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Possible Guidelines for Problem Pregnancy Counseling

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IN 1967, when the Reverend Howard Moody, pastor of the Judson Memorial Church in New York, organized a small group of clergymen, he created the Clergy Consultation Service on Abortion, a movement which has been sweeping the country. Not only have hundreds of clergymen begun to organize themselves in most states, but other professionals such as counselors in Planned Parenthood, mental health workers in social agencies, and counseling personnel in colleges and universities, are finding themselves suddenly involved in problem pregnancy counseling where abortion is being considered as one of the most viable alternatives.

Many clergy groups, especially the original one in New York, have been very activistic, political, and otherwise outspoken on their stand about abortion, approaching the issue as one of civil rights. The New York group led a crusade which was influential in the decision of the New York State Legislature to reform its abortion law. Other professionals may not have been as socially aggressive about the matter but nevertheless join the clergy in the conviction that women who are thinking about an abortion ought to have professional assistance available in making a decision, and in finding abortion facilities to suit their needs.

My concern is not the civil rights issue, nor (in this article) is it about the ethical issues involved in abortion. Rather, I wish to contribute to a discussion of the counseling aspects of the consultation process. Clergymen especially are seeing thousands of women every month, women who are in various stages of a decision-making process about an unwanted, unplanned, or otherwise problematic pregnancy. In April, 1970, Howard Moody reported that about 8000 women utilized the New York group in the two year period of 1968-1970.[1] The Reverend E. Spencer Parsons, chairman of the Chicago group, has reported that about 150 women each week consult that service.[2] In February, 1971, the Reverend Alden Hathaway, chairman of the Michigan service, reported that Michigan clergy referred

1. At the National Campus Ministry Association Conference on Abortion, Houston, Texas, April 7-10, 1970.
2. In "Criterion," Winter, 1971; a journal published by The Divinity School, The University of Chicago.

almost 15,000 women for abortions in the calendar year 1970.[3] Clergy are indeed on the front line of hard-nosed problem pregnancy counseling.

But they are not the only ones. In my community there are four groupings of counselors actively involved in such counseling. In addition to a group of clergy (as part of the Michigan Clergy for Problem Pregnancy Counseling), the Planned Parenthood office and a Free Peoples' Clinic are offering consultations and referrals. Also a group of women—housewives, students and others, many of whom themselves have had an abortion—has established the Women's Abortion Counseling Service, and offer consultations and referrals. Finally, University of Michigan counseling personnel in several units, coordinated by our Office of Religious Affairs, have established a counseling and referral system for problem pregnancies. Through the University services alone, some 300-400 students, staff, and faculty seek consultation each year about a possible pregnancy or problem pregnancy.

To be of truly pastoral and therapeutic assistance in what is usually a crisis situation, the counseling interview about this problem must be as skillfully and thoughtfully conducted as any other sensitive counseling problem. Over the past two years I have developed a conceptual analysis of this counseling situation in order to establish some means for evaluating my procedure. Although a complete evaluation would include an experimental design,[4] I have found it operationally useful to at least reflect clinically about my interviews. I offer the following in the spirit of discussion to others who also might be involved in this type of counseling.

Counseling Technique and Style Pertinent to this Problem.

Women are typically wary about how the counselor will respond to this problem. They often expect one of two extremes, and according to my own observations, counselors sometimes tend toward one or the other of these extremes until they learn how to respond to this problem in a balanced way.

Many women fear that the counselor will moralize, that is, take a position on what is right or wrong, and try to persuade them to take a specific course of action. This fear is almost totally justified on the basis that counselors of every stripe—not only clergymen—have in the past participated in the taboo in this country against anyone "caught" pregnant outside of marriage, or against anyone (whether married or not) thinking about an abortion. And indeed the idea of abortion is often one so mixed with conflicting emotion in a woman's own mind that she may project her personal moralizing tendencies onto the counselor.

If the counselor has unresolved conflicts about abortion, he or she may tend to be conservative in approach and want the counselee to think through everything in the counselor's presence so that the *counselor* will feel better. If the counselee is not ready for such a struggle of her own, the interview may seem moralizing to her, because the counselor has things to work through and is projecting on to the counselee his or her own struggle.

3. In a statement presented to a meeting of the Michigan Council for the Study of Abortion, February 6, 1971.

4. An interesting experimental design for evaluation of counselor effectiveness might include a counselee's evaluation of the interview as to what was particularly helpful—perhaps just after the interview, and again several days or weeks later, after the crisis has passed. Few of us, however, are in positions or roles conducive to gathering such data.

Other women, however, usually the more sophisticated ones, often expect a different extreme. They are afraid the counselor will barely respond to the problem by merely passing out information without taking an interest in the whole situation. They are aware that they can be given reliable information about alternatives to problem pregnancies, but fear that is all they will receive, often wishing that someone would help them think and feel through some of the complexities. Because of their own nervousness or manner, they often help bring this fear to a reality by acting at first as though indeed all they do want is information. If the counselor cannot put such a woman at ease immediately, she will feel convinced that either the counselor does not have the time or does not really want to get involved in her problem.

In my experience, counselors tend more toward this latter extreme than toward the other one of moralizing. Either they are so concerned *not* to moralize that they fail to facilitate a comprehensive interview, or they simply assume the woman has made up her mind and that she would not respond to any discussion. Clergy who are particularly publically outspoken for abortion may tend toward assuming all that is needed is information and referral about abortion. They are correct in assuming that women are coming to them *because* the counselor has abortion information (since women do want that information), but they sometimes close the case prematurely by assuming that is the *only* reason they are coming.

Goals in a Problem Pregnancy Interview.

The adjective "problem" in the phrase "problem pregnancy" isn't a bad one. Not all pregnancies are problematic. Many are welcomed with delight. But when a pregnancy occurs against one's will, or when a willed pregnancy unexpectedly causes severe problems in or for the lives of those involved, the pregnancy presents a problem situation of crisis proportions. A typical crisis involves a decision-making process over a relatively short period of time. Women and couples are thrown into a crisis primarily because of the pressure of time. And it is this factor of time which often produces special dynamics in a problem pregnancy interview.

One of my goals in a typical interview is to assess the stage of the decision-making process current at the time of the interview. Below I have identified several stages in this process. Sometimes movement occurs from one to another stage during the interview itself. In any case, however, I think it is highly desirable to discern the point and quality of participation in whatever stage a woman (or a couple) might be situated in the process. The counselor's sense of "where the counselee is at" will determine in part his or her own response, and particularly the kinds of things he or she may wish to raise for conversation.

A second goal is to facilitate further movement in the decision-making process by both empathic reflection and clarification of the full range of concerns in the counselee, and by providing information relevant to those concerns. This goal is the work of the interview; the first goal helps indicate where the work might begin.

I assume the necessity of the second goal in every interview. A woman or a couple are rarely so completely decided about their decision that an interview which is sensitive to their stage in the decision-making process would be rejected. Rather, no matter what the decision might be, there will always be some degree of ambiguity persisting about a matter as important as a pregnancy

Furthermore, the crisis nature of the situation inevitably causes distortion and denial about some aspects of the matter. The second goal facilitates awareness of these blocked areas and helps bring some balance into a mind usually reeling with conflicting emotions.

Another value of the second goal is that it allows a means by which the counselor can communicate an interest in the *whole* situation and hopefully avoid the extremes discussed above. Aside from passing on reliable information to the counselee, the clarification process is the essence of the counseling interview and the basis of any lasting help the counselor can offer. The means by which this goal is achieved is outlined below under "content areas" of the interview.

Typical Stages in the Decision-Making Process.

In the women and couples I have seen about problem pregnancies, I have been able to distinguish five significantly different stages of involvement in the decision-making process. Each case, of course, has its own particular dynamics and is more complicated than one place on a simple scheme of five places, but the shifts in dynamics between these five stages is significant enough to require particular shifts in sensitivities on the part of the counselor. One could discern more subtle differences than these five if one were to carefully work out a complex scheme. But for the purpose of practice rather than sophisticated theory, these five seem useful.

The stages suggest points on a continuum in the decision-making process, with stage three being a typical major detour. A woman or a couple may be in any one of the stages at the time of the interview. They often move from one stage to another during the interview. An interview may serve to release them from being fixed in one stage so that they are free to complete the process on their own after the interview. Some women and couples require more than one interview. Each case must be assessed individually and responded to accordingly.

1. *The stage of psychological shock.* The central phenomenon here is that the fact and/or the consequences of the pregnancy are not yet appropriated. Some women (and men) are hit hard at this stage, particularly young, unmarried women who are pregnant for the first time and have been trying to avoid a pregnancy. Confusion and conflicting emotions take their toll of the couple's energies, the overriding emotions often being shame or guilt, and especially fear. Many women and couples work through this stage by themselves or with their peers. Often when they have no supportive persons in their normal relationships they may find themselves in the counselor's office at this early stage.

The primary function of the counselor in response to this stage is to respect the strong emotional tension, respond empathically to the various emotional strains, and not press for much rational thinking until the counselee is ready. The key is to do whatever is possible to help the woman relax and feel that she can take as much of the counselor's time as she needs. As indicated above, she may desperately want to know how she can obtain an abortion. The counselor should give her the basic facts in order to assure her that she can have an abortion if indeed that is what she finally will want.

It is the *assurance of the possibility* that is important here. She will more than likely be unable to absorb all the details of the referral procedure at this stage because she is overwhelmed with

emotional uncertainty. When she is more relaxed, feels assured, and accepted by the counselor, she will at her own pace begin the more rational aspects of the decision-making process. It is a mistake to assume that because she might be asking for abortion information at the beginning that the matter is settled in her own mind.

2. *The stage of uncertainty, but with deliberation.* The major characteristic of this stage is that the fact and feelings about the pregnancy are more or less "owned," and the consequences and possible solutions are able to be thought about actively. Here the counselee has implicity said to herself, "I accept my situation and myself in it and now must thoughtfully decide what I am going to do about it." At this stage the emotional reactions are brought into greater balance by becoming more integrated through some reasoning about the matter. The counselee responds to the clarification process with acceptance because she is now ready for it.

The counselor at this point will be able to discuss at least the alternatives to a problem pregnancy. I have a wider range of concerns that I am prepared to respond to, which are listed below. Information, as needed, is very relevant at this stage. The counselor must remember, however, not to preclude this stage by assuming too much. The aspects of indecision must be respected and allowed to run their course. This may mean more than one interview, as is often the case in my own experience. At this stage neither the emotional nor the rational levels of decision-making have run the full course.

3. (*The stage of being decided but manifesting strong anxiety with a reluctance to discuss much at all.*) I include this as one stage I have experienced and put the phrase parenthetically to indicate this stage as a detour or deviation from the desired process. In this stage, the problem is compounded by a resistance to work it through. Denial and distortion run very high here. A decision—either emotional or rational—has been made, but is only partially integrated. The problem may either be centered dynamically in the counselee, or be a function of the counseling relationship, or, of course, partially both.

The counselor must use his or her own knowledge to try to discern the cause of the resistance. It is not enough to assume that the problem resides in the counselee alone. More than likely the resistance arises from a clash between the counselee's expectations and the counselor's manner. There is a certain awkwardness built into problem pregnancy counseling at this point in time. Many women feel resentful at having to go to a professional, whom otherwise they may not choose to see, because he or she has abortion information which they feel should be public and given on demand. A woman may therefore feel that this counseling interview is only one more manipulation of her life by so-called professionals. So counselors must be open to this attitude and decide whether they will be merely the dispensers of information. I have found, however, that when I have not resisted such attitudes in the counselee, she has relaxed and, in fact, utilized our relationship to move herself further along in the process.

If a counselee in no way develops an interest in discussing the problem, and if she does not respond to the counselor's openness to the whole situation, then little can be accomplished therapeutically in the interview. The counselor, in addition to providing any information the counselee requests, may want to suggest his own concerns and what he feels is important to consider, and let it go at that. Of course, if the counselor is alarm-

ed and senses that the counselee is doing something potentially harmful to herself, the counselor may wish to raise that concern with her.

4. *The stage of being decided and requiring internal support and clarification.* Because of the way many clergy consultation systems are set up, many women reach the clergy-counselor in this stage. The public image of the clergy groups tends to suggest that only after a woman knows it is an abortion she wants, should she then seek out a clergy-counselor. Some telephone-recorded answering services operated by the clergy groups ask the caller to bring a note from her doctor verifying the length of her pregnancy. Although this is done to save unnecessary interviews and for the convenience of counselees who have difficulty in arranging even one interview, it tends largely to encourage women who feel more or less decided about their dilemma, and come primarily to receive information. In my own situation, in the University setting, where convenience is no problem, we are able to respond to women in earlier stages of the process by inviting them in immediately, and on a walk-in basis.

Perhaps this stage of the process, more than others, could be subdivided into many parts. Two that immediately occur to me are the following: (a) the case when an emotional decision has been made but has not been fully accepted or integrated rationally, and (b) the case when a rational decision has been made but has not been fully accepted or integrated emotionally. What distinguishes this fourth stage from the third stage is the counselee's desire to talk about her situation. The task of the counselor is self-evident in this stage, namely, to help the counselee review and integrate the decision, resulting in an increased state of internal self-assurance.

The word "internal" is important. The counselee must, to minimize future repercussions, develop her own affirmation of herself in whatever her decision may be. She must not feel as though someone else has pushed her into a decision or has taken responsibility from her for making it.

5. *The stage of being decided and requiring mostly information to carry out the decision.* When a woman has reached this stage, what she wants most to talk about is what will be involved in carrying out her decision. She is self-assured internally enough so that review of her decision-making process will do little more than reassure the counselor of her readiness. The counselor talks with her long enough to determine that for her the crisis of decision-making is over.

The counselor's task is not over, however. The counselor can help prepare her for the course of action she is about to take. If she is seeking an abortion, she will need to know about various facilities and the experiences she can expect to encounter at them. If she is planning to have the child, preparation for that event may require special arrangements. If she is unmarried and signals a desire for marriage, this interview may be the first in a series of preparations for the couple. In any case, she should not be left "hanging." If a referral to another professional is appropriate, the counselor should see that referral through.

Although I have presented these stages almost as though a person could be either in or out of any one of them, the reality is much more complex. A woman's or a couple's energies may be primarily centered in one of these stages, but elements of any one of the stages could appear at any time, and should be responded to when they become visible.

Criteria for Evaluating the Decision-Making Process.

How can a counselor evaluate the decision-making process? How does he or she know whether the process is a healthy one in the counselee? Every counselor has implicit ideas of what "ought to be" in counseling situations, and knows what he or she values by feeling "good" if an interview goes "well." Though this intuitive approach is often reliable, it can be even further satisfying if one knows just what one is feeling good about!

If we look at the stages outlined above, and which I have tried to discern from my experience, several criteria suggest themselves as ways to measure a progressing decision or a healthy process. The first is the counselee's acceptance of her situation and of her position in it. She "own's" the situation and perceives herself as the agent who will work it out. Behaviorally, this acceptance will show itself by the frequent use of words which describe her situation concretely (such as "pregnant," "fetus," "child," "abortion," "marriage," "adoption.") Also, she will use the personal pronouns "I" or "we" frequently, indicating some degree of personal responsibility for the situation.

A second criterion is the degree of integration in the counselee's thinking and feeling. There is more than one aspect to this criterion. First, there is the relationship between thinking and feeling. Is one part of the process lagging behind the other? Is she refusing to deal with both thoughts *and* feelings? Secondly, there is the *range* of emotional and rational concerns. Does her decision include most of these concerns? Is she denying specific concerns? Behaviorally, one measures denial or acceptance of this sort by the extent to which the counselee discusses these concerns, either of her own volition or in response to the counselor's prompting.

The third criterion is the counselee's own internal sense of self-assurance about a matter that began by creating a crisis in her life. Has she sufficiently brought it all together in a manageable way for herself? Have the conflicts or contradictions been reduced to a minimum? Behaviorally, self-assurance manifests itself in a gradual disappearance of vacillation and a predominance of discussion about one of the alternatives. When ambiguity is reduced to a minimum, the counselee is most probably settled on a course of action.

I recognize, however, that no matter what the counselee's decision may be, there will always be some degree of ambiguity persisting about a matter as important as a pregnancy.

Possible Content Areas in a Typical Interview.

Below are listed what often represent a comprehensive range of concerns about a problem pregnancy. They are concerns, most of which inevitably come up in almost every interview if the counselor is alert. Sometimes the counselor may want to raise them, but usually they are spontaneously alluded to by the counselee at one point or another. There is no particular progression implied in the order below. An interview could begin with any one of them. Some are packed with more significance than others, and each woman or couple may develop their own range of concerns which may at first include some of these, but then progress to others more characteristic of their particular situation.

The best technique for dealing with these concerns is to let them arise spontaneously in the counselee and respond to them in a way that invites elaboration. The worst technique would be to system-

atically run down the list by asking, "Have you thought of . . .?"

1. How long has she been thinking about her situation? Has she recently found out about her pregnancy? Has she suspected it for quite some time? What were her first thoughts? Her first reactions? Have her thoughts changed any? If so, what seemed to change them?

2. With whom has she discussed the matter? Which important people in her relationships are in on the situation? Does she have support from any of them? What has been their reactions or advice? Is she looking toward anyone in particular for help or advice?

3. What is her relationship to the man involved with her? Boy friend, husband, or partner in a passing affair? Is he aware of her predicament? Does her relationship to him matter in this decision? Has the pregnancy affected the relationship in any way? How has it changed? Does she feel abandoned, emotionally or otherwise? What are her present needs with respect to the man involved?

4. What are her feelings about that process going on inside her uterus? Does she feel warm about it, cold, neutral, hate it, think of it as a thing, a fetus, a child, a baby; does she want it, fear it, feel trapped by it, feel responsibility to it in any way? (Her feelings here are very likely to be conflictual and contradictory. Pregnancy induces very powerful emotions physiologically which may then be further complicated by the nature of the total social situation.)

5. (This concern is often relevant to young or unmarried women.) What is the state of her relationship with her parents? Is it relevant to her now? Are the parents aware of the situation? Does she require psychological approval or support from them? Is she independently strong? If she is young, is her decision about such an important matter to be her first really independent act, a critical step in her growing maturity?

6. Has she been upset about her predicament? What particularly is upsetting? What specifically worries her or makes her afraid? What does she think needs to be changed to help her through this situation with less fear or worry?

7. What are the alternatives most viable for her? Does she have any feelings or pressures to carry the pregnancy to term? What are those feelings about? What would be the risks involved? How would her life be changed? Would she keep the child? Give it up for adoption? If she is unmarried, would she want to be married? Stay single? Is she thinking about an abortion? What are her feelings about an abortion? Have those feelings changed recently? What were they originally? What made the change? Does she have fears or a distorted understanding about abortions? What has her family and or religion implied about abortion? Are there feelings of right and wrong involved? Is this decision mostly a matter of practicality? (I do not raise the question of suicide, but will respond to it if I sense it is already there. The meaning of that idea should be pursued as far as possible if it comes up.)

8. Does she feel that she has a choice in her situation? Does she feel in control? Is there any sense of freedom? Does she feel trapped? Is there only one way out? Is the whole thing happening to her from the outside?

9. What were the factors causing the pregnancy? Does she understand what happened? Did a contraceptive device fail? Was it used improperly? Was the couple operating on faulty information?

Did they take a knowing chance? Was it pure carelessness? Did she feel safe? Was there any desire to become pregnant, or a feeling that it would be all right if it happened? Is the pregnancy symbolizing something one is trying to say to the other? Is she utterly confused about what happened? (At some point in the interview, usually in relation to this grouping of concerns, I offer my own advice about contraceptive devices and often hand out literature on methods. Also this grouping of concerns sometimes leads into a discussion on sexual style, values, and any shift in feelings about sexuality in general. I pursue this as far as it is carried by the counselee, recognizing that it may not be germane to her more immediate concerns.)

If the woman or couple pursues the idea of an abortion, I prepare them for the experience by filling them in on whatever they do not know about the following procedures:

(a) General information about procedures: describe vacuum aspiration, dilatation and curettage, legal and illegal possibilities, out-patient and in-patient possibilities, safe aspects, danger aspects, costs, and how the ten-week point in the length of pregnancy is critical to the situation.

(b) Specific information about referral: describe in detail what is entailed at various facilities, including medical, psychological, and economic aspects. Finally, I give the woman full information on the facility of her choice so that she may call and make her own arrangements for an abortion. I ask her to contact me upon her return from the facility to let me know how things went.

Concluding Remarks

Although not every woman or couple is looking to abortion as a solution for a problem pregnancy, many currently are doing so. The freedom to proceed legally and without public restraint is very recent. Abortion could become a temporary standard solution in this country for problem pregnancies, particularly in the light of changing moralities and marriage patterns, and concern about overpopulation.

I am of the opinion, however, that those of us involved in problem pregnancy counseling should let the internal dynamics of each case work itself out afresh each time. As counselors we should be open to all the elements in the situation and not be surprised, for example, that some women may even choose to have a child outside of marriage. In some communities, social attitude is making this alternative more and more possible. A pregnant woman is a very powerful center of intense energy and feeling, often unfathomable even to her.

In a recent "Life" magazine article, a German movie actress who herself has had an abortion was quoted as saying:

> Look, there's never going to be anything easy about an abortion. It isn't easy. No girl will ever make the decision simply. No matter what anyone says, it can't ever be just five unpleasant minutes. The law, the church, stupid morals have nothing to do with the way a woman feels when she makes a decision like this. She herself knows how painful, difficult, complicated it all is.[5]

According to my experience, this statement reflects the intense involvement most women seem to have. And we, as counselors, should respect the complexity of the situation by being as sensitive and responsive as we can to *all* the elements in it.

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5. "Life," July 9, 1971, p. 69.