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COUNSELOR IDEOLOGIES AND VALUE SYSTEMS:
EFFECT ON ETHICAL PRACTICE OF PREGNANCY OPTIONS
COUNSELING

by
Betty Lincoln Leon

A Master's Research Project Submitted in Partial Fulfillment of the Requirements for the Degree Master of Arts

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COUNSELOR IDEOLOGIES AND VALUE SYSTEMS: EFFECT ON ETHICAL PRACTICE OF PREGNANCY OPTIONS COUNSELING

by

Betty Lincoln Leon

has been approved

November 1996

APPROVED:

[Signature]

[Signature]

ACCEPTED:

[Signature]

Associate Dean for Graduate Studies
ABSTRACT

Unplanned or unwanted pregnancies tend to be emotionally charged at many levels. The decisions around these pregnancies have life altering consequences for the pregnant woman, for the child she may or may not bear, for the woman's nuclear and extended family, and ultimately for all of society. These pregnancies often occur in young women with minimal decision making skills and in those with limited knowledge of available resources. These pregnant women are often nearly totally dependent upon parents or a partner; the options choice frequently needs to be made under constraints of time.

Pregnancy options counseling among this vulnerable population becomes a fertile field for potential ethical abuses. It is known that many factions outside the counseling session have concern about what goes on in that session. The focus of this project was to explore how counselors' ideologies and value systems may affect their ethical practice of pregnancy options counseling.

Seventeen sources were identified as providers of pregnancy options services. A descriptive design was chosen and a survey instrument was prepared by this researcher in consultation with Ottawa University faculty. The survey was administered in the format of semi-structured oral interviews. Basic demographic information was obtained. The survey then polled counselor participant's attitudes, beliefs, opinions in four ideological areas related to pregnancy options: (1) The role of religion, the church, (2) the role of government, politics, the law, (3) the role of the school, and, (4) the
role of the family. And finally, each participant was polled as to their perception of the role of the counselor and their actual practice of pregnancy options counseling.

Literature review and researcher's observations and experiences identified four areas where pregnant women felt they were sometimes not well served, or were harmed by counseling: (1) Inadequate information, (2) inaccurate information, (3) pressure or perception of pressure and (4) that client made a decision in conflict with her own values.

Participant responses were examined in terms of (1) How the counselors' roles and actual practice appeared to be influenced by their ideologies and (2) how this resultant practice "fared ethically" when measured in terms of provision of adequate and accurate information, protection from pressure by counselor or by outsiders, and the facilitating of a safe and encouraging environment where the client could thoroughly and consciously explore her own value system.

A relationship was found between lay/pastoral Catholic or strong Christian based counselors, (including one counselor who acknowledged being conservative politically and one whose comments suggested political conservatism), and a limiting of information, inaccurate information and/or less inclusive referrals offered. A positive relationship was found between professionally credentialed counselors or staff trained and supervised by professional counselors, and "ethical" counseling, irrespective of the counselors' personal ideological positions.
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CHAPTER 1

THE PROBLEM

Introduction

An unintended and unwanted pregnancy is an emotionally charged situation. A woman's decisions surrounding this pregnancy will have a life altering impact upon her, upon the fetus or the infant she may bear, upon her nuclear and extended family and upon society as a whole. The approach and interventions a pregnancy options counselor uses may have great and far reaching consequences.

Pregnancy options counselors will see patients or clients at a very vulnerable time in their lives. These patients or clients will often be experiencing intense emotions. They may be in denial of critical factors pertinent to their situations. Many will be experiencing adverse physical symptoms. They may be expressing great conflict or ambivalence. Counselors will be seeing women with varying levels of maturity and cognitive development. They will need to help them within a limited time-frame.

Interest and pressure from sources outside the counseling session may have significant impact upon what happens in that session. Issues around unplanned pregnancies and pregnancy options are the grist for political discussion and platform and are the content of a wide spectrum of social and socio-economic concern and policy. These issues around unplanned pregnancies provide topic for theological moral debate and religious dogma and sermon. In addition, these issues incite lay factions to a range of activist behaviors.
The overlapping and inter-relatedness of the biological, medical, moral, religious, legal, social and socio-economic aspects of pregnancy decisions, necessarily figure into the way in which pregnancy options are available and are presented to a pregnant woman. The great difficulty with which any of these factors can or should be separated from the whole counseling options process and the manner in which these factors may be explored in the decision making setting add complexity to pregnancy options counseling. The pregnancy options counseling setting may become an arena for ethical abuses. This counseling setting becomes an environment open to the potential for subverting client self-determination and for inflicting upon a pregnant woman, the value systems or biases of a counselor, religious sect, political party, organization or agency.

Development of the Problem

Today there are a number of safe and legal options for a woman facing an unplanned or unwanted pregnancy. While technological advances and judicial-legal struggles have made these options possible, at the same time there is also more vocal dissent and public controversy and greater conflictual regulation regarding a woman's personal reproductive matters.

Examination of the historical evolution of women's reproductive choices and rights traces the broad social, medical and legal trends to the point one finds them affecting pregnancy outcomes presently. "The moral and legal issues raised by the practice of abortion have tested the philosophers, theologians, and statesmen of every age since the dawn of civilization" (Rubin, 1994, p. 3).
An examination of the literature reveals changes in the provisions for the whole spectrum of women's health care which occurred with the advent of the modern medical model and with the formation and increasing power of the American Medical Association (AMA). Delineated are ways physicians enlisted state power and appealed to broad social and religious concerns to effect restriction of access to reproductive choices (Rubin, 1994). During its early years, the AMA encouraged legislation which criminalized reproductive choice. This resulted in restriction of access to abortion and to other reproductive rights, including the availability and legality of contraception and freedom to use services of lay midwives (Rubin, 1994; Sanford & Donavon, 1984).

Dr. Margaret Sanger (1938) referred to the years from the mid-nineteenth century through the early twentieth century as the dark ages of women's reproductivity. She described in case by case scenario, the results of restricted choices and options around pregnancy and childbirth. This theme was underscored by the contemporary films Motherless (Attie, Goldwater, & Pontius Productions, 1994) and When Abortion was Illegal: The Untold Stories (Bullfrog Films/Concentric Media Productions, 1992).

The years from 1960 to 1973 saw reform actions initiated out of the Women's Movement. Feminists contended that it was a woman's right to exercise control over her body, and the government had no business interfering in private decisions by women and their families (Rubin, 1994). Public opinion seemed to be changing in ways that supported change of reproductive laws (Rubin, 1994).

Battle lines were drawn and men of religion, medicine and science presented their positions in congressional subcommittee hearings and on other
reproductive rights platforms. The ethical and moral implications of contraception and abortion were laboriously debated (Rubin, 1994; Films for the Humanities and Sciences, 1994).

From 1967 through 1970, one saw numerous pieces of state legislation supportive of women's reproductive choice. The landmark Roe v. Wade decision was handed down in 1973. There was immediate religious and political challenge (Rubin, 1994) to the renewed legal choices for women.

Dr. Mary S. Calderone, medical director of an early chapter of the Planned Parenthood Federation of America, participated in a major conference on reproductive issues, edited and presented the findings. Legislation offering more legal choices to women also presented dilemmas about these choices. Out of this conference came the first mention of the importance of formal counseling:

It was recommended that counseling centers be set up for women to allow them to discuss their problems, to explore alternatives to abortion, and to determine whether they were actually pregnant. It was also determined that services should be available on a more equal basis; that there was a need for more and better information regarding abortion, sexuality, contraception, and a responsible approach to pregnancy. (Rubin, 1994, pp. 37-38)

In addition to Planned Parenthood, other institutions and individuals responded to this counseling need. Works by Reardon (1987); Dudley (1995); Blanchard (1994); Collins (1988); Hoshiko (1993); Steffan (1994); Macklin (1993) and Baker, (1994) offered input into the pregnancy options dilemma and implications related to the helping process. Through presentations of case studies and through commentary on various aspects of the problem pregnancy dilemma, these individuals offered diverse viewpoints and hinted at the spectrum pregnancy options counseling concerns.
Need for the study

"Currently, half the pregnancies to American women are unintended" (Harvey, Beckman, Castle and Coeytaux, 1995 p. 205). In America, each year one million teenagers become pregnant and 85% of these pregnancies are unintended (Dudley, 1995). This represents a staggering number of women, often very young women, who must make choices which will determine the outcome of their unplanned pregnancies.

In 1992, in Arizona, 14,353 total legal abortions were reported to the Center for Disease Control (CDC); or 17 per 1,000 women 15-44 years of age. Of these, 2,692 were obtained by teenagers; 94 by teenagers younger than 15 years of age. Almost fifteen (14.6) out of every 100 pregnancies in Arizona in 1993 were reported to end in abortion (Center for Disease Control and Prevention, 1996). The Arizona Department of Health Services received 13, 648 reports of abortions performed in Arizona for the calendar year of 1993 (Arizona Department of Health Services, 1994). These figures translate into many cases where women may be helped or harmed by counseling related to the abortion option.

During a personal interview, adoption agency counselor, Shirley Pusey (April, 1996) reported that fewer infants are being placed with adoptive families. She cited changing societal attitudes toward unwed mothers, increased reliance on social programs, and more liberal abortion laws as responsible for adoption trends in recent years. Women seeking counseling with her agency, she believed, have already chosen adoption as their option.

Large numbers of single teenage women in Arizona are deciding to carry pregnancies to term and to keep and raise their infants. Numerous articles
offer insight into some realities and consequences of teen parenting. Wagner and Mueller, The Department of Health Services and state legislator, Ruth Solomon enumerate some of the particular concerns and needs this option presents.

Steinberg (1989) examined the role of counseling for woman with an unintended pregnancy, and particularly those who may choose abortion. Steinberg's in depth study offered several important conclusions: (1) Counseling helps to identify at risk patients, especially, those at risk for post-abortion trauma, (2) biased counseling or inadequate or inaccurate counseling harms women and, that (3) the health profession inadequately fulfills women's needs for this type of counseling (Steinberg, 1989). Steinberg elaborates that "unbiased counseling means the counselor recognizes differences among women and provides information and emotional support on an individual basis, without advocating a particular moral view of abortion. Biased counseling means that a counselor favors one position over another and may counsel from that favored position" (1989, p. 482).

Reardon (1987) related, with individual case studies, significant consequences of counseling biases upon women who chose to terminate their pregnancies. He includes in discussion, the vulnerable states of the clients and the particular missions or agendas those women's counselors seemed to support.

Former United States Surgeon General, C. Everet Koop described the divergent psychological and emotional results of pregnancy options choices, and acknowledged the helping professionals' impact upon these choices (Steinberg, 1989). Koop listed "helping professionals" as family physicians, psychiatrists, clinical psychologists, marriage and family therapists, social
workers, pastoral counselors and the clergy. Other helpers include nurses, teachers, school counselors, genetic counselors and various trained or untrained lay counselors (Lindsay, 1989; Malloy & Patterson, 1992; Films for the Humanities and Sciences, 1994).

These "helping individuals" represent various academic or religious backgrounds. They hold diverse credentials or may have no credentials; thus, they logically operate under differing ethical codes of behavior or are bound by no professional ethical codes. Additionally, one may assume that these helpers, because of the way they grew up and were socialized, because of the ways they were educated, and because of their agency or organizational affiliations, may hold and profess differing fundamental beliefs and value systems pertaining to women's reproductive health choices.

Meara, Schmidt and Davis express concern related to the understanding of patients rights with respect to the "pluralism of the culture" (1996, p. 4). They note that a serious mistrust of professionals has escalated; that there seems to be a large void in formal conversations regarding ethics which includes a need to "improve research and instruction of professional ethics and result in a code and practices that are more cognizant of cultural pluralism and thus more inclusive and appropriate for the public served by psychology" (Meara, Schmidt and Davis, 1996, p. 5).

A structured examination of how counselor ideologies or values can affect pregnancy options counseling is necessary because of the emotionally laden topic and because of the diverse backgrounds of the counseling providers. Potential exists for these factors to compromise a uniform, ethical pregnancy options counseling product.
Purpose of the Study

The purpose of this study is to describe how counselor's ideologies and value systems affect ethical practice in pregnancy options counseling. The results will endeavor to be a basis of resource materials helpful to persons who offer pregnancy options counseling or who refer clients or patients for this service.

Research Question

How do a counselor's ideologies and value system affect the ethics of their practice in pregnancy options counseling?

Definition of Terms

Abortion: Removal of the fetus from the uterus before it is mature enough to live on its own. When this happens spontaneously it is called a miscarriage. Induced abortion is brought about deliberately by a medical procedure (Dudley, 1995)

Abortion Trauma Syndrome: A set of adverse psychological symptoms women often experience following an abortion (Reardon, 1989). Other sources dispute the occurrence or frequency of these symptoms (Baker, 1995).

Clergyman's Consultation Service on Problem Pregnancies: A pro-choice group established in 1967 (Blanchard, 1994).
D & E: (Dilation and evacuation) An abortion performed after week 14-15, where larger opening of the cervix is required; may be completed over two days (Dudley, 1995).

D & X: (Dilation and extraction) A controversial late term abortion procedure, performed rarely, only in cases of severe fetal indications, or when life of pregnant woman is in jeopardy (Baker, 1995).

Embryo: The developing human organism, until the eighth week of gestation (PPFA, 1995).

Fetus: The developing human organism after the eighth week of gestation, until time of birth (PPFA, 1995).


Informed Consent: Details about a procedure and its risks, provided before an individual signs consent for said procedure; According to PPFA language preferences, is not to include information authored as propaganda to frighten women (PPFA, 1995).

NRRC: National Right to Life Committee; an anti-choice organization (Rubin, 1994).

Operation Rescue: An anti-choice activist organization (Rubin, 1994).

PLAN: Pro-Life Action Network, an activist group (Blanchard, 1994).

PPFA: Planned Parenthood Federation of America, is successor to Margaret Sanger's Birth Control League of America (Blanchard, 1994).

Pro-Choice: Supporting multiple legal reproductive choices for women, not to be used interchangeably with pro-abortion (PPFA, 1995).

Pro-Life: Associated with an anti-abortion position; does not accept abortion as a pregnancy option for women in most circumstances (PPFA, 1995).

Quickening: The first perception by the pregnant woman, of fetal movement in the womb (Rubin, 1994).

Religious Coalition for Abortion Rights: An interdenominational pro-choice organization (Blanchard, 1994).

Sentience: Condition or capacity for sensation or feeling (Webster's, 1989).
Vacuum Aspiration: First trimester abortion procedure; term suction curettage may be used, almost synonomously (Dudley, 1995).

Viability: The point at which a fetus can survive outside the womb (Rubin, 1994).

WEBA: Women Exploited by Abortion, strong religious, anti-abortion group (Reardon, 1987).
CHAPTER 2
LITERATURE REVIEW

Introduction

The decision making process and the counseling implications around unintended and unwanted pregnancies are complex. This literature review has attempted to explore and share information about four aspects of this topic:

The first section offers an overview of the historical evolution of women's reproductive choices. It includes comment on the philosophical, religious, medical and socio-legal positions as they changed through history and allowed or restricted lawful access to the whole range of safe, medically appropriate health care options for pregnant women.

The second section enumerates women's pregnancy options, as they are legally available at this time. This section defines each of the choices and offers information pertinent to each of these options.

The third section describes the kinds of helpers who may provide pregnancy options counseling. One will see that these "helping individuals" represent different training backgrounds and hold varying credentials. Thus, they may logically operate under differing ethical codes of behavior or are bound by no professional ethical codes. Additionally, this section will demonstrate how these helpers, because of the way the helpers grew up, were socialized, educated and religiously shaped, may hold differing fundamental values. Ways in which individual counselors may vary in their presentation of
options and in the referrals they offer clients because of these value or ideological differences are discussed.

The final section focuses on literature pertinent to religion, politics and morality as they impact the ethics of problem pregnancy counseling. It offers definition of ethics, in general terms; then explores how the political, religious and moral ideologies may more specifically affect ethics in the pregnancy options counseling setting.

Historical Evolution of Women's Reproductive Rights

The Stoics' belief that abortion should be allowed up to the moment of birth was vigorously opposed by the Pathoreans who believed that the soul was infused into the body at the time of conception and that to abort a fetus would be to commit murder. Early Roman law was silent about abortion. Apparently, both abortion and infanticide were common in Rome (Rubin, 1994).

Opposition by scholars and the growing influence of Christianity brought about the first prohibitions against abortion and ascribed criminality and punishments to women and the abortion providers who violated the provisions (Rubin, 1994). "During the European Middle Ages, major church theologians differentiated between an embryo informatus (prior to endowment of a soul) and embryo formatus (after endowment of a soul)" (Rubin, 1994, p. 4).

English common law adopted the doctrine of "quickening," i.e., the first time fetal movement is discerned in the mother's womb, to pinpoint the time when abortion would incur sanctions. It is not, however, described how this was determined or validated by the legal authorities who imposed the sanctions. In the United States, until the mid-nineteenth century, this pre-
existing English common law was followed and adopted as statute by most states, according sources in the U.S. Library of Congress, Congressional Research Service on Abortion, Judicial and Legislative Control (Rubin, 1994). By the time of the Civil War, an influential anti-abortion movement began to affect legislation by inducing states to add or revise statutes in order to prohibit abortion in all stages of gestation (Rubin, 1994). Other aspects of women's reproductive health care were also being challenged and restricted:

Only relatively late in history did men take over health care, and they did so by the establishing of medicine as a profession from which women were entirely excluded. While the female lay healer operated within a network of sharing and mutual support, the male medical profession hoarded up his knowledge as a kind of property, to be dispensed to wealthy patrons or sold on the market as a commodity. His goal was not to spread the skills of healing, but to concentrate them within the elite interest group which the profession had come to represent. The triumph of the male medical profession involved the destruction of women's networks of mutual help--leaving women in a position of isolation and dependency. (Sanford and Donovan, 1984, p. 246)

Between 1850 and 1880 the newly formed American Medical Association, through some of its vigorously active members, became the single most important factor in altering the legal policies toward abortion in this country. "Nineteenth century regular physicians enlisted state power to limit access to abortion for reasons that are in retrospect, parochial" (Rubin, 1994, p. 13). The doctors found an audience for their effort to restrict abortion because they appealed to broader concerns of maternal health, consumer protection, and nativist fears generated by the fact that elite Protestant women often sought abortions (Rubin, 1994). Concerns over the dangers of surgical or other induced abortions were well founded, but physicians persuaded male
political leaders that "abortion constituted a threat to the social order and to male authority. . . Since the 1840's, a growing movement for women's suffrage and equality had generated fears that women were departing from their purely maternal role" (Rubin, 1994, p. 16). These fears were fueled by the fact that family size declined sharply in the nineteenth century. Opposition to abortion and to birth control were closely linked.

During these years the AMA sought to restrict access to abortion and other reproductive choices by pushing more and more for legislation which criminalized reproductive choices. In 1871 the AMA's Committee on Criminal Abortion described the woman who sought abortion:

She becomes unmindful of the course marked out for her by Providence; she overlooks the duties imposed on her by the marriage contract. She yields to the pleasure--but shrinks from the pains and responsibility of maternity; and destitute of all delicacy and refinements, resigns herself, body and soul, into the hands of unscrupulous and wicked men. Let not the husband of such a wife flatter himself that he possesses her affection. Nor can she ever merit even the respect of a virtuous husband. She sinks into old age like a withered tree, stripped of its foliage; with the stain of blood upon her soul, she dies without the hand of affection to smooth her pillow. (Rubin, 1994, p. 16)

In response to the feminist demand for control of reproduction, the Federal government, in 1873 (Rubin, 1994) countered by enacting legislation which banned access to information about both contraception and abortion. The Comstock law, which was "an act for the suppression of trade in and circulation of obscene literature and articles of immoral use" (Rubin, 1994, p. 28) restricted not only medical information on abortion such as medical and physiology texts, but also literary depictions and moral literature.
In 1876 federal courts struck down the rights of physicians to be allowed to distribute contraceptive information. The core purposes of some of the new legislation seemed to be to enforce chastity on the young and unmarried and to preserve the subserviant position of women within a traditional family structure. The nineteenth-century restrictions on contraception and abortion can "only sensibly be understood as a reaction to the uncertainties generated by large shifts in family functions and anxieties generated by women's challenges to their historic roles of silence and subservience" (Rubin, 1994, p. 17).

The complexity and intensity of emotion around the issue of women's right to bear—or not to bear a child has been described in an almost limitles number of sources. Mary B. Mahowald (cited in Howell and Sale, 1995) presents that laws often have a settling as well as regulative influence on individuals; but notes that rather than quelling the heat of public debate about abortion, more permissive legislation has escalated the long debate. "I cannot honestly align myself with either pro-choice or pro-life activists. Either side betrays, to me, the enormous complexity of the issue" (Howell and Sale, 1995, p. 97).

Christine Northrup (1994), physician, mother and writer offers:

I performed abortions for years, and I will always be a proponent of reproductive choice for women. But I've come to see along the way how complex the issue of abortion is, and I've learned there are no easy answers. . . Abortion is always a loaded topic because it forces each woman to face her deepest feelings about men's ability to impregnate women and women's power to either retain or reject the result of his impregnation. Abortion hits at the heart of our society's beliefs about the role of women. Abortion exemplifies political control of the personal and the physiological. . . It thus bridges the intensely individual and the
broadly political. On every level, to talk of abortion is to speak of power. (Northrup, 1994, pp. 326-327).

Authors of *Women and Self-Esteem* cite an example of contemporary opinion, which, rather than expressing the complexity of women's reproductive health choices, appears narrow and misogynistic by almost any standards. This report found in a physician's professional journal, was published just three years prior to the landmark Roe v. Wade decision:

Writing in the September 1970 issue of the *Journal of Obstetrics and Gynecology*, Dr. George S. Walter, Maternal and Child Health Consultant to the Indian Health Service in Fort Defiance, Arizona, explained his reasons for being opposed to abortion rights as follows: "The pregnant woman symbolizes proof of male potency and if the male loosens his rule over women and grants them the right to dispose of that proof when they want to, the men then feel terribly threatened lest women can, at will rob them of their potency and masculinity. (Sanford and Donovan, pp. 250-251)

Dr. Walter goes on to elaborate that professional insistence upon sterilization as part of the package deal with abortion would be one way physicians could maintain control (Sanford and Donovan, 1984).

The social implications of birth control and reproductive decisions were throughout history, and continue to be at the forefront in many minds. In addition to woman's place and role with her partner and in her family, race and ethnicity population figures have continuously been translated into fear and concerns of power and of economics (Rubin, 1994).

A dated chronology of important events and legislation related to the topic of women's reproductive choices is offered in Rubin's work (1994). It
allows one to see the evolution of attitude and action resulting in the pregnancy options a woman is currently legally permitted.

**Pregnancy Options: Overview**

When a woman finds herself facing the situation of being pregnant and that pregnancy is unplanned, unintended, or unwanted, she has several choices legally available to her. The appropriateness of each of these may be explored by the pregnant woman alone, with her partner, with other family members or close associates, or in a counseling setting.

She may choose to carry the pregnancy to term give birth and keep and parent the infant; she may carry the pregnancy to term, give birth and arrange to place the infant with adoptive parents; or she may choose to terminate the pregnancy. Descriptions of each option, its potential meaning to the pregnant woman and the counseling implications of each option follow:

**Carry Pregnancy to Term, Give Birth and Parent:**

**Incidence of this option.** In Arizona in 1994, there were 67 pregnancies per 1,000 girls age 15 to 17; 4,300 births to girls 17 years of age and younger were reported (Wagner, Mueller & Arizona Department of Health Services, 1995). In 1995, the annual Kids Count Report conducted by the Annie E. Casey Foundation, offers figures which show that Arizona leads the nation in numbers (proportionate to population) of teens ages 15 to 19 giving birth (Wagner, Mueller and Arizona Department of Health Services, 1995).

Since 1987, information provided by the CDC (1996, p. 1) shows a trend of a declining abortion to live birth ratio; with the 1992 statistics revealing the lowest recorded since 1977. More women are opting to carry to term rather
than choosing abortion, according to the CDC Surveillance Summary of May 3, 1996.

According to Shirley Pusey, (1996) very few of these young women who carry pregnancies to term are placing their infants with adoptive families; most choose to parent, alone or with extended family. The American Journal of Public Health (Sells and Blum, 1996) reports that of the 1,043,600 adolescent females in the United States who became pregnant in 1989, nearly half gave birth, and that with the decreased stigmatization of childbearing among unmarried mothers, very few made adoption plans. Most chose to parent. Wagner and Mueller's report (1995) substantiates this trend in Arizona. Karen Liptak, of Tucson, Arizona, notes that tendency to keep an unplanned baby is especially prevalent among younger girls and among girls without goals; without anything to look forward to (Liptak, 1993).

Adoption experts say that those who relinquish for adoption are generally older teens who are better able to separate themselves from their child and make the difficult decision about what is in the child's best interest... Girls twelve to fourteen tend to be very concrete in their thinking. Because they are not ready to think in the abstract, they can't remove themselves from the situation and examine what is best for them and for the potential life growing inside them.... It's a developmental issue.... you can't teach that thought process. (Liptak, 1993, p. 19)

Consequences of young, single parenting. Arizona State Senator, Ruth Solomon, an advocate of responsible parenting, offers insight into some of the most negative outcomes of early, unplanned parenting. The senator enumerated concerns that:

1. The pattern for a young poor woman who becomes pregnant and gives birth is predictable: She fares badly; her children and society pay the costs;
2. she is likely to have a second child within two years;
3. she is unlikely to finish high school;
4. she is unlikely to marry;
5. she is at great risk for cycling in and out of the welfare system; and
6. her children will share her poverty and will grow up at greater risk for
drug and alcohol abuse, mental illness, poor educational performance and
criminality (Solomon, 1995).

Schmidt, in the *New York Law Review* (1993), acknowledged the above-
mentioned problems, as well as presenting physical problems seen more
frequently in women who bear children at seventeen or younger. Their
children are more likely to be born prematurely, have low birth weights, and
suffer subsequent higher infant mortality rates, more childhood illnesses, more
neurological defects and have lower IQ scores.

Bender and Leone (1995) reiterated some of these above mentioned
concerns and introduced other concerns when they cite Marvin Olasky.
Olasky strongly challenged the feminist viewpoint which supports single
parenting or abortion as a woman chooses. The feminist views of non-
restrictive reproductive choices are also aggressively challenged by
Kopaczynski (1995), in *No Higher Court: Contemporary Feminism and the
Right to Abortion*, as this author takes on the reasoning of Simone De
Beauvoir, Mary Daly, Carol Gilligan, and Beverly Wildung Harrison.

Dudley (1995) of the National Abortion Federation, supports choice but
expresses concern that the young woman will have a greater tendency to
receive poor prenatal care, develop health problems, and in the event that she
does marry, will have her marriage(s) end in divorce.
Recent Arizona legislation impacting young single parents. On December 1, 1995 (Wagner and Muller, 1995) Arizona implemented new welfare regulations: Teen parents, in order to receive cash from Aid to Families with Dependent Children must (1) live with parent, adult relative or legal guardian, and that adult's income will be considered in application, (2) may receive exemption if adult cannot be found, is dead, or is neglectful or abusive and (3) will remain eligible for medical care and the state's job program. The new rules also state: No additional cash will be provided for additional children. (4) Adults can receive cash for only 24 months over five years. (5) Medical and child care will be extended from 12 to 24 months after cash payments stop. (6) Adults may save up to $9,000 for education and training, and it will not count against their benefits.

No laws were found restricting a woman from parenting at any age. In Arizona, parental consent is required for marriage of individuals under the age of majority, 18 (Alan Guttmacher Institute, 1995). No laws were found permitting or restricting prenatal care without consent for a woman under the age of majority (Alan Guttmacher Institute, 1995).

Exploring this option in counseling. Reality Therapy may be useful in working with young pregnant clients who are considering carrying to term and are ambivalent with their choices (Lindsay, 1989). Pregnancy options counseling most often consists of only one or two sessions. Glasser's model of Reality Therapy may lend itself to this setting (Corey, 1991). Precepts which focus on responsibility and consequences, on examining current behaviors (in pregnancy options, behavior would be the option choice) and how this behavior (choice) would or would not fit their present picture, what they want
now, and then expand to explore directions they would like to take their lives (and that of their child) in the future (Corey, 1991).

A solution focused, brief approach is advocated at Planned Parenthood of Central and Northern Arizona, according to Joseph Feldman, during personal interview and training sessions (1995 and 1996).

Baker, in her comprehensive text on pregnancy options counseling (1995) presented a series of questions, which are helpful reality checks if a client is unsure whether she will be able to raise a child on her own, or if a teenager assumes parenthood will be "a piece of cake" (p. 37). "Let her know parenthood can work out when pregnancy occurs at a time that is not ideal as long as she finds workable solutions to the following questions" (Baker, 1995, p. 37).

1. Do you have a place to live before and after the baby is born? If you are planning to live with someone else, have you asked them and received a definite answer?

2. If you plan to live on your own, have you priced rent and utilities? Have you found an affordable apartment yet? Do you need to set time aside to start searching?

3. How will the doctor, prenatal, hospital and pediatrician bills be paid? Have you found out how much they will be?

4. Do you have medical insurance? Are you eligible for any government assistance? Have you contacted (AHCCCS in Arizona) to check on your eligibility?

5. If you already know how much aid you will receive, have you added up your expenses to find out in this amount will cover everything?

6. If your expenses are more than aid you will receive, how will you cover the remaining expenses? Have you asked your parents how much they are willing to provide for you and the child?
7. Do you or your partner have a job? How much does it pay? Will this amount cover rent utilities, food, transportation, clothing, laundry, babysitter, doctor, and other bare essentials for you, him, and the child? Will you or your partner need to take a second job? Will you need to continue working after the baby is born?

8. Do you know someone who will give or lend you baby clothes, maternity clothes, crib, car seat? Have you priced these items?

9. Do you have a baby-sitter to care for the child while you work or go to school? Have you asked them and have you received an answer? How much will they charge?

10. Do you want to continue your education? How will you accomplish this? Will you need to work as well as attend classes? Have you planned a schedule to see how this can work?

11. If you plan to attend college, who will pay?

12. How much time do you want to spend with your child? What will your schedule be like, including weekends? Will it be OK if you do not have time for going out with your friends? What kinds of recreation and fun do you not want to give up? How can you schedule some of this after the baby is born?

13. How will having the baby affect your family? Your relationship with each one?

14. If there is bitter conflict between you and your family, are you willing to live with it? What is the probability of reconciling the differences?

15. If your parents want you to have an abortion, and you want to keep the baby, could you ask them, your boyfriend, and his parents to come together for a family conference? Counseling?

16. Will your decision to parent a child come the closest to what you want in your life at this time over all the other alternatives? (Baker, 1995, p. 37)
Information for the client who will carry to term and parent. This should include at least referrals for prenatal care. There are many physicians and clinics providing pre-natal care and obstetrical services. Three agencies specializing in the needs of young pregnant patients from PPCNA referral list (1996) are Baby Arizona, Pre-Natal Care Access and Teen Pre-Natal Express. A client should also contact Arizona State DES Division of Benefits and Medical Eligibility, WIC and Maricopa County Community Services and Public Health Agency. These agencies can provide information about services and funding available, about self-care and healthy pre-natal lifestyle. Specifics can be provided about nutrition, abstinence from alcohol and from any drugs unsafe or unapproved for use in pre-natal women. If a client has not completed high school, or in some cases, middle-school, she may be referred to her school nurse or counselor to discuss how she may be accommodated to meet her educational needs best while pregnant.

As the option to carry to term and parent is considered, the counseling process may include identifying and clarifying values and priorities and beliefs. It may include helping her to define her available resources and support systems and evaluating her capacity to seek out others (Baker, 1995).

It is sometimes helpful to reframe the consequences of each alternative "in terms of life losses and life gains" (Baker, 1995, p. 36). "What would you stand to lose in your life if you carried to term" "What would you gain" "How would carrying to term benefit your life" (p. 36)? If she already has a child or children, Baker suggests including questions of their welfare in the gain and loss questions (1995, p. 36).

The pregnancy options counseling text by Baker (1995, p. 38) emphasizes that counselors provide comprehensive factual information about this option,
as well as the others. Client's fear of the unknown may appear as indecision and the more facts she has on which to base her decision, the greater the potential for a sound decision (Baker, 1995). This source also encourages a client to explore how her decision may affect others; and, likewise, how significant others may be influencing her decision. The teenager who lives with her parents and depends upon them for survival will probably be in greater quandary than the woman who no longer needs her parents for survival (Baker, 1995).

Although it is important to let client know she does not need to make her decision immediately, if the pregnant woman is considering the possibility of terminating the pregnancy, she needs to be made aware of time frames within which she may make that decision. Date of last menstrual period, physical examination by physician or nurse practitioner, or sonogram for greater accuracy will be necessary (Baker, 1995).

Option to Carry Pregnancy to Term, Give Birth and Place for Adoption

Historical background of adoption.

Practiced throughout recorded history, only recently has adoption come to be seen as a distinct benefit to children. Ancient Romans, for example, practiced adoption primarily as a way to provide heirs for adults. Much later, in colonial America, illegitimate children were apprenticed to tradesmen, essentially a form of indentured servitude. Indentured and apprenticed children were often cared for by orphanages supported by their masters. Common law at the time, as cited by judges and courts, deemed blood ties necessary for parentage. (Bender & Leone, 1995, p. 12)

According to Bender and Leone (1995), it was not until the late nineteenth century that legislative bodies in the United States began to grant
legal status to parents of adoptive children. In 1891, Michigan law required that judges investigate adoptive placements before granting final decrees. In 1917, Minnesota was the first state to require that agencies or state welfare departments make formal recommendations to the court after investigations. The Minnesota legislation of 1917 was also the first to mandate closed records in adoption (Lindsay and Monserrat, 1989). By about 1925, adoption was formalized as an institution, granting rights and protection to adoptive children and their families (Bender and Leone, 1995). It seems in the early years of legal adoption, less attention was paid to the needs and concerns of the birth mother and birth family.

Incidence of adoption choice. Forty years ago, approximately eighty percent of pregnant, unmarried Caucasian teenagers placed their infants for adoption; in 1989 that number had dropped to less than five percent (Lindsay and Monserrat, 1989). More recent statistics have seen that percentage drop even lower, to between 1% and 2% (Liptak, 1993). According to these sources, incidence of young birth mothers placing their infants for adoption are less for African-American and Hispanic women.

Which pregnant women choose adoption option? Younger teens tend to consider adoption less frequently than somewhat older teens (Lindsay and Monserrat, 1989). Lindsay and Monserat (1989) cite the developmental issues of concrete thinking with thinking being more present than future oriented, cognitive immaturity and lack of experience as playing roles in the infrequency of this choice by younger teens.

Adoption experts say "Those who relinquish for adoption are generally older teens who are better able to separate themselves from their child and make the difficult but realistic decision about what is in that child's best
interest" (Liptak, 1993, p. 19). The Journal of the American Medical Association Council on Judicial and Ethical Affairs (1993) disputes this, citing a study of minors who considered abortion, where researchers found "no age-related differences for the three measures of cognitive competence studied (thoroughness of consideration of consequences, number of reasons considered, and content of reasoning about the pregnancy)" (p. 83).

Mary Griffin-Carlson and Kathleen Mackin, (1993), presented studies by Olson (1980) and Eisen, Zellman, Teibowitz, Chow and Evans (1983) which support the power of modeling as a significant influence upon the choices young pregnant women make. They note that individuals are more likely to follow a course of action taken by others they know. Fewer women are modeling the adoption choice.

Among teens who reported strongly disagreeing with abortion, yet opting to abort rather than carry to term and parent or place infant for adoption, the discrepancy was attributed to the influence of the adolescent's mother or the prospective father, favoring abortion over the other options (Griffin-Carlson and Mackin, 1993).

**Adoption defined.** Adoption very simply defined is the legal process by which parental rights are transferred from a child's birth parent(s) to his or her adoptive parent(s). This may be either a closed adoption, in which birth parents have no contact or ongoing communication, and few facts about them are exchanged. There may be the provision of non-identifying information, or general facts about birth parents, but not including their names and addresses. Although less common now, sealed records include documents and files about an adoption that are restricted by law or policy from being seen by the public.
An open adoption is that in which the birth parents and adoptive families have some degree of contact and/or ongoing communication. The adoptive triad (Liptak, 1993) consists of (1) the adoptee, (2) the birth parent(s), and (3) the adoptive parent(s). Liptak (1993) stresses attentiveness to the needs and concerns of each of the parties in the adoptive triad.

**Agency versus independent adoptions.** People interested in adoptions, prospective birth parents or prospective adoptive parents have several options. They may consider an independent adoption, done through a private attorney. The American Academy of Adoption Attorneys is a resource for attorneys who specialize in this service. Public sources, locally, for information and to begin the process include the Juvenile Division of the Maricopa County Attorney's Office and the Department of Economic Security. Numerous private, competent and certified adoption agencies are available in Arizona. Two agencies generous in sharing information about their services for this project were Adoption Care Center, of Mesa Arizona and Family Services Agency, located in central Phoenix. The National Adoption Information Clearing house (NAIC), at 301-231-6512, provides free fact sheets on adoption issues, as well as national listings of adoption agencies, crisis pregnancy centers, counseling agencies and other adoption related services (Liptak, 1993).

There is controversy and no consensus regarding whether independent (attorney) adoptions or agency adoptions are better. "According to the National Committee for Adoption, about half of the healthy infants in the United States are now placed independently" (Liptak, 1993, p. 43). Some believe birth parents are able to have more control and may have more input into the adoptive parent selection when they choose independent adoption
(Liptak, 1993). Janet Dawes of the Arizona Children's Home feels the agency approach is best because the birth mother's interest is better represented (Liptak, 1993). Multiple sources indicate both of these positions may be true; that services and benefits to each in the adoptive triad will vary from agency to agency and from attorney to attorney (Liptak, 1993; Lindsay and Monserratt; 1989; Lindsay, 1989; Gagnier, 1996; Bender and Leone, 1995).

**Arizona state legal position.** Arizona age of majority is 18. The birth mother of minor age may consent to adoption; consent is also required of the birth father (Alan Guttmacher Institute, 1995). Other states, variously, require parents of birth parents below age of majority to be involved in the consent. Some states have no laws related to minors consenting to adoption of their children (Alan Guttmacher Institute, 1995). Arizona has no laws allowing or restricting women of minor age to receive prenatal care.

**Counseling issues and the adoption option.** "The decision to carry a pregnancy to term and then place the baby for adoption requires a tremendous amount of thought and courage" (Lindsay and Monserratt, 1989, p. 50). The dynamics of peer pressure, modeling by other teens and need of adolescents to fit in figures significantly into the young pregnant woman's decision making process. The teen's cognitive immaturity, difficulty thinking and planning at an abstract level and "fantasy" ideas of parenting make consideration of the adoption choice very complex (Lindsay and Monserratt, 1989).

It is emphasized that when the adoption option is considered, perhaps more so than with the other options, it is very important that the counseling process be ongoing and not just a brief, solution focused event (Gagnier, 1996). It is further recommended by these sources that it is helpful and
compassionate to bring into counseling birth grandparents and others individuals close to the birth parent(s).

Because agencies, policies, practices and philosophies differ greatly, it is appropriate to suggest that a patient/client leaning toward adoption check out a number of individuals and agencies to ascertain which she feels would best meet her needs. If she opts to place for adoption, the pregnant woman will need help and support deciding which type of adoption, i.e., open or closed would be best for her. If she wishes to be actively involved in the selection of adoptive parents, an open process will be necessary. She will need help through the myriad of legal, technical and financial details.

The same prenatal care and general healthy lifestyle details will need to be attended to, with special sensitivity for the woman who is placing her child for adoption. The events around delivery and relinquishment need to be planned carefully. The emotional needs may be greater with this option than others.

Lindsay and Monserrat (1989) stress importance of the personal locus of control for the young woman, and help to enact this with such language preferences as "I am making an adoption plan for my baby" versus "I'm giving up my baby." They also stress her legal rights, including the right to change her decision, until final documents are signed.

All sources spoke of the need to prepare and deal with the loss and grief issues, which are significant and often long-term. Emphasized was the importance to begin early in this process and to have a plan for ongoing support and grief work.
Lindsay and Monserrat (1989) offered sample questionnaire and guidelines for individual support and for support groups for teens considering the adoption option.

**Option to Terminate the Pregnancy: Abortion**

Although technically simple and quite safe, medically, this option elicits greater emotion and more rhetoric than any other. Schmidt (1993) introduces issues contributing to the complexity and offers a broad plea:

If it is a question of the law, protect (the legal right to choose). If it is a question of financing, protect the poorest of women as well as the rich. If it is a question of procedure and medical facility, protect us in safe medical places with fully trained personnel who care for women's lives. If it is a question of morality, protect each of us to answer to our own God and religion of our choice. If it is a question of age, protect the young as well as the adult. If it is a question of illness or violence, protect the victim who must live the rest of her life based on her decision. (p. 597)

**Incidence of abortion choice.** The *Mortality and Morbidity Weekly Report* (Center for Disease Control, 1996) presents statistics from abortion data compiled from 1980 through 1992. The surveillance survey indicates since 1980, the number and rate of abortions have remained relatively stable, with year to year fluctuations of $\leq 5\%$. However, since 1987, the abortion-to-live birth ratio has declined; in 1992, the abortion ratio was the lowest recorded since 1977. More pregnant women have been opting to carry to term rather than choosing to have an abortion. 76% of women opting for abortion were unmarried; a ratio nine times greater than for married women (CDC, 1996). Other sources report that even a greater number (82%) of patients choosing abortion are unmarried (Adler et al., 1992, p. 1196). Abortion rates
are higher among women 18-19 years of age; 12% are minors, aged 17 or younger.

In 1992, 1,359,145 legal abortions were reported to the CDC, representing a 2.1% decline from the number reported in 1991 (nationally). In Arizona, in 1992, 14,353 abortions were reported (AZ Department of Health Services, 1994).

Approximately 51% of abortions were obtained at \(\leq 8\) weeks gestation, and about 87% were obtained at \(\leq 13\) weeks gestation. Few abortions were performed after 15 weeks of gestation; 4% were obtained at 16-20 weeks. 1.5% were obtained at \(\geq 21\) weeks (CDC, 1996).

**Types of abortion procedures.** Abortions may be differentiated by type of procedure, with type performed most often dictated by gestational age, and of course within medical policy and legal statute. Types of procedures enumerated in MMWR Surveillance Summaries (CDC, 1996) include suction curettage, sharp curettage, intrauterine saline instillation, intrauterine prostaglandin instillation, hysterotomy/hysterectomy, other and unknown.

Vacuum aspiration, or suction curettage is the usual procedure to end a pregnancy of up to 14 menstrual weeks (approximately 12 gestational weeks) (Planned Parenthood of Central and Northern Arizona, 1993). After counseling, screening and all appropriate preliminary activities, a local anesthetic is usually injected into or around the cervix. The opening of the cervix is then gradually enlarged with a series of dilators; alternatively, the dilating process may be begun with osmotic dilators called laminaria, inserted the day before the procedure. When adequate cervical dilation is achieved, the doctor inserts a small tube (cannula or vacurette), which is attached to a suction machine and the contents of the uterus are removed. After the uterus
has been emptied, a spoon-shaped instrument (curette) may be used to
determine that the uterus has been emptied completely. The patient is escorted
to the recovery area, where she is observed, provided with refreshments, and
follow-up materials. (Planned Parenthood of Central and Northern Arizona,
1993)

With pregnancies at 14 gestational weeks or beyond, within the second
trimester, dilation and evacuation (D & E) procedure is most commonly used
(Baker, 1995). This is a two-step process which includes the insertion of
osmotic dilators the day prior to the final procedure. The patient will go home
after insertion. There is possibility that miscarriage, with potentiality for
hemorrhage may occur overnight, if dilation happens faster than usual. The
patient returns the following day and the procedure is completed. She will
usually have an intravenous line inserted, and will generally have pain
medications and muscle relaxants (which will vary from physician to
physician and clinic to clinic, and with gestational weeks). Local anesthesia
will be to cervix, and the uterus will then be evacuated by a combination of
vacuum aspiration and forceps. In recovery, her I.V. fluids, vital signs and
bleeding will be monitored and follow-up instructions will be reviewed.
(Baker, 1995)

Instillation procedures with saline and prostaglandins are generally not
used unless the patient is past 19 gestational weeks (Baker, 1995). The
abortion, induced secondary to the instillation of saline solutions and a
medication, are very rarely done at this time. According to statistics of
incidence provided by the CDC (1996) none of this type were done in Arizona
during the last years for which they had analyzed records. Later abortions are
often done for "fetal indications" or "abnormalities not detectable until the
fifth or sixth month" (Baker, 1995, p. 131). These situations would be indications for this type of abortion procedure.

Hysterotomy and hysterectomy are terms which refer, respectively to a surgical opening of the uterus (hysterotomy) and to the removal of the uterus (hysterectomy). There were no reported incidents of this abortion procedure done in Arizona for last available statistics; 45 were reported nationwide (CDC, 1996). Little information is available about these radical procedures; one must assume they would be performed only secondary to severe maternal or fetal indications. Grimes and Cates (1980), in their early study of legal abortion complications state this a "major surgery. . . restricted to unique circumstances" (p. 177).

Medical/chemical abortions are a final category to be considered. includes all chemical inductions. In addition to the saline, prostaglandins described above, other drugs have abortifacient properties (CDC, 1996).

Significant news coverage has recently been given RU 486 (mifepristone). Commonly referred to as the French abortion pill, this medication has been used in Europe for a little more than eight years by more than 200,000 women. Clinical trials have been done in the United States and scientific advisers, with some conditions, recommended FDA approval (Neergaard, 1996). This procedure is recommended to be used within 49 days of conception. The regimen entails taking three tablets of mifepristone, a steroid analog which blocks the development of a natural hormone which is essential in maintaining the pregnancy; two days later, a second medication, misoprostol (cytotec), which contains a synthetic prostoglandin analog, is administered. This medication causes uterine contractions which expel the products of conception (Neergaard, 1996).
Dr. Diana Petitti of Kaiser Permanente Medical Care Program cautioned, however, that "The term safe should not be misinterpreted as free of adverse events, and serious adverse events" (Neergaard, 1996, p. A1). Harvey, (1995) in discussion of the pros and cons of this method, on the verge of FDA approval cited earlier use, a 96% effectiveness rate and the non-invasive nature of this technique which does not place patient in danger of complication by instrumentation as positive aspects. Possible complications include excessive bleeding and incomplete abortion (which would necessitate a surgical intervention), or in rare cases, failure to abort. Banwell and Paxman (1992) reported that testing, to date, had not determined the effects on fetuses, should the procedure fail and pregnancy become established. "Therefore, women in France are required to agree to a surgical abortion should the RU 486/PG therapy fail" (Banwell and Paxman, 1992, p. 1400). Neergaard (1996) cites a more recent study which indicated 21 European women, of 200,000 who had taken RU 486 did remain pregnant and carry to term. One infant of this group had severe defects and died; two had mild limb deformities.

**Potential physical risks or complications of surgical abortion.** Since women seeking abortions tend to be young and in their early reproductive careers, the safety and subsequent reproductive well-being are important concerns.

Grimes and Cates report in their 1980 summary study of abortion complications that abortion is a safe surgical procedure, as documented in numerous large studies. In 1990 a well-controlled, comprehensive study of results of 170,000 cases was reported, showing complication rates "well below any of the cumulative table of Cates and Grimes" (Hakim-Elahi, Tovell, Burnhill, 1990, p. 132).
According to Planned Parenthood Fact Sheet (1993), one early abortion procedure should not have any adverse effect upon women’s subsequent ability to conceive and carry pregnancies to term; they note however that research is limited on the effects of more than one abortion. Some sources (Reardon, 1989) (PPCNA, 1993) suggest that there is greater incidence of miscarriage and premature births.

**Mortality figures.** Statistics reported in surveillance studies continue to show a downward trend in abortion related mortality. Lawson, Frye, Hani, Smith, Shulman and Ramick, (1994) note that abortion related deaths fell 95% from illegal procedures (1972 to 1987) and fell from 4.1 per 100,000 procedures to 0.4 per 100,000 with legal procedures during that same time period. The MMWR (CDC, 1996) most recent statistics report a 0.3 per 100,000 mortality figure for legal, induced abortions.

Abortion related deaths were categorized as being secondary to: (1) hemorrhage, (2) infection, (3) emboli, (4) anesthesia complications and (5) other (Lawson, Frye, and Hani et al., 1994).

**Morbidity figures.** The Obstetrics and Gynecology article (Hakim-Elahi, et. al., 1990, p. 131) summarized major complications (those requiring hospitalization) as: incomplete abortion, sepsis (infection), uterine perforation, excessive vaginal bleeding, inability to complete abortion, tubal pregnancy; categorized as minor complications were mild infection, retained blood or tissue, requiring re suctioning, cervical tear, underestimation of gestational age, and seizure. Lower gestational age and those abortions performed by a suction/evacuation procedure are associated with lower mortality and morbidity figures (Lawson et al., 1994). Teenagers had the lowest mortality rates; risk was three times greater for women ≥40 years old.
Risk also increased with increasing parity (previous births), if woman had given birth three times or more.

"When pregnancy terminations are performed on patients less than 14 weeks from the LMP, who have no other health contraindications to outpatient surgery, the procedure is extremely safe" (Hakim-Elahi et al., 1990, p. 134). Current Center for Disease Control figures support this (1996).

**Psychological sequelae of abortion.** Reardon, (1989) in *Aborted Women: Silent No More*, reports with sensational and pejorative language, a systematic cover-up of widespread negative physical and psychological sequelae to induced abortion. This work, however, is noted in its foreword to be a reflection of the experiences and function of the members of the pro-life group, *Women Exploited by Abortion* (WEBA). Some of their statistics and methods for gathering data were very different from those presented by the CDC (1996) and in the journals of *Obstetrics and Gynecology* (Lawson, et. al., 1994; Hakim-Elahi et al., 1990).

One study, reported to be controlled and methodologically sound, which supported the occurrence of a post-abortion trauma syndrome was described in *Science and the Christian Faith*, similar findings were discussed in *Christian Counseling: A Comprehensive Guide* (Collins. 1988).

In 1989, the American Phychological Association (APA) appointed a panel of experts to examine the relevant psychological considerations of induced abortion (Adler et al., 1992). This panel presented evidence that "abortion is not likely to be followed by severe psychological responses and that psychological aspects can best be understood within a framework of normal stress and coping rather than a model of psychopathology" (1992).
This APA panel did discuss correlates of the more negative responses, and listed among key variables: (1) social support, (2) the attributions for the cause of the event, (3) the meaning attached to the event and, (4) the coping strategies used for dealing with the event (Adler et al., 1992, p. 1197). Also figuring into the psychological outcome of the abortion patient was the entire context of the abortion procedure. This study panel suggested that the reasons for the occurrence of the pregnancy (e.g., whether pregnancy was intended or not, whether it was the result or rape, and the hardship the pregnancy would pose) were important factors. Also impacting outcome were the circumstances under which the decision to terminate was made (e.g., as a result of diagnostic testing, whether it was made with the support of others). And, finally, the experience of the procedure itself (e.g. type of procedure, treatment by the provider, experience with protesters) (Adler et al., 1992).

The negative psychological responses found by the group were divided into two groups: (1) termed socially based, were those consisting of shame, guilt, and fear of disapproval and (2) termed internally based, were emotions of regret, anxiety, depression, doubt and anger. This second group seemed to relate to the loss of the pregnancy and the meaning it had for the woman (Adler et al., 1992). In summarizing, this group reported that "women who are satisfied with their choice or who report little difficulty in making their decision show more positive responses post abortion. Greater meaningfulness and intentionality of the pregnancy, in contrast are associated with poorer post abortion adjustment (Adler et al., p. 1200).

Women who report greater difficulty in deciding to abort are more likely to be married, Catholic, to have negative attitudes toward abortion and to perceive little social support for their decision.
For the vast majority of women, an abortion will be followed by a mixture of emotions, with a predominance of positive feelings. This holds immediately after the abortion and for some time afterward. We do not know about the very long term effects. However, the positive picture shown up to eight years after abortion makes it unlikely that more negative responses will emerge later... The best studies available on psychological responses to unwanted pregnancy terminated by abortion in the United States suggest that severe negative reactions are rare, and they parallel those following other normal life stresses. The time of greatest distress is likely to be before the abortion. (Adler et al., 1992 pp. 1201-1202)

This researcher's practicum experience with post-abortion clients and review of many case studies yielded concerns in four general areas:
(1) Lack of information, (2) misinformation, (3) perceived pressure from various professional staff persons, partner or parents or, (4) that client had made a decision in conflict with her own value system.

The in-depth Terry Steinberg work (1989) and the extensive APA literature review and study (Adler et al., 1992) both support the benefits of certain types of counseling prior to the abortion procedure in preventing or minimizing negative post-abortion responses. Steinberg (1989) points out that some pregnancy counseling may be harmful and that providers do not counsel equally.

Pregnancy Options Counseling Providers

Many professional groups and training backgrounds are represented among pregnancy options counselors. C. E. Koop (cited in Steinberg, 1989) offers that these counselors may include: family physicians, psychiatrists, clinical psychologists, marriage and family therapists, social workers, pastoral counselors, and the clergy. Other sources enumerated school counselors and
teachers, nurses employed in clinics, schools, and by doctors offices and hospitals. Adoption agencies, family service agencies and women's reproductive health care providers have staff members of varying background and credentials, both professional and lay, who participate in pregnancy options counseling (Lindsay, 1989; Lindsay and Monserrat, 1989; Reardon, 1987; Gagnier, 1996; Pusey, 1996; Feldman, 1995; Baker, 1995). Abortion: The Moral Dilemma, (Films for the Humanities and Sciences, 1994) enlarges this list to include geneticists, bio-ethicists, and a diverse spectrum of ethnic and religious representation among pregnancy counselors.

Legislation requiring parental notification and/or parental consent for health care or abortion for minors has brought courts and judges into the pregnancy options counseling arena (Council on Ethical and Judicial Affairs, AMA, 1993; Clark, 1991; Council on Scientific Affairs, 1993; State of Arizona, Senate, Forty-second Legislature, 1996; State of Arizona, House of Representatives, Forty-second Legislature, 1996 and Blanchard, 1994).

Although not participants in formal counseling settings, vocal and often high profile "sidewalk" and "media" counselors seek to influence decisions of women faced with unintended or unwanted pregnancies (MPI Home Video/ABC News, 1992; Cinema Guild Productions, 1989; Szykowny, 1992 and Blanchard, 1994).

Political, Religious and Moral Ideologies and Values and Their Effect on Ethical Pregnancy Options Counseling

Professional ethics defined. A profession, according to Webster's (1989, p. 1148) is a vocation requiring knowledge of some department of learning or science (or) the body of persons engaged in an occupation or calling. Ethics
is defined as a system of moral principles, rules of conduct recognized in respect to a particular class of human actions or a particular group, culture; a branch of philosophy dealing with values related to human conduct, with respect to the rightness or wrongness of certain actions and to the goodness or badness of the motives and ends of such actions (p. 488).

Kultgen (1988) expands upon the semantics of the term 'professions' to include not just the narrow and traditional, learned, elite professions, but can be taken more broadly to embrace "literally hundreds of occupations that so label themselves" (p. 5). Kultgen further notes that, though professional associations monitor practice, there is significant limitation of the mechanisms at their disposal. He states "By and large, the mechanisms are not sufficient to enforce a high level or either competency or morality. In the first place, the mechanisms do not reach most practitioners. Only a minority of professionals belong to professional associations" (p. 136).

Kultgen's (1988) second semantical remark broadens the concept of 'ethics' beyond rules of conduct, to include "ideals and aspirations" and the "conception of mission and the responsibility they reflect" (1988, p. 5).

A third relevant concept explored by Kultgen (1988) is that of professional ideologies, which he defines as a belief system developed within the profession through which practitioners make sense of their experiences. "It uses the same ideas to guide its own activities and to justify them to outsiders" (p. 106). Kultgen (1988) notes that "The connections between professional and total ideology are indirect and concealed. The efficacy of professional ideology is enhanced by remaining silent on broader questions" (p. 107).
Corey, Corey and Callanan (1993) address both the concern of missions and the concept of concealment where agency policy may challenge ethical practice. A hypothetical case is presented where services are advertised for pregnancy counseling of unwed mothers: "What it does not advertise is that all counselors are instructed to promote maintaining the pregnancy, with the option of adoption. Clients are not informed that no other options will be suggested" (1993, p. 356). Corey et al. (1993) ask if an absence of information constitutes a lack of informed consent and if this agency policy promotes the self-determination of the client.

During a 1995 interview, Joseph Feldman, C.P.C., trainer of pregnancy options counselors for Planned Parenthood of Central and Northern Arizona, emphasized the imperative of presenting all options to every client. Feldman expressed concern that some counselors in some agencies may bring ideologies into the setting which subvert the vulnerable client's self-determination.

**Counselor values and their ethical implications.** According to Gerald Corey (1991), "Counseling or psychotherapy is not a form of indoctrination whereby practitioners persuade clients to act or feel in the 'right way'... a core issue is the degree to which the counselor's values should enter a therapeutic relationship" (pp. 18-19). Corey asked "How can helping professionals retain their own sense of values and remain true to themselves yet at the same time allow their clients the freedom to select values and behavior that differ sharply from theirs?" (p. 19). Corey lists pregnancy counseling and abortion as most value laden issues.
Baker (1995) offers a very detailed and specific value clarification questionnaire for trainees preparing to work as pregnancy options counselors. This questionnaire offers one tool helpful in determining how well, and in which areas one will be able to function ethically; and, likewise, areas where one may be value conflicted to such an extent that one's ethical practice would be effected.

Corey, et. al., (1993) also present a survey specific to values around pregnancy options.

suggest that referrals are appropriate when moral religious or political values are centrally involved in the client's presenting problem. . . and the therapist has extreme discomfort with a client's values, the therapist is unable to maintain objectivity, or the therapist has grave concerns about imposing his or her values on the client. (1993, p. 63)

Debates over the subtleties in professional ethics. Meara, Schmidt and Day, (1996) debate the approaches to ethical decision making by counseling professionals:

Principle ethics can be described as a set of prima facie obligations when confronted with an ethical dilemma. Virtue ethics focuses on character traits and nonobligatory ideals that facilitate the development of ethical individuals. Within the context of the assumption that major responsibilities or primary goals of professionals are to be competent and to serve the common good, we suggest that integrating these complementary ethical perspectives provides a coherent structure for enhancing the ethical competence of psychologists and counselors and the level of public trust in the character and action of these professions and their members. (p. 4)

Meara et al., (1996) support codes which integrate virtue and principle ethics and result in codes and practices which are "more cognizant of cultural
pluralism and thus more inclusive and appropriate for the publics served" (p. 5). They note that proper professional conduct is "seldom either totally absolute or completely relative, and thus requires virtuous, competent individuals to exercise careful professional judgment" (p. 5).

Ethicist, Bersoff, (1996), comments that "if acting ethically depends on character, I wonder if the outcomes will be too individualized and idiosyncratic" (pp. 88-89). He elaborates: "I see the dangers of a communitarian view as outweighing its benefits. It would be difficult for me to subscribe to a system that led me to act in ways that denied women responsible choices in deciding whether to bear children" (p. 90).

Kitchener (1996), who recently wrote *The Foundation of Ethical Practice in Psychology*, supports some of the philosophy of Meara et al., but presents some real concerns. Significant among these is "my suspicion that many acts of intolerance have been committed in the name of virtue as in the name of principle. . . [including] the murder of abortion physicians in Florida" (p. 95).

**Various counseling associations codes and ethics explored.** Patterns one sees when exploring various ethical codes are those of vagueness, generality and a distinct lack of detail for dealing with specific situations. Norman (1992) compared ethical codes that varied widely on several points: "(1) the requirements to be a counselor; (2) the consequences of failing to fulfill the ethical standards; (3) a discussion of how these standards are to be implemented and; (4) the enforcement process used to insure that the standards are adhered to" (p. 99). He also cited conflict of interest and referral policies as problematic.
Garcia, Glasoff and Smith, in their report of the ACA Ethics Committee, (1994) enumerated categories of ethical complaints and inquiry. The counseling settings out of which these arose were not reported, however, several of these may be pertinent to the pregnancy options setting including: Maintaining high standards of professional conduct, meeting personal needs at client's expense, advocacy for clients (versus some other primary interest or agenda), and issues dealing with minor clients.

Gibson and Pope (1993) presented a study with data collected from 579 counselors certified by the National Board of Certified Counselors (NBCC). The study queried whether they believed each of 88 counseling behaviors was ethical, and also questioned their level of confidence in those beliefs. Pertinent to this project was the response by 22% of the surveyed counselors that they believed it was ethical to tell clients that their values were incorrect. Gibson and Pope, (1993) noted that one may not be able to generalize results to other counselors, and also commented that counselor beliefs are not necessarily [always] indicative of counselor behaviors.

**Morality of influencing in counseling.** Sometimes influencing is overt, as in persuasion; sometimes it is covert, as in guilt manipulation. Sometimes the influencer is doing it on purpose; sometimes it is unintentional. These concepts, presented in *Counseling and Values* (Schulte, 1990) figure prominently in the ethics of pregnancy options counseling. These [pregnancy options] counselors work with vulnerable people and should be aware that almost anything they do can significantly influence clients (Schulte, 1990). The role of the counselor seems to carry with it the responsibility to help (influence) a client achieve better awareness, improved problem solving skills, or whatever the appropriate goal may be.
Schulte (1990) cautions that some means of influencing are moral and some are immoral. One might consider in this latter category some of the Pro-Life factions who withhold information or present unsolicited, sensationalized misinformation as a means to influence pregnant women or their health care providers (MPI Home Video and ABC News, 1992; Cinema Guild Productions, 1986 and Szykowny, 1992).

Schulte (1990) concludes that "one expects counselors, as professionals to be alert about their effects on clients...and take the extra steps to recognize their own biases and to access accurately how they are affecting their clients" (p. 109).

Religion and politics in the pregnancy options arena. The politicizing and the parochialising of women's reproductive choices were demonstrated through voluminous literature sources. Topical literature indicates that the moral, the religious, and the political ideologies are oftentimes intertwined with professionalism in women's reproductive counseling. Only occasionally, it seems, are they not.

One has only to review any chronology of legal opinion and statute to see the involvement and impact of political decisions on, not only which choices women were allowed to make about their pregnancies and childbearing, but also, upon how pregnant women were permitted to be counseled.

Rubin (1994) noted "there were secular (non-religious) reasons behind early abortion laws" (p. 215). The secular medical reasons for outlawing abortions in the mid-nineteenth century were presented in context of the dangerousness of the procedure to the mother. However, all surgical procedures at that time were relatively dangerous, given that antiseptic
techniques were based on discoveries by Lister, Pasteur and others, first announced in 1867 (Rubin, 1994; Blanchard, 1994).

Given the great progress in medical technology and in infectious disease control of the past century, this argument no longer offers cause to restrict abortions. Yet, there has been continuous challenge to the spectrum of safe, legal procedures, and, in recent years one has seen an intense social movement against rights of choice for women.

Rubin (1994) hints at the increasing power of the AMA, with its growing elitism, power and drawing in of the moral, legislative and religious contingents as responsible for the trend toward diminished reproductive rights for women.

Banwell and Paxman (1992) expressed concern:

Should the law be called upon to weigh in with criminal sanctions in areas of fine medical distinction such as the physiology of the reproductive process? We believe the answer is no, for several reasons. First, issues of reproductive health are a complicated mix of medical, cultural, social, and personal elements, and simply do not lend themselves to the rigid framework of criminal law. Second, as the legislative examples cited throughout this article show, criminal law is ill equipped to keep pace with an ever evolving field of medicine, such as fertility control. (p. 1404)

Banwell and Paxman (1992) presented diverse political and religious positions, from around the world and from many bodies of law and church doctrine. One can see there is little consensus answering the questions of when life begins, the religious and legal meanings of zygote, embryo, fetus, and the issues of pre and post implantation.
Indeed, a major debate in the Roe v. Wade hearings centered around when life begins, as well as whose rights and privacy to protect. Nobel prize winning biologist, Dr. Gerald Edelman (Rubin, 1994), called on to testify as to the beginning of human life, stated he could cite no reputable, scientific paper that has proven when life begins. Edelman noted a continuum of properties possessed by cells, tissues, organs and individuals and adds that "If someone attempts to glorify a fertilized egg or even an early embryo, one must confront the questions that are not capable of scientific answers" (Rubin, p. 197). Edelman asked: "At what step of development does a living, individual human being appear? This is essentially a religious and moral question and is therefore open to sectarian interpretations and prejudices" (Rubin, 1994, p. 197).

These interpretations and prejudices are the subject of and reasoning for a multitude of opinions and actions directed toward pregnant women and their helpers. And, while some have organized to work for maintaining pregnancy choices for women, many actively support an anti-choice position.

Blanchard (1994) cited a study by Eric Woodrum and Beth Davison which concluded that "sexual moralism is the strongest predictor of anti-abortion attitudes" (1994, p. 40). Whether the motivation of various courts and legislative bodies has been related moralism, to paternalism and power, or to the more altruistic goals of family values and maternal and child well-being and the greater good of society, the impact of their decisions has been significant.

Davis (1995), shared information about political health care funding decisions which will represent "for maternal and child health, a 15% reduction in funding [and] would eliminate prenatal care for 200,000 women and
primary care for 400,000. In family planning, a similar cut would eliminate services for 600,000 women" (p. 1052). "Budgetary proposal. . . will limit women's choices and their ability to obtain care from health care providers sensitive to their concerns" (Davis, 1995, 1052). Davis (1995) sees as a consequence an increase in unwanted births and a diminished quality of services.

Henshaw (1995) elaborates on ways legislation and governmental regulation have created additional barriers for both women and their care providers. Henshaw (1995) noted that abortion is a semi-urgent health concern because the risk of complication increases with gestation, the cost of abortion increases with gestation, and abortion becomes impossible if it is delayed too long. Provider shortages, mandatory delays or waiting periods, coupled with the exclusion of abortion coverage through Medicaid add up to major barriers for many needy women.

Twenty some years after medical technology and Roe v. Wade provided for safe, legal abortions, the political right has been pushing legislation not only to restrict this option, but also to limit the whole spectrum of family planning services to the most vulnerable and powerless. Funding for Title X of the Public Health Service Act, which annually serves nearly five million poor women and teens, was slashed by millions of dollars (Wattleton, 1990). A "squeal rule" was proposed in 1982, which mandated stringent parental notification requirements for teens obtaining any family planning services under Title X (Wattelton, 1990). And, continuously being challenged is the "gag rule," originating in the Reagan Administration, which forbids the provision of abortion information, referral, or counseling in clinics which
receive Title X funds—even when withholding of such information would endanger a woman's health (Wattelton, 1990).

The Alan Guttmacher Institute (1995) reports the challenge and enjoining of the "squeal" rule, with the issue of parental notification subsequently being dealt with as a state level. The Adolescent Family Life Act (AFLA) popularly dubbed the "chastity bill" was a demonstrator program whose purpose was to test and evaluate interventions to promote abstinence and adoption (Alan Guttmacher Institute, 1995). The Institute's review reveals that to date there is much legal inconsistency within states and from state to state regarding reproductive health law: "Some states leave a teenage mother in the anomalous position of being able to consent to medical care for her child, but not for herself " (Alan Guttmacher Institute, 1995, p. 6).

Many additional articles offer evidence supporting the idea that barriers and restrictions to the spectrum of legal pregnancy information and options can have deleterious personal and societal consequences. Exemplifying these are: Commentary: The public health consequence of restricted abortion, a lesson from Romania (Stevenson, Marsden, and Bedea, et. al., 1992), The effects of mandatory delay laws on patients and providers (Althaus and Henshaw, 1994), Mandatory parental consent to abortion, JAMA, (Council on Ethical and Judicial Affairs, AMA, 1993), Teenagers and abortion: The issues, (Clark, 1991), Confidential health services for adolescents (Council on Scientific Affairs, AMA, 1993), Parental consent: Factors influencing adolescent disclosure regarding abortion (Griffin-Carlson and Mackin, 1993), and Impact of legalized abortion on adolescent childbearing in New York City (Joyce and Naci, 1990).
Reynolds (1994) presents biographical sketches of eleven of the most prominent women advocates of reproductive rights—who pressed for political-legal reform. While acknowledging great progress and successes, Reynolds acknowledges a current "undesirable patchwork of (state) laws (p. 137).

**Philosophical and religious beliefs about pregnancy options** These global topics have inescapable influence on the pregnancy options decision setting. Some approach these serious issues with an indirectness of language that is likened to the slavery-anti-slavery debates, and is described by Mckenna (1995) as a "Lincolnian position" (p 51) on abortion. Others are more firm and direct:

Value absolutism in the abortion debate will always be a destructive force, for it authorizes the absolutist to disregard other goods to which the good life is related and turn away the appeals of practical reasonableness. . . A morally moderate approach to abortion must begin by affirming that if no one good of life is absolute, then the goods of life and the values that attach to them are interrelated. (Steffen, 1994, p. 20)

Steffen (1994), sets forth six conditions or criteria necessary for a "just abortion" (pp. 77-104) and within these affirms the notion that the pregnant woman is the "competent authority" (p. 79) to make the decision. More significantly, as a moderate, he puts forth the idea that abortion is morally complex and problematic.

The spectrum of absolutist views, and their impact upon the pregnancy options helpers is evident. Throughout the literature, conversations as to the justice of any decision come back to strong beliefs about ensoulment; about the beginning of life, and about criteria around these concepts.

Coughlan, (1990) offers ancient perspective: ". . . patron saint of moral theology regarded it as certain that the fetus is not ensouled from the moment
of conception, but only after it is formed (a term generally understood in St. Augustine's sense of a body endowed with an active power of sensing)" (p.86).

These conditions of humanoid appearance (form) and sentience and suffering are repeatedly explored in other more contemporary sources. Alpern (1992) grapples with each of these in his work on conflicting perspectives.

Descriptions of human developmental stages, including estimations of levels of form, size, appearance and of sentience may be helpful to counselors and to pregnant women, for whom these are decision making criterion.

Muldoon (1991), reported on the vast range of positions held within the Christian tradition in North America, and she presents a basic position statement from most major denomination represented. Sister Mary Theresa Glynn, stated "I am here to say that the Catholic position is not so cohesive, not so monolithic as is often presented. . . " (Muldoon, 1991, p. 144). It is probably safe for a counselor to generalize the same to other denominations and be open to the possibility that these are, likewise, not necessarily monolithic or cohesive. One cannot make assumptions that because a client or patient professes a specific religion, that her beliefs about pregnancy options will then follow a prescribed doctrine.

The clergy and pastoral counseling. "Incorporating spirituality into counseling can get very tricky when it appears that religion is playing a role in the client's dilemma or could help to resolve it. . . " (Morrisey, 1995, p. 2). This may be especially true when the issue is a problem pregnancy, and when the client does not disclose her faith or degree of religiousness. Morrisey (1995), emphasized that while the counseling session is "not the place to evangelize" (p. 2), one "may be liberal towards self-disclosure in response to counselee questions" (p. 2).
Collins (1988) stresses thinking through and clarifying one's own values before facing clients with problem pregnancies. In his Christian counseling text he states that "counselors are rarely able to hide their own views on abortion, and probably you shouldn't try" (1988, p. 433). When encountering a client who is choosing abortion "it has been suggested that the counselor can either help the woman find competent medical care or graciously withdraw from counseling and refer her to a counselor who is not opposed to abortion" (Collins, 1988, p. 433). In the same paragraph he emphasizes, however: "When clear sin is involved, Christian counseling cannot be neutral" (p. 433), equating neutrality and referral with sending a drug abuse client to a counselor who would encourage him to continue using drugs.

On the issue of the function of pastoral counseling, and particularly its uniqueness, Peterson (1990) comments that there is an assumption of a particular value orientation and that the pastoral counseling setting creates a context in which the recognition of values as legitimate becomes acceptable. Peterson (1990) also points out the unique function of the pastoral counselor as being a religious authority figure, and that he or she can be especially effective if he/she "is an accepting authority rather than authoritarian" (p. 120). The assumed agreement of values and also the ability of a young vulnerable client to differentiate authority from authoritarian, particularly if she has been taken to the clergy by an authoritarian parent or other person in a position of power can be questioned.

Power (1990) offered one concept useful to problem pregnancy counseling: "If the pastoral counselors are to really listen, they must understand the qualitatively different ways in which individuals construct meaning and value in their lives" (Power, 1990, p. 85). As described earlier in
this chapter, one significant predictor of positive or negative psychological outcome of a problem pregnancy is the meaning and value the woman attached to that pregnancy.

Stevenson (1990) introduces the positive potential for the sharing of ideas and help between mental health care providers and the church; that is, using the church as an adjunct to the secular counseling when dealing with youthful pregnancies. "It behooves clinicians to cease the under-utilization of the church and other survival strongholds. . . " (Stevenson, 1990, p. 132). He acknowledges the prospect of teenage pregnancy as scary (for some church personnel to take on) but cites the church as "community reservoir of untapped and disengaged strengths" (Stevenson, 1990, p. 133).

Many church doctrines are presented as absolutes and tend to be punitive and exclusive; others appear supportive, forgiving and may be helpful primary sources of pregnancy counseling or useful adjuncts. Some religious organizations choose to remain silent or uninvolved.

Political rhetoric and policy making may ostensibly address child and maternal health concerns and family values issues, while in fact, the true agendas may remain hidden.

Summary of Literature Review

Much has been written about political and parochial response and involvement in women's reproductive health issues. Materials show socio-economic statistics translated into predictors of dire life outcomes and societal consequences when women make certain pregnancy options choices.

The professional literature sources superficially explored the circumstances around the pregnancy decision. These same sources did not
share the particular details of the options choice, the setting in which the choices were made, or the process through which women arrived at their decision. Little was offered which defined whether the selections of options were made by default, that is when no choice became the choice; if the choices were made under pressure; or how much guidance was available and useful by pregnancy options helpers.

Women's own stories were related in such works as Our Choices: Women's Personal Decisions about Abortion (Hoshiko, 1993), Bitter Fruit: Women's Experiences of Unplanned Pregnancy, Abortion and Adoption (Townsend and Perkins, 1992), Aborted Women: Silent No More (Reardon, 1987), Birth or Adoption: Private Struggles in a Political World (Maloy and Patterson, 1992), Adoption Awareness (Lindsay and Monserrat, 1989), Parents, Pregnant Teens and the Adoption Option (Lindsay, 1989) and When Abortion was Illegal: Untold Stories (Bullfrog Films/Concentric Media Productions, 1992). These were compelling and often sensational renditions of some of the worst and some of the better pregnancy dilemmas and their outcomes. Presentations of these experiences were anecdotal and were not, in most cases, explored in the context of formal scientific research. They were reported through writers and film makers representing, it seemed in most cases, extreme opposite poles of the "pro-choice" and "pro-life" spectrum.

Themes which emerged in the telling of these experiences were perceptions that poor outcomes were secondary to not receiving enough information or receiving inaccurate information, not receiving information about social resources available, lack of support, being judged, being pressured and, being treated as if one were in a "mill."
Positive outcomes, conversely, were reported by women who were grateful for all the options being available; who believed they were not judged; who felt supported rather than pressured, who were in possession of adequate and accurate information and who had a sense of a personal, internal locus of control.

Among those who described poor life outcomes and those who were troubled by ongoing physical or mental health problems, it seems there was attribution of these problems to the pregnancy decision, when the connection may or may not have been a fact. This was, however "their truth."

Religious positions and governmental policy about what is just, moral, legal, and right or wrong in relation to women's choices with unplanned pregnancies was debated limitlessly.

Steinberg (1989) pointed out the Supreme Court's "narrow view of counseling" (p. 482) and offered research-based conclusion that, related to pregnancy options, "unbiased counseling benefits women, while inadequate or inaccurate counseling harms women, increasing the risk of post abortion trauma" (p. 482).

Little was presented in the professional literature which addressed the pregnancy decision making process, specifically, and which addressed this process in the context of differently value laden counseling settings. Baker (1995) offers a values and attitude inventory for counselors, specific to pregnancy options. Exactly how this is translated to the counseling setting was not described. Baker is strongly associated with a "pro-choice" stance and with the training of "pro-choice" counselors. Equivalent training materials were not found for counselors representing a "pro-life" position.
Scientifically researched literature did not reveal what happens at a most personal and detailed level in various settings with one vulnerable pregnant woman and one "helper" who necessarily brings his/her collective values and ideologies to the pregnancy options counseling setting. Not well answered in the literature were the questions about how these values and ideologies are used or are kept separate in a way that affects ethical practice in that setting.
CHAPTER 3
METHODOLOGY

Purpose

The purpose of this study was to describe how counselor ideologies and value systems affect ethical practice of pregnancy options counseling. The results will endeavor to be a basis of resource materials helpful to persons who provide pregnancy options counseling or who may refer patients or clients for this service.

Research Design

To explore and compare the ways in which counselor ideologies and value systems may affect ethical practice in pregnancy options counseling, a descriptive research design was chosen. According to Merriam and Simpson (1995) descriptive designs are one of the most commonly used methodologies, where the focus of the research is to examine facts about people, their opinions and attitudes.

This study systematically explored and described counselor opinions, attitudes and characteristics through a survey. The survey questions attempted to ascertain: (1) what ideological and value system qualities the counselors bring to the pregnancy options counseling setting, and (2) how these ideological and value system qualities affect the counselor's actual practice in that counseling setting. The survey sought to discover which and
in what ways counselor ideologies and value systems impacted ethical practice of pregnancy options counseling.

Sample and Population

Pregnancy options counseling is offered, at some level, in a wide variety of agencies or offices. In selecting counselor participants for the survey, there was an attempt made to determine the various settings where pregnancy options counseling is provided in the Phoenix metropolitan area, including those which openly present a "pro-choice" stance, those which hold a "pro-life" or "anti-abortion" position, and, those whose position with regard to this reproductive issue was unknown or unadvertised. These may include doctor's offices, medical clinics, hospital or surgery centers, at some schools, and with a number of independent or group counseling practitioners.

Participants in this study were limited to counselors who provide pregnancy counseling at: (1) agencies listed under pregnancy counseling in the Maricopa County Directory of Human Resources 1995, 18th Edition and (2) and to those agencies appearing under pregnancy options related headings in the Yellow Pages of the Phoenix Phone Directory. Seventeen agencies were identified between these two sources to survey for this project.

Assumptions and Limitations

An obvious limitation in this study is the inability to identify and survey a larger or more comprehensive sample of individuals or agencies providing pregnancy options counseling. Because of the extreme sensitivity and of pregnancy options, and especially the abortion component of this issue, it is common knowledge that some individuals offering services addressing this
aspect of health care prefer not to acknowledge association or offer comment about their work. Although it may have been useful and desirable to include patients/clients in this study and to survey their experience with pregnancy options counseling, this was not feasible for several reasons. The very sensitive nature of this topic, the confidentiality issues, and the level of difficulty in obtaining consent for release of information from the individuals and permission from the agencies where they were counseled precluded actual patients/clients from being participants in this project.

It is an assumption that some of the pregnancy options counselors may attempt to educate, convert, or in other ways promote their positions in the context of this survey.

It was not possible to survey the ideological position or impact of subsequent, unofficial counseling by partners, friends, parents or other concerned associates of the patient.

It is believed that, because participation is voluntary, and because responses will be presented anonymously, answers will be honest.

Procedure

Seventeen agencies were contacted by telephone. An invitation was extended to counselors who provided pregnancy counseling to participate in the survey. The general purpose and scope of the survey were described, as well as the context within which the study was being conducted, i.e., as a culminating graduate school project from Ottawa University.

It was shared with each potential participant that: (1) the survey would be conducted through oral interview, (2) That this could be accomplished either in person at the participant's office or by telephone, (3) that the interview
would require a minimum of twenty minutes and (4) that all responses would be reported anonymously; that anonymity would be maintained both as to individual and to agency and, (5) that a summary of study results would be made available to each participant, upon request.

Researcher was prepared to complete the interview at time of initial contact or during a subsequent call or personal appointment at participant's convenience. It was decided that no more than two (2) calls would be made to each agency, and that researcher's phone number would be provided, as well as the phone number to Ottawa University's graduate studies thesis chairman. This permitted potential participants to reach the researcher at their convenience and to verify the basis of the study.

Since the first agency in which an interview was conducted declined permission to tape the interview, it was decided to not request permission to tape subsequent interviews. Responses were recorded in writing by researcher during the interview. Immediately following the interview session, further details and impressions were completed.

Instrumentation

The survey was conducted in the format of individual semi-structured interviews. Individual questions from the instrument were used for greater focus and to obtain more specific information when pertinent details were not shared in the course the discussion in each of the categories being surveyed. A face-to-face interview was felt to be the most desirable. The importance of data obtained from non-verbal communications and from the messages inherent in the physical site cannot be discounted. However, when an in-person interview was not feasible, a telephone interview was utilized. The
limitations of the telephone surveys are recognized in that the data was somewhat less complete.

Questions covered in these data collecting interviews fell into three categories:

**Demographics:** Questions addressed basic demographics of the counselor. Counselors were asked to provide information about their general educational background, training specific to pregnancy options counseling; degrees, credentials, certification, or licensure; professional organization and agency affiliations; and the counselor's basic religious and political preferences and participation.

**Counselor beliefs, attitudes and opinions:** Open ended discussion questions queried the counselor's beliefs, attitudes and opinions in a series of four areas:

(1) The role of religion, the church in pregnancy options,

(2) The role of the family in pregnancy options,

(3) The role of the school in pregnancy options, and

(4) The role of government, politics, law in pregnancy options.

The questions were designed to explore which ideologies or values were held, embraced or promoted by each participant and to poll the participants' views of the rightness or wrongness of any of the pregnancy options with respect to their religious, political or social belief systems.

**Counselor's role and practice:** The third section of the interview addressed the role of the counselor in the pregnancy options counseling setting. These questions examined how the counselor perceived her/his role; what she/he perceived as needs of the client; what is asked of the client and
what is offered to the client. This section requested "mission statements" and asked for information, education and referrals provided the client.

The instrument for this study was prepared with input and supervision by Ottawa University faculty advisor. Its validity has not been formally assessed. The instrument, in its entirety is included in appendices 1-3.

Method of Analysis

Responses were examined and explored for recurring themes and prevailing trends. The numbers of responses in each of the categories were noted. The researcher looked specifically for relationships between the responses offered in the categories exploring beliefs, attitudes and opinions of the roles of religion, government, politics, law, family and school and the way the participants perceives and carries out the role of the pregnancy options counselor.

The researcher looked for patterns of the ways in which pregnancy options counselors' ideologies and values appeared to be kept separate from or were communicated to the client in a manner which might significantly affect ethical practice.
CHAPTER 4
PRESENTATION AND ANALYSIS OF DATA

Findings and Results

In review, the purpose of this study was two-fold: The first objective was to attempt to ascertain some of the different ideologies and value systems subscribed to by individuals who provide pregnancy options counseling. The second objective was to explore how these counselor held ideologies and value systems were or were not incorporated into the counseling process in a way that affected the ethics of that pregnancy options counseling practice.

Agencies Identified for Study

1. Area served: Metro Phoenix and East Valley.
   Funding: Donations.
   Accreditation: None.
   Eligibility: Women, all stages of pregnancy or suspecting pregnancy.
   Fees: None.

2. Area served: Arizona.
   Funding: Memberships, donations, fees.
   Accreditation: DES, JCAHO, DBH, CASFC
   Eligibility: Varies with programs.

3. Area served: Arizona, multiple offices.
Funding: Bishops Charity and Development Fund, fees.
Accreditation: DES License, COA, Catholic Family and Community Services

4. Area served: One office, Phoenix, Tucson phone number listed.
Funding: Contract for services, donations, fees.
Accreditation: DES license/Child placement and adoption.

5. Area served: Phoenix metro.
Funding: Donations.
Accreditation: None

6. Area served: Phoenix (PUHSD), Two branches listed.
Funding: PUHSD.
Accreditation: North Central Schools.

7. Area served: Maricopa County, four offices Phoenix metro area.
Funding: DES, Superior Court, MCJOC, ComCare, United Way, EAP, donations, fees.
Accreditation: Licensed by DES, Child Placement/Adoption, BHS.

Funding: Donations.
Accreditation: Alternatives to Abortion, International.

Accreditation: Licensed outpatient treatment clinic (medical),
Licensed outpatient behavioral health facility.
Funding: Partially deleted to protect participants anonymity . . .
. . . Foundation, AHCCCS.

10. No participant response.

11 Area served: Phoenix metro, nine branch offices.
Funding: Fees, insurance, contributions
Accreditation: Hospital

12. Area served: Central and norther Arizona, 16 offices.
Funding: Title X Family Planning Grant, Federal HHS, Title XX,
contributions, Fees.
Accreditation: PPFA, ADHS.

* The final five agencies were not listed in Community Referral source book,
and therefore (some) preliminary information related to accreditation,
affiliations and funding was not available.

13. No participant response.

14. Area served: Phoenix, one address.
Funding: No information.
Accreditation: No information.

15. No participant response.
   Funding: Private donations.
   Accreditation: No information.

17. Area served: One office, Phoenix metro.
   Funding: No information
   Accreditation: No information.

From this identified population, fourteen (14) interviews were conducted with participants representing twelve (12) agencies. Two respondents were interviewed from agency # six (6): 6A and 6B. Two respondents from agency # seven (7) were interviewed: 7A and 7B.

Participant Demographics:

1. Participant categorizes counseling as lay/pastoral, with no degrees, certification or licensure in counseling or a counseling related field. Participant shares that pregnancy counseling training was provided in an inservice setting, with teaching done by Sisters (two names given) from Catholic church; the agency also provided tapes and conferences for training of lay, pastoral counselors. This participant lists religion at Catholic; denies any political party affiliation; denies affiliation with any organizations related to reproductive issues.

2. Respondent to researcher's call to this agency states he/she is not a counselor; nor is anyone at this agency a "pregnancy counselor." This
individual, in response to other demographic questions offered: "We are a state agency. We do not express a position in any of these areas."

3. In initial phone contact, this counselor participant stated he/she was too busy, but was agreeable to an interview at a later time. A follow-up call was made during which researcher provided phone number. This did not facilitate an interview.

4. Phone contact with receptionist for this agency yielded three (3) professional counselors. In follow-up call, researcher's message number was provided. This did not facilitate an interview with counselor(s) from this agency.

5. In initial phone contact, an in-person interview appointment was scheduled. Participant interviewed categorizes counseling as lay, with professional supervision and consultation. (Professional supervisor called to verify this statement and to provide any additional information this researcher would find helpful). Participant offered that he/she held bachelor's degree in Psychology; received pregnancy counseling training through agency's inservice program (thirty, plus hours). Participant acknowledged religious affiliation and counseling was "Christian based;" stated political affiliation is "in a conservative direction." This participant denied affiliation with any organizations related to reproductive issues.
6. Attempts to contact agency # 6 found that the agency as described in referral source book was no longer operational. Researcher left phone number with individual fielding pregnancy related calls. Two participants responded:
A. First respondent described counseling as professional; post graduate studies in counseling, i.e. school guidance; denied any certification or licensure; denied any training specific to pregnancy options counseling. This participant offered no response to religious or political affiliation, citing employment in state agency.
B. Second respondent also described counseling as professional. This participant held master's degree in social work. This counselor cited some post MSW work: "CEU's in the area" (related to teen pregnancy). This individual declined to to share religious and political position, stating "I am a school employee."

7. Agency # 7 yielded two respondents.
A. The first of these was only a partial interview. This participant was interviewed before instrument was approved and was open to a follow-up interview at a later time. The follow-up interview did not take place, as this participant was reported to be on an an extended sick leave from agency. This individual held master of social work. Other limited comments are shared later in this project.
B. The second respondent referred to degree(s) of other employees in the agency. It is believed this individual did not hold a degree or any counseling certification. This respondent reported involvement in this type of counseling for "more than twenty years." This participant used "we," "the agency," and/or "no position" or "no comment" in response to almost every question.
8. Agency # 8 was not contacted secondary to researcher's personal reasons: Researcher's personal relationship with members of this organization precluded an objective sampling from this source. Consultation with Ottawa thesis committee chair supported this decision.

9. Respondent from agency #9 categorizes counseling as professional; holds certification as nurse-midwife. Licensed as registered nurse for eighteen years, with training specific to pregnancy in ongoing professional education. This participant notes affiliation with the American College of Nurse Midwives and an associate membership with the College of Obstetrics and Gynecology. Respondent acknowledges religious affiliation as Protestant; shares that political affiliation is with democratic party.

10. No response from this agency to two calls. No return call to researcher's message number.

11. Respondent from this agency states this agency does not provide pregnancy options counseling. However, respondent is in a position to field calls and to provide referrals. Participant holds bachelor of science in nursing; denies training specific to pregnancy options; declines to comment on personal religious or political affiliations (considers N/A); denies affiliation with any organizations related to reproductive issues.

12. Respondent from agency # 12 categorizes counseling as professional; has completed coursework for master of counseling; holds previous degree in
exercise physiology with certification in body work/massage. This respondent received inservice pregnancy options counseling training through nationally affiliated pro-choice organization. Participant describes religious affiliation as Eastern Ecclectic; political affiliation as independent. Acknowledges support (financial) to a pro-choice organization.

13. Did not receive a response or call back from agency # 13.

14. Respondent from agency # 14 categorized counseling as lay, but noted that professionals are available within the agency. Offered that training was inservice within the agency. Declines to offer comment or position related to religion, political affiliation or organizational affiliations.

15. Researcher had difficulty contacting this agency. A follow-up call yielded a recording which referred callers seeking pregnancy counseling to agency # 14.

16. Respondent from agency # 16 states all individuals at this agency are lay counselors. Describes training as inservice within agency and "on the job." Categorizes religion as Protestant. This individual stated: "I'm an old Atheist, who converted to Christianity as an adult." This respondent did not report any political affiliation (though in subsequent comments, offered strong political opinions). Respondent denied membership in any organizations related to reproductive issues, but later acknowledges working to unite "various local pro-life agencies."
17. Respondent from this source was not a counselor. Researcher was able to elicit very little information from this individual. This participant was unable or unwilling to connect researcher with a counselor. This individual did not provide responses to any of the demographic questions. Researcher offered phone number and address, hopeful that a counselor from this agency might be available for interview at a later time. A packet of brochures was received by mail from the source and will be discussed in following sections of this project.

Participant Responses to: "Role of religion and the church in pregnancy counseling"

Respondent # 1 replied that "faith should play a role" in the pregnancy options dilemma; that counselor should "look to client's beliefs;" that therapists' beliefs "should not matter, except should be generally Christian." In response to questions about personal views of the beginnings and sanctity of life and the soul, this participant responded that "We hold a pro-life position" and noted that the "abortion" option was in conflict with personal beliefs. With respect to conflict in the session respondent replied "if she wanted an abortion. . . we would not. . . we do not refer for abortions; we do not refer to Planned Parenthood." "If she chose this (abortion option), we would tell her we would help her afterwards." Respondent might recognize client was experiencing religious value conflict if "they say they know what's right but. . . need encouragement." In response to whether religious issues should be explored with client: "Usually, but only if she wants to." Respondent offered that religious conflicts were explored through "talking to her," a brochure called 'Coming Home'. . . a spiritual pamphlet printed by the
Catholic church is offered." "Also, we use education". (asked for specifics)
"Sometimes we use videos such as No Easy Way Out, After the Choice and
The Silent Scream."

Respondent #2 declined response to this category, noting: "We are a state
agency; we do not express any position in any of these areas."

Identified agencies # 3 and # 4 were not available for survey interviews.

Respondent #5 offered "I'm not exactly sure how to answer what the role of
the church or religion should be." "I don't have any pat answers... as to
whether religion should be explored with every client, it may differ in every
situation. I don't believe religious discussion... religious material should be
forced on any client." "I... we here are Christian based in our beliefs." This
respondent shared a written mission statement which included: "The___Center
is a Christian ministry focused on promoting the values of the sanctity of
human life, abstinence, and fidelity, to our community and beyond"... "Sanctity of Human Life Ethic...the reverence for and sacredness of each and
every human life based on its intrinsic worth and equal value regardless of its
stage or condition from conception to natural death." This respondent
expressed agreement with agency's mission: "I support life at all levels, our
beliefs do not support abortion," notes that "I let client know all the options,
but do share my beliefs." Respondent recognizes red flags of possible
religious value conflict when "Client may show extreme emotions or no
emotions." When this happens "we listen and give feedback," we have client
make pro and con lists," "we believe she has the ability to make her choice (when provided) with good information." "We do not manipulate."

Respondent #6A offered: "I personally believe religion is very important in this dilemma," "however I'm limited by policy... and law... where I work." This counselor believes it is important and should be part of the client's decision process, but reiterates "religion cannot be discussed in this setting."

Respondent #6B reiterates essential importance of consideration of religious values, but firmly supports separation of church and state.

Respondent #7A was available only for a preliminary interview, and not after instrument was approved. This individual shared that there was "an assumption of the client's choice" (adoption) when client presented at that agency. The comments did not share details of an assumed similarity of religious values or beliefs, or how religious values may have figured into counselor's practice or client's choice of that agency.

Respondent #7B was most defensive, responding to questions with questions or with brief platitudes: "I have no position on that..." "We honor her decisions and her beliefs." "The agency is non-judgmental and supportive." "As mothers come here planning adoption, this (religion) is not an issue." To query as to possible red flags that client might be experiencing conflicts of religious values, participant asked: "Pick up on it? I don't know what you mean." This participant offered no specific details about her beliefs, her perception of the appropriate role of church or religion in the pregnancy options counseling process.
Respondent from agency #9 offered "We cannot avoid the importance the role the client's religious beliefs play in this decision process." As a professional, I hold strong beliefs (about the beginnings, sanctity of life, the soul) but do not present mine. I do, frequently, have beliefs that are in conflict with patients. . . I'm firm about keeping these separate." "I cannot. . . I will not impinge mine on my patient." "If she expresses any doubts. . . conflicts, I encourage her to talk with family members and with her clergy." Respondent shared that many of her clients are of a very different religious/spiritual background than her own, and she encourages them to seek resolution with helpers who are more knowledgable and are more in line with their own beliefs.

No respondent from agency # 10.

Respondent from agency # 11 was firm in statement that agency 11 did not do pregnancy options counseling. This participant was in position to offer referrals, however. This respondent shared that "Patient's religion is an important factor;" that "the counselor's belief system shouldn't figure." This participant noted that personal (religious) belief system was not in conflict with any of the pregnancy options and that referrals would include those to an agency where all options would be presented to a pregnant woman.

Respondent from agency # 12 offered that church or formalized religious doctrines "should not mandate choice or options for a pregnant woman." "Her (the client's) spiritual values (respondent draws a distinction between organized religion and her spirituality) have to be considered." With respect
to the therapist's beliefs, participant responds that "if the therapist is an integrated spiritual whole, this will be a guiding force. . . " stresses this helps the counselor without being judgmental to the client. Respondent states "I can stay within my value system and help her with any of the options." "I can stay equal. . . neutral. . . but believe I would struggle with a late term abortion" (has never encountered that issue). With respect to beliefs about the beginnings of life, sanctity of life and the soul, states "I've given much time to. . . I've wrestled with this, when does the soul enter human form?. . . I believe everything is spirit." "I don't believe there is any one right choice, only a wise choice, and this will always be with sacrifice." This participant sees vagueness or ambivalence as possible red flags of religious value conflict, i.e., client's statements of "I just couldn't do it." This counselor would use this as a point of religious value exploration. "I always at least open the door of religious value exploration."

No response from agency # 13.

Respondent from agency # 14 shares that the role of the client's religion is important in the pregnancy options dilemma. This participant states that the counselor should not project her own beliefs onto the client, but states "this a tough line. . . counseling is really never value free." Respondent offers belief that "life begins with conception. . . this is biological," and expresses personal conflict with "abortion option." This counselor deals with conflict by providing "well rounded information" and by asking what (client's ) beliefs mean to them. "What did you feel about religion and pregnancy before you were in this situation?" "What would you tell. . . how would you advise your
friend if she were in this position?" "How do you think you will be living 5, or 10 years down the road?" Respondent sees drug use or client self-judgments as red flags of religious value conflict, and shares that religion should be explored to some extent, unless client is not willing to do so. "My willingness is there."

Agency # 15 voice message referred callers to agency # 14 for pregnancy counseling.

Respondent from agency #16 was self-described "old Atheist, converted to Christianity." This respondent promoted strongly the importance of religion: "Not a church itself, but God and Christianity are very important in this question." Stated that (pregnancy) decisions "are moral decisions that have a long impact on women." States that "abortion is an absolute in conflict with God." If a client leans toward this option, "I will try to help her to see how this (abortion) will not be good for her. . . will try to educate and support her." Cites prevalence "of post-abortion trauma" (syndrome).

Agency # 17 did not respond to this section of survey.

Participant Responses to Role of Family in Pregnancy Options Counseling

Respondent # 1 stated "family is important." Family members should be included in session "If they want." "I encourage girl to include "whoever she wants to include." Did not have response to techniques for handling conflicts
between girl's/woman's wishes and partner's or parents' wishes, for handling family pressures toward a decision or how to involve family in a helpful way.

Respondent # 2 did not respond to this section; refers clients for options counseling.

Agency # 3. No participation from this agency.

Agency # 4. No participation from this agency.

Respondent from agency # 5 states "we offer counseling with her family if she chooses; we always have time for her alone, first, then are open to her needs and wishes (about including family members). We honor her confidentiality, always, but do encourage family participation, if it is safe and is her wish. This respondent spoke of importance of bringing family in with preventative work and also for post abortion grief work. Did not share specific plan or guidelines for determining when and how family might be helpful or harmful--but stressed client's wishes honored in bringing in family--or not.

Respondent #6A offers "Our... policy defers to family, especially if girl is considering terminating the pregnancy. Did not respond to further role of family questions.

Respondent # 6B (same agency as above) perceives family involvement as very important (this participant often works with very young clients). Notes that because of precedent in the agency and previous problems, works very
closely with attorney—to stay within law and policy and still optimally represent the client. This counselor states that "in obtaining consent . . . that pregnancy is one area where I may have to breach confidentiality." "I strongly believe in parental involvement—but only with girl's prior knowledge and with her consent."

Respondent # 7A. No response to this section.

Respondent # 7B offers no comment to the general importance of the role of the family. Participant shares "I encourage (family involvement) whenever appropriate; my obligation is to the client. She is the one receiving services." No response to questions regarding conflict between client's needs and parents or how to determine if involvement would be harmful or how it may be helpful.

Agency #8 was not surveyed.

Respondent #9 was very thoughtful and divided in response to role of the family. "It depends very much on the family. Some families I deal with are very helpful; other are fragmented, (many) abusive. . . . high incidence of alcohol and substance abuse and cannot be of much help" "I always see client alone first." "Then it is her decision." "If there is conflict (between family and patient) I allow expression of their opinions, but support her rights." "You support that she has the right to make the decision. Offered numerous community support services as referrals when family is not capable of being supportive."
Agency # 10 did not respond to survey.

Agency # 11 representative reiterated that he/she primarily offered referrals. Did not respond to this section of questions.

Respondent from agency # 12 emphasized, when referring to importance of the role of the family "age is important and her sense of safety and support." "I always see client alone initially; I always touch on family." "... (then) whoever client wants, feels important to have here, we bring in." In response to conflicts between client's wishes and family's, respondent shares: "This is not unusual." "I maintain alliance with my client." "I restate that the choice is ultimately hers." "I try to find common ground." When there is perception of client being pressured? "I explore family of origin issues. . . (discuss) how free her choice is? I try to explore with her ways or kinds of pressures others may be exerting." When family does not know of pregnancy? "Again, I am tough on family. . . on family history. . . her age and circumstances are very important here." How do you help client determine if family can be helpful? "I explore the greater issues. . . choice as a free act. . . how she's attached. . . explore these, then may use some reality check questions." How might the family be helpful to her in her decision making process? "I believe they can be helpful with their presence, their understanding, their own sense of responsibility." I try to assess their lovingness; if I observe a sense of lovingness. . . good! Otherwise, I step in with boundaries."

Agency # 13. No response to interview request.
Agency # 14 respondent shares that age and cognitive level of the client make a difference. This participant generally encourages family involvement and may help facilitate this involvement. "If a minor, I usually see with parent(s), but I honor her confidentiality and her rights." When conflicts are noted between pregnant patient and family "I will see together and separately. . . we can all talk about the emotions and the bigger picture." "This is helpful when family members may be pressuring for a particular decision." "Whether family will be helpful depends on situation with each different client." "We provide many resources for the whole family" (when family does not know how to be helpful).

Agency # 15 deferred calls to agency #14.

Respondent from agency #16 believes role of family is "very important." "I go by her wishes" (whether and when to include family members in the pregnancy counseling process). This counselor shared two personal, family events which have impacted, have demonstrated "how pregnancy decisions can cause enormous mental disturbance" and result in "long-term healing needs." "I honor her. . . but educate and help her to find out how to bring in her parents as helpers." "Family members shouldn't be allowed to make her decision." (The girls) "need to win over their parents. . . " "I try to work with the family. . . I try to teach her how to talk to her parents to get their help."

Agency # 17. No response to this survey section.
Responses to Role of the School in Pregnancy Counseling

Responses were minimal to this category. None differentiated between roles of public versus private schools.

Respondent #1: Schools should offer more education. Provided no specifics.

Respondent #2: No response to this section.

Agency #3: Did not participate in survey.

Agency #4: Did not participate in survey.

Respondent #5: School may be a realistic channel for more preventive services. Did not specify types of services. This participant promotes agency mission of abstinence outside of marriage.

Respondent #6A: School is limited by policy, staffing, and funding; school (should) mostly refer out for pregnancy counseling services. Shared several referral sources. School does have role in prevention (named program), in a parenting group, and in Health and Life Management classes.

Respondent #6B: Acknowledges school is often the first place a young pregnant woman may seek help. This respondent sees role of the school as very conflicted, and sees role of school as three-fold: educational, preventive, and supportive. This participant acknowledges many variations of individuals (who may be sought out to provide service) in any one district. "Policies aren't
as clear-cut as one might believe." (there is) "much individual interpretation of practice. . . which does affect how one counsels. . . according to one's beliefs."

Respondent # 7A: No response in this category.

Respondent # 7B: This respondent gave no response to current role of school in pregnancy counseling. However, offered historical perspective that "years ago, there used to be schools out of town for pregnant girls." "They had their babies, then placed the baby for adoption. . . now more of them turn toward parenting or abortion. . . a lot of them choose this."

Agency # 8 was not surveyed.

Respondent # 9: "The school shouldn't have a place in the pregnancy decision." This participant is an advocate of school based clinics, on or near schools, but separate. "School's work should be to educate; not to deliver health care." "Education in the old sense. . . the three R's, should be school's primary mission."

Agency # 10: No participation in this survey.

Respondent from agency # 11: No response to this category. Again, "We refer for pregnancy counseling."
Respondent from agency # 12: Would like to see schools have more leeway in dealing with the whole child; more up-front-preventive education and counseling.

Agency # 13: Did not participate in survey.

Respondent from agency # 14: "School and pregnancy counseling is an issue I don't know very much about." "Parents should be privy" (to what is or is not done in this area.

Agency # 15: Refers calls to agency # 14.

Respondent from agency # 16: Believes "schools are so limited... they should refer out for this problem"... "schools are too afraid to talk about religion or morals or behavior." (offered several referral agencies considered appropriate and one considered inappropriate for school to refer to)

Agency # 17 did not respond to survey questions.

Responses to Role of Government and Law in Pregnancy Counseling

Respondent # 1: "This is a personal and moral area; government should not have a role." Other than "of course, we do not support (government funding of) abortion," this respondent offered little knowledge of or opinion about any reproductive laws or governmental policies. Stated "I'm not involved in
politics." Offered no response to laws being in conflict with belief system, or any this counselor would advocate changing.

Respondent # 2: No comment in this category.

Agency # 3: Did not participate in survey.

Agency # 4: Did not participate in survey.

Respondent from agency # 5: "I, we are not political." With respect to adoption laws offered "when a woman is considering adoption, I refer to professionals who network with lawyers to help her through the legal aspects of the adoption." Deferred other political or legal related questions to supervisor.

Respondent # 6A: Did not respond specifically to this section of survey; rather, discussed how affected by policy of place of employment. This participant shared "clear limitations" (set forth in policy guidelines) of subject matter which could be discussed or referrals which were permitted.

Respondent # 6B: This participant (from same agency as above) described an awareness of all pertinent reproductive laws. Unlike participant 6A, this participant offered that there were significant gray areas; that law and policy were not always clear cut and that different individuals in the same large agency may interpret and carry out policy quite differently. Participant expressed that "gag and squeal rules were ethically troublesome" and, as noted previously, this individual reported working closely with agency attorney.
Different individuals have different ways of getting around some of the restrictive ... to deliver best service to girls while staying within law and agency policy." This participant would advocate making law and policy around reproductive counseling be less restrictive. This individual did not express any opinions related to funding of reproductive choices.

Respondent # 7A: No response in this category.

Respondent # 7B. Responds that reproductive decisions "should not be the government business. To further questions offered "agency does not hold a political position." Later, amended this to "a representative body might have a position."

Agency # 8 not surveyed.

Respondent from agency # 9: "The importance of the role of government? This is a hard one." Expressed a comprehensive knowledge of reproductive law, noting that "I believe the general public is often misinformed." Expressed mixed feelings about adoption policies as they pertained to most of participant's client population. Expressed feeling conflicted regarding gag rules, citing need to provide more information than this policy permits. Saw pros and cons of pending parental consent legislation (in legislative process during preparation of this project); commenting that this legislation might be helpful but, could also be harmful to some young women, depending on their family situations. Advocated greater equality in funding, i.e. if an option is legal, then it follows that equal funding should be provided.
Agency # 10 did not participate in survey.

Respondent from agency # 11 did not respond to specific questions in this category, however noted that referrals are offered to an agency where "all options will be presented and explored."

Respondent from agency # 12: "The only role I see for the government is to support the humanness of the woman. . . (role should be) in keeping all choices legal and safe. . . governments need to work on this on a world-wide basis." "I have to follow the law. . . I work to educate and protect the client within the scope of the law." Offers, generally that laws need be less restrictive, less punitive, more supportive of all women's needs. Advocates equal coverage (funding) for all options "... as an umbrella, limited but not excluding any option then (the government and its funding) out." Express that existing laws are "tricky, delicate, tough." Opposes parental consent law (pending) but does advocate parental involvement when this is safe for the client. Participant uses every opportunity to legally advocate for laws which support her beliefs about choice and honoring women's humanness.

Agency # 13 did not participate in survey.

Respondent from agency #14: "Our agency is not political; I try to leave my political views at home." Does not believe in legal abortion. Does not advocate government funding for contraception, citing: "It does not deliver its promises." Also notes that it doesn't address STD concerns well enough to protect kids. Reiterates non-political stance in response to other questions.
Agency # 15 refers caller to agency # 14.

Respondent from agency # 16 offered strong political opinions: Pregnancy related law-making should be left to states; federal government's function should be solely to protect the country; expressed strong anti-Clinton position; promotes newer open-adoption policies; state governments should "say no to all abortion", which is equated with murder; views gag and squeal rules as conflictual; related to parental consent laws, advocates involving parents but supports girl's confidentiality; advocates state funding for medical services, but emphasizes private sector help; advocates laws around abortion should be more restrictive, starting now with "partial birth abortions." This participant cited statistics of numbers of these procedures being done (which could not be substantiated by any of this researcher's sources).

Participant from agency # 17 did not respond to any questions from this part of survey. Brochure provided in mail outlined some current Arizona adoptive law and offered further legal advice (related to adoption) upon request.

The Role of the Pregnancy Options Counselor

While the previous four sections explored counselors' beliefs and values related to four areas of society which may affect pregnancy decisions, this final section examined (1) what the participant perceives as the counselors' role and (2) some ways in which that participant enacts the practice of pregnancy options counseling.
Respondent #1 shares that the role of pregnancy counselor is "to help women decide," "to educate her," and "to be there for her." This respondent states that mission or goal of the counseling is "to save babies." When asked, do you reveal your biases, participant says "usually, but I might not if they said they weren't Christian." Respondent denies having any personal experiences which might impact counseling, however acknowledges some pregnancy experiences among close associates (does not offer details). Describes as primary concerns for the client "her health" and "her knowledge." What information is asked of women? Demographic information, "Questions about her health, LMP, pregnancy history, symptoms and thether she is decided or undecided." Information about options is presented. "We tell what happens after abortions--that she may be sterile after having an abortion." Informational videos include No Easy Way Out, After the Choice and The Silent Scream. Referrals include those made to medical, prenatal facilities and to adoption agencies; would "never refer to an abortion clinic." What specific details are offered to provide for an informed decision? "Just knowledge."

Respondent # 2: We do not do pregnancy counseling, specifically; usually refer back to Com Care. No other comments.

Agency # 3 and agency # 4: Did not respond to survey.

Respondent from agency #5: Participant perceives role of pregnancy counselor as a provider of "information about all three pregnancy options and also possible consequences of each; concerns for the client include: "what are her needs right now? How can we help her? What are her support systems?"
Questions asked of the client include general intake information. Also asked are "what are her physical needs?" "What are her social needs?" "What community support systems would be helpful to her?" "Client chooses what information she wants; we do not push information or services on her." This participant shared fact sheets, mission statements and a sample of films available for clients to select from. Rooms furnished as small, homey living rooms were available for reading and for viewing videos. Information appeared factual and not sensational. This participant acknowledged that long-term sequelae of abortions are not well known; notes that agency does see some clients for post-abortion grief work. Participant shares that although information is provided about all pregnancy options, "we do not make referrals for abortions." Participant emphasized availability of a wide scope of support services, variety of professional counseling services, for both crisis and follow-up needs. Participant provided referral sources, which were extensive-excluding only abortion services.

Participant 6A. This participant expresses "We are very limited, both by law and by policy in what we can offer in counseling or in referrals." This participant did not provide any specific answers to this section of questions except that "we refer out." Participant offered as referral examples: Catholic Family Services, Black Family and Children's Services, Chicanos por la Causa, Family Services Agency and ComCare; participant stated "we cannot refer to Planned Parenthood--but the girl's family could do that."

Participant 6B. (From same agency, different office, as above) This participant shares awareness of being "often the first line of counseling a girl
will receive." Primary concern is that she have adequate referrals, both to help with decision and to the various community support services. Initial questions asked of girl will include "does your family know." Participant believes family involvement is very important; and works to help girl connect with her family. This participant believes it is important that referrals be provided which will not be "psychologically oppressive." Does offer information about all options. Does include Planned Parenthood among referrals, with parental knowledge and approval. This participant did not name the religious based agencies among referrals; did share a lengthy list of support agencies which could offer resources (social, educational, medical and legal) for all three options. This participant emphasized, more than once how counseling minors who are pregnant is complicated by personal ethics and by law and agency policy. Reiterated importance of "providing accurate information, support and "psychological space for the decision making process," and of "working closely with agency attorney" to best meet client needs while staying within bounds of professional ethics and agency policy. Described this process as both complicated and conflictual.

Respondent # 7A (Partial interview) Noted only that there was an "assumption" that clients seeking services at this agency "were considering adoption." This participant shared that all options were discussed and that client was informed she had right to change her decision (to place for adoption). Did not provide which details or how much information was offered in discussion of options.
Respondent # 7B. Participant reiterated assumption that adoption was client's choice when presenting at this agency. Stated as role and mission of the agency: "We recognize the family as the basic unit of society"... "We provide a supportive, ethical and non-judgmental setting..." "We are knowledgable about referral sources." "We always refer for pre-natal services" and "to other support agencies." Are there any agencies to which you would not refer? "Any which would not be able to help her." What information do you believe the client needs to help her make a decision? "Positives and negatives of all the choices... the losses... how each could be a loss." Other open ended questions were responded to with questions or the first line of agency's mission statement.

Agency # 8 not included in survey.

Respondent from agency # 9: Provided detailed answers to each question. This participant perceived as basic to role: (1) assess her situation, physical and psych-social and (2) Present all legal options; noted that "I do not describe specific details of abortion procedures, as we are not abortion providers and the procedures may vary slightly at different clinics. I make certain she knows where to obtain this information." (3) Make appropriate referrals; I often help her make appointments for her care in my office. "I start with how they feel about being pregnant and we go from there." "... take into consideration her whole life style and support systems" "We discuss all options; what is available here"... "details of each option, health and medical details, what services she will need." (emphasized complete and accurate information) "refer out if she is considering abortion," "And, I always refer to a specialist if
(physically) any factors are outside the pregnancy norms... if any high risk factors are present." "I also always provide vitamins, whether or not she is planning to carry pregnancy to term... most of the girls I see are not well nourished." This participant provided an extensive list of services provided within the agency and of outside referral sources for medical services, behavioral health services and social/community resources.

Agency # 10 did not participate in this survey.

Respondent from agency # 11 offers that while pregnancy options are not done here, "I support pregnant women's right to choose and refer to a pro-choice agency where all options can be explored."

Respondent from agency # 12: This participant responded to all questions in this section. How do you perceive your role as a pregnancy options counselor? "To help client with an educated and conscious (decision) process." (emphasized process) Mission or goal? "To create a safe environment for women to make a conscious decision." Do you reveal your biases? "No, but I believe I hear my position back." Personal pregnancy experiences? "Yes, I know what it feels like to hear 'you are pregnant'... and that it is life changing... affects my womanness, my wholeness." What questions do you ask? "I work intuitively, get into their space... drive with them fearlessly... that is when the questions that need to be asked come up." Your concerns for the client? "That she comes to know herself, comes to conscious, present awareness... of herself, first, and of her responsibilities, her freedom... that she takes conscious action (in the decision making
process). What information does she need? "to know all options, every time; that she have solid information about each option." What details about an informed decision? "Education about fetal development" . . . "about being a parent, what that role will mean for her" . . . information about the specifics of abortion". What do you provide for an informed consent, if she is considering terminating the pregnancy? "Education about the details of the procedure, may show instruments used in describing procedures. . . also the potential risks and complications". What if client does not wish certain information or details? "I make sure at least she knows her three options and that referrals and assistance can be provided for each." What about your role in offering referrals? "I want her to be educated in the possibilities available to her."

This participant provided fact sheets and referral lists, (which are provided to patients/clients) documenting details and accuracy of information and scope of referrals. Also spoke at length about the grief/loss cycle, elements of sacrifice entailed in this process, and the spiritual/ life/death/life cycles as important components of this topic.

Agency #13 did not respond to survey.

Respondent from agency #14: What do you perceive as your role as pregnancy counselor? "To be a facilitator and aid to pregnant women." Mission or goals? None stated. Do you reveal your biases? "Sometimes. . . Pro-life. . . that we support birth." Your concerns for the client? "Her health, her social and emotional situation". What questions do you ask of client? "Married or single?" "her age" " her support". What information do you
believe she needs to help her make a decision? "information about fetal
development. . . about health. . . self-care, about abortions complications,
risks" (did not supply specifics) Your role in referrals? "We are not an
adoption agency, we may refer to adoption agency if she is interested". "We
always refer to pre-natal services" "We do not refer to abortion clinics." "We
aren't affiliated with any other agencies, but refer to quite a few places for pre-
natal and for different social services." "We might have just one session, or
might have more if she needs more."

Agency # 15 refers calls to agency # 14.

Respondent from agency # 16: Although not indicated in name of agency, this
participant offers, up front that "we facilitate open adoptions." Mission or
goal? "We offer positive alternatives to unplanned pregnancies through open,
independent adoptions." "We offer assistance, counseling, education,
education and mediation" (did not provide specifics, here) Do you reveal your
biases? "Yes." (with emphasis) Personal pregnancy experiences which have
impacted how you counsel? "Yes, my mother and my daughter. . . my mother
had an illegal abortion many years ago. . . and died of cancer which we are
sure was caused by the abortion." Your concerns for the client are? "That she
has information about consequences. . . the many. . . both physical and
emotional consequences of her decision." Participant followed with
discussion of consequences of abortion including "green cervix,", high
incidence of "injury" of subsequent "miscarriages" of "scar tissue, with poor
implantation" "some may not have this problem, but many will not be able to
carry." What questions do you ask her? "If you were my daughter, what
could I do for you" . . . "and some doctor's office type questions." What information do you believe the client needs to help her with decision" "I talk about chastity; I do not talk about contraception" "She needs help with all . . . such as pre-natal care, referrals . . . such as to AHCCCS." Did not offer response to what details needed for informed decision; informed consent was not applicable here. If client does not wish to receive certain information, how do you handle this? No response; then read a lengthy statement of faith, beginning with "God's grace. . . " and citing biblical scriptures and interpretation.

Agency # 17: This respondent was not a counselor. Information mailed to researcher from this agency included (1) List of negative consequences of single parenting, (2) Information about advantages of adoption and (3) Arizona law described under "How adoptive parents can help a birth mother." Brochure stated "Birth mothers can receive free adoption information without committing to adoption. Anyone can call to schedule a free adoption consultation, or to ask an adoption question."

Researcher Observations

Respondents from agency five (5), nine (9) and twelve (12) granted on site interviews.

Participant from agency five was verbally low key; described all options in terms and detail that appeared factual; showed educational materials which were not sensational or exaggerated. The messages, however, offered by the physical plant, its decor, the bulletin boards were strongly and unmistakably "pro-baby," "pro-life." Pictures of smiling babies, pictures of babies with
smiling parents, were everywhere. Photographs depicting stages of fetal development, with final one showing a smiling infant lined one hallway. Furnishings, wall colors were shades of pink and blue. Advertisement for MUMS (Mothers United in Mutual Support) were prominently displayed. One large room housed donated baby furnishings, baby and maternity clothing, infant car seats, available free to clients. A tour was provided researcher with "proud and enthusiastic commentary offered by participant."

The physical site housing agency nine (9) was very clinical. There were no overt messages, either pro-choice or pro-life notable in the decor, in posters or present on bulletin boards. Some community resources, particular to the community served at this site were displayed. Atmosphere was businesslike and professional.

Agency number twelve (12) was a professional, clinical setting. Hallway displayed framed poster: "Every Child a Wanted Child." Individual counseling office featured soft, indirect lighting, flowers, painting depicting a Native American woman, A framed "feelings" chart with "feelings faces" and "feelings words." Bulletin board and shelves featured many informational brochures on topics of reproductive health and many community resources--related to all three pregnancy options. Fact sheets and referral lists were provided researcher.

Among the telephone interviews, types of response varied. Some offered little or no personal information, in demographics section or in their attitudes and opinions in the four ideological categories. Some cited that they held no position; had given no previous thought to the particular question. Some believed their positions on certain issues not applicable to their practice; some
declined to state their positions, citing "employer policy restrictions." Others offered little information for unknown reasons.

One respondent expressed suspicion of researcher's motives for asking any of the survey questions.

The remainder offered replies of varying length and detail. Some of these responses appeared to be in form of "pat answers" or "lines" replicating agency's mission and policy statements. Some seemed to reflect an attempt by respondent to present their positions, missions or agendas. Others were presentation of counselors' thoughtful struggles to offer a counseling product reflecting their beliefs and value systems, within the scope of agency policy, the law and parameters of ethical practice.

Relationships between counselors' demographics, their opinions and attitudes in the four surveyed ideological areas, and their actual practice of pregnancy options counseling are explored in the analysis of this data.

Analysis of Data

Identified agencies number three (3), four (4), eight (8) and ten (10) were not participants in the survey. Agency number fifteen (15) referred all pregnancy counseling inquiries to agency fourteen (14).

Respondent from agency number (2) reported that this agency does not provide specific pregnancy counseling, and provided only that there would be referral out for this service. Only referral agency named was ComCare. Respondent from agency eleven (11) provided professional status (RN, BSN); did not provide any other personal demographic information, nor responses to the four ideological survey topics. This respondent offered that agency (11) "refers out for options counseling." This respondent named only Planned
Parenthood, stating this is the agency where all options would be discussed. I support women having all choices available to them.

Of respondents, those who described their counseling as professional, with one exception (6A), offered information and referral sources for all pregnancy options. Materials provided this researcher indicated that information supplied by these professional counselors appeared comprehensive, was accurate; was not exaggerated or sensational. Scope of referrals offered by these respondents included those which could service all options and, additionally, address other social needs. This included respondents 6B, 7A, who did not provide personal religious or political demographics, respondent 9, who described religion as protestant and political affiliation as with the Democratic party, respondent 12, who described religion as eastern eclectic and political affiliation as Independent. These respondents appeared cognizant of differing developmental stages, of need to assess whole person, need to consider variations of the clients' family and social support systems. Each sees client alone; then may include others in session.

Respondent 6A, who describes counseling as professional, did not provide demographic information about religious or political affiliations. This respondent cited limitations of law and of agency policy as limiting counseling he/she was permitted to offer. Referrals provided were noted to be to pro-life agencies and to community support services.

Respondent 5 and 14, describe their counseling as lay with professional training and supervision. Respondent 5 reports a strong Christian belief system and a Christian based counseling philosophy; denies any political affiliation. Respondent 14 does not report religious or political position. Both of these respondents report discussing all three options. Information provided
researcher in interview appears accurate; researcher is unsure how comprehensive as relatively few details and no fact sheets were provided. Materials used did not appear to be inflammatory or sensational. Respondent 5 sees client alone, then may include others; respondent 14, was more vague, citing depends on her age. These two respondents describe their counseling positions as pro-life and do not provide referrals to abortion clinics; other broad spectrum referrals are provided.

Respondents 1 and 16 describe their counseling as lay or lay/pastoral. Respondent 7B is presumably a lay counselor. It remains uncertain what information this counselor provides. Respondent 1 offers that religious preference is Catholic; denies any political affiliation; counseling training was obtained within the church in a program facilitated by Sisters; pregnancy counseling is Christian and pro-life. Respondent 16 describes self as a strong Christian; denies political affiliation but subsequently offers strong political opinions; expressed difficulty when a "professional counselor" was briefly involved with their agency; described training as "on the job." These individuals do not present the option of abortion. Inaccuracies were noted in materials these counselors stated they offered. Some sensational and inflammatory films were described as part of educational materials used. Neither offer referral to any agency which may be involved with abortions. Respondent 16 presented statistics which researcher was unable to verify; (researcher's information obtained from CDC professionals directly contradicted these figures). Respondent 16 cited Biblical quotes used as part of counseling process. Neither respondent 1 or 16 described their policies regarding how clients are seen, i.e. separately from, or together with family or partners who may accompany client to agency.
Demographic information and philosophical positions were not shared by respondent 17. Materials provided by this respondent promote only one option: Independent adoptions.

How do counselor ideologies and value systems affect the ethics of their practice of pregnancy options counseling? In analyzing data with respect to this question, researcher referred to important points presented in literature review. The first, is that pregnancy counseling can help; but that inadequate or inaccurate counseling can harm (Steinberg, 1989). The second included four identified areas in which clients described in case studies felt they were not well served by pregnancy options counseling:

(1) Received inadequate information.
(2) Received misinformation
(3) Perceived pressure, by staff or by own family or partners.
(4) Made a decision in conflict with their value systems.

The surveyed counselors subscribed to different ethical codes, or some to no codes; professional ethical codes are characterized by vagueness and by generalness. Researcher elected to examine data provided by respondents in terms of (1) how ideologies and values appeared to figure into their counseling practice and (2) how their resultant counseling practice was helpful, or did no harm, in the four previously identified areas.

Five of the counselors identified as professional stated a firm separation between their personal belief systems and their counseling practice. Three of these did not choose to share many of their own ideological positions; one shared political and religious beliefs which were not characteristically in opposition to any of the pregnancy options; one shared that personal religious
beliefs were frequently in conflict with at least one option, but felt ethically compelled to present all options. Each valued families' role in pregnancy issue, but noted that client was seen individually, at least first; that client consent was obtained to bring in any others. Responses of these professional counselors indicated information they presented in counseling was comprehensive and accurate (or that referral was made to sources which would provide comprehensive and accurate information). Client conflict or ambivalence was addressed in a safe, private environment with space, with education, with encouragement of client to explore their own beliefs, needs and resources. Three struggled with what they described as conflictual policy and law, to deliver counseling that best served their clients within the scope of those laws and policies.

One professional, who did not offer personal demographic or ideological information, reported very limited counseling provided and reported only pro-life and community support agencies supplied as referrals.

Of the two lay counselors who reported training and supervision by professionals, both at least describe all three options. Details which were shared with researcher appeared accurate and not inflammatory or sensational. Both do integrate their own religious ideologies in their counseling process. One reports that conservative political direction does figure into counseling work. One, firmly sees client alone, at least first session; the second of these was more vague in this response. Limited referrals reflect their ideologies and value systems.

Of the three lay or lay/pastoral counselors, one did not provide enough information to analyze. Of the other two, there was direct relationship noted between their religious affiliations, religious ideologies and their counseling
practice. Biases were strong and were revealed in the counseling setting in several ways. Referrals were limited. Some information was noted to be inaccurate. Some materials were noted to be inflammatory or sensational. One of these respondents reported self to be non political, and this seemed to be substantiated in the interview; the other professed no political affiliation, but subsequently expressed many strong ultra-conservative opinions. These two counselors did not define how they did or did not protect client from pressure of others. Client conflict appeared to be addressed with religious doctrine.

Respondents two, fifteen and seventeen did not provide enough information for any analysis if relationship between ideologies and practice.

Data supports that professionals six B, seven A, nine, eleven and twelve effectively separated their ideologies, or used the same in a way that provided adequate and accurate information, that permitted and encouraged clients' exploration of their own values, that protected client from pressure and/or provided referrals which were able to meet these client needs.

Professional six A, whose ideological positions were not shared, reported offering little information and limited referrals. It is not known if these limitations were related (more) to counselor's beliefs and value system or to counselor's perception of and response to agency's restrictive policies.

Lay counselors who were trained and supervised by professionals did provide information identifying each of three options and information shared with researcher appeared accurate. Their religious ideologies were integrated into the counseling practice; it is not possible to ascertain with survey information how much the Christian based, pro-life approach was perceived as pressure by the clients or prevented clients from comfortably exploring their
own belief and value systems. Limitation of scope of referrals might be perceived as not receiving adequate information.

The ideologies and value systems of the lay and lay/pastoral counselors, (one and sixteen), were integral in their counseling practice. This was evidenced in a way that appeared to affect the ethics of practice by limited information, by misinformation; by sensational and inflammatory educational materials and brochures delineating church doctrine, by counselor's recitation of scripture and by limited referrals. The clients' perception of pressure secondary to this type of counseling cannot be quantified by this study.
CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The purpose of the study was to explore how or in what ways counselor ideologies and value systems were kept separate from or became a part of the pregnancy options counseling process in ways which affected the ethics of that practice.

Seventeen local agencies which were advertised to provide pregnancy counseling were identified. Fourteen individuals representing twelve of these agencies were participants in the research.

An instrument developed by the researcher with supervision from Ottawa faculty was used to survey (1) counselor demographics, (2) counselor attitudes, opinions, value positions in four defined ideological areas, and (3) counselors' role in their practice of pregnancy options counseling. This study was conducted in the format of semi-structured oral interviews.

Conclusions

The research process validated several preconceptions about this topic: Pregnancy and women's reproductive choices around unplanned or unintended pregnancies continue to be sensitive and very complex issues. This researcher encountered individuals who were reluctant to share information; some were suspicious of motives for the study; one was defensive and overtly hostile.
Several made attempts to promote their points of view and their personal agendas. Others expressed great conflict and difficulty imposed by outside factors which the counselor experiences while attempting to provide what they each perceived as appropriate and adequate pregnancy options counseling.

This study surveyed only a small sample of counseling providers. The counselors' perceptions and descriptions of their counseling role may not be exactly translated in the enactment of that role. An individual outside the counseling setting cannot really know the subtleties of that counseling process which may influence or subvert a vulnerable client's self-determination.

Respective of these concerns, several themes emerged from the study. Five of the six professional counselors surveyed appeared to sense the importance of separation of counselor values from the counseling setting. These professionals appeared to possess the ability, awarenesses and motivation to keep separate their personal value systems from their counseling practice in a way that allowed them to (1) provide comprehensive pregnancy options information and referrals, (2) to present accurate information, (3) to protect their clients from pressure and (4) to provide a space, environment and encouragement within which clients could explore their own conflicts and needs. This separation promoted ethical practice, in the way it helped or "did not harm" according to standards described in literature review.

One of the professional providers offered limited information and referral sources. It is unknown if these limitations could be attributed to her personal ideologies and value system or were the result of those parameters the counselor felt were imposed by the employing agency.

Lay providers, who reported training and supervision by professionals, presented information about each of three options. Their information, though
slightly less detailed, appeared accurate and neither sensational or exaggerated. Referral sources were limited, in that none were offered to help a client who might choose to terminate her pregnancy. Personal belief systems were acknowledged to be part of their counseling curriculum and presentation. It is unknown to what degree the religious aspect of the counseling was perceived as pressure or detracted from the client's ability to freely and safely explore her own value conflicts. These disparities may affect the ethical standard of the counseling product provided by these counselors.

The counselors surveyed for this study who described themselves as lay or lay/pastoral provided limited information and referrals; provided some information which was known to be inaccurate; used some "educational materials" which were exaggerated and inflammatory. These participants held personal ideological positions and agendas which were integral in their counseling practice and there seemed to be an assumption of shared values between counselor and client, or an attempt to install counselor values in the troubled client. Data from these participants presents concerns that their integration of their personal values systems into the pregnancy options setting seriously compromises an "ethical counseling product."

As lay providers, however, they are not bound by any professional codes of conduct; they do not receive funds from any sources which could impose restrictive guidelines; and, they have legal, constitutional right to present their views in the settings in which they work.

The diversity and relative freedom which is a cherished part of American culture may also serve to perpetuate this disparity of counseling product.
Recommendations

Short of massive regulation and of restriction of rights Americans have been guaranteed by their government, a uniform pregnancy options counseling standard of practice will not be a fact. Perhaps it should not be. Answers to the dilemma of how well or poorly served young women with problem pregnancies are will continue to be complex.

In an ideal world, there would be fewer problem pregnancies. In this ideal world, the women seeking pregnancy counseling would be both informed and assertive consumers. Unfortunately, the converse is usually true: The women sitting across from the pregnancy counselor are most often ill-informed, are seeking resolution to their dilemmas under the pressure of time, and are experiencing their greatest feelings of vulnerability.

Certainly some interim goals would be the promotion of higher visibility and accessibility of professionals and professional agencies where an inclusive, ethical pregnancy counseling service is provided; the education of persons in referring positions; and, the provision of information about the diversity and disparity of pregnancy counseling services at a community and consumer level--before the crisis pregnancy occurs.

Implications for counselors in referring positions must include that they: (1) continually update their clinical information bases to keep abreast of evolving changes in policy, professional ethical codes and local statutes relating to pregnancy options and (2) that they obtain pertinent facts about the missions, agendas, training and scope of services offered by potential referral sources. A strong recommendation offered here is that the basics of pregnancy options counseling be presented to all counseling students. Weekend
professional seminars, such as those offered to graduate students at Ottawa University, would be one excellent format within which to present this topic.

An inclusive and descriptive referral source list prepared at a lay level would be helpful to pregnant individuals, their families, or others on the first line of helping with the pregnancy decision. This informational brochure should necessarily address the potential of each agency or counselor to: provide adequate and accurate information; to provide parameters in the counseling environment which encourage exploration of the woman's beliefs, values and resources related to each pregnancy option; to definitively protect her from pressure, within or outside the session; and to openly and willingly disclose any ideological positions or agendas which will direct or limit what is offered the pregnant client.
REFERENCE LIST


Bullfrog Films/Concentric Media Productions (1992). When abortion was illegal: The untold stories. Oley, PA.


APPENDIX 1

INTRODUCTION AND DEMOGRAPHICS OF SURVEY
Introduction

I am a graduate student at Ottawa University. As part of my culminating graduate project, I am looking at the scope of pregnancy options counseling in the central Arizona area. I am particularly interested in how political, religious, and personal belief systems are related to one's practice of pregnancy options counseling. I would appreciate your responses to my survey on this topic. All responses will be presented anonymously. No individuals or agencies will be identified. I would be happy to provide you with a summary of my research results.

Demographics of interview subjects:

1. Would you describe your counseling as:

   Lay___Pastoral___Professional___?

2. What is the type or level of your education in counseling (or counseling related field)?

   None___Associate___Bachelors___Masters___Post Masters___

   Degree held__________________________________________

3. Do you hold a license or certification in counseling or in a related field? ___If yes, specify__________________________________________________________

4. Have you received training specific to pregnancy options counseling? ___If yes, where/how was this training obtained? ________________________________

5. Religious affiliation? If yes, specify_____________________________________

6. Political affiliation? If yes, specify_____________________________________

7. Affiliation with any organization(s) related to reproductive issues: No___
   Yes___ If yes, specify__________________________________________________
APPENDIX 2

INSTRUMENT QUESTIONS SURVEYING COUNSELOR ATTITUDES AND OPINIONS ABOUT ROLES OF RELIGIÓN, POLITICS/GOVERNMENT, SCHOOL AND FAMILY RELATED TO PREGNANCY OPTIONS
Religion /The church

1. What role do you believe religion and/or the church should play in the pregnancy options dilemma?

1. A. Client's religious beliefs/ church?

1. B. The therapist's religious beliefs, church?

2. What beliefs/views do you hold about the beginnings of life? the soul? the sanctity of life? which are important to you as you counsel women struggling with pregnancy decisions?

3. A. Are any of your religious beliefs in conflict with any of the pregnancy options?

3. B. If yes, how do you handle this in sessions?

4. How or in what ways do you help clients explore their own religious value conflicts?

5. What are the red flags which indicate a client may be experiencing religious value conflicts?

6. A. Should religious issues be explored with each client? Always? Never? Usually?

6. B. Why?
Role of the Family:

16. What are your beliefs about the role of the family in a young woman's pregnancy options decision?

17. Do you include family members in the session?

18. Do you encourage family participation? Prohibit? How is this accomplished in your sessions?

19. If family members participation is encouraged or permitted, which family members do you include? Parent(s)? Husband? Partner? Others?

20. A. How do you handle situations where family members wishes are expressed and differ from those of your pregnant client?

20. B. When family members pressure for or against woman's decision?

20 C. When family members do not know about the pregnancy and pending decision?

21. How do you help client determine if family involvement may be helpful? Or harmful?

22. What types of information or assistance from family might be needed in helping the young woman with her decision?
Role of the School

School may be the first place a young pregnant woman seeks help:

23. Do you believe the school should have any role in counseling pregnant teens?

24. What do you see as the role of the school counselor or nurse in pregnancy options counseling? What do you see as an appropriate scope of the school nurse/counselor role?

25. Are you aware of how this role may differ between public schools and private schools? Does this present concerns to you? In what ways?
Government/Politics and Women's Reproductive Decisions

26. What do you believe the role of government should be in women's reproductive decisions?

27. Do you have feelings or opinions about existing reproductive laws? Discuss.

27. A. Adoption?

27. B. Abortion?

27. C. Parental Consent laws?

27. D. Gag rules?

27. E. Squeal Rules?

28. Do you advocate Government funding for:

28. A. Contraception?

28. B. Pre-natal care?

28. C. Maternal and infant care?

28. D. Abortion?

29. E. Other public assistance?

30. Do you believe laws should be more or less restrictive?

31. Would you wish to change any existing laws related to reproductive choices?

32. If yes to 31, Which ones? How would you change them?

33. Which political direction is most in line with your belief system?

34. How do you deal with situations in which law or statute or policy are in conflict with your beliefs and value system?
APPENDIX 3

ROLE AND PRACTICE OF THE COUNSELOR: SURVEY QUESTIONS
Role of the Counselor:

7. What do you perceive as your role as a pregnancy options counselor?

8. Do you have a "mission statement" or particular goals for the session(s)?

9. Do you reveal your biases?

10. What personal pregnancy experiences have you had which may impact how you counsel? Do you share these? In what context?

11. What questions do you ask the pregnant client?

12. What are some of your concerns for the client?

13. What information do you believe the client needs to help her make a decision?

13. A. What specific details do you provide for an informed decision?

13. B. What information do you provide for an informed consent, if terminating the pregnancy is her choice or is an option she is considering?

13. C. If client does not wish to receive certain information or details, how do you handled this request?

14. A. From whom do you receive referrals?

14. B. What do you see as your role in offering referrals?

14. C. In what situations do you always refer? Why?

14. D. In what situations do you sometimes refer? Why?

14. E. In what situations would you never refer? Why?

14. F. Which agencies do you refer to?

14. G. Which agencies do you never refer to?

15. A. Who is included, invited into sessions?
15. B. Length of sessions? How many sessions?

15. C. What types of follow-up counseling is offered? Through decision process? Post abortion? Through and following the adoption process? Support through pre-natal/post-natal period?
BIOGRAPHICAL NOTE

Betty Lincoln Leon is a third generation Arizona native. She received an Associate Degree of Nursing from Phoenix College and has held a license as a registered nurse continuously, since 1967. Areas of practice included Medical Intensive Care and Coronary Care within the Maricopa County Health System. She returned to academia in 1990, and completed studies in Chemical Dependency Counseling at Rio Salado Community College in 1992. She continued her education at Ottawa University, where she majored in Psychology and was granted a Bachelors Degree in January of 1995. Graduate studies will culminate with the awarding of a Master of Arts degree and certificate in Marriage, Family and Addictive Disorders in January 1997.

Ms. Leon is the mother of three sons and currently resides in Paradise Valley, Arizona.