where the medical staff takes over, although the Client Advocate remains in the room as a (mostly) silent observer. In a stark contrast to Mountain Care, the medical portion of client appointments is highly regimented, structured, and brief.

Donned in a white lab coat and scrubs, Olivia or Stephanie sit in a chair beside the client and begin her appointment by gathering a standard health history and asking questions about the client's health concerns with this pregnancy. Then, the practitioner briefly explains the ultrasound process, often repeating what a Client Advocate has just told them. Before she begins the ultrasound, the practitioner will ask if the client would like to invite any support persons into the room. All appointments (regardless of projected gestational age based on a client's last menstrual period) begin with an abdominal ultrasound before moving to the more invasive transvaginal ultrasound for 'better imaging.'[94] As many clients seek care early in their pregnancies, transvaginal ultrasounds are standard practice.

In the ultrasound room a vinyl exam table takes center stage. After gathering her medical history, the practitioner instructs the client to get on the table, lay back and roll her pants down to expose her lower abdomen. Here, Urban Care's practice takes a notable departure from Mountain Care. The screen of the ultrasound machine is turned slightly away from the client and

[94] Conscious of language, Urban Care's staff intentionally changed and standardized the way in which they describe transvaginal ultrasounds during my fieldwork. Staff were told to explain that transvaginal ultrasounds "provide the best images and information possible," as opposed to saying an abdominal ultrasound, "isn't good enough," or "doesn't provide the best images."

the wall-mounted television screen is off. Standing beside the reclining client, the practitioner states that they will first take pictures of the "things I need to send to a doctor" and then explain that they will offer the client the opportunity to view her ultrasound by asking: "do you want to see what I'm seeing?" The language practitioners use is intentionally neutral or medical—thing, embryo, or fetus—and prioritizes a client's consent to viewing her ultrasound. As warmed jelly is applied to the client's abdomen, the Client Advocate dims the lights and turns on soft classical music. The practitioner begins the ultrasound, her silent concentration accompanied by the occasional whir of a printer etching black and white images onto photo paper.

Client Advocates remain in the room throughout the ultrasound, generally seated or standing off to the side, with the express intent to support and advocate for clients. Generally, Client Advocates silently observe the ultrasound, interrupting only to assess a client with a gentle, "how are you doing?" or by reminding the client to breathe. However, occasionally a Client Advocate spoke directly to the medical staff, stepping in when a client was verbally unsure or visibly uncomfortable—each of these instances involved consent to a transvaginal ultrasound.[95]

Clients generally stare at the ceiling as the provider, gaze fixated on the ultrasound screen, silently moves a probe over the client's abdomen. After a few minutes and a few pictures, Stephanie or Olivia will ask: "do you want to see what I'm seeing?" Most clients say yes or nod their heads, at which point the Client Advocate moves silently to turn on the flat screen mounted to the wall near the foot of the exam table. Making sense of the projected

[95] This occurred when Olivia or Stephanie did not explicitly *ask* a client if they would like a transvaginal ultrasound, but rather stated they needed to perform one in order to obtain better pictures. In all three cases, the Client Advocate interrupted to check in with the client and tell her a transvaginal ultrasound was her *choice*, often embarrassing the practitioner and client. I do not know if this 'check-in' was for my benefit, or if it occurs regardless of my presence.

images for a client, Olivia or Stephanie first point out the client's anatomy (vaginal canal, cervix, uterus) to orient her before pointing out fetal landmarks.[96] Unlike the nurses at Mountain Care, Stephanie and Olivia are efficient and clinical. In professional voices, they rapidly point out markers and body parts—like a spine, head, heartbeat, and yolk sac—only expanding upon their function if prompted by a client's question. These showings last fewer than five minutes and rarely do Urban Care's practitioners point out a 'baby,' preferring instead to list various limbs, tissues, and organs. Concluding the ultrasound, the practitioner will hand the client paper towels, instructing her to wipe the gel off of her abdomen before finishing up her paperwork. While uncommon, there are occasions when the television screen is left on to play a five-second loop of a woman's ultrasound images, while the client completes her paperwork with the physician assistant or sonographer.

The ultrasounds provided at Urban Care construct a different emotional context than those at Mountain Care. While the practitioner is friendly—she smiles, asks if a client has any questions—the tone of these ultrasounds are clinical. In a sharp contrast to Mountain Care, staff do not use ultrasound images to cultivate a sense of connection to an 'unborn child.' Medical staff do not compare fetuses to "teddy grahams" or "gummy bears," nor do they use possessive gender pronouns (*his* heart, *she's* waving). Rather, they clinically list parts. Throughout the appointment, their tone of voice is neutral, lacking the high-pitched excitement, swooping intonation, and fetal-directed speech of the nurses at Mountain Care. Ultrasounds do not feel rushed, but they are vastly shorter than those at Mountain Care, as providers quickly point out anatomical markers without lingering to coo or enliven the images on the screen. Staff here are

[96] Pointing out client anatomy is standard, routine practice at Urban Care but rarely occurs at Mountain Care.

more careful about language and tend toward the use of fetus (especially with ambivalent clients), although 'baby' slips out at times.

The higher degree of neutrality apparent in Urban Care ultrasounds is due, in part, to the limited role of the medical provider. Unlike at Mountain Care, where nurses guide clients through an entire appointment, Urban Care's medical staff do not have the same relationship with clients. Their interactions are clinical, rather than relational; the only insight on clients they receive, if any, is through a brief, verbal summary delivered by a Client Advocate before the ultrasound. While the exchanges between medical provider and client are still important, Urban Care's social work model removes the focus from fetal imagery. In this way, Urban Care's interpretation of pro-woman care is distinct from Mountain Care.

Through Mountain Care's medical model of care, staff understand their role as knowledge-bearing experts to tell women the 'truth' about abortion's risks and documented harms. They guide ultrasounds which reveal 'truths' held by women's bodies and actively attempt to cultivate a sense of connection between 'mother and child.' Mountain Care's medical model prioritizes beneficence—staff try to care for women and to save women from harming themselves by choosing an abortion.

Conversely, Urban Care's social work model prioritizes autonomy. At Urban Care, staff position themselves as advocates—care managers who ask, rather than tell. Here, staff pose questions that guide women into appropriate self-regulation. This is a much more subtle form of management that, as explained on Urban Care's website, allows staff to "enable and encourage [clients] to choose life every day." Due to the difficulty of gaining entrée into pregnancy centers, the data and analysis I present below, represents the first ethnographic examination of options

counseling in a pregnancy center. Previous research has taken a 'secret shopper' approach to collect data, documenting the widespread use of coercive, deceptive, and unethical tactics in pregnancy centers (Bryant and Levi 2012; Rosen 2012; Waxman 2006). This prior scholarship has shed much needed light on the quality and accuracy of medical information provided by centers (Bryant and Levi 2012), yet focuses heavily on abortion misinformation. The data and analysis I provide below enrich and complicate previous findings by broadening the scope of analysis to examine non-medicalized counseling. The options counseling that occurs at Urban Care provides an example of pregnancy center care that helps to illuminate the complicated dynamics that occur within counseling rooms.

In the following section, I illustrate the management techniques staff use in this interpretation of pro-woman care. As I discuss in previous chapters, staff differentiate between "easy" and "difficult" appointments; "difficult" appointments refer to those that require a great deal of emotional labor from staff, and typically occur with a client who is actively considering abortion. Below, I briefly summarize key elements of options counseling within "easy" appointments, analyze staff strategies, and describe how this approach resonates with clients. I then illustrate and analyze the dynamics present in "difficult" appointments.

III. Counseling and the Performance of Pro-Woman Care at Urban Care

A client's appointment always starts in the counseling room. I observed counseling appointments facilitated by center directors, volunteers, and interns at Urban Care; though I primarily sat in on those performed by directors. Client Advocates would, if they felt it appropriate, introduce my study to a client in the first few minutes of her appointment. With a client's consent I would join her and her advocate in the counseling room.

Before a client enters the counseling room, the Client Advocate has reviewed the client's intake documents, which tell the Client Advocate what services, information, and referrals a client is seeking as well as her basic demographic information. Yet, Client Advocates often begin the conversation with, "so what brings you in today?" or "I see you're here for a pregnancy test, what's going on?" Staff report these broad questions allow clients to lead the appointment and narrate their own story of pregnancy. Client Advocates typically spend 30 minutes in these initial appointments, which include "getting to know you" conversations and options counseling before a client takes a urine pregnancy test. After confirming the results of a client's pregnancy test, the Client Advocate almost always asks, "how are you feeling now?" At this point, some clients return to their discussion of pregnancy options, but often this is a shorter conversation and staff quickly steer it toward coordinating and scheduling a follow-up ultrasound.[97]

Like at Mountain Care, at Urban Care I frequently observed "easy" appointments in which women wanted to continue their (often unplanned) pregnancies and were seeking an ultrasound. In these appointments, staff ensure that they mention a client's "three options" and often probe a client's feelings on abortion, but the options counseling tends to be brief and cursory, focused instead on building rapport with the client. "Difficult" appointments are less common, but are more meaningful to staff and reveal important "pro-woman" care techniques. In Chapter Four, I explained how the central components of the *pro-woman care script* employed by both Mountain Care and Urban Care function to create a common understanding of abortion, clients, and care. This script constructs abortion as trauma, frames clients as in crisis, and serves to legitimize evangelical schemas of care. This *pro-woman care script* primarily functions to

[97] Same-day ultrasounds are infrequent at Urban Care.

inform staffs' emotional state and approach to counseling. In constructing abortion as trauma, staff focus on women and on providing Christ-like practical care so that a woman can avoid feeling pressured into an agonizing choice. In framing clients in crisis, staff emphasize the importance of approaching clients with empathy, slowing clients down, and "tenderly confronting" clients' rationale for choosing abortion. Finally, a foundation in evangelism shapes staffs' approach in appointments. Staff emphasize relationships, reflect individual strengths, and stress the hope that clients can overcome short-term circumstances to avoid long-term pain. These techniques are present in all appointments, but are particularly visible in "difficult" cases.

A. "Easy" Appointments

Nestled in an over-stuffed chair in the cozy counseling room, Jillian first asks Molly (22, white), "is that your husband out there?" After an animated conversation about Molly's new marriage and new business venture, Jillian explains how Molly's appointment at Urban Care will progress: "first, I just want to get to know you a bit; then, here at Urban Care, we like to discuss all your options. We'll then take a pregnancy test and get you in for an ultrasound because Dr. Gonzalez, our retired OBGYN doc, is volunteering today." Jillian goes on to explain that Molly will receive a limited ultrasound in which the doctor will confirm that the pregnancy is in the uterus, establish a fetal heart rate, and determine gestational age. Then, looking Molly in the eyes, Jillian asks, in a carefully measured voice, "how did you find out you were pregnant?"

Molly crosses her legs, gently popping her flipflop as she recalls noting some weight gain, "I was kinda getting a lump last month…I really didn't want to be pregnant but I took a test three weeks ago, and-" she trails off. Molly goes on to explain she took three at-home pregnancy tests and even made her husband take one to verify their accuracy because she did not recognize

any other 'typical' pregnancy symptoms. She tells Jillian she really wants to go to the doctor for an ultrasound and prenatal care but is waiting for the open enrollment period to get insurance coverage.

Patiently listening, Jillian waits for Molly to pause before softly observing, "when you first started talking, you said you didn't want to be pregnant right now. Tell me about that." Molly explains her desire to "leave it up to God," and her subsequent avoidance of birth control, saying, "I was just hoping and praying I didn't get pregnant because we're just starting a business." She offers Jillian a half-smile and says, "I guess God had different plans. I didn't plan on being a mom at 22 but here I am." Jillian then probes Molly about her feelings on abortion and adoption, listening for any contradictions, before summarizing, "so even if your own health was endangered, you wouldn't have an abortion?" Molly nods, replying, "God has a plan for this baby. I'd rather have God planning this, than me!" Placated, Jillian smiles and nods her head, before asking, "what kind of resources do you need?" After listening to Molly discuss her insecurities about being a new, young mom and offering a few words of comfort, Jillian moves the appointment along by declaring, "ok, well let's do the pregnancy test and then move to the ultrasound. I'm assuming you want your husband in the ultrasound?"

While Molly's religious views play a more prominent role in her pregnancy decision-making than many of Urban Care's other clients, her counseling at Meadowview is characteristic of "easy" appointments. Through the process of 'getting to know' clients, Client Advocates use counseling appointments to gather information about the context in which a client is making a decision. In Molly's appointment, Jillian began by asking detailed questions about her job, relationships, living situation, and family life. Doing so offers what Urban Care refers to as

"whole-person help," which addresses a client's physical, emotional, social, and spiritual health. Through these conversations, Client Advocates cultivate a sense of trust and assess a client's vulnerabilities. Clients report these conversations feel respectful and caring. These in-depth conversations serve the dual purpose of making a client feel heard and cared for, while allowing a Client Advocate to evaluate any potential risks that could lead to an abortion decision.

Despite stating her intentions to carry her pregnancy to term and to mother, Molly's counseling session lasts nearly 45 minutes and Jillian made it a point to discuss "all three options." Staff often insist on addressing abortion, adoption, and parenting with clients who have expressed their intention to pursue one option. This is to reveal "hidden contradictions" or to assess if others will "sway" her decision once she leaves. Similarly, Jillian asked Molly to articulate, in detail, her thoughts and feelings about abortion. Even in "easy" appointments, these questions facilitate moral reflection as clients are often asked, "why?" and "are there any circumstances under which you would consider having an abortion?" Unlike at Mountain Care, where clients who state they do not want an abortion are taken at face-value and validated, Urban Care clients are asked to justify their decision, for the express reason of identifying potential vulnerabilities to abortion.

For some clients, this insistence on discussing all options and abortion, in particular, felt unwanted and imposed. Ophelia (18, white-Hispanic) desperately wanted to be pregnant and voiced her frustration at feeling forced to talk about abortion:

> I told her I don't like fucking abortion. I don't like it, I'm not going to do it. I don't want to do adoption. And they keep pushing! …I don't know if it's persuading or if it's just me taking it personal or something. It's just she's so fucking pushy. When I say it's not what I want, don't keep being like, 'well there's these perks to abortion!" …Maybe they're trying to explain all my options because I'm so young or because I'm an addict. I don't know—like I'm high risk or like maybe I'm not good. Because I go in there, I'm honest: I'm an addict. And maybe they're like, 'oh shit, [abortion] is best for the baby." …They're really comfortable to talk to, it's just I hate when they push that, after you say 'no, that's not an option." I don't know if that's their job, but I promise you, I know all three of my fucking options very well.

Because Ophelia believed that her Client Advocate had judged her to be unfit to mother, Ophelia left Urban Care with the sense that her Client Advocate endorsed abortion. Carli (29, African American) also felt as if her Client Advocate ignored her. After stating she wanted to mother, Carli's Client Advocate continued to give her a pamphlet on adoption, "I was like, 'listen, I don't want to look at *that*. I know I want to have my baby—this is my *life!* Ten years I've been trying.'" As Ophelia and Carli highlight, Client Advocates insist on discussing all three options with clients, believing this makes them less coercive. Yet, in attempting to be more 'objective,' and approaching every client as if she were 'abortion vulnerable,' clients' desires can be ignored.

However, like all of the Urban Care clients that I interviewed, both Carli and Ophelia characterize their overall experiences at Urban Care as "comfortable" and "caring." Urban Care had functioned to provide them a vital space to talk. Their appointments did not change their pregnancy decisions, but it made them feel cared for, if not supported. Ophelia explained that she has not often been granted the space to talk about her feelings in interactions with healthcare providers or her family. Doing so at Urban Care felt significant, "they just made it comfortable, I guess—letting you talk, I don't get to do that much…and like hearing [validation] from a stranger instead of your family…it helps me, I guess." Similarly, Carli described how being allowed to narrate the story of her pregnancy felt powerful and reassuring:

> I felt like they actually cared about me. And that's rare for me…it warms your heart, it give you an idea that there is a chance. There's a possibility of survival of happiness, of understanding. Just for somebody to sit you down and want to know you and not tell you what you need to know, but to listen and wait for your response and want to know exactly what you want to do. I thought that was great.

Most clients appreciated this individualized attention and contrast their experiences at Urban Care with those of low-cost health care providers. Shiloh (29, Black) described her

appointment at Meadowview as "peaceful," "warm," and "not all public clinic-y." Shiloh spoke at length to the difference between Urban Care and her harried Medicaid provider:

> It didn't feel so bureaucratic, like whenever you go to [Public Health]. You go there and it's just like: take a number, sit down—like you're not a person. They have free pregnancy tests there and stuff like that, but you're not a person. And [at Urban Care] you were a person, you know? They spoke to you. They got to know you: 'Why are you here? What choices? What's going on in your life? Let's discuss some things. Maybe this isn't an option at all but maybe this is, let's talk.' And it's good to have that.

Similarly, Teresa (37, white) went to Urban Care specifically to "talk it out." Teresa was experiencing pregnancy symptoms and came to Urban Care wondering if her tubal ligation had failed. She was "trying not to get excited" about the potential for another (unexpected) baby, but knew she would mother. At the same time, Teresa reported she was glad her Client Advocate spent so much time talking about options, "because it's not like you're treated like at [Public Health]: 'oh you're not pregnant, get outta here. Or let's just do the test and get it over with.' Like, I kinda felt bad because I was there for so long!" Like many clients, Teresa reported that the time she spent with an advocate and the opportunity to talk about her feelings felt caring. Importantly, it was not about gaining clarity for a decision—Teresa, like Ophelia and Carli, knew she would mother—it was because Urban Care offered a space for her to talk about her feelings and be validated: "I gotta let it out—how I felt about it. It's so much easier to talk to somebody at a pregnancy center who understands, than it would be to like talk to my friend who'd be like 'bitch, shut up, you're stupid.'"

Similarly, when Shiloh explained what made her feel cared for at Urban Care, it was not the information she received or the guidance in decision-making, but rather because:

> [Jillian] was warm. You know, it wasn't like it was just her job, but more like her passion. Like she got into it to help people…and not because she needed to pay a bill…[it was] the way she spoke, the questions she asked, her body language. Things like that. She didn't seem like she had other things to do and other things to get to…I felt comfortable. I felt like she was actually listening…at that moment in time, she was actually, actively listening to what I was saying to her. And that meant a lot.

The majority of Urban Care's clients are low-income and either lack health insurance or are on Medicaid. Clients reported many frustrating interactions with conventional healthcare providers that left them feeling neglected and disregarded. At Urban Care they felt like they were 'treated like a person,' highlighting the importance of non-medical services in evoking feelings of care and trust. In "easy" appointments, Client Advocates facilitated moral reflection as a means to validate a client's desire to mother (often in the face of challenging circumstances). Clients often left feeling validated for their desire to mother and grateful for free services. Unlike "easy" appointments, in "difficult" appointments clients are often struggling with a decision or have stated that they are considering abortion. In "difficult" appointments, the process of facilitating moral reflection is particularly salient, where conversations about abortion function to emphasize its emotional and ethical complexity.

B. "Difficult" Appointments

Staff at Urban Care label emotionally challenging appointments "difficult." These appointments are difficult because they require a great deal of emotional labor from staff in order to remain empathetic and present, as required by Urban Care's pro-woman approach. Most frequently, "difficult" is used to describe appointments in which a client is actively considering abortion. At the same time, "difficult" also denotes those appointments in which a client wants to be pregnant and receives a negative test, and appointments in which staff cannot adequately assist a client (like when a client leaves feeling as if she does not have a definitive test result or ultrasound, or is experiencing domestic violence or homelessness). In this section, I focus my attention on appointments deemed challenging because a client is considering a pregnancy

termination. These appointments reveal important strategies Urban Care employs to facilitate moral reflection in clients and that align with their understanding of pro-woman ministry.

In these appointments, staff use specific questions and statements to facilitate appropriate reflection and sentiment in clients. Rather than the 'beneficent' approach of Mountain Care, in which a medical authority clearly articulates abortion's harms, the staff at Urban Care generally avoid lengthy discussions of the specifics of abortion procedures in favor of questions that provoke the meaning and essence of motherhood and humanity with the intent that a client will go through the 'right' process (asking herself important questions) and with the hope that a client will arrive at the 'right' conclusion (avoiding an abortion decision). Client Advocates are particularly skilled at asking questions that connect a woman's values to the avoidance of an abortion decision. Through "discussing all the options," Urban Care's staff carefully manages individuals so that they willingly adopt a particular frame of reference surrounding abortion and motherhood.

As I sat in on options counseling at Urban Care, I frequently thought about Foucault's theories about diffuse power. Unlike at Mountain Care, where the medical gaze exerted power over women's bodies through the ultrasound, at Urban Care power was diffuse and embodied in discourse about emotions and trauma that promoted self-management. It was powerful to witness how clients were encouraged to adopt practices defined as 'self-care' so as to prevent the trauma of abortion. As I reflected on these observations in my field notes, I often found myself grappling with conflicting emotions and attempting to identify the line between care, persuasion, and manipulation. An excerpt from my fieldnotes after a "difficult" appointment highlights this confusion:

> *What is happening here? Why do these appointments feel both caring and manipulative to me? This counsel is heartfelt and sincere. I hear techniques used by therapists and social workers. It is strategic and genuinely intended to save clients from trauma. Yet, this care still seems to imply a 'good,' or less painful, outcome. Her motive is not to coerce the client into a decision, but to bypass her 'illogical,' uninformed defenses.*

"Difficult" appointments were also often 'difficult' for me. These appointments tended to be highly emotional and my note-taking and lack of eye contact with clients often felt cold and detached. At the same time, constant annotation enabled me to suppress my own emotional expression. I found my own anger or sadness could retreat into my notes, particularly when I perceived staffs' counsel to be manipulative. Notably, none of the clients whose appointments I highlight below felt manipulated or coerced in their appointments. Instead, in later interviews, they described feeling "supported" and "heard." Jada (27, mixed race) explains that the questions she was asked were valuable and "help a lot. It helps you also think outside the box. They help me look at stuff that I never even knew—beyond the pro and con's list."

In the following sections I use examples from three "difficult" counseling sessions to highlight the use of three overlapping and intertwined strategies designed to facilitate reflection: (1) verbal techniques staff use to "slow down" clients they perceive to be in crisis and unable to accurately assess their situation; (2) the ways in which staff promote 'heart-based decision-making' and ethical contemplation by emphasizing relationships, emotions, and morality; and (3) the ways in which staff "tenderly confront" clients by connecting clients' values and strengths to the avoidance of an abortion decision.

1. Slow Down

As I discussed in Chapter Four, slowing clients down is a central component of 'pro-woman' care. Evelyn explains that this approach ensures that clients are able to "see beyond the scope of their crisis." At Urban Care, "slow care" is enacted in two primary ways: (1)

scheduling clients for multiple appointments, at least a week apart; and (2) the framing of abortion. In each of the "difficult" appointments I observed, clients were either present for their second appointment—scheduled for the purposes of receiving an ultrasound—or, at the end of their appointment, made arrangements for a follow-up ultrasound. This protracted care reinforced a message of "slow down." However, the most important technique employed in slowing a client's decision was the framing of abortion as accessible.

Staff at Urban Care frequently began conversations about abortion by informing clients that, legally, they could elect to have an abortion at any point in their pregnancy. With that simple statement, staff fail to address other important factors that clients reported were important in their abortion decisions, including access to providers, cost, and risk. In an appointment with Quinn (21, white) who is actively considering abortion, Hope quickly moves the conversation from the logistics of abortion back to Quinn's emotions.

Hope: What's your timeline?
Quinn: When do they do abortions to?
Hope: In this state, they do them to the date of delivery. That's by law.
Quinn: That's horrible! But I thought Planned Parenthood only went to 13 weeks?
Hope: It depends on the provider. We don't refer for abortions.
Quinn: I can see why. [My first abortion] was horrible…
Hope: I've heard that from other women, too. How do you feel about adoption?

This approach is important because clients consider Urban Care a trusted source of information and some clients seek care here because they want to discuss their options. Shiloh explains that she chose Urban Care over another provider that offered free pregnancy tests because the Urban Care website offered "other services and other things. You know, like, they actually talk to you and stuff." A recent transplant from out-of-state, Shiloh was actively considering abortion and explains:

> I didn't know what I wanted to do at that moment in time, so I didn't want to go somewhere where they were just like, 'Okay, yeah. You're pregnant. Yeah you're gonna have a baby. Bye.' And like I don't know the state law. Like I don't know any of the stuff that goes on in this state…so I don't know if I can still have an abortion, and even if I want to have one, can I? Where do I go to do that? I've never done anything like that. And that's not something that people just talk about.

Yet, in Shiloh's appointment, Jillian did not differentiate between the legal status of abortion and the reality of obtaining one in the region. Rather she raises issues of morality:

> *Shiloh*: If I'm in the range to get one, I want to get one; I just don't know the time limits here.
>
> *Jillian*: Well in this state, you can get one at any time.
>
> *Shiloh*: Oh! Well maybe I'm only ok with like 3- to 4-months.
>
> *Jillian*: Why is your time limit 3- to 4-months? What happens then? Do you think it's less of a baby before then?

This technique is effective in slowing Shiloh down. Later in her appointment, Shiloh tells Jillian, "now that I know there is no time limit, I can really go back and talk with him." Later in an interview, Shiloh reports that she has decided to continue her pregnancy, yet the information Jillian shared about the legal status of abortion was a relief:

> And it's an even gianter weight off my shoulders knowing there's no time limit. So, if things don't work, when I am three months I don't have to just count that off the table. Even though I really don't want to [have an abortion], it's good to know that it's there…cuz some laws can trap women if you didn't find out in the first three months…now you're stuck with this for the rest of your life or you gotta go outta state, do a whole bunch of other stuff, pay a whole bunch of money, get the man's permission.

Here, it is evident that Shiloh no longer felt her pregnancy decision was urgent because of an external timeline and she believes that because "there's no time limit," obtaining an abortion past three months is as accessible and financially feasible as a first-trimester abortion. While Shiloh is now excited to continue her pregnancy and welcome a second child into her family, she does not have a full picture of abortion in the region. According to NARAL, in the state where my research was conducted and at the time of Shiloh's appointment, 87% of counties did not have

access to an abortion provider and most providers only offer out-patient abortions to 13 weeks.[98] As a pregnancy progresses both the financial cost and health risk increase, yet these details were not mentioned in any appointment I observed at Urban Care. Additionally, Client Advocates rarely informed clients about procedure timelines—significant for many clients because staff reported clients express a preference for medication abortions (something mirrored in my interviews with clients).

2. Heart-Based Decision Making

In "difficult" appointments, staff consistently emphasize the importance of emotions, explaining that a client's heart and mind may be saying different things, but that it is important that a client makes a decision that they "can live with," by listening to their heart. With clients struggling to make a decision, staff stress that within the head and heart dichotomy, clients should listen to their hearts, often repeating that phrase multiple times in the space of a single appointment. Jada's appointment with Jillian illustrates how staff sympathetically promote heart-centered decision-making that privileges a client's emotions.

Jada is a single mother of three children under the age of 10. She loves children and wants to have another child eventually, but with trying to meet graduation requirements, the demands of single-motherhood, the instability of her housing situation, financial struggles, and significant health issues, she feels overwhelmed by an unexpected pregnancy that occurred just six months after she gave birth to her third child. Jada's eyes swell with tears as she describes to

[98] In the state, out-patient abortion is legal and available to 26 weeks; however, most providers only offer out-patient abortion to 13 weeks. Additionally, the state has one provider (of three nationally) who performs terminations to 34 weeks. However, abortions past 26 weeks are only provided for pregnancies with severe fetal anomalies, genetic disorders, fetal demise, or medical conditions that endanger the health of the pregnant person. These late-term abortions represent less than 1% of abortions performed nationally, typically terminate a desired pregnancy, and generally cost tens of thousands of dollars.

Jillian her "miracle pregnancies:" while each pregnancy was complicated, pregnancy was the only time in the past seven years when she was not struggling with cancer. Just before she found out about this pregnancy, Jada was diagnosed with stage one-cervical cancer and had just begun another round of chemotherapy for stage-three ovarian cancer. As Jada tearfully recounted her struggle with cancer, Jillian "tenderly confronts" her logic and emphasizes the importance of making heart-centered decisions:

> *Jada*: I'm really struggling with cancer. My heath is really down and I can't take care of my kids. And I feel like I've pushed back my own dreams of education and bettering myself for so long. I just want to feel more stable.
>
> *Jillian*: Why do it when you are stable?
>
> *Jada*: It's hard. I don't know what's going to happen. It's hard raising four kids. I would really like to get my health under control.
>
> *Jillian*: Those are all the facts and the reality. What is your *heart* telling you?
>
> *Jada*: I don't know…I've got through so much. I don't believe in abortion but when you are in that situation, it's different. I made so many [abortion] appointments for [my last pregnancy] but it's so hard. Is keeping my child the best choice for me? My mind says no. My heart is more complicated.
>
> *Jillian*: From what I know about you, you can do it!

Jillian goes on to remind Jada that stability is possible, that her partner "sounds like a good guy," and that "her children are fighters!" In a sympathetic voice, she tells Jada that "this is a tough decision that your head and heart have to deal with. Your head tells you everything is overwhelming. Your heart feels all the good things. You know the trauma of abortion." Later, as Jillian begins to conclude Jada's appointment, she says, "I would encourage you to listen to your heart," and referring to a previous client, she cautions Jada, "a client said she was glad she didn't make a long-term decision in short-term circumstances."

Staff frequently accentuate abortion as a long-term decision in "difficult" appointments by asking clients to reflect on their future emotions. This often involves asking clients about how they will feel in the future, and specifically if they will feel regret. For example, when

Shiloh explains that she believes abortion is the best decision, Jillian queries, "would you have regrets down the road? Would your partner have regrets?" Quinn, who has already experienced an abortion, explained that she still struggles with that decision, characterizing her emotions as "regret." In asking about her decision making, Hope urged Quinn to consider her future:

> *Hope*: It seems the question in front of you is: have the abortion and keep your relationship intact and the unknown of those feelings; or, keep it and parent along and lose that relationship. What would a second abortion feel like?
>
> *Quinn*: I don't know. Guilt? As if I'm left with nothing?
>
> *Hope*: With choosing abortion, what may happen? Will you feel better or worse? What will you feel five years from now?
>
> *Quinn*: I don't know? What if I can't get pregnant and I ruined it?
>
> *Hope*: A few knowns I can provide you. Urban Care has been around for 35 years so we've seen a lot. We often see men and women coming to us years after, like 20-30 years. Some said it was harder to get pregnant. So what you say matches with what other women have said. That being said, parenting would be hard. What would you feel about that?

Amidst options counseling, Hope frames the ultrasound—the reason for Quinn's appointment—as a tool that will help to give Quinn some clarity. After Quinn's ultrasound, Stephanie, the sonographer, left a five-second loop of Quinn's ultrasound images playing on the screen. As Quinn dressed and completed her paper work, the enlivened images of a fetus, dating 9-weeks, animated the screen. After returning to the counseling room, Hope checked-in with Quinn:

> *Hope*: How do you feel?
>
> *Quinn*: It's just crazy to see it move around.
>
> *Hope*: It's a little different than seven weeks, right? What emotions can you name?
>
> *Quinn*: Scary. It's scary that it's developing so fast. Relieved that it's ok?
>
> *Hope*: Ya, it's on track. We can hold fear and joy in the same place. Do you feel it was helpful?
>
> *Quinn*: I guess it's helpful if I decide to keep it. It's not helpful in making my decision, it makes it harder.
>
> *Hope*: You'll see what future-you can live with best. Hold these [different futures] up and maybe they can help with your decision making. This is *you*, and *your future,* and your head, and your heart, and your body.

In Quinn's appointment, Hope validates her emotions and carefully avoids implying one 'future' is better than another. At the same time, Hope indicates that the important factors in making a

pregnancy decision include an orientation toward the future and consideration of one's head, heart, and body. Notably, Hope did not include Quinn's partner's feelings in this list—undoubtedly because Quinn reported her boyfriend was pressuring her to have an abortion.

In asking questions that facilitate emotional reflection, staff suggest that making a good decision is one in which women choose to avoid the negative emotions they (and some clients) associate with abortion. As the cases above highlight, staff use the specter of future regret and other client's experiences[99] to signal how to make decisions and to subtly imply the most moral, judicious resolution. Ultimately, these counseling strategies suggest to clients that they can accurately predict their future emotional state, that negative emotions should be avoided, and that regret is a common experience after an abortion. Additionally, these techniques reflect staffs' understanding of abortion as trauma, a belief that according to staff is informed by years of pregnancy center work and their own experiences. It is important to note, however, that research on women's emotional experiences with abortion find that while a small proportion of women experience negative emotional outcomes after abortion, the most commonly voiced emotion is relief (Adler et al. 1990; Major et al. 2000; Charles et al. 2008; Robinson et al. 2009; Warren et al. 2010).[100]

The other important component of making a heart-based decision is a client's partner's emotions. Staff always inquire about a partner and frequently emphasize the importance of a partner's emotions in "difficult" appointments, by asking "how does *he* feel about that?" In

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[99] Both clients who were happy they made the "right" decision, and clients who made the "wrong" decision and were punished with infertility.

[100] A woman's mental health state before an abortion is a strong predictor of her emotional state after (APA 2008) and qualitative research has begun to add nuance to our understanding of negative emotional experiences after an abortion. Among women who *did* experience emotional difficulty after an abortion, Kimport and colleagues (2011) found that these outcomes were a result of women feeling as if an abortion decision was not *her* decision or because she felt as if she did not have clear sources of emotional support after the termination.

spotlighting the emotions of others, clients are reminded of their location within a matrix of interconnected relationships, relationships to which they are obligated to consider in a decision that is ultimately about their body. This implies that clients are responsible for the emotions of others, particularly their partner's emotions. For example, in Jada's appointment she reveals, "I'm still considering abortion. Adoption is out of the question because he doesn't believe in it." Jillian immediately shifts the focus to her partner, "does *he* believe in abortion?" Jada explains it is complicated, that neither she nor her partner like the idea of abortion, but it is an option because they are both in transitional housing, financially insecure, and unsure of their future as a couple. Jillian returns the appointment's focus to Jada's partner repeatedly:

> *Jillian*: Would you [and he] get together to be a family for this child?
> *Jada*: We might co-parent and try to get along, but I would still bear most of the responsibility.
> *Jillian*: But he would provide financially—that's huge! How would he react to an abortion?

Later, after Jada's ultrasound, Jillian assures her "we can do another ultrasound if you think [he] would like to be here; he can come, too." This is a common offer by staff, who frequently characterize men as "forgotten" in an abortion decision. As Jillian wraps up Jada's appointment, she asks "what are you going to tell [him]?" Jada explains she plans on sharing her gestational dates and notes "he'll want to see pictures even if I do get the abortion. This is very important to him." Jillian leans forward, looks Jada in the eyes and says in a soft voice, "ultimately, it's your decision, but it's important to listen to *that,* too…you have time, you don't have to rush."

A similar focus on a partner's emotions arises in Shiloh's appointment. Earlier, I noted that Jillian asked Shiloh if her partner would have regrets about an abortion decision. The way she reframes Shiloh's response is revealing. Jillian indicates that Shiloh should carefully consider the way in which her abortion decision will hurt him:

Jillian: Would you have regrets down the road? Would your partner have regrets?

Shiloh: I don't know. I might. But he probably won't—he never planned on children.

Jillian: He'll probably feel sad. We forget about men. He'll probably feel sad for you *and* for him. He's left out of the choice. Think down the road, you already know what it's like to be a mom. Would you miss that in five years down the road? This is what I've heard from clients.

Staff consistently frame women's abortion decision in terms of their partner's feelings. This serves to remind women of their responsibility to the emotional well-being of others. In indicating that women's partners will likely feel 'sad,' staff imply that women, as caretakers, should not selfishly contribute to the pain of others and that men share (or should share) decision-making power. This is a powerful, effective technique that reflects staffs' beliefs about the meaning of motherhood. What it means to be a mother is to be selfless, to care for others, and to prioritize others' feelings above your own. Viewing these women as mothers, staff ask questions that evoke the responsibilities of motherhood. For clients, this reminded them they were not alone in this decision, or as Shiloh and Jada individually asserted in later interviews: "we're in this together." In her interview, Jada states these questions reminded her to be less selfish and consider others, something she characterized as "supportive":

Kendra: And so when you said these questions are very supportive, what was it in particular that felt supportive to you?

Jada: Just opening my mind more about like the pros and cons list. Actually caring about what the father thinks. In my last abortion, I didn't care what he thought.

Kendra: Why does that matter to you—what the father thinks?

Jada: Because I don't feel like the choice should be on me, we are in this together. We need to make a decision together. Why? Just because the woman gets pregnant, just because we are the only ones that are allowed to get pregnant, why do we always have to make the decisions? …I need your input, it's a life-changing decision and I don't have to be alone! I shouldn't have to be alone! Unless that's what I choose to. But it's important for me to understand what he wants. Because it might effect my decision. It's important to me.

In "difficult" appointments staff attempt to facilitate a particular form of reflection: one which prioritizes emotions over "the reality" of clients' situations and one in which women are

placed in a nexus of relationships to which they are beholden. As Jada highlighted, these relationships affix additional layers to an abortion decision. In this way, abortion gains emotional and moral complexity as it becomes about making the correct emotional choice for themselves and others.

3. "Tender Confrontation"

In Chapters 3 and 4, I discuss how staff talk about "tender confrontation." Staff are trained to use tender confrontation as a communication technique that allows them to minister to clients rather than manipulate them:

> The purpose of tender confrontation is not to change another person's behaviors or choices. Tender confrontation gives a person the opportunity to hear the justifications, contradictions, rationalizations, excuses and potentially false or misleading information in their own words and actions. Giving a person the opportunity to hear what they are saying can provide them with objective feedback and information. How they use this information and feedback is up to them (Urban Care Training Manual 2017).

Often, staff use 'reflective listening' to tenderly confront clients with their own words. Reflective listening is paired with interpretive listening, in which staff point out what it sounds like a client is feeling—especially when their tone of voice, body language, or comportment seems to contradict their words. Finally, staff are trained to give 'helpful feedback,' in the form of information or resources, as a means to tenderly confront clients. Staff carefully avoid providing advice or directly guiding a client's decision, understanding that *telling* crosses the threshold from ministry to manipulation. In practice, tender confrontation took two primary forms that combined reflective listening, interpretive listening, and tender confrontation: (1) staff would often reflect clients' values as strengths and then use them to tenderly confront a client's rationalizations for an abortion decision; and (2) staff would provide 'helpful feedback' in the form of information (often faith-based pamphlets), a decision guide, and other resources

(including a resource guide which did not include abortion providers and scheduling an ultrasound as a source of information). Tender confrontation is consequential for both clients and staff. In clients, tender confrontation facilitates moral and emotional reflection, and for staff, tender confrontation serves to reaffirm staffs' moral identities and as a means by which staff perform their religious identities.

Jada's appointment highlights tender confrontation in action. In this appointment, Jillian skillfully assesses Jada's values—being a good parent, valuing family, and seeing herself as resilient—and reflected them as strengths. Importantly, Jillian framed these strengths as providing Jada the skills necessary to withstand her temporary hardships for the fulfilling experience of motherhood and in order to avoid the trauma of another abortion. Multiple times throughout Jada's appointment, Jillian called Jada's children "fighters," and she reminded Jada that she had been pregnant through cancer before. Jillian directly encourages Jada by saying "from what I know about you, you can do it!" Although Jillian never directly advises Jada to continue her pregnancy, she implies Jada's personal resiliency, the strength of her children, and her love of motherhood would help her to successfully carry this pregnancy to term and expand her family. Additionally, when Jillian turned the conversation to Jada's previous abortion, she "tenderly confronts" Jada's framing:

> *Jillian*: Do you have any regrets about that decision?
>
> *Jada*: No, not now.
>
> *Jillian*: Well, you can be thankful for not having a child, but do you *regret* the abortion? Do you think you will regret this one?
>
> *Jada*: I don't know yet.

Jillian, who experienced an abortion herself, probes Jada to differentiate between relief (not having a child) and regret. By immediately following her inquiry with a question asking if Jada

will regret terminating her current pregnancy, the concept of regret and its association with abortion is reinforced.

By comparison, in Shiloh's appointment the line between tender confrontation and manipulation becomes blurry:

> *Jillian*: I hear you say you don't want to hurt your baby, and I hear you say you'll have an abortion—what's going on?
>
> *Shiloh*: I have to be rational and responsible. I have a five-year-old autistic son. I have to give him the best life.
>
> *Jillian*: Would you benefit from more information on fetal development, like when the heart beats?
>
> *Shiloh*: No.
>
> *Jillian*: Ok, we'll do the ultrasound and that will provide some answers. How do you feel about adoption?
>
> *Shiloh*: If I'm going to keep my baby, I'm going to *keep* my baby!
>
> *Jillian*: Adoptions seem to take away the worry about how to provide for two kids, right?
>
> *Shiloh*: Well, it's kinda a slap in the face to the second. Like I could be a mother to the first, but not to the second….
>
> *Jillian*: Well there's a lot of misinformation about adoption, it's changed a lot in the past few years with open adoption…you could be open about it.

In this exchange, Jillian's values guide her counsel as she insinuates that abortion will hurt Shiloh's "baby," that information on fetal development (particularly when the heart begins to beat) would benefit Shiloh's decision, and that Shiloh is misinformed about adoption. After Shiloh's urine pregnancy test reveals a positive reading, Jillian uses Shiloh's last menstrual period to date her pregnancy at 11 weeks (though later an ultrasound dates Shiloh's pregnancy at seven weeks). Here it becomes difficult for Jillian to separate her personal beliefs from her counseling:

> So how are you feeling *knowing* you are 11 weeks along? You are almost in the second trimester. It's no longer a cluster of cells. It has arms and legs and a heart beat and eyes. So obviously it's a baby at this point. So you are past the pill part and now an abortion becomes a surgical procedure. [Jillian hands Shiloh a pamphlet on abortion.] This one shows you the different types of surgery. I don't know you how you feel about that. It's likely your doctor will provide a D and E; which kills the baby and then pulls it out….I would encourage you to think about the physical pain, psychological effects, and fetal development. That's all part of informed consent. You

> should also be sure to ask your doctor about the risks, the effects of STIs, preexisting conditions, and potential complications of abortion.

In Shiloh's appointment, Jillian breaks from the typical practice of reflecting a client's language. Instead of referring to the entity in Shiloh's uterus as "it," Jillian introduces and continues to use the term "baby." Even after Shiloh carefully explains, "it's a cluster of cells, it can't live without a mother. If the baby can survive without its mother, then it's a baby. If not, then it's not a baby." For Jillian "it" is not an it; and using the term baby is a powerful reminder to Shiloh—already a mother to a young son—that "it" becomes a baby. Additionally, Jillian shares what she believes to be "helpful information" with Shiloh about abortion to tenderly confront what she perceives as Shiloh's misinformation—Jillian thinks it's important for Shiloh to know an abortion "kills the baby" not an "it." She believes information on fetal development, abortion procedures, and the risks associated with abortion are important to Shiloh's informed consent. Finally, before Shiloh leaves, Jillian hands her a *Before You Decide* magazine saying, "this is a good resource—it's so cool. I think it will be helpful."

While Jillian and other staff did not often go into this level of detail with clients regarding abortion procedures, nor do they often use phrases like "kill the baby," Jillian's appointment with Shiloh demonstrates how difficult it is for staff to enact the emotional and moral labor necessary to leave their own beliefs out of the appointment. Yet these appointments are often the most meaningful for staff in that they serve to affirm that doing hard work is doing good work. After Shiloh left, Jillian sighed heavily and said, "that was hard, but so, so, so important. I pray for her." After appointments such as these, staff express sadness and I observed them seek others with whom to share prayer and reflection. As I discuss in Chapter Four, this is a way in which staff reaffirm their own religious identities within the pregnancy center context: Jillian offered

important, pro-woman care to Shiloh in an empathetic manner and, while it was hard, she found comfort in prayer and knowing that she did "important" work. Jillian perceives her counseling (and thus, herself) to be faith-filled and caring as she provides God's love to others through practical action.

IV. Conclusion: Doing Religion and Creating Moral Meaning Through Pro-Woman Care

Throughout this chapter I have demonstrated the ways in which Urban Care's "social work model of care" structures its 'pro-woman' ministry to facilitate moral reflection in clients. Counseling at Urban Care reflects staffs' view of motherhood in which motherhood is understood to be a self-sacrificing role that prioritizes the wellbeing of others. Staff facilitate conversations that require clients to reflect on their obligations to the emotional welfare of others, as well as their current and future feelings. Through this process, staff evoke emotional subjectivity in clients by emphasizing the ways in which clients should prioritize internal emotions (their heart), rather than external 'facts' (their head). In this 'heart-centered ministry' staff repetitively return to clients emotions, insisting these emotions are to be weighed carefully against what a client's "head" is telling her. While the question: "what is your heart telling you?" might be addressed to clients, it also serves to reaffirm staffs' own gendered, religious identities.

As I discuss throughout this dissertation, evangelical Christianity provides the value framework that guides 'pro-women' ministry. Evangelical Christianity prescribes essentialist gender roles that characterize women as tender-hearted, empathetic, submissive caregivers. Women are created by God to be naturally nurturing, caring, and loving. In this way, care at Urban Care is religious practice but, importantly, it is gendered religious practice. In many ways, staffs' ministry aligns with traditional, evangelical gender roles. Staff enact feminized

practices in their professional role as counselors who provide empathetic counsel to women in need. Additionally, the questions they ask in counseling—about feelings and relationships—reflect important components of biblical womanhood that emphasize emotions and nurturance. Staff affirm they are good, Christian women through performing a 'heart-centered' ministry that emphasizes talking and focuses on clients emotions. This is highly gendered labor that is framed as kinder, softer, more effective, and more Christian than highly visual approaches. 'Pro-woman' care simultaneously creates moral meaning for staff and is a means by which they *do* religion and construct a feminized evangelism.

At the same time, staffs' practices deviate in important ways from these evangelical frames. Women head nearly every component of pregnancy center work at Urban Care—leadership that sits in direct contradiction to an ideology promoting female submissiveness. At Urban Care staff are trained to refute their 'jobs as Christians' to proselytize and instead taught to minister by providing practical care. In negotiating these identity dilemmas, staff rely on gender to reimagine effective Christian practice and confirm their sense of self as good Christian women. In the pregnancy center context, this happens in three specific ways. First, staff use their gender as a means of legitimizing their authority as ministers (see also Kelly 2012). As is common practice among pregnancy centers, at Urban Care only women can meet with female clients. Staff maintain that women are the best suited to help other women and celebrate the characteristics that enable them to caretake effectively (even if these have to be taught through a *pro-woman care script*). So not only do women lead, but women define what leadership looks like at Urban Care. Second, staff rely upon their own gendered experiences to cultivate empathy for other women they see as deviating from their natural, Godly roles as women. Staff at Urban

Care are taught "you are not so different than the client" and use their own reproductive histories and experiences with heartbreak and emotional strife to inform how they approach clients. Thus, gender essentialism serves as a means for cultivating empathy for 'other' women. Third, staff frame the masculinist practice of assertive proselytizing as "missing the heart of women," claiming a more effective ministry 'plants seeds' through the performance of loving care. In this way, staff create a unique, feminized evangelism particular to the pregnancy center context that allows them to deliberately craft an identity as an effective, loving Christian woman. This is a means by which staffs' bodily expressions of empathetic ministry reflect their lived religion.

As Avishi (2008) argues, in order to understand women's participation in conservative religions, scholarship must move beyond dichotomizing frames which characterize their actions as either compliant or resistant. Doing so allows for a consideration of women's actions as the intentional construction of an authentic identity. At Urban Care, staff have constructed a particular religious identity through the practice of their 'pro-woman' ministry. Staff have renegotiated the boundaries of evangelical Christianity in their ministry and differentiate between evangelical ideology and living evangelical femininity. This form of feminized evangelism provides deep moral meaning for staff and becomes a frame through which staff evaluate themselves and their work. A 'pro-woman' ministry is performed for religious ends, characterizing their care as in service of God and "life-affirming choices," but is concomitant with their gendered experiences in the world. Ultimately, it becomes the means by which staff construct religious identities, come to understand themselves as virtuous Christian women, and live their religion.

Chapter 7: Conclusion

I. Introduction

Central to this study of faith-based pregnancy centers are questions about how religious practices operate for staff who enact them and for the clients who are subject to them. In this dissertation, I examine how staff in two pregnancy centers narratively construct and perform care as a form of ministry. I argue these constructions and performances are central to their gendered, religious identities, as staff make sense of themselves, abortion, clients, and strive to be good Christian women in a "fallen" world. For staff, care is a meaningful source of religious power that provides evangelical women with strategies and resources for grappling with abortion and their own gendered experiences in society. To explore how this identity project is experienced within the pregnancy center context my study offers a two-part analysis.

First, I explore staffs' narratives, how they 'talk' about abortion and their work, and how these accounts are structured by gender and religion. I locate these narratives within a specific organizational context, demonstrating how this sense-making is scripted by larger organizational narratives that shape how staff feel and how they conceptualize a feminized evangelism that challenges orthodox, evangelical ministries. These narratives do not just reflect staffs' feelings and experiences, they create them. These stories provide a virtuous pathway to becoming and being a good Christian woman who effectively ministers to women in need. Further, I consider how these narratives manifest in client care. Therefore, the second part of my analysis explores how staff 'do' religion and negotiate their identities in appointments through two distinct models of care: Mountain Care's "medical model" and Urban Care's "social work model." In this section, I pair my observations of appointments with clients' reported experiences to interrogate

the effects of this style of care on clients. Through an examination of the identity projects associated with care, I show how macro-level phenomena are manifested and actualized at the organizational-level and in the lived experiences and day-to-day unfolding of client care in Mountain Care and Urban Care.

In this final chapter, I present my concluding thoughts on this project. I first put my two fieldsites 'in-conversation' with each other to highlight some key findings and contributions of my research. Additionally, I reflect on the client experience in each center. I then discuss the larger implications of my project, particularly given the recent trends towards pregnancy center corporatization. Finally, I end with a consideration of the limitations of this study and note directions for future research.

II. Concluding Thoughts

A. Gendered Evangelism

At both Urban Care and Mountain Care, staff cultivate moral identities through their work. Staff position themselves as clear-sighted authorities compared to clients, other religious people, and secular individuals. These women used the concept of "pro-woman" care to show how they are doing faithful, effective Christian work according to the definitions provided by each organization. As a scripted framework, pro-woman care dictates how staff should feel about abortion and clients, and how they should effectively minister care to clients. Pro-woman care also presents evangelism as a flexible doctrine. At Mountain Care and Urban Care evangelism is expressed as caring action. Staff report that their approach is a ministry for the heart rather than a ministry that seeks to convert clients. The staff "planted seeds" in caring action rather than proselytizing. Staff believe that this is 'right' means of ministry and that this

style of evangelism makes their centers unique. Staff at both centers explain that this manner of care is effective and should become more widespread among pregnancy centers—those that fail to adopt this approach are "out-of-touch" with client needs.

In questioning both the rightness and efficacy of staff-initiated faith-sharing in the pregnancy center, staff present a challenge to evangelical conventions and CPC Network decrees. In reimagining a feminine evangelism that is appropriate to the pregnancy center context, staffs' narratives reflect the adaptability and power of gender within evangelical Christianity. This finding represents a new addition to scholarly understandings of evangelicalism and pregnancy centers. As Kelly (2009, 2012) points out, the influence and widespread support of the CPC movement has provided pregnancy centers the opportunity to alter the nature of pro-life activism in the United States and to inspire deeper shifts in evangelical Christianity, itself. Through envisioning and enacting a gendered evangelism, the staff at these centers are modifying core practices of evangelical Christianity. In using religious frames to present arguments for a different form of evangelizing, staff are beginning to dismantle established evangelical norms with the very tools of evangelical Christianity.

B. Gender and the Construction of Care

In addition to restructuring evangelism, gender also influences the ways in which staff construct "pro-woman" care as a ministry, more broadly. Pro-woman care is established amidst a backdrop of conservative, gender ideology in evangelical Christianity that emphasizes the separate spheres of men and women and characterizes women as nurturing, empathetic, and dutiful (Gallagher 2003). Mountain Care and Urban Care have constructed a ministry that staff follow because adherence makes them feel like authentic Christian women: feminine, caring, and

effectively implementing their evangelical, pro-life responsibility. Pro-woman care conveys the guidelines through which staff can live their faith. Rather than perceiving their roles in tension with evangelical Christianity, staff conceptualize their work in alignment with their faithful ideology.

Staffs' authority on abortion, clients, and choice is rooted in both their gendered experiences and their faith. Reaching into their evangelical 'toolkit,' staff rely upon understanding gender as an essential characteristic that enables them to do their work more effectively than men. Because they are women, they "understand women as women" and are naturally more suited to lead and enact this caring work. Women have authority in the pregnancy center movement and within individual pregnancy centers to determine practices and to define men's role in centers. In this way, staff found empowerment within a conservative belief system because of their gendered identities.

In the pregnancy center context, staff use both gender and religion to mediate a cohesive moral identity and pro-woman care emerges from staffs' ongoing identity projects. Through ultrasounds and 'hard conversations,' this care inspires continued commitment to pregnancy center work. Yet, as Chapters 5 and 6 demonstrate, pro-woman care, itself, is malleable. Pro-woman care filters through two distinct organizational models that create different persuasive strategies, frame staffs' caring actions, and structure client appointments.

C. Why Different Models of Care?

Mountain Care follows a "medical model of care," while Urban Care supports a "social work model of care." These two models reflect the social location of each center. While both non-profits operate under similar missions, purport matching worldviews, and are affiliated with

the same CPC networks, the organizational leadership at Mountain Care and Urban Care differs and attracts different volunteers and supporters.

Mountain Care enacts a hierarchical structure that gives their executive director broad latitude. Anne's leadership style emphasizes her authority; she often uses commands to structure the workplace and references corporate models as evidence of efficacy. Anne initiated several radical changes at Mountain Care, beginning with the creation of a more professional organization that emphasizes medical services. At the beginning of her tenure, she prioritized hiring medical staff and transitioned away from the lay-counselor model. She focused on rebranding Mountain Care as a medical practice, and later led the efforts towards corporatization by initiating a merger with a large, Catholic social service provider and faith-based health care center. Stemming from this medical focus, nurses lead client care at Mountain Care. Outside of their initial, weekend-long training in Christian counseling, Mountain Care's professional nurses had little exposure to other therapeutic models. This creates an appointment structure that heavily emphasizes medicalized interactions and the ultrasound, in particular.

By comparison, while Urban Care also has a hierarchical structure, it is composed of more checks and balances. Urban Care's executive director recruited a team of highly educated professional counselors and licensed social workers that employ a highly collaborative approach to client services. Imogene relies upon 'data' and 'evidence' to inform Urban Care's practices (for example, by collaborating with a university research team to evaluate their workshop series on personal relationships), but emphasizes collaboration, visioning, storytelling, and emotions in her directorship. Urban Care's leadership team meets weekly and frequently makes team-based decisions based on their experiences in client appointments and counselor reports. Here, the

executive director and client services directors work together to structure client appointments in a way that reflects their backgrounds in social and emotional interventions. This results in client appointments that are lead by staff and volunteer lay-counselors, rather than medical staff. Because of this focus, Urban Care stresses ongoing counselor training. They require all staff and volunteers to participate in an initial five-day 'intensive' training and 'continuing education' workshops and training events held throughout the year. These trainings integrate both 'top-down' knowledge from the highly educated staff, as well as 'bottom up,' experiential knowledge gained in client appointments and from client feedback. This social work model is reinforced through mandatory self-care and reflection. Client Advocates are required to meet regularly in group therapy and one-on-one therapy with a Licensed Professional Counselor who acts as a clinal supervisor. All these practices create an organizational structure that heavily emphasizes the importance of counseling.

In this way, these two organizations created models based on access to different forms of knowledge and understanding. This knowledge informed specific models of care with different focuses, priorities, and understandings of how to effectively minister to women. Consequently, these models of care place them in different relationships with clients. Mountain Care's "medical model" fosters appointments that prioritize the ultrasound. Ultrasound imagery acts as a powerful tool through which nurses co-construct "life" and the experience of pregnancy with clients. For staff, the ultrasound is a means by which to "do" religion. In contrast, Urban Care follows a "social work" model in which counseling distinguishes their ministry. Staff structure appointments that cultivate emotional and moral reflection through options counseling. For staff at Urban Care, this is a more "heart-centered" ministry in which counseling facilitates

appropriate emotional and moral reflection in clients. This form of structured management of clients is how staff "do" God's work.

In highlighting how staff conceptualize secular care practices as 'doing' religious practice, these findings demonstrate how adherents can 'do' religion and practice their faith in a lived manner. While rituals like prayer were important for staff, religious observance and conduct also occur outside of rites and practices associated with orthodoxy. In this way, 'doing' religion can be extended to lifestyle practices and can act as the foundation of religious identity. Key to this caring ministry is emotion work. 'Doing' religion and caring well for clients is 'hard' for staff. While the requisite emotional and moral labor is 'hard,' it is not a burden as Hochschild claims, but rather a legitimate aspect of meaningful work. Doing 'hard' work is doing 'good' work for staff; the emotion work required of staff helps to establish the importance of their ministry, resonates with important aspects of evangelical religious culture, and encourages their engagement in pro-life pregnancy center work to save troubled women considering abortion.

D. Reflections on the Client Experience

Central to my study was a consideration of how clients experienced care. I wanted to understand clients' perspectives on their appointments—did visiting a pregnancy center change their experience of pregnancy or shape their decision-making? To better assess these questions, I paired my observations of appointments with client interviews.

"Pro-woman" care is incredibly effective at cultivating a space that feels compassionate to clients. Clients overwhelming reported positive experiences at both Mountain Care and Urban Care. While free services initially brought clients in the door, clients explained that it is how those services are delivered that matters. Clients often compare their experiences at Mountain

Care and Urban Care with large, public healthcare providers in the area. They explain how the staff at pregnancy centers humanize service delivery: clients can schedule same-day appointments; the lobbies they enter are peaceful; they do not have to wait to see a provider; and they have a highly personable appointment with a provider who seems to genuinely care about their feelings. Instead of manipulation, most clients report appointments feel supportive, helpful, and as if the staff they meet with are deeply concerned with their welfare.

Client accounts reveal the experience of care is rooted in emotions. What made clients feel cared for was feeling acknowledged as a human, rather than the receipt of free health services like pregnancy tests or ultrasounds. Clients felt valued when they were asked questions about their lives and emotions, and when they felt practitioners valued their time by facilitating same-day, unhurried appointments. Even among clients who reported moments of discomfort in their appointments—whether a result of being asked about their religions beliefs or sexual decision-making—each explained they would recommend Mountain Care and Urban Care to a friend, albeit with a slight disclaimer. So rather than feeling judged or manipulated in their appointments, the techniques employed by staff ensured pro-woman care felt altruistic and compassionate.

This experience of care has important implications for how clients perceive their pregnancies. At Urban Care and Mountain Care, most clients did not change their minds about their pregnancy decision, but many changed their feelings. For some clients, they left feeling more confident in their decision to mother. For others, it felt good to talk about the difficulty of decision-making. As Quinn, who was considering abortion, pointed out, her appointment "helped me feel like I'm not alone, but it didn't help with my decision. Ultimately with my

decision, I am kinda alone." In other words, rather than shifting how clients made pregnancy decisions, staff were more successful in shifting how clients felt about themselves. This is significant. In the pregnancy center setting, where most clients are drawn to these spaces for medical services, women's bodies become not only the subjects of medical surveillance and management but also the sites of religious control.

The visual culture of Mountain Care uses the ultrasound to extend the religious gaze to women's bodies; while the emotional and moral reflection facilitated by staff at Urban Care reflect their own deeply felt ideological beliefs. These practices, as a performance of religious values, can imply a more virtuous, less traumatic pathway in pregnancy decision-making. Rather than directly intervening in pregnancy decisions, staff instead cultivate a context that may reinforce stigmatizing social narratives around abortion. Within this context, pro-woman care—which informs, modifies, or changes how a pregnant client feels about themselves—can successfully link, or reinforce a pre-existing link, between a pregnancy decision and self-concept. For those clients considering abortion, this can heighten an identity dilemma—a pregnancy decision becomes about who you are rather than what you choose to do. Because clients' perceive this as 'care' rather than judgment, staffs' religious values help to frame clients' self-regulation. Not only do staff believe they have clients' best interests at heart, clients believe this, too. In this way my analysis suggests that pro-woman care is a means by which women's bodies are being managed and policed by faith-based pregnancy centers. My observations provide empirical evidence of how biopower manifests in these cultures of care. At Mountain Care, medicalization provides the vehicle through which religious control can be exerted, while at Urban Care, counseling serves as a means by which to manage women.

II. Implications

Pregnancy centers are not isolated aberrations in a functioning healthcare system but rather a product of critical absences in reproductive healthcare and severe economic inequality in the United States. The vast majority of clients I observed and interviewed are low income women, who are uninsured or enrolled in Medicaid. Many reported frustrating experiences in the healthcare system with detached, hassled providers that left them feeling disregarded and suspicious of health "care." Pregnancy centers recognize this and are moving to change the face of healthcare. They are redefining the boundaries of formal care by addressing gaps in our current healthcare system and positing themselves in dialogue with a network of health care and social service providers.

As pregnancy centers typically target and attract low-income, uninsured women and clients of color, and as the role contraception and abortion has shifted from liberator of career-seeking women to become a safety net for the poor (Freednam and Weitz 2012), recent trends in the CPC movement towards medicalization have significant implications for health disparities. In trying to compete directly with low-cost, comprehensive providers, pregnancy centers hold the potential to entrench existing inequalities by limiting the range of reproductive-health options available to low-income women. In refusing to offer or refer for contraception and abortion, pregnancy centers can limit the ability of economically marginalized women to easily and quickly access services that enable them to control their own fertility. At the same time, pregnancy centers could potentially help battle the "politics of poverty" by providing low-income women who *want* to mother the material resources they need in order to make that option a choice. A better understanding of how pregnancy centers create cultures of care, the dynamics

that occur within centers, and the services they offer are imperative to understanding if and how pregnancy centers fit into the spectrum of reproductive health. This is particularly important as a notable trend of corporatization emerges in the CPC movement.

Pro-life organizations like the Obria Group are working to provide an "alternative healthcare model" that can "more effectively compete with major pro-abortion providers" (Obria Group 2019a). The Obria Group is following the model of large healthcare corporations by creating a national, pro-life "brand" for pregnancy centers that offer medical services: Obria Medical Clinics. Obria's 21 clinics do not provide contraceptives or abortions but as licensed clinics they are able to bill medicaid, private insurers, and apply for some federal grants. The Obria group is not alone. In the Midwest, the Guiding Star Project has emerged and, in the Rocky Mountain region, Mountain Care partnered with another group working to create a national chain of branded, pro-life reproductive healthcare providers.

As pregnancy centers continue towards medicalization and professionalization, corporatization represents the newest trend redefining pregnancy center care in the United States. Corporate chains use less overt pro-life names, in favor of more ambiguous 'brands' and, compared to conventional healthcare providers, they continue to offer less wait time, more personalized appointments, and free or inexpensive services. As the clients in my study report, these are all important factors in the experience of care. Pregnancy centers are poised to expand their reach and influence through these appeals to clients and, importantly, through their push for federal funding. The Obria Group is at the forefront of the CPC movement's efforts to obtain Title X family planning funding. In March of 2019, the Trump Administration awarded the Obria Group $5.1 million in Title X family planning funds, to be released over the course of

three years (Obria 2019b; Vogel and Pear 2019). Organizations like Obria promote themselves as "holistic," "comprehensive" alternatives to Planned Parenthood. Yet, because of their religious foundations, these centers do not offer integral services for reproductive health; absences that will become increasingly significant as pregnancy centers continue to expand their reach and if they succeed in displacing other low-cost providers like Planned Parenthood.

Pregnancy centers' willingness to engage with conventional healthcare providers as well as their ability to exist outside of regulatory systems, has implications for healthcare, the pro-life movement, and the evangelical women at the forefront of this campaign. They need to be carefully evaluated by state and federal officials. These policy-makers should rigorously assess the delivery and receipt of services in pregnancy centers alongside definitions of informed consent when drafting legislation and making funding decisions. For example, to ensure women are informed about their healthcare, in September of 2018, the city of Hartford, Connecticut approved a city ordinance that requires CPCs to disclose if there are licensed medical providers on site to provide services (H.B. 5416). City officials characterized this regulation as a "common-sense rule" that does not infringe on pregnancy centers religious freedom and ensures women are not subject to deceptive practices (Hartford City Hall 2018). In addition, pro-choice advocates should carefully consider their strategies "exposing" pregnancy centers as "fake clinics." While CPC practices should be carefully scrutinized, these simplistic, polarizing narratives re-inspire engagement in the pro-life movement; limit the potential for collaboration; ignore the lived experiences of many clients served by pregnancy centers; and do little to improve the health literacy of under-resourced clients. To more effectively advocate for women's healthcare, the pro-choice movement should consider ways in which their response to

pregnancy centers can be reframed to emphasize gaps between their values and practices. Additionally, pro-choice advocates can continue to increase health literacy, enabling women to more accurately assess the spectrum of services available to them before, during, and after a pregnancy.

III. Future Research

Throughout the research process, additional areas of inquiry arose. In this section, I highlight three exciting areas for further inquiry. First, given the aforementioned trend towards corporatization, future research should consider this corporate model as well as the development of and transition towards becoming a 'branded' provider. How do brands cultivate and maintain consistent organizational cultures? How will pregnancy centers blend the secular and non-secular to create a cohesive corporate image? Will the feminized evangelism of Mountain Care and Urban Care become standard practice in corporate pregnancy center ministries? What are the implications of this for staff, clients, and the movement as a whole? How are these new models modifying and initiating new avenues of public funding for pro-life/antiabortion organizations? Furthermore, how will this trend influence the pro-choice movement and comprehensive, low-cost reproductive healthcare providers? More research that provides empirical evidence of the effects of this trend should be a priority.

Second, this dissertation examines two uniquely situated pregnancy centers. Mountain Care and Urban Care are located in politically liberal, affluent, white communities in the West. This social context shapes how they construct caring ministries and my study contributes to an understanding of the processes whereby uniquely situated evangelical women make sense of gender and religion in their locally performed ministry. Therefore, the findings I present should

not be generalized to other pregnancy centers, situated in other communities. These limitations create opportunities to explore how differently situated pregnancy centers might perform similar or dissimilar work, in diverse locations. Future research could explore pregnancy center work in different geographic areas, political communities, and in areas with a different demographic. Similarly, I narrowed my analytic focus to examine the most salient identities identified by staff: gender and religion. While this has given me the opportunity to more fully explore gendered religious identities, there is a notable racial divide between staff and clients that my study does not interrogate. The ways in which race structures care is an important consideration for future research, particularly given the long history of reproductive control exercised over women of color in the United States, the efforts of the CPC movement to target women of color, and the tight coupling of race and class in the US. Additionally, future research could explore the movement's growing attention to men. This may be useful for understanding how the movement continues to represent and understand gender.

Third, I have attempted to achieve a balance between centering the voices of the women in my study and examining the deeper sociological processes embedded within their stories and actions. While I have worked to stay true to my data and accurately represent the participants my analyses may not align perfectly with their positions. In an attempt to control for this discrepancy, I vetted my findings and interpretations with Urban Care, soliciting their feedback, while offering my own suggestions for ways in which they could improve their services to better prioritize client consent in appointments. Through these processes, I hope I have managed to represent a story that is authentic and respectful.

Yet, as I move forward with these findings, I think it is important that feminist sociologists continue to reflect on the potential disparity between the stories and experiences of participants and how participants are represented in their findings and in scholarly analysis. With respect to this study, in particular, I often found my analysis of client appointments did not correlate with clients' reported experiences. Where I saw potential manipulation, clients felt care. Recognizing the dilemma this creates for a researcher, I attempted to prioritize clients' voices in this work, perhaps at the sacrifice of greater sociological analysis. Thus, my research raises important methodological considerations and opens up continued inquiry into the challenges of ethnographic research and feminist approaches that attempt to prioritize both agency and intellectual rigor. Continued theorization around doing rigorous feminist research is imperative, particularly when that research involves marginalized, vulnerable populations or people with whom you do not share ideological beliefs.

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APPENDIX A: RECRUITMENT FORMS
Mountain Care

Confidential Client Number:_____

Study about Unplanned Pregnancy and Experience at Mountain Care

I am a researcher from the CU Boulder Sociology Department and I would like to know more about your about your experiences at Mountain Care. Unplanned pregnancy is complicated and you may be experiencing a range of emotions. There is no right or wrong way to feel. I want to understand this experience from your perspective and provide you with an opportunity to share your story. I believe your stories are important and demonstrate the range of experiences that can emerge from unplanned pregnancies and the choices women face about their reproductive and sexual health.

I am not a counselor nor I am employed by Mountain Care or any other pregnancy center or clinic. I am a social researcher who wants the real experiences of women facing unplanned pregnancy, choice, and abortion to inform healthcare services.

If you are interested in sharing your story and/or participating in this research, your participation will be completely **confidential**. Please complete the following:

May I observe your meeting with the nurse?

☐ Yes ☐ No ☐ Not Applicable

May I observe your ultrasound? Your privacy will be requested. You all be draped at all times.

☐ Yes ☐ No ☐ Not Applicable

Trans-vaginal Ultrasound

☐ Yes ☐ No ☐ Not Applicable

Abdominal Ultrasound

☐ Yes ☐ No ☐ Not Applicable

If you choose to participate in the Mentoring Program, may I observe one of your sessions?

☐ Yes ☐ No ☐ Not Applicable

May I contact you for an interview?**?**

☐ Yes ☐ No

** If you are interested in sharing your story through an interview, you will be asked to join me for an in-person interview that will last approximately one to two hours. These interviews will be private and confidential. I will not provide you with any medical advice but I will provide you with a judgement-free, compassionate space to share your story. Before we begin the interview I will go over an informed consent form with you to explain a bit more about this project and answer any questions you might have. With your consent, I will audio-record these interviews. If you check yes, I will contact you directly through the email or phone number you share with Mountain Care. **As a small token of my appreciation for sharing your time and experiences you will be paid $30 cash.**

If you have any questions or would like more information, please contact Kendra Hutchens:
701.260.3899
kendra.hutchens@colorado.edu

APPENDIX A: RECRUITMENT FORMS
Urban Care

Client Advocate Script:
Before we get started today, did you meet Kendra out in the lobby? Kendra is a student at CU Boulder is is doing a research project for her doctorate program. I have a consent for here that I will let you read with more information about her project, but basically, with your permission, she would observe our time together today. You would also have an opportunity to do an interview with Kendra outside of your time here at Urban Care in a place an time of your choosing. Kendra is mot a staff member of Urban Care and is not affiliated with Urban Care in any way. She is simply doing a research project in order to better understand women's experience at Pregnancy Resource Centers. I will let you read this concept form, but please let me know if you have any additional questions. Also please know that giving your consent is completely optional. You can give as much or as little permission to Kendra as you feel comfortable with, or you can choose not to be a part of the research project all together.

Client Identification:_____

Study about Unplanned Pregnancy and Experience at Urban Care

I am a researcher from the CU Boulder Sociology Department and I would like to know more about your about your experiences at Urban Care and with an unplanned pregnancy or a suspected pregnancy. Unplanned pregnancy is complicated and you may be experiencing a range of emotions. There is no right or wrong way to feel. I want to understand this experience from your perspective and provide you with an opportunity to share your story. I believe your stories are important and demonstrate the range of experiences that can emerge from unplanned pregnancies and the choices women face about their reproductive and sexual health.

I am not a counselor nor I am employed by Urban Care or any other pregnancy center or clinic. I am a social researcher who wants the real experiences of women facing unplanned pregnancy, choice, and abortion to inform healthcare services.

If you are interested in participating in this research and/or sharing your story through an interview, your participation will be completely **confidential**. Please complete the following:

May I observe your meeting with an Alternatives Advocate?

☐ Yes ☐ No ☐ Not Applicable

May I observe your ultrasound? Your privacy will be requested. You all be draped at all times.

☐ Yes ☐ No ☐ Not Applicable

Trans-vaginal Ultrasound

☐ Yes ☐ No ☐ Not Applicable

Abdominal Ultrasound

☐ Yes ☐ No ☐ Not Applicable

May I contact you for an interview?**?**

☐ Yes ☐ No

** If you are interested in sharing your story through an interview, you will be asked to join me for an in-person interview that will last approximately one to two hours. These interviews will be **private and**

confidential. I will not provide you with any medical advice but I will provide you with a judgement-free, compassionate space to share your story. Before we begin the interview I will go over an informed consent form with you to explain a bit more about my project and answer any questions you might have. With your consent, I will audio-record these interviews. I truly respect your time and the bravery it takes to share these stories. If you check yes, I will contact you directly through the email or phone number you share with Urban Care. **As a small token of my appreciation for sharing your time and experiences you will be paid $30 cash.**

If you have any questions or would like more information, please contact Kendra Hutchens:
701.260.3899
kendra.hutchens@colorado.edu

APPENDIX B: INTERVIEW GUIDES

Client Interview

I. Introduction
   A. First, I want to get to know you a little bit, so I'm going to ask you a few questions about yourself.
      1. Where are you from/living?
      2. Do you go to school?
         a) Where?
         b) What grade are you in?
         c) What is school like?
      3. What kinds of things do you like to do?
      4. What is your family like?
      5. Do you work? Tell me about your job
      6. How old are you?
      7. How do you racially and ethnically identify?
      8. Do you have religious views? What are they?
      9. Are you on insurance?
         a) What kind?
         b) What does it cover?

II. Motivations for Seeking Support at CPC
   A. So one of the reasons why I wanted to interview you is because I study unplanned pregnancy and pregnancy centers. Is it ok if I ask you some questions about your pregnancy and your experience at XXX?
      1. Is this your first pregnancy?
      2. When did you first find out you were pregnant?
         a) How?
      3. How did you feel when you first found out you were pregnant?
         a) <u>What was going through your mind?</u> Feelings, thoughts, experiences?
         b) Who know's you are pregnant?
            (1) Who did you first tell? Why?
            (2) Support?
            (3) How did you tell the FOB?
            (4) How did you tell your friends?
            (5) How did you tell your family?
         c) Was this a planned pregnancy?
         d) Were you using any form of contraception around the time you got pregnant?
         e) Did you ever consider taking Plan B?
            (1) How do you feel about Plan B?
         f) Do you know anyone else or have you had friends who are pregnant?
         g) Do you know anyone else who has had an abortion?
         h) Do you know anyone else who has a child? Or who has elected adoption?

4. How do you feel about the future?
    a) Did you ever consider terminating the pregnancy? Did you ever consider adoption?
    b) Why do you want a child?
    c) Sometimes our past and they way we were raised can shape our future,
        (1) What kind of relationship did you have with your parents or family?
        (2) What kind of household were you raised in?
        (3) What kind of relationship did or do you have with the FOB?
        (4) Trauma: sexual assault, rape, abuse, neglect, drug abuse.
    d) What type of relationship do you want to have with your child?
    e) Has this experience influenced your religious views at all?
5. People often haven't had a chance to talk about everything that lead up to their pregnancy. Would it be ok if I asked you a few questions about sex and sexuality?
    a) When did you first become sexually active? Why?
    b) How do you feel about having sex? What is your relationship with sex?
    c) How did you learn about sex? Did you ever have any sexual education?
    d) Has this experience (pregnancy, abortion, motherhood, pregnancy scare) made you think any differently about sex and sexuality?
    e) How do you think we should talk to young people about sex?
    f) How will you talk to your child about sex?
6. What lead you to XXX?
7. How did you find XXX — search engines, word of mouth, recommendation?
8. How did you feel about making the decision to go to XXX?

III. Experience at CPC

1. What first brought you toXXX?
2. What sticks out about your initial visit to XXX
3. How many times have you visited to XXX?
    a) Can you tell me about those visits? What did they look like?
    b) What services did you use? Did you attend classes? What were those like?
    c) Have you visited anyone else? Have you been to a health center? Counselor/ therapist? Social services?
4. What was your experience like at XXX?
    a) What happened?
    b) What information did they share with you?
    c) How did that information make you feel? Why?
    d) How did the staff make you feel? What did they do to make you feel that way?
5. Did you have an ultra-sound?
    a) What did it feel like to have an ultrasound?
    b) How did the overall experience make you feel?

IV. Making Sense of Unplanned Pregnancy after CPC

1. How did your experience at XXX make you think/feel about your pregnancy?

2. Would you feel comfortable telling me what you did after XXX?
    a) How did you make sense of your pregnancy after?
    b) How has this experience made you think about choice?
    c) About abortion?
3. How would you advise a friend who is dealing with an unintended pregnancy?
    a) What advice would you give them?
    b) What parts of your story would you share?
    c) How would you advise this friend if they were considering abortion?
4. Have you had any friends who have gone to XXX?
    a) What were their experiences like?

V. Overall Experience with Unplanned Pregnancy
    1. We've talked a lot about your experiences at XXX. Is there anything you would like to share about your experience with an unplanned pregnancy in general? Is there anything you think is really important for other people—whether they be adults, teens, other pregnant women, or heath care providers—to know about your experience?

VI. Closing
    1. What is your support system like? Do you have people you can talk to or things that you can do that offer some comfort?
    2. What are some of your strengths that helped you get through tough times? What are some things in your life you are proud of?
    3. What are some of your dreams for the future? What are some of your future goals? How is what you are doing right now allowing you to meet those?
    4. This is the end of the interview, thank you for taking the time to share your experiences with me!

Staff and Volunteer Interview

I.**Outline:**

A.Personal Biography
B. Experiences at NCC
C.Self and Values
1.Abortion
2.Motherhood
3.Contraception
4.What does it mean to have choices?
D. Responses to Critiques of Pregnancy Centers
E.Overall reflection on XXX
F.Close

II. General Biography

A. born, raised, family, married, children
B. parent's occupation, education, politics
C. hobbies
D. religion!
1. *I know XXX is a faith-based organization. Can you tell me about your personal faith or religious beliefs?*
1. development of relationship to church?
2. times in life that have fallen away from faith?
3. times faith has chanced or deepened?
4. relationship with church ideas?
a) most important teachings of your faith
b) teaching you disagree with?
5. how does your faith influence your work at XXX?

III. XXX and Experiences at XXX

A. How long have you been working/volunteering/interning?
B. How would you describe your role at XXX?
1. What is the most important part of your job
2. Best and worst parts?
C. Do you see yourself as an activist?
1. ask if XXX staff are asked to to participate in social actions
D. How would you describe XXX mission?
1. has it changed over time
2. do you see XXX and your work as part of the pro-life movement?
E. How would you characterize the role of XXX in the community?
1. is it well received? why or why not?

2. Why do women chose to come to XXX? How does XXX differ from other organizations like planned parenthood?
3. A number of clients have remarked on the environment at XXX—what kind of environment do you work to create; how?

F. What are your interactions with clients like?
1. You describe XXX as a faith based not faith-forced organization; what does that mean?
2. how do you talk about abortion with clients?
3. how do you talk about carrying a pregnancy and parenting or choosing adoption?
4. why does XXX offer ultrasounds?
5. some clients are rather quiet through their appointment—what markers or cue's do you take from clients to interpret that silence?

IV. Response to Critiques

A. Recently the attacks Pregnancy Centers are under, have been on my mind—and obviously yours. Can I ask you how you would respond to some criticisms raised by the "Fake Clinic's" 'movement'?

1. How do you respond to people calling XXX a 'fake clinic?"
   a) what makes a clinic?
2. **What is the difference between ministry and manipulation? What does that look like in your every day work?**
   a) what is ministry?
3. How do you respond to claims that pregnancy centers manipulate women?
   a) What does it mean to care for a client?
4. Do you talk to clients about abstinence?
   a) how and why? How would you respond to the critiques of abstinence education?
5. One of the critiques of Pregnancy Centers is that they only care about the baby; what are ways in which you see your work caring for women?
   a) Why provide one-time gifts?
6. Is XXX unique amongst pregnancy centers?
   a) do you see a similar medical turn with other pregnancy centers (increasing medical services)
7. How effective do you think XXX is at meeting it's goals/purpose/mission?
8. What language do you prefer I use in my research?
   a) Crisis Pregnancy Centers? Pregnancy Centers
   b) Faith Based? Evangelical? Religious?
   c) Pro-Life; Anti-abortion? Pro-Choice?

V. Self and Values

A. Earlier we spoke of your personal faith, and given XXX faith-based mission, do you feel an internal conflict between your personal beliefs and your professional ethic? I have seen you all work very hard to leave God out of the conversation and create space for clients to explore abortion. How do you do that? What how does it feel to do that? How do you walk that line?

B. Abortion:

C. We've been talking a lot around abortion—it is something that colors your everyday work —would it be ok if I asked you some personal questions about abortion?
    1. How does XXX feel about abortion? How do you feel?
        a) first time ever hears of or thought about abortion?
        b) first time ever did something about abortion?
            (1) Development of [activism]—different organizations or phases?
    3. Has abortion touched your life personally? How?
        a) personal experiences with abortions, adoptions, miscarriages, premature births, children with disabilities, and sexual abuse.
    4. Are there situations in which you feel abortion is justified?
    5. How do we know abortion is wrong?
    6. How do you talk to clients about abortion? Co-workers? Family? Friends?
    7. We've talked about the trauma that can be involved in abortion—how it can harm women—what does it mean for you to talk to women about all of their choices? In other words, how do you present all there options in a neutral manner?
        a) how would you describe reproductive choice? how would XXX describe it?
            (1) why?
    8. How have your ideas about abortion developed?
    9. Where have you learned the most about abortion?
    10. What do you think are the best sources of information on abortion?

D. How has your work at XXX made you reflect on your own life and experiences?
    1. How do you think your role as a [woman/man] has shaped your experiences at XXX?
        a) Has it changed over time? How?
        b) Has it changed your relationships (with others, with your family, with your partner, with your church?) How?

E. Tell me about **motherhood**. Many of the women who come to XXX are making big decisions about mothering. How do you feel about motherhood? How do you talk to clients about motherhood?
    1. Has your work here made you reflect upon your own reproductive and sexual health?

VI. Closing
    1. Is there anything else you would like to share with me? Is there anything else you think is important to know about XXX or the role it plays in the community?
    2. Something that you are proud of?
    3. Hopes and dreams for the future?

TABLE 1: RESERACH PARTICIPANTS

Client Participants									
Pseudonym	**GID**	**Age**	**Race**	**SE Status**	**Services**	**Marital Status**	**Insurance Status**	**Education Level**	**MC/ UC**
Ariel	F	18	American-Indonesian	Working Class	EWYL	Single	On parents	High School Graduate	MC
Brittany	F	21	White	Middle	PT and US	Single	On parents	Some College	MC
Caroline	F	23	White	Middle	PT and US	Single	On parents	Some College	MC
Dominique	F	20	Did not identify	Working Class	EWYL	Single	Medicaid	High School Graudate	MC
Yvette	F	18	Hispanic	Working Class	PT and US	Single	Medicaid	Some High School	MC
Faith	F	26	White	Working Class	PT and US	Single	Uninsured	Some College	MC
Grace	F	29	Hispanic	Middle Class	PT	Divorced	Uninsured	Some College	MC
Jimena	F	18	Chicana	Working Class	EWYL	Single	Medicaid	College Graduate	MC
Ina	F	33	Nigerian	Middle Class	PT and US	Married	Uninsured	Graduate Degree: MD	MC
Mae	F	37	White	Lower Middle Class	PT	Married	Insured through Employer	Graduate Degree: PhD	MC
Katie	F	34	White	Middle Class	PT and US	Separated/ / Polyamorus	Uninsured	Graduate Degree: PhD	MC
Lauren	F	30	White	Middle Class	PT and US	Married	Insured through Employer	College Graduate	MC
Jada	F	27	African American	Working Poor	PT and US	Single	Medicaid	Some College	UC
Norma	F	21	Native American	Underclass	PT and US	Engaged	Medicaid	High School Degree	UC
Octavia	F	31	Black	Underclass	Material Services	Single	Medicaid	Some High School	UC
Ophelia	F	18	White-Hispanic	Underclass	PT	Married	Medicaid	Some High School	UC

Client Participants									
Quinn	F	21	White	Middle Class	PT and US	Single	Insured through Parents	Some College	UC
Racquel	F	20	Hispanic	Working Poor	PT	Single	Medicaid	GED; Some College	UC
Shiloh	F	29	Black	Working Poor	PT and US	Single	Uninsured		UC
Teresa	F	37	White	Working Class	PT	Single	Medicaid	Some High School	UC
Una	Fluid	23	White-Hispanic	Underclass	Material Services	Single	Medicaid	High School Degree	UC
Vera	F	30	Hispanic	Middle Class	PT and US	Married	Uninsured	College Graduate	UC
Walker	F	25	Hispanic	Working Poor	Material Services	Married	Emergency Medicaid	Some Technical College	UC
Xandra	F	22	White	Middle Class	PT	Married	Insured through Good Samaritan Ministries Sharing Plan	High School Graduate	UC
Yvonne	F	35	White	Middle Class	PT and US	Single	Uninsured	Graduate Degree: MA	UC
Zadie	F	26	African American/ Other	Working Poor	Material Services	Single	Medicaid	College Graduate; Medical Assistant Degree	UC
Brook	F	37	Navajo	Working Class	PT and US	Married	Medicaid	Graduate Degree: MD	UC
Carli	F	29	African American	Working Poor	PT and US	Single	None	Some College	UC

Staff Participants										
Pseudonym	**GID**	**Age**	**Race**	**Educ**	**SES**	**Marital Status**	**Faith**	**MC/ UC**	**Role**	**Mother**
Anne	F	62	White	AA	Middle Class	Married	Disciple of Christ	MC	Executive Director	2
Blanche	F	64	White	BA	MC	Married	Deep relationship with Christ	MC	Community Engagement Director; Post-Abortion Counseling	No
Celeste	F	61	White	RN	MC	Widow	Christian Believer	MC	RN	4
Danielle	F	26	White	BA	MC	Married	Bible-Based Christian: Attends Acts 29 Church	MC	Volunteer Coordinator	No
Evelyn	F	27	White	MA	MC	Single	Non-Denominational Christian	UC	Director	No
Fiona	F	58	White	BA	MC	Divorced; Remarried	Christian	UC	Client Services Coordinator	2
Geraldine	F	64	White	MA	MC	Married	Christian—Anglican Church	UC	Post-Abortion Counselor	5
Hope	F	38	White	MA	MC	Married	Christian Believer	UC	Director	3
Imogene	F	41	White	MA	MC	Single; Never Married	Personal relationship with God; Gave her life to Jesus; Attends an Acts 29 Church	UC	Executive Director	No
Jillian	F	39	White	BA	MC	Married	Personal relationship; accepted Jesus	UC	Director	2