Options Counseling: Techniques for Caring for Women With Unintended Pregnancies

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An unplanned pregnancy is a crisis in a woman's life. She may request assistance from the health care provider in reviewing her options of becoming a parent, continuing the pregnancy and placing her baby for adoption, or terminating the pregnancy. To facilitate the decision-making process for women facing these choices, the clinician must first examine her own values and biases. To aid the clinician in providing nonjudgmental and nondirective counseling, this article provides factual information about abortion and adoption, values clarification exercises, and concrete approaches to help women examine their beliefs. J Midwifery Womens Health 2004;49:235–242 © 2004 by the American College of Nurse-Midwives.

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Counseling a woman with an unplanned pregnancy can be very challenging for health care providers and the women in their care. The challenge comes from the personal feelings each clinician has about unplanned pregnancy, abortion or adoption, and from the fact that an unplanned pregnancy is a crisis in a woman's life. This article outlines a process for sorting out one's beliefs and increasing one's understanding of that crisis. Options counseling offers a woman, who is undecided about her choices, the support and information she needs to explore her alternatives and clarify her values and feelings. It differs from abortion counseling, which is provided to women who have already decided not to continue their pregnancies, and informed consent, which reviews the specific procedure, risks associated with it, anticipated benefits, and alternative therapeutic regimens.[1] Suggestions for providing options counseling within an ethical framework are made. Frequently voiced concerns about abortion and adoption are discussed, and values clarification exercises are provided for readers to complete in an effort to make readers more aware of their own personal biases and thereby minimize the degree to which these biases impact counseling sessions. The exercises focus disproportionately on abortion, because it is the reproductive choice that tends to trigger the strongest reactions.

OPTIONS COUNSELING

Nearly half of the pregnancies in the United States are unintended. Forty-seven percent of unintended pregnancies end in abortion, 40% end in birth, and 13% end in miscarriage.[2] There are no official statistics kept on the number of infants and children who are adopted each year, but estimates range from 1% to 3% of unplanned pregnancies. Family members adopt many of these infants and children, but it is believed that about 52,000 of them are relinquished to unrelated adoptive parents, many of those adoptees coming through foster care.[3,4]

The American College of Nurse-Midwives (ACNM) Position Statement on Reproductive Choices specifies "that every woman has the right to make reproductive choices" and "that every woman has the right to factual, unbiased information about reproductive choices, in order to make an informed decision."[5] Midwives and other clinicians need specific skills when counseling a woman with an unintended pregnancy, as she chooses among her options of continuing the pregnancy and becoming a parent, continuing the pregnancy and placing the baby with adoptive parent(s), or terminating the pregnancy.

Unfortunately, the literature on the topic of options counseling is extremely limited. There are a few guides, written mostly by counselors with extensive experience at abortion clinics. These sources provide useful information, although they are limited by their anecdotal nature and by the fact that the patient encounters they draw from (patients who come to abortion clinics) may not be representative of the entire population of women with unplanned pregnancies. There are no published studies of different approaches to options counseling or different types of counselors or the positive or negative effects of counseling. There is almost no literature on whether counselors with strongly held negative personal beliefs about any of the options can, in fact, provide high-quality options counseling. One study performed by an international health organization suggests that it is possible.[6] The study examined attitudes of health care providers toward women needing postabortion care in the Philippines where abortion is illegal. Attitudes among care providers were examined before and after participation in a skills-building program on prevention and management of abortion complications. The researchers found that despite very negative attitudes toward abortion, health care providers offered markedly improved supportive counseling after training.[6]

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VALUES CLARIFICATION FOR POTENTIAL COUNSELORS

Joan Garrity, an experienced options counselor, author, and trainer, encourages those who attend her counseling workshops to strive for a "healthy detachment" from their personal views when they do options counseling. Individual clinicians might be very uncomfortable with choices an individual woman makes. Health care providers need to understand and accept that the woman's goals and her chosen way of achieving them might conflict with their own personal values. Ideally, a counselor should be disinterested in the decision the woman makes. This intention helps the clinician provide counseling that is non-judgmental and non-directive (Garrity J, personal communication, November 2002).

Within the ACNM core competencies is a list of 16 "Hallmarks of Midwifery," two of which presume midwives will offer objective counseling. The sixth hallmark, "empowerment of women as partners in healthcare," and the eleventh hallmark, "advocacy for informed choice, shared decision-making, and the right to self-determination," require separation of personal and professional values when offering assistance to women grappling with an unplanned pregnancy.[7]

Before the clinician can put aside her or his own beliefs and biases about the range of reproductive choices, the clinician needs to do a thoughtful and thorough exploration of those beliefs and biases.[8] Midwives, of course, have a wide range of beliefs about the choices a woman might make when faced with an unplanned pregnancy. Values are influenced by education, culture, religion, and personal experience. Because values are so deeply ingrained, it can be difficult to be aware of one's own values until they are challenged by someone with differing values.[9] Health care providers have the responsibility to explore how their personal views might impact the care they give.

Exercises in Appendix A are designed to help clarify one's views on unplanned pregnancy, adoption, and abortion in the hope of minimizing the impact of one's personal views on the response to a particular client's situation. These exercises contain questions that may be difficult or even painful to contemplate. There are no "correct" answers; the exercises should be used to identify emotions and reactions to the issues.

COMMON EMOTIONS ASSOCIATED WITH UNINTENDED PREGNANCY

The crisis of an unintended pregnancy can stir up numerous and sometimes competing emotions in women as well as providers. Denial might surface to protect the woman from the pain of facing her situation. Dealing with a client who is in denial can be particularly challenging for the midwife-counselor. With reflection, discussion, and support, the woman can give up denial, but the counselor cannot take denial away.[10] The woman must feel safe enough and supported enough to let herself feel the internal tension and discomfort (Garrity J, personal communication, November 2002). When the woman recognizes and acknowledges ambivalent feelings, she can move past denial and engage in the process of decision making.

Major life decisions usually involve ambivalence. Ambivalence is "a state of mind in which a person has coexisting but conflicting feelings about something."[11] The woman with an unintended pregnancy might feel ambivalence because she wants to parent but cannot afford a baby now or does not want to be a single mother or worries about losing her freedom. She may experience ambivalence because she wants an abortion but believes it is immoral or it is a dangerous procedure or feels like she is losing her baby. She may feel ambivalence because she wants to place her baby for adoption but believes a baby should be with its "real" mother or worries she will not be able to go through with it or does not know how she will explain it to the children she already has. It is important that conflicting feelings and the grief she might feel be identified as normal.[12] Often, the ambivalence has less to do with confusion about options than the realization that her present life circumstance is not what she might wish.

PRINCIPLES OF OPTIONS COUNSELING

Active Listening

Discussing difficult life decisions, such as abortion, adoption, or parenting can be an emotionally laden experience and can create anxiety in both the client and the counselor. It is helpful for the counselor to keep in mind that the woman is responsible for defining how the unintended pregnancy is a problem for her; she is responsible for her own self-exploration, for assessing her options, and ultimately for making a decision and acting on that decision. The counselor's role is to listen actively, provide information, give support, and assist the woman in evaluating her options. The solution to the unintended pregnancy lies with the woman.[13]

Although giving entirely unbiased counseling is probably impossible, the clinician must be committed to and vigilant about keeping her or his biases out of the conversation. Midwives whose personal opposition to any of the three options is too overpowering to allow "healthy detachment" from the woman's decision, should refer the woman elsewhere for counseling. However, the provider still must provide accurate information about all three options. She or he can help the woman begin the decision-making process in a way that respects her autonomy and right to self-determination. Even limited support can be extremely helpful for a woman in crisis. Providing accurate informa-

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Table 1. Answers to Frequently Voiced Questions About Abortion

- Nearly 90% of abortions in the United States are done in the first trimester.
- Although women used to be told to wait until 8 weeks from the last menstrual period to have a surgical abortion, with advances in surgical technique and the availability of manual vacuum aspirators, surgical abortions may be able to be performed soon after a woman knows she's pregnant.
- Surgical abortion is one of the safest procedures in medicine. Generally, the earlier it is performed, the safer it is. Fewer than 0.5% of women having a surgical abortion experience a complication.
- First-trimester abortion (including having multiple abortions) poses virtually no risk to future reproductive health—no increased risk of secondary infertility, miscarriage, preterm birth, and breast cancer.
- After an abortion, most women feel relief. Some women feel sadness and/or guilt. Usually these feelings are transient.
- Mifepristone (RU486) has been available in the United States since September 2000.
- Medical abortion with mifepristone can be performed at least up to 7 weeks from the last menstrual period, with a growing number of providers offering it up to 9 weeks from the last menstrual period.
- Laws and regulations about abortion vary from state to state. A state-by-state guide can be found at *http://www.guttmacher.org.* The most common restrictions in effect are parental notification or consent requirements for minors, state-sponsored counseling and waiting periods, and limitations on public funding.

Sources: Baker,[1] Elam-Evans et al.,[14] and Paul et al.[15]

tion and helping her realize she is not alone can relieve many of her fears.

PROVIDING ACCURATE INFORMATION

To assist the woman in decision making, it is imperative for the counselor to have current and accurate information about abortion, adoption, and parenting. The counselor should first assess what information the client already has and her general level of education. A useful way to assess her knowledge base is to ask her what questions she has and what she has heard (as opposed to what she knows). This allows the counselor to avoid giving information the woman already has and to fill in the knowledge gaps in a way she can understand.[12] Giving information is one of the main objectives of options counseling, and it can be done even by those who do not feel equipped to provide full options counseling.

Abortion

An estimated 43% of American women will have an abortion during their reproductive years.[2] Abortion rates are highest in women age 20 to 24.[14] Both midwives and their clients have been exposed to information and misinformation about abortion. Although a full discussion of abortion procedures and options is beyond the scope of this article, Table 1 provides answers to some frequently voiced questions that can clarify misconceptions and inform counseling. Readers who want more information should refer to Paul et al.[15] (Table 1).

Adoption

Historically in the United States, relatively open adoption was common until the 1930s. In the next decades, secrecy surrounding adoption grew. This secrecy was encouraged as a way to protect babies from the stigma of illegitimacy and to save the birth mother from the shame of her unintended pregnancy. There was little understanding at the time of the long-term effects of grief. Since the 1960s, there has been an evolution toward more openness in adoption, both to let the adopted child know the truth of his or her origins and to give birth mothers more control over the process.[16] The contact a birth mother might have with the

Table 2. Issues That Can Be Raised in the Discussion of Adoption

- Feeling ready and able to place a baby for adoption requires planning.
- Giving birth and raising a child are two different things. You might be ready for one and not for the other.
- It can be a good parenting decision to decide not to parent.
- Seeing the baby and claiming the baby can make it easier to relinquish the baby.
- All birth mothers feel sadness about relinquishing a child, even though it might be the best decision for all involved.
- The grief after relinquishing a baby can be similar to the grief women experience after a stillbirth.
- Adoption agencies might provide excellent counseling to birth mothers, but agencies are not disinterested parties. They are in the business of finding babies for adoptive parents.
- A birth mother can think of adoption as a way to give parents to her baby, as opposed to giving her baby to adoptive parents.
- A birth mother can select the adoptive parents she wants for her baby.
- There is a difference between privacy and secrecy.

Sources: Pavao J, PhD, Clinical and Executive Director of the Center for Family Connections, a non-profit organization serving families touched by adoption and the professionals that work with them (personal communication, May 2003); Runkle 1998[18]; and Independent Adoption Center.[19]

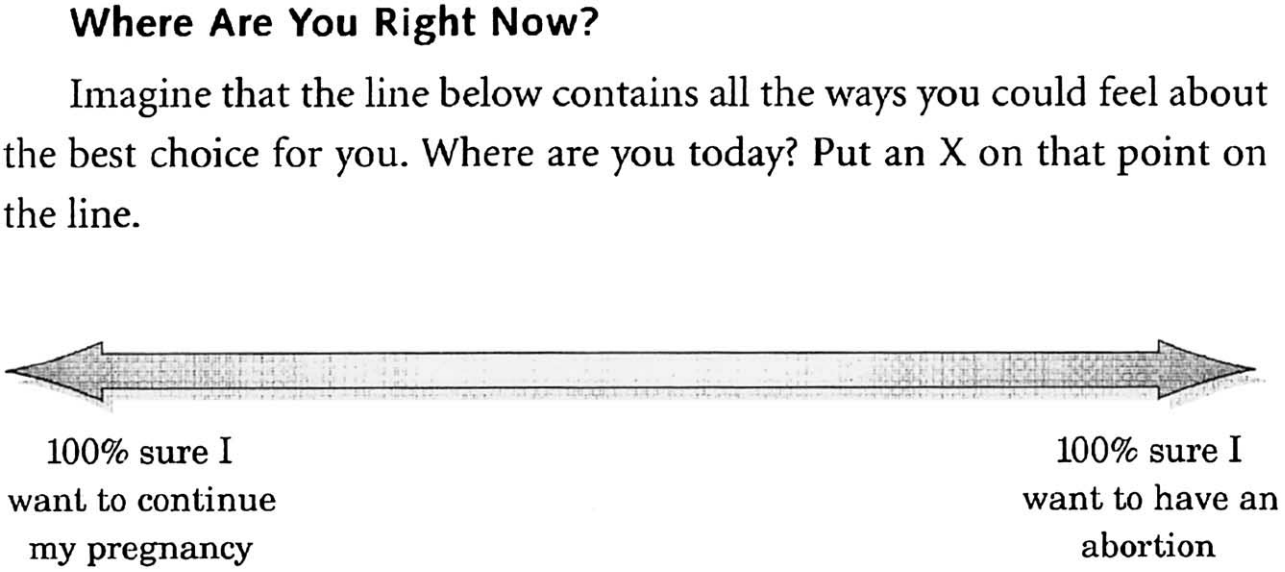

Figure 1. An exercise to initiate the counseling session. Reprinted with permission from Runkle.[18]

child she is placing and with the adoptive parents varies tremendously—from occasionally sharing pictures, to having regular communication, or to having frequent visits. For many birth mothers, knowing who will raise their baby allows them to feel more at peace with letting their baby go.[17] Table 2 provides some issues that can be raised to help a woman explore the option of adoption. Appendix B provides selected resources for the woman considering adoption.

GETTING STARTED

A review of basic communication/counseling skills is not included here; it is assumed that the midwife understands the importance of creating a comfortable environment, being mindful of tone and body language, and using open-ended questions to encourage client participation in the counseling session. The clinician should keep in mind that options counseling focuses on a single decision. Options counselors are not therapists, and options counseling is not intended to help the woman solve all the issues in her life that make her undecided about her pregnancy. Reasonable expectations for the counseling session can be set with a statement such as, "The purpose of this session is to help you come to a decision about your pregnancy."

Figure 1 can be used to initiate the counseling session. This exercise gives the counselor an indication of the direction, if any, toward which the woman is leaning. In addition, it will help her acknowledge where she is starting as she contemplates a decision.

It may be helpful for the woman to return to this exercise at different points in the counseling session. Table 3 lists a number of questions that can serve as a starting point for discussion. Asking these questions will provide an opportunity for the client to begin exploring her options. Her answers will help the clinician gain an understanding of her feelings, values, and the personal circumstances that brought her to the counseling session. Additional exercises are provided in Appendix B.

Use of these tools, if appropriate to the client's literacy and understanding, can help direct the discussion. Women

Table 3. Options Counseling: Starting Points for Discussion

- How are you feeling about this pregnancy?
- Prior to finding out you were pregnant, what were your feelings about abortion/adoption/parenting?
- Under what circumstances do you believe abortion, adoption, parenting is okay? Not okay? Why?
- Under what circumstances would you like to become a parent?
- What are your goals for the next year? Five years? How would each alternative help or hinder the achievement of these goals?
- What part of your circumstances frightens you the most?
- What is the worst thing you think might happen?
- How would you like things to turn out for you ideally?
- It can be helpful to some women to look at what they believe and separate that from what they have been taught to believe. "You've said what your church's/boyfriend's/parent's beliefs are. Could you tell me more about what you yourself believe at this time in your life?"

Source: Baker 1995[1]; Garrity J (personal communication, November 2002); National Abortion Federation[20]; and Runkle 1998.[18]

complete the "Sorting Out the Consequences" grid (Appendix B) in many different ways. Sometimes the answers reveal the woman's emotional state. For example, an answer such as, "The negative consequences of an abortion are that I will feel like a murderer," call for emotional support and further investigation. It is important to remain non-judgmental and non-directional. The counselor might respond to such a comment with, "Tell me more about that" or "What makes you feel that way?" The counselor should not respond by saying, "That's a crazy idea" or "Clearly abortion would be the wrong choice for you." Other answers might reveal the woman's knowledge or lack of knowledge about the options: "An abortion will be physically painful and I'm not good at coping with pain." This type of answer calls for information about options for anesthesia or pain medications that can eliminate or decrease the discomfort of the procedure. The counselor's awareness of the woman's situation and views allows the discussion to be tailored to the woman's specific needs.

A final exercise encourages the client to sort through feelings about each option and what might be influencing those feelings. Her answers might reveal misinformation she has about the options, giving the counselor an opportunity to provide accurate information. For instance, if the woman says the idea of arranging for an adoption makes her feel great sadness because she would never see her child again, providing information about open adoption might help her see adoption as a viable option. If the woman is afraid of abortion because she hates the idea of having something placed inside her uterus, information about medical abortion might ease her fear.

BEING COMFORTABLE AS AN OPTIONS COUNSELOR

Midwives and other clinicians, especially those new to options counseling, will undoubtedly feel some trepidation about helping a woman through the crisis of an unplanned pregnancy. Being self-aware and informed about abortion, adoption, and parenting will alleviate some of the anxiety. Still, it is easier to ask questions than to respond to the answers a client might give. As the client explores her values, there might be times when the counselor feels uncomfortable, even shocked or angry, and unsure how to proceed. While it is not possible to foresee every situation that might arise during the counseling session, having a supply of neutral responses will help the counselor through those times when she or he feels overwhelmed or needs a moment to think about what to say next. Table 4 offers some examples.

The responses in the table are phrased to promote the client's willingness to confide in the counselor and continue the exploratory process. In addition, clinicians new to options counseling should identify an experienced role model with whom she or he can discuss the more difficult sessions.

Ideally, the clinician is not the only person supporting a woman through the decision-making process, and she or he should help her identify others she has told about the pregnancy and can rely on for support. If the client has kept the pregnancy a secret, she probably has not yet fully explored her options. Sometimes a woman believes that if no one knows about her situation and the choice she makes, the problem of the unintended pregnancy can be minimized. She may not realize how valuable support is, or she may believe there is no one to whom she can turn. If she has confided in people, ask about their reactions. Are they supportive of her? Are they supportive of her decision? If not, how does she feel about their objections? Whom else might she turn to for support.[1]

Table 4. Options Counseling: Neutral Responses

- That is a question lots of people wonder about.
- I'm glad you asked that question.
- That's a difficult question for me to answer.
- Tell me more.
- Tell me more about what is concerning you.
- Is that what you were asking me?
- Do you want to ask me more about that?
- It is expected that you'll have mixed feelings about this.
- Some other women I have spoken with have ___. How would that work for you? What would make that difficult?

Source: Beresford T, Garrity J, 1982[13]; and Garrity J (personal communication, November 2002).

CONCLUSION

Midwives are particularly suited to provide pregnancy options counseling for women experiencing the crisis of an unintended pregnancy. This type of counseling requires a commitment to respecting autonomy, preserving dignity, and supporting women in their choices. Those midwives with very strong personal feelings about abortion, adoption, and/or parenthood will be unable to provide non-directive options counseling and should refer women seeking this service to another provider. Becoming a skilled options counselor involves exploring one's values and biases and learning accurate information about abortion, adoption, and parenting. The values clarification exercises, open-ended questions, and non-judgmental responses provided here should be useful tools for the counselor. Like any new skill, providing helpful options counseling requires practice and experience.

With accurate information and support from the counselor, a woman facing an unintended pregnancy can explore all the alternatives available to her. The counselor's goal is to support the woman in making the decision that is best for her—a decision made by examining her own values and life situations, a decision that she can feel comfortable with, both immediately and in the future.

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Values clarification regarding unintended pregnancy, adoption, and abortion

Label each statement "true" or "false" depending on your initial reaction.

___ 1. When someone has an unplanned pregnancy, continuing the pregnancy and raising the child is the responsible thing to do.
___ 2. A sixteen year old is too young to have a child.
___ 3. Anyone who is old enough to get pregnant is old enough to make her own decisions about what to do about the pregnancy.
___ 4. Abortion is an acceptable option in cases of rape or incest.
___ 5. A poor woman with no insurance or income has the same right to continue a pregnancy and parent her child as anyone else does.
___ 6. If I were involved in an unplanned pregnancy, I would be able to choose to have an abortion.
___ 7. If I were involved in an unplanned pregnancy, I would be able to choose to place the child for adoption.
___ 8. A woman who receives AFDC and already has two children should not be allowed to keep her baby if she becomes pregnant again.
___ 9. No one who really loves her baby could consider giving it away to someone else.
___10. No one who really loves children could consider an abortion.
___11. Although people should have the right to choose abortion, adoption or parenting are always better choices.
___12. It is not right for someone to parent a child if that person is not financially and emotionally stable.
___13. Parenting is a serious commitment and should happen because someone has consciously decided they are ready, not because they become pregnant accidentally.

After completing this exercise, look back over your answers. Which answers were easiest to choose? Which were the most challenging? Why? Take a moment to reflect on your answers. Are you surprised by any of the answers you gave? How do you think your beliefs might impact your ability to care for a woman who has different beliefs?

Reprinted with permission from The Abortion Access Project. Caring for the woman with an unintended pregnancy [CD-ROM]. Cambridge (MA): 2001.[21]

Values Clarification Exercises

Exercise #1: The hardest cases
It can be very difficult for some people to separate their personal feelings and beliefs about abortion from their practice of providing or referring for abortion services. Inevitably some abortion cases will touch you deeply and conjure up strong feelings of sympathy and others will make you angry or frustrated.

Before Roe v. Wade, some hospitals provided a very limited number of "special case" abortions. Hospital committees had the task of determining which cases were worthy of being granted an abortion. Pretend you are on that committee and must determine which one of the patients, all of whom are requesting an abortion, will be granted the one remaining legal abortion left in your yearly quota.

___12-year-old incest victim
___15-year-old rape victim
___22-year-old carrying a fetus with severe deformity
___24-year-old heroin addict who already has three children in state custody
___26-year-old single mother who has a young child with leukemia
___30-year-old with 2 children whose husband died recently in a car crash

What factors influenced your choice? How did it feel to have to make this choice?

Exercise #2: The last abortion
There is a wide range of circumstance under which different people believe abortion is justifiable. For many, certain are more compelling than others. This exercise is designed to help you identify what criteria are most compelling to you.

Pretend that the 6 women described below have come to you requesting a referral for abortion. Pretend that due to circumstances beyond your control, only one more abortion can be done and that you must choose which one of your 6 patients is to receive the last abortion.

___Gloria is 14, unsure about what to do. She has supportive parents.
___Louise is 19, has two children and has had two previous abortions.
___Selma is 24, a student in medical school and engaged to be married. She wants to begin her career before starting a family.
___Eileen is 29, single, and pregnant with an IUD in place.
___Margaret is 35, divorced, pregnant from a one-night encounter, her first sexual experience following her divorce.
___Dorothy is 45, married with three grown children. Neither she nor her husband wants any more children.

What guided your choice for number 1? Number 6? Was making your choices difficult or easy for you?

Exercise #3: Most uncomfortable
Rank who you would feel most uncomfortable referring for an abortion: a woman who

___is ambivalent about having an abortion but whose partner wants her to terminate the pregnancy
___wishes to obtain an abortion because she is carrying a female fetus
___has had what I consider too many previous abortions
___shows little emotion about becoming pregnant and choosing abortion
___has indicated that she does not want any birth control method to use in the future
___is nearing the end of her second trimester
___is morally opposed to abortion, but wants one for herself

Doing these exercises can be a very emotional experience. If you have not taken the time to go through them now, come back to them when you do have the time. Although doing these exercises on your own can help you gain insight about your personal values, you might also find it helpful to discuss them with colleagues.

Reprinted with permission from: Tews L, Beresford T. Obtaining abortion training: A guide for informed decision making. Washington (DC): National Abortion Federation, 1998.[22]

Resources for Women Considering Adoption

Concerned United Birth Parents. Available from: *http://www.Cubirthparents.org*

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Exercises for Women Making Reproductive Choices

1. Sorting Out the Consequences

	Abortion	**Adoption**	**Parenting**
Positive consequences of			
Short term			
Long term			
Negative consequences of			
Short term			
Long term			

Source: Baker, 1995.[1]

2. Sorting Out Her Feelings

The idea of becoming a parent makes me feel___because___.
The idea of having an abortion makes me feel___because___.
The idea of arranging for an adoption makes me feel___because___.

Source: National Abortion Federation.[20]