Proxemics: The Application of Theory to Conflict Arising from Antiabortion Demonstrations

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ABSTRACT: Theories concerning the cultural use of space have found an unexpected application. Antiabortion demonstrators at Boulder Abortion Clinic in Boulder, Colorado became increasingly aggressive and provoked widespread community opposition to their activities. As the result of harassment of the clinic's patients, a pro-choice group asked the Boulder City Council to enact a "buffer zone" ordinance to protect women entering the clinic from anti-abortion harassment. The ordinance, containing specific approach distance limitations, was adopted and was immediately challenged in court. Clinic officials then called Dr. Edward Hall and a social psychologist, Dr. Marianne LaFrance, to testify concerning proxemic theory. The ordinance was upheld.

More than most social protest movements, the antiabortion campaign has used the tactics of active harassment against those engaged in legal activities. Antiabortion activists have openly advocated and used tactics that interfere with normal communication and movement (Scheidler, 1985; Enda, 1988; Brozan, 1988; Mayer, 1988). These tactics have frequently escalated into violent physical confrontation and destruction of property (Associated Press, 1984; Donovan, 1985; Forrest, et al, 1987; Hern, 19888; Nice, 1988; *Daily Camera*, 1988; Robey, 1988).

On a daily basis, antiabortion protesters invoke less dramatic tactics that result in serious stress for women seeking abortion and also for those providing the services. The commoner tactics involve picketing of abortion clinics or doctors' offices and the verbal abuse of women entering the offices. "Sidewalk counselors," as they call themselves, approach closely to women and their companions about to enter clinics and offer literature. They actively attempt to persuade the prospective abortion patient not to have an abortion.

"Don't murder your baby." "You'll never come out of there alive." "Give your baby a chance to live." "Don't let yourself be exploited by the abortionist." These are some of the milder expressions made to women seeking abortion by the antiabortion demonstrators. Their verbal admonitions are usually accompanied by lurid signs spattered with red paint and showing images of dismembered fetuses.

In Boulder, Colorado, one clinic in particular, a private physician's office, has been the target of these attacks and demonstrations for nearly fifteen years (Brennan, 1985a). The clinic's director, a physician highly associated with the provision of abortion services, has particularly drawn the ire of antiabortion activists (*Newsletter*, Boulder Valley Right to Life, May, 1985; September, 1985; October, 1985; November, 1985; December, 1985; January, 1986; Horsley, 1986).

In the fall of 1985, Boulder Abortion Clinic became the publicly identified target of state and national antiabortion crusaders, who descended on the clinic in large numbers on various occasions. Just before the scheduled appearance of Joseph Scheidler, head of the radical Chicago Pro-Life Action League, a brick was thrown through the clinic's front window during business hours (Langer, 1985). On several subsequent occasions, demonstrators appeared in large numbers and with bullhorns (Putnam, 1985).

Even without these highly visible and publicized demonstrations, clinic personnel observed that patients experienced harassment and added stress from even a few picketers.

The patients would enter the clinic's waiting room crying and shaking from fear and anger. A significant part of such a patient's subsequent time in the clinic would be spent helping her deal with the psychological stress that she had experienced at the hands of the antiabortion demonstrators.

Evidence of the psychophysiological stress was obvious. In addition to crying, patients exhibited evidence of adrenergic "fight-or-flight" reaction such as pallor, shaking, sweating, papillary dilation, palpitations, hyperventilation, and urinary retention (Best and Taylor, 1961). The patients were extremely uncomfortable both physically and psychologically following these encounters.

These signs and symptoms had direct bearing on the patient's medical status and safety. For example, urinary retention made it difficult or impossible to perform a pelvic examination and determine the size of the patient's uterus or the presence of any co-existing pelvic pathology. Accurate determination of uterine size and length of gestation is essential in the proper preoperative evaluation of abortion patients (Hern, 1984). In addition, hyperventilation can lead to uncomfortable symptoms such as muscle spasms, circumoral numbness, and numbness and tingling of the fingers. These symptoms heighten anxiety even more in a patient under considerable stress, and can even lead to loss of consciousness if a vasovagal syndrome occurs. If such a patient becomes agitated during the preoperative procedure or during the abortion, she could easily experience serious complications of the abortion that would be extremely unlikely under other circumstances.

In May, 1986, the Colorado chapter of the National Abortion Rights Action League organized an effort to persuade the Boulder City Council to pass a "buffer zone" ordinance that would protect women entering abortion clinics and doctors' offices from antiabortion harassment (Bourne, 1986; McGrath, 1986a; Diaz, 1986). After initial consideration, the City Council recommended that the antiabortion and pro-choice groups submit to "mediation" in order to resolve their differences. Both sides acceded to the charade of this fruitless activity with the rationale that each would appear more "reasonable" to political leaders.

In November, 1986, after numerous public hearings and continued community controversy, the City Council adopted an ordinance requiring demonstrators to remain at least 4 feet from anyone approaching a health care facility unless the patron gave her permission for the demonstrator to approach (McGrath, 1986c). This was soon revised to make the limit 8 feet instead of 4. Pro-choice advocates had recommended a limit of at least 100 feet in accordance with prohibitions against electioneering near voting booths (Diaz, 1986b, 1986c; McGrath, 1986d; Brennan, 1986b).

Within a few weeks, opponents of abortion filed suit to overturn the ordinance. A hearing for a preliminary injunction was heard in federal District Court in Denver on March 6, 1987 (Buchanan v. Jorgensen, 1987).

At the beginning of the hearing, the clinic administrator, a woman with more than 12 years' experience in abortion services, described the reaction of a very young adolescent patient:

"A 13 year old patient whose pregnancy was the result of rape was leaving the clinic

> with her mother after one phase of her treatment….The patient saw through the window that there were…two picketers present. She hovered in the corner of the waiting room and…[became withdrawn]. She started to quiver, and she wouldn't respond to me or to her mother for several minutes…."

The administrator described some of her own reactions and reactions of other patients:

> [When crossing the picket lines] "…Other times, I feel really intimidated having someone who obviously doesn't approve of what I do shouting at me or shoving a sign into my face, saying things like, 'How can you live with yourself? How can you sleep at night?'
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> "One day, there were two male picketers…who were out in front of the clinic. One of them was speaking into a bullhorn. The amplified sound was quite frightening, and there was a violent tone in his voice. He was saying, 'Don't stay in there. Don't let the blood drip down the inside of your legs forever. Don't let them stick that instrument up your crotch.' There was a patient and her friend in the waiting room at the time, and they were frightened. They didn't want to sit there anymore and it was pretty scary. I called the police, and they stopped them from using the bullhorn, and then they left."

Following the administrator, a former patient testified to her experience:

> "The day I went back to be rechecked after my abortion, there were over 50 picketers out front. When I was trying to turn into the parking lot…they crowded around the entrance to the parking lot and would not permit my car to pass. I had to go around to the back alley and park back there and walk up the drive on the side; and I was running around the edge of the building to run to the front of the clinic so that no one would approach me."
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> City Attorney: "Were you able to use the sidewalk to get to the clinic?"
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> A. "No, there were too many people on it already."
>
> Q. "How did you feel?"
>
> A. "I was frightened, very frightened. I – my heart was pounding, my palms were sweaty. I was – I felt very intimidated."
>
> Q. "Would an 8 foot buffer zone have helped you?"
>
> A. "Yes, it would have, because I would have felt more confident using the sidewalk and public thoroughfare instead of coming through the yard."

In addition to various witnesses called by the city of Boulder, the clinic staff contacted two social scientists, Dr. Edward hall and Dr. Marianne LaFrance. Dr. Hall is well known as the author of the theory of proxemics, the cultural use of space, and is an internationally recognized authority on the subject (Hall, 1959, 1966, 1974, 1989). Dr. LaFrance, a social

psychologist, has conducted research and published widely on the same subject (LaFrance, 1978, 1979; Polit & LaFrance, 1977).

Plaintiff's attorney objected to the presence of Dr. Hall, but the Court overruled the objection. Dr. Hall was admitted as an expert anthropologist and more specifically as an expert in proxemics.

The first witness was Dr. Hall, who testified concerning his proxemic theory and the classifications within it. He testified that there are four social distances: the intimate distance, for intimate relationship; personal distance for personal relationships; social and consultative distances for social and consultative relationships, and public distance for public relationships. Intimate distance is defined as close contact up to about 18 inches. Personal distance ranges from ½ feet to 4 feet, permitting personal conversation. Social consultative distance is 4-12 feet, and public distance is from 12 feet or more.

Hall illustrated his theory by describing spatial behavior at a social gathering: "Just move the distance [forward] a quarter of an inch and the person backs up."

From 8-15 feet is the close part of public distance and not a "normal" situation for an American to receive a message from a stranger, according to Hall.

Hall testified:

> "To receive this kind of [normative] information out of context from a stranger is a violation of these unwritten rules….There are three situations in which strangers will approach you in public at a personal distance: 1) if your mugged; 2) when you're panhandled; and 3) when someone…is crazy. Normally people avoid all of these. There are eleemosynary things - voluntary processes [such as the solicitation of charitable funds] that are benign, when you know exactly where they stand within the culture. You can ignore them, but if one of those people gets too close to me or if they start shouting at me, I feel very uncomfortable and stressed. An 8 foot distance would tend to reduce the impact of the hostility and anger. If it were just a matter of communicating in a neutral sense or in a benign sense, it would have no effect at all. Outdoors, you need a little more space.
>
> "Public behavior is different than personal, private, or professional behavior. An approach [in public], if you don't know the person, is normally interpreted as a threat. A rapid approach within personal distances by a stranger [is] usually …interpreted [only] as a hostile act. Eight feet would be an absolute minimum. I would put it at 10 or 12 [feet]. Eight feet does not infringe upon your ability to communicate with me and does not infringe upon my ability to say yes or no."
>
> "There is no communication without context," said Dr. Hall.

The next witness, Dr. LaFrance, testified to much of the same scientific evidence:

> "A close interpersonal approach by a stranger in a public setting is stressful. Interpersonal space is something that we need in order to protect ourselves. Close interpersonal distance is allowed to those people whom we know, whom we trust, [and with] whom the interaction is likely to be positive or at the very least

neutral…The expectations are very clear that people are entering this mutually; they both agree to be there.

"As people approach more closely,…[there is] increased eye contact…[one is] able to see facial expression…[One is] able to detect the possibility of aggressive posturing. At close interpersonal distances, the effect [is] magnified. [The] stress reaction is proportionate. [The effect of stress] in [an] interpersonal context in which strangers are involved…is almost perfectly monotonic:…as distance lessens between people, stress increases.

"'Close interpersonal distance' means…violating the…expected norms for any given interaction. We do, in a variety of subtle ways, give permission…If that permission is not granted, people feel violated. As children age, as they grow up, [the] distances they adopt become greater."

Q. "Would an individual experience a sense of invasion if that communication took place from less than 8 feet?"

A. "The first basic assumption is that strangers should adopt the furthest interpersonal distance that the physical environment allows. The second [concerns] the expectation of interaction. If I expect to have interaction with you,…closer distances are allowed. If I do not expect and do not want interaction, the distance adopted will be further away and [there] will be…[a] stress [reaction] if that distances is collapsed [to less than] where I feel comfortable.

"A third factor is the tone of the interaction. *A close interpersonal distance in a context which is negatively toned will exacerbate the stress already experienced* (emphasis supplied).

"Health and medical [problems] are matters that most Americans would describe as being…of great privacy. Even in medical schools, nurses, doctors, and interns are instructed in order to be more sensitive to the distance adopted [in providing health care].

"Research [indicates] that 8 feet is not only [sufficient] in terms of communicating a verbal message; [research results] would probably recommend [that specific distance]. At distances of about 3 years, there is greater influence, more openness, greater communication, and more comprehensi9n of the message than at close interpersonal distance. Close interpersonal distance tends to create an arousal context within which the content of the message may not be heard (Mehrabian & Williams, 1969).

"[There is some] negotiation. Both people convey through a variety of verbal and nonverbal means that a distance is appropriate or inappropriate. If a distance is too close in one person's frame, [there is] stress and discomfort. The expectation in our culture [is that] at [less] than 3 yards, people begin to expect the possibility of tactile contact. That's why messages, typically nonverbal, are engaged in before 3 yards."

Discussion

- Both social scientists were accepted as expert witnesses for their expertise in proxemic theory and research results (Rosen, 1977).
- Both expert witnesses testified that the appropriate distances in American culture for certain kinds of verbal and nonverbal communication are specific, are measurable, and are well-known. They testified that intrusions on these distances are interpreted as threats, are considered hostile acts, produce psychophysiologic reactions, and reduce communication.
- The clinic administrator's testimony described psychophysiogical reactions taking place in a young and highly vulnerable patient even at a relatively large distance from the picketers and within the building.
- The clinic's physician director supported the social scientists' statements by testifying that even one picketer constitutes harassment since that person and his or her message is unwelcome; it intrudes on the patient's privacy in an important way. He also described psychophysiologic effects of harassment that affect patient safety and comfort (Hern, at 141, in Buchanan v. Jorgensen, 1987).
- The Court ruled that the preliminary injunction against the ordinance would not be granted, thereby upholding the buffer zone ordinance.
- An article in the *Harvard Law Review* stated that the buffer zone ordinance would be a constitutional means of protecting patients outside medical facilities (Harvard Law Review, 1988).

Antiabortion demonstrations purposely violate many accepted social norms. They expose persons seeking medical care to loss of privacy, particularly with regard to a most personal condition, pregnancy, which frequently occurs in unapproved social contexts; they expose the person's request for a treatment, abortion, which is highly controversial and which is highly stigmatized in our society; they intrude on social consultative, personal, and even intimate space limitations by the use of harassment tactics including use of a bullhorn, accosting people on narrow sidewalks, forcing an unwelcome confrontation; they invoke guilt, fear, and shame, undesirable and unwelcome emotions.

The strategy of antiabortion activists is to make the targets of their protests acutely uncomfortable by purposefully violating accepted cultural norms for the use of space, and to use social distances in deliberately inappropriate ways. Their goal is normative: antiabortion groups are normative organizations operating in both norm-oriented and value-oriented movements (Etzioni, 1961; Smelser, 1962). The value-oriented movement aspect derives its energy from the national fundamentalist evangelical Christian movement which seeks to "restore" America to its mythological bucolic past grounded in home, family, and church (Conway & Siegelman, 1984; Hern, 1989, 1990). The harassment of individual abortion patients is a tactic expressing this goal, which is also politically theocratic. When one person forces another to experience something they do not want, such as fear, guilt, shame, embarrassment, they are exerting power and control over that person.

The entrance to an abortion clinic is an inappropriate context for normative moral messages. The messages are not voluntarily sought as when one is attending church or synagogue.

Antiabortion demonstrators do not accept the evidence that pregnancy is a medical condition with life risks and that term pregnancy is more dangerous to a woman's health than a properly performed early abortion (Hern, 1984). They do not accept abortion as a legitimate treatment for the condition of pregnancy regardless of these facts. Their normative goals far outweigh any consideration for the health of women who wish to make this choice or seek this treatment. They insist not only that pregnant women accept their values and accept their norms of behavior; they insist that their normative values be encoded into law and backed by the coercive police power of the state (Hern, 1981).

The antiabortion demonstrators' message is not formally a political message at the clinic level, but it has that function because it attempts to exert power by controlling the behavior, movements, and even emotions of those subjected to their influence. From the point of view of those who are the targets, it is an unwelcome normative influence. The messages are not only unwelcome, they are actively deleterious to the health and well-being of women. The demonstrators state clearly that they are more concerned about the fetus than about any woman. To advance the normative goals of the antiabortion demonstrators, the fetus is used as a fetish object in what amounts to more than psychological abuse: the demonstrators' violation of personal space deliberately assaults both the mental and physical status of patients seeking medical assistance.

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