Concepts

Chris Schlesiger, Research & Innovation Director - Adapted from an article written by Jim Harden

In the commitment to providing a relevant service, CompassCare Pregnancy Center in Rochester New York began investigating what a typical patient's questions were when she was facing an unplanned pregnancy. It was through this research that it was realized that a woman earnestly desired information on all her options including abortion. Once we asked ourselves why we were not providing this information we realized that it was because of our philosophy of service. *We were focusing on the baby, not what the mother needed in order to have the baby.* We needed to move from a baby-centered model to a woman-centered model. The theory is that if a woman feels secure and supported she will likely have her baby. If she does not, then she will likely have an abortion.

We need to identify what drives a woman to get an abortion and address that. Thus, the primary objective of the organization has become: "Erase the (perceived) need for abortion by transforming a woman's fears into confidence." **Our job is not to assume the worst of her and influence her toward our agenda but rather to insulate her from additional external pressures driving her to get an abortion.**

We must be proactive about providing her information about all her options so that the decision in front of her will be clear in her mind. Or if she has already made a decision, to help her understand the options associated with that decision. *Our perception of women facing an unplanned pregnancy as people who WANT to have abortions needs to change to understanding that they are people who do NOT want to have abortions*.

The basis of our service to the women who come to us is not an empirical, evidence-based debate where we represent one side and she represents another – but rather, one of advocacy with a heightened respect and support for the autonomy of the individual and a belief that given all the information and support, most women will choose the path leading to having her baby.

This is exactly the Biblical account of how God treated Adam and Eve in the garden. Genesis chapter 3 gives an account of the trust that God placed in humanity's first representatives. Essentially, there was a tree in the Garden of Eden, a tree of the knowledge of good and evil, the fruit from which they were prohibited from eating. However, they clearly had been given the power to do so by God with respect to their own free will. They could choose of their own free will to obey or disobey. God gave humanity free will to choose to determine his own destiny for good or for ill. And while we know that good decisions ultimately yield positive consequences and bad decisions negative ones, we determined to believe in a woman's maternal instinct to make a choice that is right for both her and her baby. Facing an unplanned pregnancy does not need to be an either/or scenario for her. It can be a both/and scenario. She wants it to be. We want it to be. This occurs only after her

anxiety is reduced to the degree that her decision is not driven by fear of the unknown, but by confidence.

Person-Centered Therapy Approach vs. Problem Centered Approach

Person-Centered Therapy Approach

The patient-centered approach, also known as Person-Centered Therapy (PCT), has its roots in 19th and 20th century existentialism philosophy. It asserts that a person is utterly alone in a world that has no value save for the value an individual assigns to it. This patient-centered approach is often employed "to help a person come to terms with a specific event or problem they are having. PCT is based on the principle of talking therapy and is a non-directive approach." (Wikipedia)

On the surface, one may think that a patient-centered approach is as it should be. A woman comes to see us because of her circumstances and needs help solving a very significant problem. While it is true that many of the women who agree to come to a pregnancy center happen to be pregnant, it is important to note that *the nature of a patient-centered approach is "non-directive," meaning the counselor / advocate does not have a set plan to deliver information of specific value to the decision-making process of the patient. The reality of this type of approach is ill-suited to engage a common human dilemma with three clear choices like unplanned pregnancy. In fact,* ***a directed plan to get specific information into the hands of the person facing the problem is exactly the opposite of the definition of the patient-centered approach.*** The counselor / advocate allows the patient to talk and follows her conversation to wherever she leads, assuming that by allowing her to talk, she will arrive at a decision wholly her own.

The counselor / advocate often finds herself in a position of having no idea of what she is going to say, what information she may inject into the conversation, etc. This is not a pure Christian environment as much as it is a secular humanism. In PCT the counselor / advocate is expected to not have an agenda when counseling a woman facing an unplanned pregnancy. *You and I both know that people passionate enough to devote their time to serving women specifically facing unplanned pregnancy whether pro-life or pro-abortion can be described as a lot of things…but "non-agenda oriented" is not one of them!!* Nevertheless, counselor / advocates are trained to engage a patient with empathy and unconditional acceptance without a specific or clear conversational plan for a presentation of steps to help her in decision-making regarding her unplanned pregnancy options. In this way, the patient-center (PCT) model of counsel in this context is used in a manner that is not in integrity with the intentions of the pregnancy center.

Please understand this clearly…if a counselor / advocate at a pregnancy center did not use this patient-centered model of counsel, then that means the counselor / advocate may be required to provide information they may be unwilling to give-more specifically, information that they fear might encourage a woman's decision to elect for abortion rather than adoption or parenting. *What is left unsaid becomes a means of manipulating outcomes toward the agenda of the counselor / advocate.*

This is both manipulative and disrespectful of the patient who has come to us believing we are going to give her information on her unplanned pregnancy options. (Please note and be assured the center's clear and unchanging value has been and will continue to be solid in its commitment to never refer or assist a women in obtaining an abortion-which includes not providing any information for abortion retention purposes.)

Furthermore, *this style of approach with a patient assumes she actually* ***wants*** *an abortion*. This then permits the counselor / advocate to interject personal experience or thoughts and empirical data about the development of the child while at the same time withholding information about the various abortion options available to the patient at that moment because, it is assumed, that women actually want to have an abortion.

It is also assumed that patients do not know that what they are aborting is a human being at its earliest stages of life. *Ironically, based on input CompassCare has compiled from focus groups, the essential reason women feel like abortion is such a hard choice is precisely because they believe that what is aborted is a child*. Moreover, it is hard choice because they feel torn. One part of them wants their life to continue as it was and the other part wants to be responsible and have the child. But complications like lack of support from the father of the baby that create a sense of overwhelming anxiety such that they cannot fathom life after having had a child. **They come seeking information to determine a course of action usually around a decision they are already predisposed to making - abortion.** They feel the weight of the choice and that is what drives them to contact the pregnancy center. **They are desperate for data and a clear understanding of the steps involved in each of their three options.** If the pregnancy center cannot deliver, then they will leave having been inoculated to ever again receiving service from a pregnancy center. Providing certain data, accurate or not, and intentionally not providing certain other types of data or service is disingenuous at best and does not allow a patient to find a solution quickly but is interpreted by her as a disrespectful waste of time.

It is our contention that there are two unacceptable things that happen when a woman is exposed to the PCT style of counsel:

1. It makes a woman who is at risk for abortion more vulnerable to external manipulation not just by what is said but by what is left unsaid by the counselor / advocate.
2. It does not increase a woman's sense of empowerment and autonomy relative to making a sound decision because she is not getting any unique information that she could not figure out for herself with 30 minutes on the internet.

Problem-Centered Approach

When a pregnancy center engages a patient in an open-ended manner providing certain information while withholding or manipulating other types of information,

whether it is truly non-agenda oriented or not, it makes assumptions about the nature of the desires of a woman facing an unplanned pregnancy. The primary assumption about the woman with the PCT (Patient Centered Therapy) style is that she wants to have an abortion and must be convinced otherwise.

On the other hand, the problem-centered approach springs from a more appropriate Biblical perspective respecting the decision-making ability of the individual (Genesis 3). The primary mode of operation on a problem-centered approach is the delivery of information and services in a very specific, step by step **approach the primary assumption being that a woman does not want to have an abortion.** *This approach moves away from the subjective patient-centered approach which focuses almost exclusively on the turbulent unpredictable emotions and thoughts of the patient, to a problem-centered approach focusing squarely on the issue or crisis and its relevant and legal (however immoral) solutions common to all patients.*

This problem-centered approach produces a focused response to a specific problem which does two things:

1. Reduces that chance of patient manipulation by ensuring a consistent and accurate delivery of a specific body of information and services.
2. Increases the patient's sense of autonomy with respect to managing the problem she is facing.

Our bottom line is how many women at risk for abortion walked out of our doors at peace enough to think clearly about the choice they have in front of them. Our objective is the autonomous support of women at risk for abortion. *This means trusting her with all the information regarding not just parenting and adoption, but abortion as well.*

In keeping with the integrity of the mission of the Center, we cannot provide nor refer for abortions but we certainly can be the best at answering the three basic questions every woman needs to have answered BEFORE she determines the outcome of her pregnancy:

- **Am I really pregnant?**
- **How far along am I in the pregnancy / Is the pregnancy viable?**
- **Is it important to know if I have a STD before I get an abortion?**

These three questions represent a focus not on the woman, but on the problem the woman is facing. This actually serves to reduce her anxiety because she knows that there is relevant information that she has to acquire in chronological order before she ever think about abortion.

When an organization engages a problem-focused approach, it creates a certain freedom when faced with each unique patient scenario. *As long as the primary driving force of the engagement between the patient and the organization is the problem called "unplanned pregnancy," then applying the same approach will work very well for most women.*