

## Mixed Methods Research of Crisis Pregnancy Counselling and Support Services

*Catherine Conlon*

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## Foreword

I am very pleased to present this research report, which gives a detailed picture of women's views on crisis pregnancy counselling services in Ireland. The research findings are based on the experiences of 400 women with a crisis pregnancy and build on a number of previous research reports. This report reflects the views of the woman herself and gives a real insight into what women with a crisis pregnancy want and need from counselling services, as well as describing the barriers some women experience when they try to access such support.

It is always the intention of the Crisis Pregnancy Agency that evidence garnered from our research programme should lead to the development of services most appropriate to alleviating crisis and preventing further crisis pregnancies. The results will help in our quest to develop woman-centred services and supports. This research has already contributed towards improving access to counselling services and raising standards within crisis pregnancy counselling through the development of a best-practice module on crisis pregnancy counselling.

Counselling not only assists women at the time of crisis; over one-third of the study participants intended to seek post-pregnancy counselling and many also hoped to access post-pregnancy supports such as medical care, contraceptive advice and parenting information. It is to be hoped that improving access to good-quality counselling and support services will enhance women's sexual and emotional wellbeing in the long-term, and thereby contribute to a reduction in the number of crisis pregnancies in the future.

I would like to thank the women who gave of their time to contribute to the research. I would also like to thank those agencies who allowed the researcher access to their clients and accommodated their needs. Finally, I would like to thank the author, Catherine Conlon, and her team from the Women's Education, Research and Resource Centre, UCD. The researchers were very successful in accessing women with a crisis pregnancy. The willingness of these women to participate in the research at such a difficult time in the lives is testimony to the sensitive and professional approach of the researchers.

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Catherine Conlon graduated with an MA in Women's Studies from UCD in 1994 and has since worked as a social researcher both within the university sector at Trinity College Dublin (Department of Sociology) and now within WERRC, University College Dublin, as well as in the public sector as Research Officer at the National Council on Ageing and Older People. She is Research Co-ordinator at WERRC, working on a range of projects in the areas of social policy, gender and equality, gender and health, and women's adult education. She is co-author of *Women and Crisis Pregnancy* (1998) with Evelyn Mahon and Lucy Dillon.

*Acknowledgments*

For my part, this research has been about gaining an understanding of what women facing a crisis pregnancy need at this critical time in their lives. I am indebted to each woman who shared her experiences with us in interviews and I hope this report does justice to their stories.

The fieldwork for this research was carried out in six different sites – four abortion clinics in England and two antenatal clinics in Ireland. In each site we received tremendous help and support that was vital to the success of the study. While it is impossible to name all of those who facilitated us in this research, I wish to extend my warmest thanks to the staff and management of every site we worked in.

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*Catherine Conlon*

*The views expressed in this report are those of the authors and do not necessarily reflect the views or policies of the sponsors*

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## Executive summary

### Study aims and objectives

This study aimed to examine women's experiences of crisis pregnancy counselling using both qualitative and quantitative methods. The study group comprised women with a crisis pregnancy who either decided on abortion or were continuing the pregnancy, with either the intention of parenting the child or placing the child for foster care or adoption. The study examined women's expectations of crisis pregnancy counselling, the extent to which their experiences corresponded with expectations, their perceptions of strengths and weaknesses of counselling and recommendations for enhanced counselling services. The study also explored the reasons why some women chose not to avail of counselling services.

### Methodology

A mix of both qualitative and quantitative methods were employed in this study of crisis pregnancy counselling. Fieldwork was conducted in a mix of settings. The fieldwork sites were selected having regard to the choices women make regarding the outcome of their pregnancies i.e. motherhood, adoption or abortion. Two sites were identified as relevant to generating the sample – antenatal clinics in Ireland and abortion clinics in Britain. The antenatal setting yielded a number of women contemplating placement of the baby for adoption or fostering.

Semi-structured, in-depth interviews with 46 women currently experiencing a crisis pregnancy were used to generate rich qualitative data. In addition, 400 women experiencing a crisis pregnancy were surveyed to allow for the exploration of some of the research questions with a more representative group.

### Summary of study group broken down by method of data collection

Data collection site	Number of survey respondents	Number of interview participants
2 antenatal clinics (Dublin and West of Ireland)	301	23
4 abortion clinics (London and Liverpool)	99	23
<b>Total study group</b>	<b>400</b>	<b>46</b>

### Factors shaping attendance at counselling

A range of factors shaped women's decisions about attendance at counselling. Survey findings showed that attendance at counselling varied significantly according to the outcome women decided upon. Over half of the women who decided on abortion (54%) attended counselling, compared with less than one fifth (19%) of those continuing to motherhood. Within the groups, women in the abortion group were most likely to attend 3-option counselling services, whereas those continuing the pregnancy attended both 3-option and 2-option services in equal numbers. Some women attended counselling for help with making a decision on how to resolve the pregnancy. However, most of those

who attended counselling had made a decision and wanted practical help and information on carrying it out.

Reasons cited by those who did not attend counselling included doubts about the inherent value of counselling. Those who usually resolved a difficult dilemma without canvassing other people's opinions took the same approach to resolving the pregnancy and did not attend counselling. Within the antenatal group, women who had been through a pregnancy before and those who had the support of their partner or family were less inclined to attend a counselling service. In particular, women who were older, in stable relationships and/or had children already tended not to consider counselling as relevant to them. Those who had not considered the option of abortion also tended not to consider attending counselling. A number of women in the antenatal group felt that counselling could have provided them with support, but they reported a lack of knowledge of counselling services. This barrier was particularly acute for women who had recently migrated to Ireland.

### **Barriers to accessing counselling**

Women in the abortion group were more likely to report experiencing barriers to accessing counselling than choosing not to do so. Of those in the abortion group who did not want to attend a counselling service some felt simply that they did not need counselling to help them with their decision. Some believed that counselling would entail an attempt to persuade them to continue the pregnancy. Women avoided counselling where they perceived it would involve them giving an account of how the pregnancy occurred or a defence of their decision.

A common barrier to attending counselling for women in both groups was lack of knowledge of who provides crisis pregnancy counselling and what such counselling entails. In particular migrant women and women living in rural areas reported this barrier. Other barriers common to both groups were difficulties accessing services due to limited contact hours, inadequate geographical spread, delays in getting an appointment and fear of being recognised entering a crisis pregnancy counselling service.

For women in the abortion group, not knowing whether a service would discuss the option of abortion or provide contact information on abortion services was the most commonly cited barrier to accessing counselling. The failure of crisis pregnancy counselling providers to communicate clearly the nature of the supports and information they offered was strongly criticised by women. Some expected counselling services would seek to influence them in making their decision. Some attributed certain 'agendas' or stances to individual agencies and these expectations shaped their decisions as to whether to attend these agencies or not.

### **Role of support networks**

Most women received support from within their own network of partners, family and friends. Still, many saw a role for crisis pregnancy counselling alongside this support system. Crisis pregnancy counsellors were often viewed as having skills and information women did not expect would be available from members of their support network. A small number of women did not have support from within a personal network and for this group access to crisis pregnancy counselling was vital.

### Role of general practitioners (GPs)

The role of GPs in supporting women through a crisis pregnancy had an important bearing on what women needed and expected from crisis pregnancy counselling. A GP who was supportive, empathetic and willing to assist women with the practical information they needed to proceed with whichever option they were considering met most of women's needs. Doctors who either made an assumption that women were happy with the pregnancy and intended to continue to motherhood, or who were non-committal and evaded the possibility that the pregnancy represented a crisis did not alleviate the sense of crisis for the woman in any way. Crucially, such doctors missed a valuable opportunity to link women with dedicated services and to foster an attachment between the woman and medical and counselling services in dealing with the pregnancy.

### Shaping good practice in crisis pregnancy counselling

Findings relating to the needs and expectations women had of counselling, together with the strengths women highlighted of the services attended, give a good indication of what would constitute best practice in crisis pregnancy counselling. Women wanted services to communicate clearly whether they provided information on all options, including abortion. Women wanted counselling to be a forum where they could talk freely about their feelings, fears and conflicting emotions in a safe environment. Overall, women felt that crisis pregnancy counselling services need to provide support, advice, reassurance and empathy in a non-judgemental way. Most wanted counselling to be non-directive and include all options. Women need counsellors to provide them with full, detailed information about the option(s) they are considering so that they can make as informed a decision as possible. The strengths highlighted in relation to the structure and organisation of the services included flexibility in the format of the service (such as telephone counselling, outreach provision and flexible appointment times), presentation of the service in a discrete format, and the provision of counselling on a no-fee basis.

Most women's need for help and support did not end when they had come to their decision. Of the women surveyed who decided on abortion, just over half intended having a post-abortion medical check-up. One in four intended to seek contraceptive advice from a medical professional. 14% intended to seek post-abortion counselling services, while a small number – 4% – intended to seek out a post-abortion support group. One in three women who were continuing with the pregnancy expressed a need for ongoing support from crisis pregnancy counselling services as they prepared for childbirth and motherhood or adoption. This included a counselling service that would provide advice on the antenatal care system and practical information on issues such as accommodation options and welfare entitlements, as well as post-natal counselling, including parenting advice. In particular, women who were contemplating placing the baby for adoption needed ongoing access to counselling during the pregnancy.

### Issues to be addressed in crisis pregnancy counselling

Deficiencies highlighted related to both 3-option and 2-option services. Overall, 2-option services were criticised for not providing information on abortion services to women. 3-option services were criticised for being unclear in communicating to women that their service included the provision of information on abortion. Women were also critical that front-line staff, in 3-option agencies in particular, lacked empathy. Another criticism of

3-option agencies was a failure on the part of some to prepare women fully for the policies and procedures of the abortion clinic.

Issues of bad practice were highlighted in relation to 'rogue agencies' through the presentation of case studies in the report. Women's accounts of these services illustrated that they were unethical in their treatment of women who came to them seeking help. The sole focus of these organisations was to deter and prevent women from accessing abortion services, through manipulation and misrepresentation. The strategies used in an attempt to dissuade women who were considering abortion from that option included the provision of spurious information about both the abortion procedure and the medical and psychological effects of abortions. The outcome of such practices was that women were distressed and worried, presented late for either abortion or antenatal care and never accessed the kind of help and support they anticipated would be provided through crisis pregnancy counselling.

### Recommendations

A set of recommendations has been formulated with the aim of ensuring that better support is available for women going through a crisis pregnancy. The central objective of crisis pregnancy counselling and support services should be to facilitate full consideration of all options. It should also offer a continuum of comprehensive support from the point of contact through to post-pregnancy care for all women, regardless of which outcome they decide upon.

We have recommended that all crisis pregnancy counselling services should be underpinned by the principle of an Ethic of Care for women going through a crisis pregnancy, regardless of their chosen outcome. The Ethic of Care must be evidence-based. The evidence from this research is that women going through a crisis pregnancy need services to incorporate both a supportive environment and comprehensive practical information on whichever option(s) they are considering. The Ethic of Care should standardise the response to a woman who makes a disclosure of a crisis pregnancy. This should represent the minimum standard of care provided by any crisis pregnancy counselling and support service. In particular it should apply to those offering crisis pregnancy counselling and to GPs.

### Principles of an Ethic of Care for crisis pregnancy counselling

A woman who makes a disclosure of a crisis pregnancy should be responded to with:

- a pro-active openness to fully exploring how she is feeling and the full range of options available
- an emotionally supportive environment that provides help, advice, reassurance and empathy in a non-judgemental way
- full, comprehensive information on whatever option the woman is considering, including abortion, motherhood and adoption
- information on care services beyond the point of making a decision.

Where a counsellor or doctor is unwilling to provide contact information on abortion services they have a duty of care to refer women on to a 3-option counselling service and to communicate clearly that this service will give the woman this information.

The implementation of this Ethic of Care involves three principal strands:

- The development of a comprehensive policy and regulatory framework. This could be led by the Crisis Pregnancy Agency.
- Good practice at the point of contact with women in the delivery of front-line services. This is the responsibility of service providers.
- A review of 1995 Regulation of Information Act to consider its capacity to impede women's access to crisis pregnancy counselling and support services.

## 1.0 Introduction to the study

### 1.1 Background to the study

The Crisis Pregnancy Agency (CPA) was established in October 2001 and its primary function is to formulate and implement a strategy to address the issue of crisis pregnancy in Ireland. As such it is a planning and co-ordinating body, rather than a service provider. In 2003 the Agency commissioned the Women's Education, Research and Resource Centre, UCD, to conduct a study of crisis pregnancy counselling in Ireland. The function of the research is to explore women's needs and expectations with respect to crisis pregnancy counselling and to evaluate their experience of it. It is also intended to elaborate on the factors associated with why some women seek out crisis pregnancy counselling and others do not. The findings are intended to feed directly into planning and service development initiatives undertaken by the Agency relating to crisis pregnancy counselling.

### 1.2 Rationale for the research

While much research has been undertaken into understanding the antecedents and outcomes of unintended pregnancy, in general, very limited research has been carried out on the role of crisis pregnancy counselling in Ireland or, indeed, internationally. Those Irish studies that have looked at this issue are limited in scope, both in relation to the study group and the treatment of the topic.

In the Irish context, research in the past has tended to equate pregnancy outside of marriage with a need for support. This was the approach taken by two comprehensive studies published by the Federation of Services for Unmarried Parents and their Children (O'Hare, Dromey, O'Connor, Clarke and Kirwan 1983) and the National Maternity Hospital (Flanagan and Richardson 1992). Both studies set out to address gaps in understanding of the social circumstances of women giving birth outside of marriage. Both included a focus on unmarried mothers' contact with social work and support services during pregnancy. A specific objective of Flanagan and Richardson's (1992) study was to provide strong empirical evidence for the development of a framework of social work practice best suited to meeting the needs of unmarried mothers.

O'Hare et al.'s 1983 study involved a survey of all women who gave birth outside marriage in Irish hospitals that year (O'Hare et al. 1983). The purpose of the research was to gather descriptive information on selected characteristics of the women, their use of services and plans they had for their children. The total number of women surveyed represented 89% of all non-marital births recorded by the Central Statistics Office for 1983.

The study included a focus on women's contact with social work agencies. This referred to contact with a hospital social worker, health board social worker, voluntary adoption society social worker or with other agencies that counsel unmarried mothers, including Ally, Barnardos and Cherish/One Family. The study found that almost three-quarters of those surveyed had had contact with at least one social work agency. Of these almost half contacted a hospital social worker (47%), 13% contacted a health board social worker, 11% contacted a voluntary adoption society social worker, while 6% attended one of the other agencies.

A strong association was found between receipt of antenatal care and contact with a social work agency. Being in receipt of antenatal care, particularly in a hospital setting, strongly raised the chances of a woman being referred to a hospital social work agency. Women attending a GP for antenatal care were less likely to have had contact. 4% of women had not received any antenatal care and three-quarters of these had no contact with an agency.

When characteristics including age, relationship status, social class and area of residence were considered, area of residence was the principal factor influencing whether a social work agency was contacted. Women resident in the Western, North-Eastern and Eastern health boards were most likely to have had contact with an agency. Residence in a city was also associated with having a social work contact. (O'Hare et al. 1983)

While O'Hare et al. (1983) included a national sample of women giving birth outside of marriage, Flanagan and Richardson (1992) focused only on unmarried mothers delivering in the National Maternity Hospital (NMH). In 1989 72% of unmarried women delivering in the NMH were referred to social work services and the authors examined the reason for these referrals. The principal reason unmarried women were referred was for assessment and basic information, accounting for over half of the group. A policy of referring all unmarried women to social work services was in operation by the NMH until 1988. The authors considered that while the policy had changed by 1989, practice changed more slowly, thus explaining this finding. The second most common reason was for adoption/parenting counselling (18%) with a further 3% attending for this reason combined with another issue. Almost one in five were referred because of relationship problems with their parents, family or partner. (Flanagan and Richardson 1992)

A profile of social workers' 'caseload' with unmarried mothers confirmed a need for information and adoption/parenting counselling as the main reason women attended. Analysis of the caseload further revealed a 5% incidence of concealed pregnancy. The authors concluded that the concept of unmarried mothers as a problematic phenomenon is outdated. They contended that the context of social support available to a woman should be considered when assessing need for support, as opposed to associating non-marital pregnancy per se with such need.

Flanagan and Richardson (1992) defined a 'crisis pregnancy' as a pregnancy that ends in abortion or a pregnancy that is concealed. They argued that women with a crisis pregnancy require a safety net of non-judgemental support services with high visibility to avoid the distress suffered by pregnant women concealing a pregnancy and to avoid possible repercussions for their children.

Both pieces of research were carried out at a time when all women giving birth outside of marriage were assumed to need the support of a social worker. It was common practice for all women presenting to a hospital for antenatal care to be referred to the social work service (Flanagan and Richardson 1992:39). At that time the development of support services outside of the social work domain was very limited in comparison with the range of crisis pregnancy counselling services available today, as discussed below. However, the figure in both studies of almost three in four women having contact with a social work agency indicates a high level of contact with support services. Unfortunately, the nature of the studies did not allow for an exploration of women's needs from or evaluation of their contacts with such social work agencies.



*Women and Crisis Pregnancy* (Mahon et al. 1998), the seminal work on crisis pregnancy in an Irish context, was published in 1998. The overall focus of the study was to provide insights into the social context in which Irish women make decisions about 'crisis' pregnancy. This qualitative study of women with a crisis pregnancy included interviews with 94 women who had decided on abortion and 249 women who were continuing their pregnancy, of whom eleven were contemplating adoption. Mahon et al. (1998) represented a departure from previous research on crisis pregnancy in two principal ways. Firstly, women deciding on abortion, women continuing to motherhood and women considering adoption were all included. Secondly, the methodology employed allowed the sample of women continuing their pregnancy to self-define the pregnancy as a crisis.

While broader in scope, Mahon et al.'s (1998) study included an examination of the role of counselling in supporting one of the three groups of women in the study – those who had travelled to England for an abortion. This research took a much more in-depth look at women's decisions regarding contact with a support service and the factors shaping these decisions than the two studies discussed earlier.

The study found that 40% of the abortion sample did not attend either a GP or counselling agency before booking an appointment with an abortion clinic in England. Of this group, five had telephoned a counselling service to access counselling but did not proceed because of the delay in getting an appointment.

Twenty women in the group (22%) consulted a GP before travelling for an abortion. Of these, seven attended their regular GP and all but one felt satisfied with how their GP responded. A further five women sought out a GP they believed would be sympathetic and would support them in the decision to have an abortion; they too were satisfied with the response they received. Eight of the twenty did not have their needs met by the GP they attended. Six of the eight women attended a GP for a pregnancy test but did not pursue a discussion about their feelings or options with the doctor. In two cases GPs would not provide information on abortion services to the women who consulted them for help with their decision to have an abortion.

Thirty of the women (34%) attended a counselling service where they received counselling and the information necessary for them to book an appointment with a service provider in England. Three of these women had attended a GP who would not provide them with the information they required prior to contacting the counselling agency. Four of the group had booked their appointment with an abortion service provider in England before contacting a counselling service in Ireland.

A further three women attended a counselling service that would not discuss the option of abortion or provide the information they required. They proceeded to self-refer to a service in England.

Mahon et al. (1998) found that women tended to have made the decision to have an abortion before consulting a GP or counselling service. This meant that in most cases women attended counselling for support with the decision they had already made or to acquire information necessary to book an appointment with an abortion service provider. Some felt more confident about attending an abortion service provider they had heard about from a counsellor or GP. Strengths associated with counselling were that women felt listened to, it helped women with coming to a decision, it was affirming for those

who had already made a decision and it was supportive of the decisions women made.

Factors contributing to women's decision to consult a GP over a counselling service were the local availability of a GP, being unaware of counselling agencies and a preference not to have to go through the process of counselling.

Some of the reasons for not attending a service were structural, comprising uncertainty about the legal regulation of the provision of information on abortion services, lack of knowledge about counselling services, the cost involved or the delay entailed in attending for counselling. Other reasons related to women's views on counselling itself. Some were sceptical about counselling or were concerned that it may be directive against abortion, and so they avoided counselling agencies.

As regards GPs, women avoided attending a doctor because they were unsure about their stance on abortion or the legal regulations governing GPs providing information on abortion services. Some avoided their GP because they did not want them to know about the abortion. This was particularly the case where other members of the woman's family also attended the GP and she was concerned about confidentiality being maintained.

Mahon et al. (1998) provided an important insight into the role of counselling for women seeking abortion. Their findings discussed barriers to accessing counselling and women's experiences of counselling. As the study had a broader focus than counselling there were some limitations in the treatment of crisis pregnancy counselling. Women's motivations for attending counselling were not explored, including their needs and expectations from counselling or the role of support networks in their decision to attend counselling. In addition, analysis of the role of crisis pregnancy counselling was confined to one group: those seeking abortion.

As noted above, previous research on crisis pregnancy counselling in Ireland is limited in scope both in relation to the study group and the treatment of the topic. As regards the study group, research in the past has tended to equate pregnancy outside of marriage with a need for support. Flanagan and Richardson (1992) set out a strong case for the limitations of such an approach. Subsequent research by Mahon et al. (1998) acknowledged this and developed a methodology that allowed women to self-define their pregnancy as a 'crisis' pregnancy. While Mahon et al.'s (1998) study included a comprehensive sample of women with a crisis pregnancy, analysis of the role of counselling was confined to those women who decided on abortion. No single research project has looked at the role of counselling in supporting all women with a crisis pregnancy, regardless of pregnancy outcome.

The treatment of counselling in those studies focusing on women continuing to motherhood was limited to looking at levels of contact with support services, the socio-demographic characteristics influencing contact, and summary reasons for contact (O'Hare et al. 1983, Flanagan and Richardson 1992). Mahon et al.'s (1998) exploration of the role of counselling in supporting women seeking abortion did not explore motivations for attending counselling or the factors shaping attendance.

The rationale for the current research is to address the gaps, described above, in our current knowledge of women's needs for and experiences of crisis pregnancy counselling, regardless of what outcome they decide upon.

### 1.3 Study aims and objectives

This study aims to examine women's experiences in relation to crisis pregnancy counselling through the application of qualitative and quantitative methods. The study group comprises women with a crisis pregnancy who decided to have an abortion or to continue the pregnancy – with either the intention of parenting the child or placing the child for foster care or adoption. In particular, the study will examine, through in-depth accounts, women's expectations of crisis pregnancy counselling, the extent to which their experiences corresponded with their expectations, their perceptions of strengths and weaknesses of counselling and their recommendations for enhanced counselling services. The study also aims to explore the reasons why some women choose not to avail of counselling services. A further aim of the study is to explore the characteristics and motivations that distinguish women who avail of crisis pregnancy counselling from those who do not.

### 1.4 Research objectives

- To explore Irish women's expectations of and need for crisis pregnancy counselling.
- To assess women's levels of knowledge in relation to crisis pregnancy counselling services and related information needs.
- To examine factors associated with decisions women make to seek or not to seek counselling.
- To identify any barriers women perceive to using existing crisis pregnancy counselling services.
- To identify counselling service providers used by and familiar to women experiencing a crisis pregnancy.
- To explore specifically women's perceptions of the role of their GP in providing crisis pregnancy counselling.
- To explore the role of pre-existing support networks as they relate to women's perceived need for counselling in relation to this pregnancy.
- To examine women's experience of directive and part-directive counselling services.
- To determine the perceptions of those women who do use crisis pregnancy counselling as to the strengths and weaknesses of counselling services and how they can be improved.
- To formulate recommendations for the enhancement of crisis pregnancy counselling services.

### 1.5 Crisis pregnancy counselling and support services in Ireland

In research commissioned by the Crisis Pregnancy Agency, Nic Gabhainn and Batt (2004) discuss the role of crisis pregnancy counselling. It is described as an opportunity for women, couples or their families to discuss their situation in a supportive and confidential atmosphere. Counselling is aimed at helping clients consider the options before them and to choose the course of action with which they can be most comfortable. They report how research literature suggests that ideally crisis pregnancy counsellors act as 'sounding boards' for their clients, helping them to identify areas of conflict rather than attempting to influence or guide their decision-making or coping processes. (2004: 5-6)

Crisis pregnancy counselling is usually offered in conjunction with information and advice on support services relating to all three pregnancy outcomes: abortion, adoption or motherhood. In the Irish context the provision of information relating to abortion is only lawfully permitted within the context of counselling.

#### *1.5.1 Regulation of crisis pregnancy counselling services*

In general there is no statutory regulation of counselling services in Ireland; the same applies to crisis pregnancy counselling services. However, where crisis pregnancy counselling includes the provision of information comprising the names and addresses of abortion services legally provided in another state then it comes under the Regulation of Information (Services outside the State for Termination of Pregnancies) Act 1995.

Under the Act, such information can only be given within the context of counselling provided by doctors, counselling agencies and related services under the following conditions:

- such information and counselling may not involve advocating or promoting abortion
- the abortion services must be lawfully available in the other country
- information, advice and counselling must be given on all options available to the pregnant woman; this information must be truthful and objective and must fully inform the woman on all options and must not be accompanied by any advocacy or promotion of abortion.

While it is lawful to give the names and addresses of abortion services, it is not lawful to make an appointment with an abortion service on behalf of the pregnant woman. This does not prevent doctors or others from giving medical records to the woman for supply to an abortion service provider outside the state.

Doctors or agencies who do not give abortion information but who do provide pregnancy counselling are not subject to any of these rules about the information and counselling they provide.

#### *1.5.2 Crisis pregnancy counselling providers*

Crisis pregnancy counselling services in Ireland consist of face-to-face counselling, telephone helplines and information provision regarding counselling and counselling services. For the purposes of this research, crisis pregnancy counselling services are organised into three definitional categories:

- *3-option agencies*

3-option agencies refer to services that include all three pregnancy outcome options – motherhood, adoption and abortion – in both counselling and the provision of information. The provision of counselling and information is in accordance with the 1995 Act, as set out above.

- *2-option agencies*

2-option agencies refer to services that preclude the option of abortion and only provide women with information on the options of motherhood or adoption. However, all three pregnancy outcome options – motherhood, adoption and abortion

are discussed in counselling, and post-abortion counselling is also provided.

- *'Rogue agencies'*

'Rogue agencies' are defined by the Crisis Pregnancy Agency in their Strategy 2004-2006 as:

Agencies which appear to offer information on all aspects of crisis pregnancy but which in reality use manipulative methods to try to persuade women not to choose abortion. (Crisis Pregnancy Agency 2004:31)

3-option and 2-option crisis pregnancy counselling is provided by organisations within both the voluntary sector and the statutory sector, with the support of state funding. Within the voluntary sector counselling is provided either face-to-face or by telephone helpline. Cherish/One Family<sup>1</sup>, Dublin Well Woman, PACT, Irish Family Planning Association (IFPA), Kerry Family Planning Clinic and Cunamh are all voluntary providers of 3-option counselling. Staff in these organisations are either trained counsellors or social workers. Cura and Life Pregnancy Care Service are voluntary providers of part-directive counselling. In both cases staff are volunteers who are given training by the organisations. As well as face-to-face counselling, Cherish/One Family, Cura, IFPA, Life and PACT offer a low-cost telephone helpline providing counselling-related information and support.

Within the statutory sector, health boards and maternity hospitals are engaged in crisis pregnancy counselling initiatives. Crisis pregnancy counselling is provided in five hospitals in Dublin, Kilkenny, Ballinasloe, Galway and Mayo by social work staff. The Midland Health Board (MHB) is engaged in two crisis-pregnancy counselling initiatives. One is staffed by social workers who received training from Cura. It is based in three centres in Mullingar, Athlone and Longford. Counselling is by appointment and home visits are offered. The second MHB initiative is in conjunction with GPs and is staffed by accredited counsellors. It is based in six urban centres in the health board area. Counselling is provided by appointment on a flexible basis, with clients guaranteed an appointment within a week of contacting the service. All counselling delivered by statutory providers is non-directive, 3-option counselling.

Crisis pregnancy counselling is also provided by some non-funded organisations. Marie Stopes Reproductive Care Services, Dublin, is linked with the UK-registered charity Marie Stopes International. They provide 3-option crisis pregnancy counselling in one Irish outlet located in Dublin in accordance with the 1995 Regulation of Information Act. Women pay a fee to attend this service.

Directive crisis pregnancy counselling providers do not receive state funding nor are they subject to any regulation. Their service is provided free of charge. They operate within the voluntary sector and their source of funding is unclear.

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<sup>1</sup> Cherish/One Family relaunched their service in 2004 under the name One Family.

## 1.6 Structure of the report

Chapter 2 gives a detailed account of the research methodology employed in the study.

Chapter 3 examines the factors associated with the decisions women make to attend counselling or not. It includes a consideration of the role of women's support networks in making this decision. An examination of the barriers women perceive to using existing crisis pregnancy counselling services is also presented here.

Chapter 4 explores women's needs from and expectations of crisis pregnancy counselling, together with their knowledge of crisis pregnancy counselling and related information needs.

Chapter 5 looks at women's perceptions of the role of their GP in providing crisis pregnancy counselling.

Chapter 6 reports on women's experiences of crisis pregnancy counselling, highlighting the strengths and criticisms of services women attended in order to determine how they might be improved.

Chapter 7 focuses on women's need for ongoing support after they make a decision on how to proceed with the pregnancy, including needs relating to post-abortion care and support, pregnancy care and support, and post-natal care and support.

Chapter 8 presents the principal conclusions from the study, focusing on women's decisions about attendance at counselling and issues relevant to shaping good practice. Finally, deficiencies and bad practice in crisis pregnancy counselling are addressed.

Chapter 9 sets out recommendations for the enhancement of crisis pregnancy counselling services derived from the research.

## 2.0 Research methodology

### 2.1 Research approach and study group

A mix of both qualitative and quantitative methods were employed in this study of crisis pregnancy counselling. Semi-structured, in-depth interviews with women currently experiencing a crisis pregnancy were used to generate rich qualitative data. In addition, a larger sample of women experiencing a crisis pregnancy were surveyed to allow for the exploration of some of the research questions with a more representative group.

The data was collected in a range of settings. The fieldwork sites were selected having regard to the choices women make regarding the outcome of their pregnancies i.e. motherhood, adoption or abortion. Pursuant to an 'outcropping' approach, two sites were identified as relevant to generating the sample – antenatal services and abortion services. Thus, the settings selected for data-collection were public antenatal clinics and abortion service providers in Britain. It was considered that some women encountered in antenatal clinic settings may be actively considering the option of adoption. Women contemplating adoption may also be contacted through agencies specifically working with women in this situation. For this research it was decided not to seek contact with women through these routes as another study specifically looking at women contemplating adoption<sup>2</sup> was underway at the same time. It was considered unsustainable for two research projects to use agencies to target this very small group of women at the same time. In the event, the antenatal setting did yield a number of women contemplating placement of the baby for adoption or fostering, as discussed below.

The qualitative component comprised in-depth, one-to-one semi-structured interviews with women experiencing a crisis pregnancy in each setting – antenatal clinics and abortion service providers in Britain. One-to-one interviews took into account the sensitivity of the topic and the centrality of women's accounts. The interviews were conducted in such a way as to allow the women who took part an element of control over how they recounted their experiences, with the aim of recreating an ambience similar to that of a 'friendly conversation'. The interviews were conducted using a thematic-based schedule devised with reference to the study aims and objectives outlined above and a review of recent literature in the area. Those interviewed included women who had and who had not attended counselling.

The quantitative aspect consisted of a self-completion questionnaire administered to a broader, more representative sample of women than that participating in the qualitative element. The questionnaire surveyed women experiencing a crisis pregnancy about their perceptions, experiences and assessments of counselling services. Those surveyed included both women who had and who had not attended counselling.

### 2.2 Ethical approval

Ethical approval for this research was granted by the Human Research Sub-Committee of the Research Ethics Committee of University College Dublin. In addition, ethical approval was secured locally in one of the antenatal clinic settings where this was requested.

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<sup>2</sup> This research was being conducted by Valerie Richardson on behalf of the Crisis Pregnancy Agency.

### 2.3 Sampling frame

The target sample population was women experiencing a crisis pregnancy, comprising both women who had and who had not attended crisis pregnancy counselling.

Our target qualitative study group was 50 women generated on the basis of a sampling frame set out below:

- *Outcome*

Both outcomes of motherhood and abortion would be equally represented in the study sample.

- *Take-up of crisis pregnancy counselling*

Our target sample was designed to include two-thirds of women who attended counselling and one-third who did not.

**Table 2.1 Summary of target qualitative study group**

	Antenatal clinic		Abortion clinic	
Counselling	Yes	No	Yes	No
	17	8	17	8
<b>N =</b>	<b>25</b>		<b>25</b>	

The target sample for the quantitative element was 200 completed questionnaires from antenatal clinic settings and the optimum number from abortion clinics.

### 2.4 Sample generation methodology

As discussed above, data collection was conducted in clinics providing abortion services in Britain and in antenatal clinics in Ireland. In both settings convenience sampling was used to generate a sample of women for both the survey and the qualitative interviews.

#### 2.4.1 Abortion clinic setting

- *Selection of abortion clinics*

The UK National Statistics Office recorded that 6,673 women usually resident in the Republic of Ireland had an abortion in 2001. Table 2.2 gives a breakdown of this statistic by age group.

An analysis of statistics held by Marie Stopes UK and the British Pregnancy Advisory Service (BPAS) showed that, in total, 78% of these 6,673 women had attended their combined services in 2001. It was decided to confine fieldwork to clinics operated by these two organisations. The strategy adopted was to identify those clinics most frequently attended by Irish women and concentrate fieldwork there.



**Table 2.2** Number of legal abortions to women usually resident in Republic of Ireland in 2001 by age

Age	Number
Under 15	12
15	29
16-19	903
20-24	2404
25-29	1685
30-34	875
35-39	508
40-44	239
45 and over	18
All ages	6673

Source: Abortion Statistics 2001, Series AB No.28, Office for National Statistics, Stationery Office, London.

Marie Stopes International has nine centres in Britain. Of the 6,673 Irish women who had an abortion in England in 2001, 3,501 or 52% attended Marie Stopes. The clinics they attended are detailed in the table below.

**Table 2.3** Number of legal abortions to women usually resident in Republic of Ireland in 2002 provided by Marie Stopes Clinics

Clinic location	Irish women
Essex	1767
Ealing, West London	1072
South London	342
Manchester	149
Bristol	127
Leeds	20
Central London	23
Maidstone	1
Reading	0
<b>Total</b>	<b>3501</b>

Source: Personal communication with Press and Public Affairs Office, Marie Stopes, UK

According to Marie Stopes's public relations office, women travelling from Ireland mainly use the centres in Essex and Ealing, West London, due to the transport links between Essex and Stansted and Ealing and Heathrow.

In 2001, 1,760 Irish women had an abortion through the BPAS. This represents 26% of Irish women having an abortion in England that year. Of the 1,760 women, 40% attended London clinics, primarily Richmond Clinic, and 40% attended their Liverpool clinic. This reflects ease of transport links with Richmond (close to Heathrow airport) and the Liverpool clinic, which is easily accessible from the city airport.

- *Access negotiation*

Managers of both service providers were contacted in the first instance and provided with details of the research, commissioning body and research team. Both granted permission to allow the research to be carried out within their clinics. Both provided a breakdown of their in-house statistics on Irish women attending the service during 2001 to allow us identify the clinics most frequently attended by Irish women.

Once managers were informed of which clinics had been selected for the research they undertook to negotiate with clinic staff on hosting the research. In all four selected clinics, clinic managers and staff agreed to hosting the study. Researchers were then introduced to each clinic management team. The principal researcher made a preliminary visit to each clinic to brief staff members about the research and discuss the process of recruiting women for the study. In the two Marie Stopes clinics the member of staff with a client liaison role acted as the key liaison person with the research team. In the BPAS clinics all staff involved in reception and counselling roles liaised with the team, led by the clinic manager.

The researchers travelled to England for short periods of time, either alone or in pairs, at regular intervals over a four-month period between October 2003 and January 2004 to collect data for the study. In total, ten visits were made to the four clinics, two of which were to pilot the sample generation methodology, the questionnaire and the interview schedule.

- *Defining the target group in abortion clinics*

The population of Irish women attending British abortion clinics was deemed a target group for the study, reflecting our assumption that abortion is likely to be an outcome of a crisis pregnancy.

- *Sample generation for the survey in abortion clinics*

In the abortion clinics staff were asked to facilitate administering the survey, in recognition of the sensitive nature of crisis pregnancy and the stigma surrounding abortion. In the interest of preserving women's confidentiality, the researchers did not seek to meet women until after they had been informed about the study and the identity of the on-site researcher.

The procedure adopted was for clinic staff to inform every Irish woman who attended about the research and provide them with written information on the study, its aims, the commissioning body, the research team and the purpose of the research. They would then ask women to participate in the survey and give them a questionnaire for self-

completion. (See Appendix 1 for Information Sheet distributed and Questionnaire administered in Abortion Clinic setting.)

In Marie Stopes clinics, client liaison staff meet all women soon after arrival at the clinic to inform them of the stages involved in their treatment over the course of the day. It was at this first point of contact that they introduced the study to Irish women. In BPAS clinics it is counselling staff who inform women of what to expect over the day during their first consultation with them. Again, it was at this first point of contact that women were informed about the study and asked to participate in the survey. Women indicated consent to participate in the survey by completing the questionnaire, which they usually returned to the staff member from whom they had received it, or sometimes to another staff member. Those who decided not to participate returned a blank questionnaire.

During the pilot stage of the fieldwork liaison staff in one clinic volunteered to administer questionnaires to all Irish women presenting to the clinic over the entire duration of the fieldwork, in addition to those days when the researcher was on site. This offered an opportunity to generate a much larger number of completed questionnaires than had been anticipated. This possibility was explored with all four clinics, and three of the four clinics were in a position to administer the questionnaire to women throughout the sixteen weeks of the fieldwork. The system in place in the fourth clinic meant that it was only possible to administer the questionnaires on the days when the researcher was in attendance. We had hoped to survey the population of every Irish woman attending the clinics during the sixteen weeks of fieldwork. However, in practice this was not possible to achieve as, due to a multitude of factors, not every Irish woman was surveyed. Therefore the sample group generated for the survey element must be treated as a convenience sample of all Irish women attending the four clinics during the fieldwork time-frame.

In total 99 questionnaires were completed by Irish women attending abortion clinics.

- *Sample generation for qualitative interviews in abortion clinics*

On days when a researcher was on site in the clinics the liaison staff asked women if they would be willing to meet a researcher to discuss the possibility of taking part in a qualitative interview as well as the survey. Women were given time to consider the request to participate in the interview so that they could settle into their surroundings and become clear about what to expect over the course of the day. Liaison staff agreed to wait until women were at ease before asking them to decide on whether or not to meet with the researcher.

Those women who agreed to meet with the researcher were then briefed further about the study by the researcher and invited to ask any questions arising from the written and verbal information provided. Once the woman and the researcher were satisfied that the woman was fully informed about the study, the woman was asked whether she would consent to an interview. Women gave signed consent to participate in the qualitative interview.

Women's circumstances and the systems in place in each clinic had to be assessed to determine when was the best time to conduct the interview. The pilot indicated that women were in a better position to consider participation in the study after the

consultation was complete and women had been given a booking and time when the procedure would take place. Women seemed more at ease at this point: they were reassured that the abortion was going ahead and they would be in time for their return flight, where this arose. This allowed them to give some dedicated attention to the question of participation, making for more informed consent.

In some cases there was sufficient time for the woman to decide whether she would prefer to be interviewed before the procedure or after. In other cases time only allowed for one of these options. Overall this meant that women were interviewed at different stages over the course of their time in the clinic across the different sites and different days when the fieldwork took place. Cross-comparison of the data indicated that this non-standard approach did not affect issues of informed consent or the quality of the data.

- *Total sample from abortion clinics*

Fieldwork was carried out in four abortion clinics operated by Marie Stopes UK and the British Pregnancy Advisory Services, based in London (3) and Liverpool (1) between October 2003 and January 2004. This yielded:

- 99 completed questionnaires
- 23 qualitative interviews, comprising fifteen women who attended counselling and eight who did not.

#### *2.4.2 Antenatal clinic setting*

- *Selection of antenatal clinics*

Women who are continuing a crisis pregnancy to motherhood are a difficult-to-reach group. We formulated a strategy to identify this sub-group out of the broader population of pregnant women. The majority of pregnant women attend antenatal care and so we targeted antenatal clinics as locations where these women gather.

Taking into account the timeframe and resources available, it was decided to carry out fieldwork in two antenatal clinics, ensuring regional spread. Clinics with over 1500 annual births were included in a sampling frame. These clinics were, in turn, stratified to ensure inclusion of one urban-based clinic and one clinic with a large rural catchment group.

One clinic in the eastern region with a large number of births, a high proportion of non-marital births, high coverage of counselling services and a predominantly urban catchment area was selected. A second clinic in the West, with over 1,500 births annually, a rural catchment area and good coverage of counselling services was also selected.

- *Access negotiation to antenatal clinics*

For antenatal clinics the Master or Manager of the hospital was initially contacted for access to the hospital. A further level of access negotiation was undertaken with staff at each site. The goodwill of staff members was crucial to the success of the research. In order to maximise this goodwill, staff had to be fully informed of the research process, the nature of the recruitment process for research participants and the ethical procedures in place to protect participants. Dedicated time and resources were given over to this task at each site.

In one hospital a group briefing session was hosted for all medical, midwifery, nursing, social work and antenatal education staff, where the researchers made a presentation on the research and its methodology. Staff were invited to ask questions and were given copies of the questionnaire and information sheet designed for circulation to women. In the second hospital the Ethics Committee appointed the Head of Social Work to liaise with the researchers. Through the Head of Social Work the research and researchers were introduced to each of the key staff groupings individually. Each group was given written and/or verbal information on the study and was invited to contact the researchers with any questions or issues of clarification that arose.

• *Defining the target group in antenatal clinics*

Our target sample in antenatal clinics was women continuing their pregnancy who described their pregnancy as a crisis and who attended pregnancy counselling, as well as women who described their pregnancy as a crisis and did not attend pregnancy counselling.

In the antenatal clinic setting the questionnaire was instrumental to the sampling procedure, as well as being a data-collection tool in its own right. Women attending antenatal clinics have a range of responses to their pregnancy, and the questionnaire was the means used to identify those indicating a 'crisis-type' response.

• *Sample generation for the survey in antenatal clinics*

The fieldwork in each antenatal clinic was carried out over a four-week period, during November 2003 in the case of the clinic in the West and during February 2004 in the case of the clinic in the East.

All women attending the antenatal clinic during the fieldwork period were invited to participate in the survey element through a direct approach from a member of the research team. While women were seated in the antenatal clinic waiting area they were given an information sheet on the study and a questionnaire (see Appendix 2). Women self-completed the questionnaire and returned it directly to the researchers.

The questionnaire asked women about:

- their response to this pregnancy
- their perceived need for support
- the role of counselling services in providing support
- whether or not they attended pregnancy counselling.

The following question was used to identify women relevant to the study:

**Q. Which of the following phrases best captures your response to this pregnancy:**

Please read the list and tick **ONE**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> 'As planned'             | <input type="checkbox"/> 'Unexpected'        | <input type="checkbox"/> 'A personal crisis' |
| <input type="checkbox"/> 'A shock'                | <input type="checkbox"/> 'Long awaited'      | <input type="checkbox"/> 'Pleased'           |
| <input type="checkbox"/> 'Didn't know what to do' | <input type="checkbox"/> 'Pleasant surprise' |  |

Please tell us more

Those indicating one of the negative type responses – ‘shock’, ‘unexpected’, ‘a personal crisis’ or ‘didn’t know what to do’ were asked to complete the questionnaire. This group were included in the study.

The table below gives a breakdown of the number of women who indicated a ‘crisis-type’ response to their pregnancy.

**Table 2.4 Breakdown of ‘crisis-type’ response to pregnancy**

Response	Number	Percentage
Unexpected	161	53
A shock	103	34
Didn’t know what to do	23	8
A personal crisis	11	4
Missing	3	1
<b>Total</b>	<b>301</b>	<b>100%</b>

- *Sample generation for qualitative interviews in antenatal clinics*

The questionnaire ended with a question asking those women who indicated a ‘crisis-type’ response to the pregnancy to consider taking part in a qualitative interview (see Appendix 2). Those willing to participate could opt to write in their details so that a researcher could contact them and arrange to conduct the interview at a time and place convenient for the woman. Alternatively, women could opt to participate in the interview after completing their visit to the antenatal clinic and be interviewed on site at the hospital.

During the pilot for the study the researchers became aware of systems already in place in the antenatal-clinic procedures for identifying women with a crisis pregnancy and in need of support. In one of the hospitals the response rate of women to participate in the qualitative interview was quite low and so a supplementary strategy based on this system was implemented. Social workers in the hospital agreed to ask women with a crisis pregnancy with whom they were in contact if they would consider participating in the study.

A total of 23 women were interviewed through the antenatal clinic setting. 20 women were recruited through the questionnaires and a further three were recruited through the supplementary strategy described above.

- *Total sample from antenatal clinics*

Data collection was carried out in each of the two hospitals for four weeks during the period between November 2003 and February 2004. In each hospital public, semi-private and private antenatal clinics were all included in the study.

This yielded:

- 301 completed questionnaires
- 23 qualitative interviews comprising six women who attended for counselling and seventeen women who did not.

## 2.5 Summary of study group

**Table 2.5 Summary of study group broken down by method of data collection**

Data collection site	Number of survey respondents	Number of interview participants
2 antenatal clinics (Dublin and West of Ireland)	301	23
4 abortion clinics (London and Liverpool)	99	23
<b>Total study group</b>	<b>400</b>	<b>46</b>

## 2.6 Data handling and analysis

The survey questionnaires completed at each site were analysed using the statistical analysis package for the social sciences, SPSS.

Qualitative interviews were transcribed in full and analysed using the qualitative data-analysis software NUD\*IST. The primary analytical procedure was coding for key themes to generate an understanding of the dimensions of each theme across the entire data set. Themes were identified having regard to the research aims and objectives, as well as a review of literature on women's use of crisis pregnancy counselling. In addition, following a grounded theory approach to qualitative data analysis, new themes that emerged inductively from the data were sought out and explored, in an attempt to discover further insights into factors shaping women's perceptions and decisions regarding counselling, and their views and experiences. Pursuant to a grounded approach, time was allocated during the data-collection stages to review interview data, so that emerging themes were tested with subsequent participants.

## 2.7 Presentation of findings

Findings from both the survey and the qualitative interviews are grouped thematically throughout the following analysis chapters. Findings from the survey are usually presented first to get a picture of the broad trends among the 400 respondents to the questionnaire. This is followed with findings from the in-depth interviews, which give us a richer, more complex picture of the processes, perceptions and experiences related to women's use of crisis pregnancy counselling services.

## 2.8 Profile of survey group

The questionnaire, administered to a broader sample of women in both the antenatal clinics and the abortion clinics, allowed us to generate a profile of women with a crisis pregnancy in both settings. As described earlier, 301 women who indicated their pregnancy was a crisis were surveyed in antenatal clinics. 99 Irish women attending abortion clinics in London and Liverpool were also surveyed.

**Table 2.6 Age profile of women with a crisis pregnancy**

Age	Antenatal group	Abortion group	Total
19 and under	15%	6%	13%
20-24	31%	38%	33%
25-29	22%	22%	22%
30-34	16%	17%	16%
35-39	11%	13%	11%
40+	4%	4%	5%
<b>Total number</b>	<b>301</b>	<b>99</b>	<b>400</b>

Women of all age groups experience crisis pregnancy. While it is often associated with very young women, these statistics confirm again (Mahon et al. 1998) that it is women in their twenties who are most likely to experience a crisis pregnancy.

There are no national statistics that would help us to build a profile of the general population of antenatal attendees with a crisis pregnancy in Ireland. However, we do have information on the total group of Irish women having abortions: the UK Office for National Statistics provides a breakdown of the age of women usually resident in Republic of Ireland who have a legal abortion in that system. The table below compares our survey findings with these official statistics on legal abortions to women usually resident in Republic of Ireland in 2001<sup>3</sup>.

**Table 2.7 Comparison of age profile of abortion study group with age profile of all Irish women who had an abortion in the UK in 2001**

Age	Abortions to Irish women 2001		Abortion group % N= 99
	Number	%	
19 and under	944	14%	6%
20-24	2404	36%	38%
25-29	1685	25%	22%
30-34	875	13%	17%
35-39	508	8%	13%
40+	257	4%	4%
<b>Total</b>	<b>6673</b>	<b>100%</b>	<b>100%</b>

Source: Abortion Statistics 2001, Series AB No.28, Office for National Statistics, Stationery Office, London.

Table 2.7 shows that women under nineteen years of age accounted for 14% of all Irish women having an abortion in 2001, compared with 6% of our surveyed group. Representation of the other age groups compares well for women in their twenties and forties, while women in their thirties are over-represented. This indicates that the

<sup>3</sup> Abortion Statistics 2001, Series AB No.28, Office for National Statistics, Stationery Office, London.



youngest group of women was less willing to participate in the survey questionnaire for this study.

**Table 2.8 Area of residence of women with a crisis pregnancy**

Area	Antenatal %	Abortion %	Total group %
City	37	40	35
Town	35	42	37
Rural area	28	18	26
<b>Total N</b>	<b>301</b>	<b>99</b>	<b>400</b>

While three in four women lived in urban areas, women attending abortion clinics were more likely to reside in an urban area than were women surveyed in antenatal clinics.

An analysis of the citizenship of the group shows that one in five respondents were of a citizenship other than Irish. Women reported citizenship of sixteen other countries right around the world. Only two of the sixteen countries – Britain and Nigeria – were represented by three or more women and so their percentages are itemised here. The remaining fourteen countries are grouped together under 'other', as each constitutes less than 1% of respondents.

**Table 2.9 Citizenship of women with a crisis pregnancy**

Citizenship	Antenatal %	Abortion %	Total group %
Irish	80	86	82
British	3	5	4
Nigerian	4	0	3
Other	13	10	11
<b>Total N</b>	<b>301</b>	<b>99</b>	<b>400</b>

**Table 2.10 Marital status of women with a crisis pregnancy**

Marital status	Antenatal %	Abortion %	Total group %
Single	70	79	72
Married	27	12	23
Separated	3	5	4
Divorced	1	4	2
<b>Total N</b>	<b>301</b>	<b>99</b>	<b>400</b>

Overall, the women surveyed were most likely to be single; single women accounted for 72% of the group. However, almost one in four women with a crisis pregnancy was married, while 6% were separated or divorced. Comparisons across the two groups illustrate that

married women with a crisis pregnancy were more likely to continue the pregnancy, while single, separated or divorced women were more likely to decide on abortion.

Other studies (e.g. Flanagan et al. 1992, Mahon et al. 1998) have argued for a need to look behind the category of 'single', as many non-married women becoming mothers are in what they described as 'paperless' or 'quasi-' marriages. The survey asked women to indicate their relationship status as well as their marital status.

**Table 2.11 Relationship status of women with a crisis pregnancy**

Relationship status	Antenatal %	Abortion %	Total group %
Not currently in a relationship	21	30	24
In a casual relationship	6	14	8
In a long-term relationship	25	31	26
Engaged	8	5	7
Co-habiting	15	8	13
Married	27	12	23
<b>Total N</b>	<b>301</b>	<b>99</b>	<b>400</b>

While 72% of respondents described themselves as single, only one-third was not in an established relationship, of which a quarter was not currently in a relationship, while a further 8% were in casual relationships. Almost half were in established relationships, of which one in four were in a long-term relationship, 7% were engaged and 13% were co-habiting.

Of the 400 women surveyed, 179 or 45% had children already, comprising 36% of women in the abortion group and almost half of the women in the antenatal group.

**Table 2.12 Number of children to women with a crisis pregnancy**

Number of children	Antenatal %	Abortion %	Total group %
0	53	63	55
1	16	17	16
2	16	9	15
3	9	5	8
4	3	4	3
5	3	1	3
6 or more	1	0	0.5
<b>Total N</b>	<b>301</b>	<b>99</b>	<b>400</b>

In both groups mothers were most likely to have either one or two children. Less than 10% of those in the antenatal group had more than three children, while the figure for those in the abortion group was only 5%.

Table 2.13 Completed education of women with a crisis pregnancy

Education	Antenatal %	Abortion %	Total %
Primary	2	0	1
Some second level	8	2	6
Inter/Junior Cert	16	8	14
Leaving Cert	28	23	27
PLC course	11	9	10
College Cert/ Diploma	18	37	23
College degree	8	7	8
Postgraduate level	3	4	3
Other	2	2	2
Missing	4	7	5
<b>Total N</b>	<b>301</b>	<b>99</b>	<b>400</b>

Overall, higher levels of education were observed among women seeking abortion. Over half of the abortion group had a third-level qualification, compared with 30% of women in the antenatal group. Meanwhile, 27% of those in the antenatal group had not completed the Leaving Certificate, compared with 11% of the abortion group.

Table 2.14 Current situation of women with a crisis pregnancy

Current situation	Antenatal %	Abortion %	Total group %
At school	3	4	3
At college	4	12	6
In training	1	2	2
Working in the home	10	6	9
Part-time employed	16	13	15
Full-time employed	32	59	40
In receipt of welfare supports	12	0	9
Unemployed	23	3	18
<b>Total N</b>	<b>296</b>	<b>97</b>	<b>393</b>

In general, over one in two women surveyed were in employment, of whom 40% were full-time employed and 15% were part-time employed. There was considerable divergence between the two groups in relation to this aspect of their social situation as compared to the other aspects considered here.

There were striking differences between the two groups in employment status. Almost 60% of the abortion group were full-time employed while less than one in three women in the antenatal group were full-time employed when surveyed. Over one in three of the antenatal group were unemployed or in receipt of state benefits<sup>4</sup>, compared with only 3% of those in the abortion group.

Similarly, 8% of women in the antenatal group were in education or training compared with 18% of the abortion group, of whom the majority – 12% – were in college.

When considering income it is notable that over one-third of the survey participants did not complete this question, reflecting the sensitivity of such information. The table below reports on the 259 women who did complete the survey question on income per year, before deductions.

**Table 2.15 Income levels of women with a crisis pregnancy**

Income (€)	Antenatal %	Abortion %	Total %
Less than 4,999	23	15	21
5,000-9,999	13	5	10
10,000-19,999	29	41	33
20,000-29,999	22	19	21
30,000-39,999	10	11	10
40,000 or more	3	9	5
<b>Total N</b>	<b>179</b>	<b>80</b>	<b>259</b>

One in three of the total study group had an income between €10,000 and €20,000, 31% earned less than €10,000 and 36% earned more than €20,000. Those in the abortion group had higher earnings, with 39% earning upwards of €20,000 compared with 35% in the antenatal group. Meanwhile, significantly more women in the antenatal group (36%) earned less than €10,000, compared with 20% of women in the abortion group.

## 2.9 Summary profile of the qualitative study group

As stated earlier, there were 46 women in total in the qualitative study group, comprising an equal number from abortion and antenatal clinics. In keeping with the focus of the study, the research design strove to include two-thirds of women who attended for pregnancy counselling and one-third of women who did not. The table below gives a breakdown of attendance at counselling by each study group. While this target was realised in the abortion clinic sample it was not achieved for the antenatal clinic sample; less than one-third of this group attended counselling. This reflects the fact that women continuing a crisis pregnancy are less likely to attend for counselling in general.

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<sup>4</sup> Such as One Parent Family Payment, Back to Education Allowance or Disability Allowance

Table 2.16 Study group's attendance at counselling

	Antenatal clinic		Abortion clinic	
Counselling	Yes	No	Yes	No
	6	17	15	8
<b>N =</b>	<b>23</b>		<b>23</b>	

Table 2.17 Age profile of qualitative study group

Age	Antenatal group	Abortion group	Total
19 and under	1	0	1
20-24	2	10	12
25-29	3	4	7
30-34	6	4	10
35-39	3	2	5
40+	3	0	3
Missing	5	3	8
<b>Total Number</b>	<b>23</b>	<b>23</b>	<b>46</b>

As noted earlier, younger women were under-represented in the study, suggesting reluctance on the part of younger women to participate in such research. This indicates a need for a dedicated research exercise targeted specifically at this group. All age groups were represented in the antenatal study group. The abortion study group did not contain any women under the age of nineteen or over the age of 40.

### 3.0 Factors shaping attendance at counselling

#### 3.1 Introduction

This chapter presents findings from both the survey and the qualitative interviews relating to women's attendance at counselling. The factors associated with the decisions women made to attend counselling or not are considered. This includes a discussion of the role of women's support networks in their decision regarding counselling. The barriers women perceive to accessing crisis pregnancy counselling services are also examined.

#### 3.2 Analysis of survey data on attendance at counselling

Of the total group of 400 women surveyed, 110 or 28% attended a crisis pregnancy counselling service. Attendance at counselling varied significantly according to the outcome of pregnancy decided upon. Over half of the women who decided on abortion (54%) attended counselling, compared with less than one-fifth (19%) of women continuing to motherhood. This suggests that when faced with a crisis pregnancy, women considering abortion are more likely to attend counselling than women who intend to continue the pregnancy.

**Table 3.1 Women's attendance at crisis pregnancy counselling**

Type of service attended	Abortion group (N=99)		Motherhood group (N=301)		Total (N= 400)	
	N	%	N	%	N	%
2-option counselling	16	16%	26	9%	42	11%
3-option counselling	31	31%	26	9%	57	14%
Other	7	7%	4	1%	11	3%
<b>Total</b>	<b>54</b>	<b>54%</b>	<b>56</b>	<b>19%</b>	<b>110</b>	<b>28%</b>

More women attended 3-option counselling (14%) than attended services offering 2-option counselling (11%). Twice as many in the abortion group attended 3-option counselling as attended 2-option. In contrast, equal proportions of women in the motherhood group attended both types of counselling service at 9% each.

3% of women attended services other than those listed on the questionnaire (see Appendix 1). These included both 3-option counselling services and 'rogue agencies'.

#### 3.3 Analysis of interview data on attendance at counselling

Findings from the survey confirm the experience of interviewing in the antenatal clinics, where it was impossible to generate the target sample of two-thirds of women who attended counselling and one-third who did not. As illustrated in Table 3.1 above, only 19% of those surveyed in the antenatal setting attended counselling. Of the 23 women interviewed from the antenatal clinics only six had attended counselling, despite specific attempts on the part of the researchers to include attendees. Of the 23 women interviewed in abortion clinics, fifteen had attended counselling. Overall, our sample reflects the greater tendency among women choosing abortion to seek counselling.

### 3.3.1 *Reasons for attending counselling*

Analysis of the interviews with the 21 women who attended counselling illustrates their reasons for doing so. Women attended counselling for the support it offered in coping with the stress of a crisis pregnancy. Some women sought help with making a decision on how to resolve the pregnancy, particularly where feelings of moral conflict meant coming to a decision was difficult:

I went to counselling because of the way I just, like, I wanted someone, because I was so two-minded, I just wanted someone to tell me what to do.

(Abortion Group A)

Being able to explore the available options, even while 'leaning' towards one particular option, also featured in women's decision to attend counselling. This served to reassure them that they had made the right decision. Meanwhile, women who had come to a definite decision attended counselling to get the practical information and help they needed to proceed with that decision.

The majority of women in the abortion group attended counselling after making the decision to have an abortion; they attended counselling to access practical information and help in arranging the abortion. This finding emerged very strongly from the interview data. Respondents described going through the decision-making process themselves, either alone or with a partner, friend or family member. They did not tend to see any role for counselling in revisiting the decision itself. The women did, however, want to attend a counselling service to discuss abortion, find out information about the procedure and, in particular, acquire contact details of abortion service providers from a trusted source. Seeking reassurance that they were doing the right thing was another factor in this group's decision to attend for counselling.

In contrast, the albeit smaller number of women in the antenatal group who attended counselling were more likely to be still going through the process of making a decision. Some had contemplated abortion and attended counselling to discuss this option and find out more information. They decided to continue the pregnancy either because they felt they could cope with the prospective role of motherhood or because of barriers they encountered to accessing abortion. For one woman the cost was beyond her means, while another, who contacted a 'rogue agency', did not know how to access information on abortion services.

Others in the antenatal group stated they knew they would continue the pregnancy but attended counselling to explore their options. Again, this served to confirm and reassure them in this decision. In three cases women were actively considering placing the baby for fostering or adoption, and counselling provided both full information and support in contemplating this option.

A key reason women continuing their pregnancy attended counselling was because it offered safe environment where they could openly express their feelings of not wanting the pregnancy. They felt that to voice such feelings towards their pregnancy is taboo in our society and they had no opportunity outside of the context of counselling to do so:

It was nice to be able to say to someone it was a pregnancy I didn't want.

(Antenatal Group Q)

### 3.3.2 *Reasons for not attending counselling*

Among those women who did not attend counselling were some who did not want to attend counselling and others who would have attended counselling but encountered barriers that prevented them from accessing a service. The barriers women encountered are explored in detail below. In general, the survey data and the interview data both indicated that women in the abortion group were more likely to have experienced barriers to attending a service than to have chosen not to attend a service. Conversely, women in the antenatal group who did not attend counselling were more likely to report not wanting to attend a service rather than having encountered a barrier.

In general, women in both groups seemed more likely to come to a decision outside the context of counselling. A strong theme emerging from the detailed interviews was that the approach women took to resolving their pregnancy was similar to the approach they took to dealing with other stressful situations in their lives that required them to choose between different options. If women usually acted autonomously, without canvassing other people's opinions, they tended to adopt the same approach to resolving the crisis pregnancy and therefore ruled out engaging with a counselling service. Indeed, the intensely personal and private nature of this particular crisis may have confirmed their resolve against attending counselling:

I never felt that I needed to talk to a stranger about it. I just, well, I wouldn't. I'm not the kind of person that would normally talk about it. I just, you know, it was never really something that I thought about doing.

(Abortion Group Q)

I was never into anything like that. I'm Irish and I've gone through a few things in my life, and that, which I probably should have gotten counselling for and I didn't. I don't know. I'm the type of person that I'm more, a very private person, that I wouldn't talk to people very freely.

(Antenatal Group D)

Women who were continuing to motherhood tended to associate crisis pregnancy counselling services with the option of abortion and so discounted its relevance to them. The associations women made with counselling often factored in their non-attendance at counselling. Counselling tended to be associated with younger women, pregnant for the first time, who had no support and did not know what to do. This meant that women with children already or those who had the support of a partner, family or friends did not consider counselling as relevant to them. Moreover, some women with a good support network of their own felt that this met all their needs and so counselling was irrelevant to them. For a number of women in the antenatal group, the crisis stemmed from their concerns for their own health or the wellbeing of the foetus. In all cases women looked to their doctor for professional support. All of these women felt their GP or gynaecologist had met their needs fully and had reassured them sufficiently to enable them to decide to continue the pregnancy:

I was worried about that, my health, and did I want this baby? Was I ready for it? ... So [the GP] was able to talk [about that]. I can't explain how well I felt after coming out of the doctor's.

(Antenatal Group R)



[Counselling] didn't really jump to my mind ... I, maybe I'm the type of person where I wouldn't even consider an abortion, you know?

(Antenatal Group G)

I suppose with my husband I didn't feel the need to go and talk to anybody because with my age, and I'm old enough to deal with it at home, anyhow.

(Antenatal Group B)

As stated above, women in the abortion group were more likely to report experiencing barriers to accessing counselling than choosing not to do so. Of those women considering abortion who did not want to attend a counselling service some felt simply that they did not need counselling to help them with their decision. In some cases they perceived that counselling would entail an attempt to persuade them to continue the pregnancy. Women avoided counselling where they perceived it would involve them giving an account of how the pregnancy occurred or a defence of their decision. They resisted having to talk through these issues because they feared it would confuse their thinking, believed it would be upsetting or because they could not see any benefit counselling could offer:

Counselling service? I personally don't think I needed counselling so I didn't take it up.

(Abortion Group E)

I probably would have used the services if, you know, I didn't know what I wanted to do, but I just knew straight away. So I just didn't feel there was any need to talk to anyone about it.

(Abortion Group P)

Well, I just thought it would be, you know, sitting down and talking it through, you'd have to go through the whole rigmarole about what happened and why you feel like this and have you thought of other options and how you do think about them, d'you know? And I was clear about everything like that in my head so I didn't really feel I had to talk about it or say it to another person, like. I don't really think it would have got me anywhere. It would have just upset me to talk about it, so I knew it all in my head.

(Abortion Group I)

Some women in the study had attended a service they expected would provide 3-option counselling but which turned out to be a 'rogue agency'. These women were then reluctant to contact another agency in case they met with the same treatment. This meant that ultimately these women did not access the kind of crisis pregnancy counselling they wanted.

In addition to these reasons that women gave for not wanting to attend counselling, women encountered barriers to accessing counselling, which also influenced whether or not they attended.

### 3.4 Barriers to accessing counselling

As noted above, some women did not attend counselling because they experienced barriers to accessing a service. This problem was more pronounced for those in the abortion group than for those in the antenatal group. This section will focus specifically on barriers women identified to attending counselling.

#### 3.4.1 Analysis of survey data on barriers to accessing counselling

Of the 400 women surveyed, 122 (30.5%) reported a barrier to attending counselling comprising of 53% of the abortion group and 23% of the antenatal group. Conversely, 47% of the abortion group and 77% of the antenatal group did not report experiencing any barrier to attending counselling. These findings again reflect that women choosing abortion are more likely to want to attend counselling.

Of the 122 women who encountered a barrier to counselling many reported encountering more than one of the barriers discussed below. The most cited barriers, reported by between 25 and 30 percent of respondents, were not knowing of any service, being unsure about what information pregnancy counselling services provided and the absence of a local service. These factors are to do with knowledge and availability.

For one in five women fear of being recognised attending a service acted as a barrier. Money issues represented a barrier for 16%. As all statutory funded counselling services are provided free of charge this indicates either a lack of knowledge that there is no charge for counselling, or prohibitive costs associated with attending such as transport or childcare costs. Delay in getting an appointment was the lowest barrier, at 7%.

**Table 3.2 Barriers to attending crisis pregnancy counselling**

Barrier to counselling	Abortion group (N=53)	Antenatal group (N=69)	Total (N=122)
Not knowing of any service	34%	19%	29%
Unsure what information service provided	30%	27%	28%
No local service	34%	19%	25%
Fear of being recognised	32%	12%	20%
Money issues	21%	13%	16%
Delay in getting an appointment	15%	2%	7%

A comparison of the barriers reported across the two groups of respondents showed similarities in the proportions that reported being unsure what information a service provided as a barrier. For all of the other barriers to accessing counselling cited, those in the abortion group were more likely to report experiencing the barrier than those in the antenatal group.

### 3.4.2 *Analysis of interview data on barriers to accessing counselling*

As discussed above, women in the abortion group were more likely to attend for counselling and more likely to report experiencing barriers to attending counselling. However, women in the antenatal clinic group did attend for counselling and did cite barriers to counselling, albeit in fewer numbers. The barriers discussed by both groups of women who participated in qualitative interviews are analysed below to get a more in-depth understanding of the nature and extent of these barriers.

- *Lack of knowledge of services*

A common barrier for women in both groups was lack of knowledge of who provides crisis pregnancy counselling and what such counselling entails. Migrant women in the study were particularly at risk of not knowing of any services. Those for whom English is not a first language argued for better awareness-raising of such services, using media targeted at non-national communities. These women felt that information about the services should be available in a number of languages. Women from rural areas felt that public information campaigns about pregnancy counselling services were less visible outside of Dublin.

Women considering abortion perceived there to be a widespread silence about services that would discuss the option of abortion; they felt this was an outcome of the stigma and taboo associated with abortion in Ireland. Such silence meant that the strategies one might employ to source a service, such as asking acquaintances, were not available to women seeking crisis pregnancy counselling services:

I mean it's such a taboo subject as well; people are afraid to ask.  
[Antenatal Group W]

In the absence of an obvious information source, women seemed to automatically refer to the classified telephone directory *The Golden Pages*. While a range of organisations are listed there, including those funded by the Crisis Pregnancy Agency, women often encountered difficulties in identifying a service that met their needs.

While women displayed an awareness of the names of organisations providing crisis pregnancy counselling, the substance of the counselling offered was unclear to them. Many in the antenatal group were unclear about how counselling could support them now that they had decided to continue the pregnancy. Women considering abortion were unclear about whether services discussed this option. (See below.)

- *Unsure whether information on abortion was provided*

Women considering abortion were often tentative about contacting a counselling service because they were not sure whether abortion would be discussed. The response they received when they first made contact with a service played a key role in whether they proceeded to make an appointment and attend for counselling.

Women found that some of the language and terminology used by counselling providers was unclear and confusing. They described trying to interpret some of the language to determine which options each service would discuss. It must be borne in mind that women are seeking information and access to services in a crisis situation, where they are stressed and worried.

Some women first made contact with a service when they attended to have a pregnancy test administered. An assumption by a doctor or nurse that the woman would continue the pregnancy deterred some of those considering abortion from attending counselling with that organisation:

[Nurse in 3-option agency B] made an appointment for me for counselling, which I didn't pursue. Just the tone of the conversation, it was basically like, 'well, you're just going to have to deal with it', but in a very nice way, so I didn't pursue it.  
[Abortion Group G]

Many women's first contact with a service was by telephone. Where the front-line staff of an organisation did not provide reassurance that information on abortion would be included as part of the counselling process, women often did not proceed with attending the service. They then found it very difficult to know where to turn next:

I rang [3-option agency A] and the woman that was on the phone just didn't know what she was talking about. I think she was new on the job or something, and she just didn't have any information at all.  
[Abortion Group T]

I was asking her, like, 'Could ye make appointments for [abortion]?' and she goes, 'Well, we can't give out that information over the phone, it's illegal.' That's all she kept saying to me.  
[Abortion Group R]

This confusion was exacerbated by the fact that some 3-option counselling agencies appeared to be particularly cautious about how they described their services over the telephone. Some services appeared to be very guarded in how they described their service and in particular their treatment of abortion information to women over the telephone. This left women who were seeking information on abortion through a counselling service unclear as to whether the agency would meet their needs:

I tried asking [3-option agency D] on the phone about what types of options were available: did they talk, would they give me information on abortion, and stuff, and they kind of, they didn't really answer me that clearly on it. They didn't sound like they would have given me the information I wanted on the abortion because they didn't seem, like, they didn't sound like they could speak freely about it.  
[Abortion Group I]

Such an apparent anxiousness to comply with the terms of the 1995 Regulation of Information Act has the negative effect of diminishing the ability of the service to communicate to women what their service comprises. It may be that the legacy of litigation against service providers between adoption of Article 40.3.3 into the Constitution in 1983 and the implementation of the Act in 1995 is a factor in such a conservative approach being taken by organisations. However, from the perspective of women seeking help with resolving a crisis pregnancy, this has the effect of impeding their access to services that do, in fact, provide the very help they are looking for.

- *Difficulty accessing services*

There were a number of factors that created difficulty for women accessing counselling services, including no local service, delays in getting an appointment and counselling only being available during 'office hours'.

Poor geographical spread of services was a significant factor causing women difficulty in attending for crisis pregnancy counselling. Women living outside of Dublin, particularly in rural areas, were critical of the absence of local services. In light of the necessity for many women to travel to the services, women with young children cited lack of childcare as a barrier.

Counselling service providers were usually only available during office hours, which made them difficult to access, particularly for women working full-time. Women pointed out that telephone helplines should operate outside working hours.

Finally, women often wanted to attend counselling very soon after making contact with an agency, so any delay in getting an appointment could result in women ultimately not attending a service.

- *Attitudes to counselling*

Women experiencing crisis pregnancy come from a broad range of backgrounds, age-groups, relationships and so on. However, some were of the impression that crisis pregnancy counselling is intended for the most 'visible' crisis pregnancies – young, single, unsupported women:

I would say it's for teenagers. That's now automatically what would come into my head: 'What would I be going there for? I'm daft. I've got a family. I've got a loving husband.' That sort of thing.

(Antenatal Group R)

Some women considering abortion held the view that counselling involves an attempt to dissuade women from this option and so avoided it.

I had a perception about [counselling] in Ireland, even the names of some of them like Life, PACT, you know, they kind of, and Cherish/One Family, like. They kind of give you the impression in [their names] that they'll try and persuade you to try and keep the baby.

(Abortion Group I)

- *Fear of being recognised entering premises*

Concerns about being seen entering a premises where pregnancy counselling is provided prevented some women from doing so. Due to the stigma women associated with abortion their sensitivities about being identified attending such services were quite high. A woman in the antenatal group shared this view. She would be embarrassed attending a visible crisis pregnancy counselling service because of the insinuation that she could not cope with the pregnancy:

I think like I'd be seen going in and 'Look, oh, that one she's cracking up, like, because she is pregnant.' That sort of thing. I'd probably be a bit worried.

(Antenatal Group R)

### 3.5 Role of support networks in coping with a crisis pregnancy

#### 3.5.1 Analysis of survey data on role of support networks

When we are faced with a crisis we all need support and usually the support of those we are closest to means the most. Analysis of the survey with 400 women facing a crisis pregnancy showed that women were most likely to seek support from their partner (60%), mother (38%) or friend (34%). Almost one in five women (19%) looked to a sister for support, while between five and ten percent looked to their father (9%), brother (4%) or another relative (4%) for support.

**Table 3.3 Details of women's support networks**

Looked to for support	Abortion group (N=99)	Antenatal group (N=301)	Total (N=400)
Partner	57%	61%	60%
Mother	25%	43%	38%
Friend	53%	27%	34%
Sister	25%	17%	19%
Father	6%	10%	9%
Other relative	11%	3%	6%
Brother	4%	4%	4%

There were some differences in who women looked to for support, depending on what outcome they decided on. Partners were looked to for support by equal proportions of women in the abortion and antenatal group. After partners, women continuing their pregnancy tended to look to their mothers for support (43%) while women choosing abortion tended to look to a friend (53%). One in four women in the abortion group did look to their mother or sister for support. Less than 10% of women in each group looked to a father or brother for support.

#### 3.5.2 Analysis of interview data on role of support networks

Analysis of our detailed interviews with women illustrated that often they looked to and received support from one or more of these key people in their lives.

Partners, mothers, friends and others provided women with emotional support and also helped them through whichever option they chose. They provided emotional support by listening to and talking with women about their concerns and options for resolving the pregnancy. Other help they provided included seeking out crisis pregnancy counselling services, making appointments and accompanying women to counselling, accompanying women having an abortion to the clinic in England, and accompanying women continuing their pregnancy to antenatal care.

The role of support networks in shaping women's needs from counselling and their decisions about attending counselling are explored here. For most women having the support of a significant other meant more than the support of a counsellor ever would:

I think that [counsellors] can only go so far. But knowing that your family is behind you is something that no service can provide.

[Abortion Group G]

However, this did not mean that many women did not see an important role for crisis pregnancy counselling alongside this support system.

- *Conflict over outcome*

There were cases where women's decisions on how to resolve the pregnancy conflicted with the views of their partner, mother, friend or other key support person. In such cases counselling came to be viewed as a particularly important resource.

Women described how their partners were dealing with both how the woman was coping with this crisis and also their own response to the prospect of becoming a father. Where there was conflict between the woman and her partner over how to resolve the pregnancy, women faced the challenge of finding how both their needs could be met. Such a situation was particularly difficult to resolve, and counselling was seen by some women as a forum that could help them deal with this conflict.

The response of mothers, friends and others to the pregnancy was usually to focus on the wellbeing of the woman. Women described how this group encouraged them to attend counselling so that they could be fully informed to make the best choice possible. Some parents advised their daughters to choose a particular option as being in their best interest. This may have differed from the option being considered by the woman, in some cases together with her partner. Women described a number of cases where one or both parents, usually their mother, advocated abortion in the interest of their daughters' physical and/or mental health.

Some women considering adoption also found this conflicted with a parent's views. In the case of the following woman, her consideration of adoption as an option was in conflict with the views of both her partner and her mother. She illustrated the role of counselling in such a situation:

He [partner] basically said that whatever decision I made that he would back me up, but I knew that if I gave it up he wouldn't be happy so it made me look at it from both sides: at what I wanted and what he wanted. It was a tough decision to have to make. Because one of us wants it and the other doesn't.

It came as a bit of a shock to [my mother] but it was an even bigger shock when I told her what I wanted to do. She wasn't happy with the idea. It's very hard when you have your mind made up. When I get an idea into my head that's it, it stays there. I act on it. I've my partner and I've my mother saying 'if you do this and if you do that' and it was hard.

[The counsellor was] somebody to talk to, somebody to get some views off my chest and somebody to sit there and just listen to what I had to say instead of, 'This is what I think you should do' or 'I think you shouldn't do this.' It was nice to talk to somebody outside the family circle.

[Antenatal Group Q]

- *Counsellor is better placed to understand*

Women sometimes felt that those in their support network could not fully comprehend the sense of crisis they were experiencing. As a result, they felt that they either could not voice their concerns or that even if they did voice them, they would not be acknowledged or appreciated. Some also felt that while their partner, parent or friend may be supportive, they were not able to empathise with them.

Counsellors, on the other hand, were seen as experienced and skilled in the area of crisis pregnancy so that they could relate better to how the woman was feeling. Having all their concerns, fears and anxieties acknowledged was something women valued and needed, and they expected counsellors would have the skills to do this. From their experience of helping other women through a crisis pregnancy, counsellors were perceived as well placed to understand why a woman was making a particular decision. Counsellors were also viewed as skilled in knowing what kind of questions to ask women to access their true feelings and concerns, as well as being knowledgeable about all possible options. These were skills and information that women did not expect from members of their support network:

I would have liked somebody just to say outside the immediate family because immediate family is delighted and they are going to be delighted for me because it's a baby to them, but for you it's, like, it's a big responsibility.

And I have a supportive partner. I have a supportive partner where if I really need to I could sit down and say 'You know, this is how I feel' and he would listen. But men don't understand.

The best way I can describe it is, you know, when people say you can still be lonely in a room full of people, and that's how I felt. I felt that, I felt guilty for not being excited. Am I being selfish, like? Here I am, like, [30-35] years of age, I mean, 'Cop on, you've had a good life.' Because people were making me feel like, 'You've had a good life, now time to cop on and it's now time to, you know, have a baby.' And you are like, 'That's it, that's it as far as I'm concerned, like. I'm over'.  
(Antenatal Group H)

Now I know I'm talking to my friend, and that, but you kind of, I just feel like I don't think she knows exactly why I did it [decided on abortion], or, you know what I mean?  
(Abortion Group F)

- *Counsellor is detached*

Many women described how they acted to protect their partners, family and friends by holding back on the full depth or range of emotions they were feeling. They were aware that these people cared about them and were concerned about them. They felt a need to show them they could cope with the crisis and would be able to cope with the decision they made. This sometimes meant women felt it necessary to withhold conflicting emotions and doubts.

A counsellor does not have a close personal relationship with the woman and is seen as a professional, skilled in dealing with crisis and emotions. For this reason women felt a counsellor was someone who could cope with hearing about everything they were feeling. Furthermore, women expected a counsellor to be able to help them manage these feelings.



Women also held back from fully expressing their emotions and thoughts in case they shocked someone close to them and caused them to judge her. Where crisis pregnancy counselling was believed to deal with all options and to be non-judgemental, it offered an outlet for women to consider such options without running the risk of putting a relationship in jeopardy:

It's different talking to a family member and sometimes it's much easier to talk to a stranger, you know what I mean? Because you don't, because your family are people who love you but they still always judge you. Not even about that but in other ways, you know what I mean? So, if you've got somebody who's completely unassociated with you, they can probably understand. It's like an outsider looking in.  
[Abortion Group E]

- *Counsellor as only support*

Finally, while most women were supported by one or more people from within their own network, there were a few women who did not have any support from family or friends. Some women felt that no-one in their support network would have been sympathetic to their position. Women who had recently migrated to Ireland were separated from their usual support network. Where a key support person was philosophically opposed to abortion this prevented them from providing support to a woman considering this option. In cases where no other support person was available, women could then find themselves without any source of help and support. In such cases access to crisis pregnancy counselling seemed vital:

My mum was no help to me because she lives [abroad]. She is too far away from me. I couldn't tell my dad because my dad is very strict, very strict. I haven't told him yet. I don't know what he is going to say.

I felt that I had nobody there for me. I had nobody there for me.

I mean, my friend, now, round the corner there, as I say she's a good friend, the first person I went to. She has three kids, the very same as me, all in the same age group, and when I said I was pregnant, she just looked at me and she was shocked. She said, 'What are you going to do?' And I said 'What would you do?' She said, 'I don't know what I would do', she said to me. And I said, 'The same as you'. I said, 'I don't know what to do'. Then that was that and I said to her then, 'I'm thinking about having a termination.' 'Oh you can't do that.' Do you know? And I said, 'But why?' and 'What would you do? You are after telling me there "What am I going to do?" like. What would you do?'

*And what did she say?*

She couldn't answer me. She couldn't answer me.  
[Antenatal Group T]

### 3.6 Summary and conclusion of factors shaping attendance at counselling

Of the 400 women surveyed 28% attended a crisis pregnancy counselling service. This comprised 54% of those in the abortion group compared with only 19% of women continuing to motherhood.

A range of factors shaped women's decisions about attendance at counselling. Women who attended counselling described doing so for help with making a decision on how to resolve the pregnancy. Some women had made a decision on how to resolve the pregnancy when they contacted a counselling service. Their intention in doing so was to access help and advice in carrying out this option, such as information on abortion services or supports for mothers. Some women attended counselling because of the support it offered them when they were going through the stress of a crisis pregnancy.

Factors in women's decisions not to attend counselling included associating counselling with certain options, not feeling the need to talk through the issues raised by the pregnancy and the decision made with a counsellor, and doubts about the inherent value of counselling. Women who had been through a pregnancy before and women who had the support of a partner, family or friends tended not to feel a need to attend professional counselling.

Where a woman attended a 'rogue' agency that actively tried to dissuade her from choosing abortion, this made her reluctant to contact another agency in case she was met with the same treatment.

The principal barriers to attending counselling cited by women were not knowing of any service, being unsure what information pregnancy counselling services provided or having no service available to them locally. These factors are to do with knowledge and availability. Lack of knowledge of who provides crisis pregnancy counselling and what such counselling entails inhibited women accessing services.

Women perceived there to be a widespread silence around abortion-related services; they felt that this was an outcome of the stigma and taboo associated with abortion in Ireland. Such silence meant that the strategies one might employ to source a service, such as asking acquaintances, were not available in relation to pregnancy counselling services.

Lack of clarity on the regulations governing the provision of information on abortion has consequences for women's capacity to access services. Women often found the language and terminology related to crisis pregnancy counselling services unclear and confusing. It must be borne in mind that women are seeking information and access to services in a crisis situation, where they are stressed and worried. Some 3-option counselling services appeared to be very guarded in how they described their service and, in particular, their treatment of abortion information over the telephone. The outcome of this was that women seeking information on abortion services through a counselling provider were left unclear as to whether or not their needs would be met. Meanwhile, the response women received when they first made contact with a service played a key role in whether or not they proceeded with making an appointment and attending for counselling.

Other issues cited as barriers were fear of being recognised, money issues and a delay in getting an appointment. Counselling services were difficult to access for women due to limited contact hours and poor geographical spread. Delay in getting an appointment

was also cited as a barrier. Women seemed to want to attend counselling very soon after making contact with an agency. Any delay in getting an appointment could result in women ultimately failing to attend the service. Finally, fear of being recognised entering the premises of a crisis pregnancy counselling service could prevent women from attending counselling.

The availability and nature of a woman's support network was also a factor in her decision regarding counselling. Women facing a crisis pregnancy were most likely to seek support from their partner, mother and/or friend. For most women having the support of a significant other meant more than the support of a counsellor ever would. However, there were women who did have an active support network but who could still see an important role for crisis pregnancy counselling alongside this support system.

There were cases where women's decisions on how to resolve the pregnancy conflicted with the views of members of their support network. In these situations, counselling came to be viewed as a particularly important resource. Women sometimes felt that those in their support network could not fully comprehend the sense of crisis they were experiencing in response to the pregnancy. Counsellors, on the other hand, were seen as experienced and skilled in the area of crisis pregnancy so that they could relate better to how the woman was feeling. Counsellors were viewed as having some skills and information that women did not expect from members of their support network.

Women described how they acted to protect their partners, family and friends by holding back on the full depth or range of emotions they were feeling. A counsellor does not have a close personal relationship with the woman and is a professional, skilled in dealing with crisis and emotions. For this reason a counsellor was someone who could cope with hearing about everything the woman was feeling.

Finally, while most women did receive support from within their own network there were some women who did not. In cases where no other support person was available to the woman she could then find herself without any source of help and support. In this situation, access to crisis pregnancy counselling was vital.

## 4.0 Needs, expectations and knowledge

### 4.1 Introduction

This chapter looks at what help and support women needed when they discovered they were pregnant. It explores women's perceptions of counselling and their expectations of the role of counselling in meeting these needs. Women's knowledge of crisis pregnancy counselling is also examined. The methods women used to access information on counselling services are described and difficulties they experienced in getting such information are discussed.

### 4.2 Women's needs when faced with a crisis pregnancy

Women's needs from crisis pregnancy counselling were explored in two ways. Firstly, in the questionnaire women were asked: 'What should a pregnancy counselling service have offered you?' They were given a list of possible answers from which they could select one or more. There was also an open-ended option where they could indicate a need other than those specified.

Needs were also explored through the qualitative interviews in two ways. The interviews all began with a general question: 'Going back to when you first discovered you were pregnant, what kind of help and support did you need at that stage?' This elicited responses on a range of needs, including needs from counselling services. This was followed later in the interview with questions specifically focused on needs from counselling services.

#### 4.2.1 Analysis of survey data on women's needs

Overall, the table below shows there were striking differences in what women reported needing from counselling depending on the outcome they had decided on.

**Table 4.1 Women's needs from crisis pregnancy counselling**

Needs from counselling service	% of abortion (N=99)	% of antenatal (N=301)	% of total N=400
A supportive listener	36%	62%	56%
Talk through all your options	38%	58%	52%
Information on pregnancy care	1%	44%	34%
Information on supports for parenting	7%	40%	32%
Information on abortion	59%	24%	32%
Help with making a decision	13%	27%	23%
Information on adoption	5%	25%	20%
Help with telling others	6%	24%	19%
Referral to abortion clinic	48%	0%	12%

Overall, fewer than one in four (23%) wanted counselling to provide help with making a decision and there were significant differences between the two groups on this. Only 13% of those in the abortion group wanted help with making a decision, compared with 27% of those in the antenatal group.

What those in the abortion group wanted most from counselling was instrumental help with accessing abortion services. Almost sixty percent (59%) stated that counselling should provide information on abortion. Almost half (48%) wanted counselling to include referral to an abortion clinic. By contrast, those in the antenatal group were most likely to want counselling to have a listening role. Around 60% wanted counselling to provide a supportive listener (62%) and to talk through all options (58%).

Women in the abortion group were less likely to want to get information on other options than women in the antenatal group were. Only one in twenty (5%) wanted information on adoption and similar proportions wanted information on supports for parenting (7%). Those in the antenatal group were more likely to want to hear about other options, with almost one in four wanting information on adoption (25%) and abortion (24%).

#### *4.2.2 Analysis of interview data on women's needs from counselling*

All 46 women who took part in interviews for this study were still in the process of coping with their crisis pregnancy. As described earlier, 21 of the 46 women had attended counselling. Over twice as many of those in the abortion group had attended counselling. During the in-depth interviews all women reflected on the optimum role counselling could play in supporting them through their crisis pregnancy. While, as discussed earlier, some women discounted counselling as something they personally would not be comfortable with, many women could see a role for counselling:

I think [counselling is] quite important, very important – I really do, because it's, what it was for me was, before I went to the counsellor or my GP I felt so unsure about everything and I just didn't know what was happening. I thought 'How is it going to happen, what's going to, where do I have to go, what do I do?' and I really did feel quite, I don't know what the word is but I just ... confused, really worried, anxious.  
[Abortion Group T]

- *Supportive listener*

Many women described needing 'just someone to talk to' when asked what they needed when faced with a crisis pregnancy. Some elaborated on what they wanted from that someone and how counselling could fulfil this role:

Somebody to talk to, somebody to get some views off my chest and somebody to sit there and just listen to what I had to say instead of 'This is what I think you should do or I think you shouldn't do'.  
[Antenatal Group Q]

Women needed counselling to allow them articulate their fears and to provide reassurance that they would be able to cope after the pregnancy, whether the pregnancy ends with motherhood or with having an abortion. They also needed to be reassured that they would receive support in coping after the pregnancy.

- *Non-judgemental response*

Women placed the strongest emphasis on the need for counselling to be non-judgemental. Women wanted to know they would not be judged for either becoming pregnant at this time or for making a particular decision. In particular, women considering abortion felt it was crucial that a pregnancy counsellor would not view them negatively for the decision they had made:

Someone who won't listen and judge me, and I think that a support network needs to be people who listen to you, understand. Not understand, because you don't necessarily need them to understand, but as long as they don't judge you.

[Abortion Group E]

Women felt that a trained, professional counsellor would be able to relate to the feelings and fears that accompany crisis pregnancy. Counselling was seen as giving a particular form of support that would not be available to women otherwise. In particular, women referred to counselling as providing a safe environment where they could talk frankly about the whole complexity of emotions they were experiencing, including feelings of fear, guilt, doubt and sadness:

I think that's why you need a counsellor, you need somebody who can tap into how a person is feeling. Even when I was coming in, I mean I was crying, it's emotional, you know? I wasn't walking in saying 'Oh yeah yeah, yeah! This is what I want', you know? And it was, I was emotional about it, so you need somebody who's, you know, clear, and just because you might be, even, like, I wouldn't have been interested in having somebody saying 'Are you sure, are you sure? Maybe do you want to think?' or 'Oh you're very upset now, do you want to leave it another week to make a decision?' I would have hated that, you know? I was upset, but it was more an emotional time, bawling, do you know what I mean?

*Yeah, absolutely.*

That makes sense and that's why it was good to have somebody who has those skills and that can talk to you.

[Abortion Group M]

- *Address all options*

We saw in Table 4.1 above that close to one in four women wanted counselling to help them with making a decision on how to resolve the pregnancy. In detailed interviews those women who wanted the support of a counsellor in coming to a decision tended to want counselling to bring them through all of their options. They articulated and emphasised the need for counselling that is non-directive and includes all options:

I think it was just the initial shock of it, really; that we did want to kind of discuss all the options but I kind of knew, I think you know in your heart of hearts what you're going to do but you just kind of have to go and route out all the pathways, just in case you change your mind, and that's what we did.

[Antenatal Group B]

I needed support in making my decisions because I found that, I always thought that, and it's stupid immaturity, that when you got pregnant, that answer would sort of come shining through and you'd just deal with it. But I was really ... I was cut between the morals and then what I want. And I didn't want to be pregnant. I was just, like. So, like, I found I needed support in making my decision.  
[Abortion Group A]

- *Support managing relationship with partner*

Some women indicated a need for support in managing their relationships in this new context of a pregnancy. This was most pronounced where the relationship was a factor in the pregnancy being a crisis. The pregnancy, in turn, may be the source of strain or conflict in a relationship and so the need for supports at this time was more pronounced. Relationships may be very recently established, going through problems or even represent a threat, for example where a partner is abusive or a risk to the woman and/or her child:

I could probably do with counselling services but not directly related to pregnancy. Relationships things around, surrounding the pregnancy.  
[Antenatal Group G]

- *Supports for partners and parents*

Women were of the view that alongside their own needs for support in dealing with the pregnancy their 'significant others', in particular partners and parents, could also benefit from pregnancy counselling. Women in both groups were concerned that partners were not being fully open about their own feelings and preferences because they were preoccupied with being supportive and protective. In other cases partners were open about their views and these conflicted with the woman's own views and decisions. Some women continuing the pregnancy described how their partners had their own fears about the prospect of fatherhood. They felt counselling could help them manage these fears:

And even with [my partner] I'm sure he was frightened. Like, I asked him 'Are you ok about this?' 'Yeah grand.' I says, 'You can't put it back and all that but you know, how do you feel?' 'Ah, it will all work out. If it happens, it happens.' But I felt very isolated even from him, like. We are very close but I felt a big distance between us where it, he wasn't being honest and even if he had, if he had of really, really, been honest, I don't think I could have took it.  
[Antenatal Group H]

In the case of parents, women were conscious that their parents could see how distressed they were by the pregnancy and may need support coping with this. Parents' need for counselling, as identified by women, primarily related to coping with seeing their daughter in crisis and reconciling themselves with their daughter's decision regarding the pregnancy.

- *Support with telling others*

Chapter 3, above, discussed the role of significant others in supporting women through a crisis pregnancy. Disclosing the pregnancy was sometimes difficult for women. Some saw counselling as a possible source of help, guidance and support in managing how to

tell others about the pregnancy. Some women continuing to motherhood looked back on how they discussed the pregnancy in the early days and regretted being negative about it. A counsellor could have helped prevent this:

Before you know, it's out in the open and you are saying things you don't want to say.  
(Antenatal Group R)

- *Continuity of support*

A recurring issue among women in both groups was the need for continuity of counselling support over a range of stages in the crisis pregnancy. Women continuing the pregnancy felt that their needs changed as the stages of the pregnancy progressed. They expected this to continue, particularly after the birth of the baby when they would be adjusting to motherhood:

If I got very, very down in myself and was wondering 'Am I doing the right thing in keeping it or would it be better giving it up?'  
(Antenatal Group Q)

Where women had decided on abortion they expressed a need to know that counselling would be available if they wanted to talk about their feelings afterwards.

- *Needs when considering abortion*

Women who attended for counselling having made up their mind to have an abortion described the specific needs they had at that point. Some were clear that the information was all they needed from counselling. A key reason why women sought this information from counselling services specifically was because they want to be confident that they would make contact with a trusted abortion service provider in England.

Women in the abortion group emphasised that counselling needs to provide practical information on how to implement the decision to have an abortion. They expressed a strong need for counselling services to give them clear, detailed and full information on:

- what the medical procedure entails
- related issues, such as options for anaesthesia, fasting requirements, and what clothing and sanitary items to bring
- how they can expect to feel physically and emotionally immediately after the abortion
- directions to get to the clinic from the airport/port
- the full detailed costs they can expect to encounter.

The extract below illustrates how a lack of such information can cause problems:

They could sit down and they could tell you how to prepare it. They could organise it for you, you know what I mean? ... Today for instance, I didn't know I wasn't to eat for six hours before. I went, got up this morning, absolutely famished, and I sat down and I ate my full breakfast and I was meant to get my procedure done at 11 o'clock this morning and I had to wait 'til 3 o'clock because I had no information that I wasn't allowed to eat, you know what I mean? And I brought a pyjamas. I know they're only simple things but someone could have got me through this.



*But this is really important, isn't it?*

Yes. Sort of pyjamas, instead of a nightdress. You're meant to have this nightdress down to your knees so they can actually do the procedure, and it didn't register at all, so I brought nothing. A pyjamas, you know what I mean? I said something about that. They are important things. If someone could sit down, and even the little simple things, bring you through them, like, to prepare how you'd feel afterwards, how you'd feel beforehand, you know? Needing to want to go home, you want to talk to someone, you know?

[Abortion Group E]

- *Needs when continuing to motherhood*

Women continuing to motherhood expressed similar needs for detailed information in relation to the antenatal care system, how it works and what to expect on attendance at a clinic. Women's accounts illustrated that they found it very stressful and even distressing trying to negotiate their way through a process they did not expect or anticipate themselves having to deal with. As this pregnancy was a crisis, women had not prepared themselves by finding out information on aspects such as antenatal care, maternity hospitals or birthing options, as women who are anticipating a pregnancy often do. These women had to learn very quickly, while at the same time adjusting to their pregnancy and dealing with a myriad of issues it may have raised in their relationships, in their job or education and in many other areas of their lives. These stresses were even more pronounced when the pregnancy occurred while a woman was living away from home, particularly if they were recent migrants to Ireland.

Women continuing the pregnancy also expressed a need for information on what to expect after the birth of the baby in terms of the demands it would place on them and advice on what supports are available to them to meet those needs:

It was a lot of worries, it was a lot of questions. I mean, when I came [to hospital] for my first visit, I didn't know what the system was. That really confused me. I sat here. My appointment was for 9.30 and I wasn't leaving here until 3 o'clock ... I had sat here and literally didn't know what way that system worked, didn't know to get a urine sample every time I visit. I had no information. This is now my fourth visit and I only found out today because I asked, for a list of things that I need to bring into the hospital. There's been no, literally if you are pregnant, like. I feel sorry for everybody who is foreign and has the language barrier because I don't. And I felt I was really thrown in the deep end here ... You are supposed to know something and for me it was totally, like, I came out of here the first day and one of the girls had said, you know, 'Did you not get a urine sample?' And I thought 'Oh my God' and I actually came out – I'm not a crier – I came out and I stood outside and I cried.

[Antenatal Group H]

Well, to be honest when I first got pregnant I was more concerned about what's going to happen when the baby's born. You know, the extra childcare costs, all that kind of thing? It was nice to have the few ideas there.

[Antenatal Group G]

The following quote from a woman in the abortion group depicts very well the role counselling can play in supporting women through a crisis pregnancy:

*What kind of things did you want from [counselling]?*

Information. Just someone to go through things to your face. Someone who knew what they were completely talking about. You know what I mean? Someone who could tell you what the different ... I know now there's four different options to pregnancy: Keep the child, foster the child, abort the child or adopt the child. I know that now but, you know, before this, you know, like, when you're due a period and you find it out but you find out the hard way. And when you're sitting there and you've a friend going 'Help' because there's nothing there for you, you know what I mean? So, like, they [counsellor] got me through that. The doctor also on my second appointment ... You need to know your options. You need to know there's people, groups, out there. People get together and they talk about it, you know what I mean? And even for people who decide to keep their children, you know when you're X months pregnant, there's people in CURA, there are people there who are willing to listen to you as you go through the different stages. And if you want to adopt, there's people there to go through the different stages. If you wanted to foster, there's people there to advise you on how is the best way to foster. That's what people need, you know?  
(Abortion Group E)

### 4.3 Expectations of crisis pregnancy counselling

Through both the questionnaires and the qualitative interviews with women, we sought to capture what expectations they held of crisis pregnancy counselling based on their general perceptions of the services before they had any contact with them. This provided an insight into what women faced with a crisis pregnancy services felt counselling could offer them at that point.

#### 4.3.1 Analysis of survey data on expectations of counselling

**Table 4.2 Women's expectations of crisis pregnancy counselling**

Expectation of crisis pregnancy counselling	Abortion (N=99)	Antenatal (N=301)	Total (N=400)
Given information on all options	39%	62%	56%
Supported whatever your decision	35%	50%	46%
Allowed to come to your own decision	48%	41%	43%
You are listened to	29%	44%	41%
Advised on future contraceptive use	32%	35%	34%
Given practical help	28%	27%	28%
Given information on some options	11%	10%	10%
Your decision is influenced	9%	4%	6%

Women in the abortion group had more positive expectations of accessing non-directive counselling than did those in the antenatal group. Almost half (48%) of the abortion group expected to be allowed to come to their own decision in counselling. This compares with 41% of the antenatal group. Only a small proportion of both groups reported in the survey that they expected that their decision would be influenced in pregnancy counselling.

However, those in the antenatal group had higher expectations of receiving practical information and support from counselling. Half of those in the antenatal group expected to be supported whatever their decision and almost two-thirds (62%) expected to be given information on all options. This contrasts with 35% of those in the abortion group expecting to be supported whatever their decision and 39% expecting to be given information on all options.

Equal proportions of the abortion and antenatal groups (28% and 27%) expected to be given practical help to carry out their decision. In addition, similar proportions (32% and 35%) expected to be advised on future contraceptive use.

#### *4.3.2 Analysis of interview data on expectations of counselling*

- *Expect to be influenced*

Analysis of the in-depth interviews showed that while only a very small proportion of those surveyed indicated an expectation that their decision would be influenced in counselling, this expectation was cited by some women in their interview. Women considering abortion were most sensitised to this possibility. They tended to connect the notion of being presented with all of your options with an attempt to be directive against abortion:

Counselling is like that: they're going to try and talk you out of it, not talk you out of it but give you options. [You] go away and maybe see if you'd change your mind.  
[Abortion Group R]

In particular, some of those considering abortion actively avoided 2-option counselling agencies because they did not perceive they would meet their needs:

They kind of give you the impression with [their names] that they'll try and persuade you to try and keep the baby or different kinds of things; that's why the names themselves ruled out a lot of them, the counsellors, for me.  
[Abortion Group I]

- *Expect support regardless of decision*

Meanwhile, even though some women expected their decision to be influenced, others saw crisis pregnancy counselling services as supportive regardless of what option one is contemplating:

I'd read, like, I presume it's like they just give you advice and just every single option and just explain the advantages and the disadvantages of both and just, like, explaining maybe other girls' experiences, or whatever. But the main thing that I read in all of them is that they're non-direct.  
[Abortion Group A]

- *Provision of information on abortion services*

The Regulation of Information Act 1995 allows agencies to provide women with information on legally available services outside the State for termination of pregnancy in the context of counselling covering all options. While some women were clear about how such information is regulated, there was a high degree of confusion among women as to the legal regulation of information on abortion.

Some women did not expect to be able to access such information directly from a counselling service or doctor at all. Others expected agencies or doctors in Ireland to be able to refer them to service providers in other countries. The outcome of this was that some women contemplating abortion were guarded about contacting any counselling services. In turn, others expected all counselling services to provide abortion information and were confused to find they did not.

2-option counselling services will provide counselling for women on all of their options but they do not provide practical information on abortion services in other countries. However, some women attended a 2-option service seeking information on abortion services. They then felt at a loss as to how to proceed when they discovered they would not get the practical information they needed from the 2-option service:

I presumed, you know, because it is legal to give information so I presumed that if you did want it, they would give it.

[Abortion Group A]

I felt that I was going to [2-option agency A] for help and that, you know, I needed help and [abortion] was my decision and I was very adamant about it. They said they didn't have information, d'you know? Even names or anything, you know, which I found kind of disappointing I suppose ... So after that I didn't really know where to go.

[Abortion Group J]

- *Associated with emotional distress*

One woman described how she associated counselling with acute psychological distress and did not see it as relevant to her situation:

Pregnancy counselling – often I think it would be if I'm going mental.

*Right. So that's what you would associate with it?*

Ah yeah. 'That person's mental. She's gone mental, like. She's needs to see a counsellor.' That's the way I would interpret it, that's the way I would feel: 'Oh God! Well what's this I'm going to?'

[Antenatal Group R]

Another women did not expect counselling would be productive in helping her:

I think it's the word, though. I'm sure it's the word 'counselling', because in the [Agency], they said 'the counsellor' and I just pictured somebody telling me how it was going to be ok. It was not productive at all.

[Abortion Group G]

#### 4.4 Knowledge of crisis pregnancy counselling services

Having examined what women needed and expected from counselling services, this section looks at their knowledge of crisis pregnancy counselling services. The survey asked women which crisis pregnancy counselling services they had heard of. The in-depth interviews allowed deeper investigation of this by focusing in particular on the means by which women became aware of services.

##### 4.4.1 Analysis of survey data on women's knowledge of services

**Table 4.3 Knowledge of crisis pregnancy counselling services**

Service	Abortion (N=99)	Antenatal (N=301)	Total (N=400)
Cura	68%	66%	67%
Well Woman	47%	44%	45%
IFPA	43%	37%	38%
Cherish/One Family	31%	23%	25%
Life	30%	18%	21%
PACT	18%	6%	9%

In general, more women in the abortion group knew about services offering pregnancy counselling than those in the antenatal group. Similar proportions in both groups had heard of both Cura and Well Woman. A greater proportion of women in the abortion group had heard of each of the other services: IFPA, Cherish/One Family, Life and PACT.

The 2-option agency Cura was the most well-known service, with two-thirds of women in both groups having heard of it. Almost half of women in both groups had heard of the 3-option service Well Woman. 43% of the abortion group and 37% of the antenatal group had heard of the 3-option service IFPA.

One in four women knew of the 3-option service Cherish/One Family, comprising 31% of the abortion group and 23% of the antenatal group. Just over one in five women knew of the 2-option service Life, again made up of more women in the abortion group (30%) than the antenatal group (18%). Less than one in ten knew of the 3-option service PACT, made up of 18% of the abortion group and 6% of the antenatal group.

##### 4.4.2 Analysis of interview data on women's knowledge of services

###### • Sources of knowledge

Cura was the most widely known service and women had heard about it through radio advertisements, newspaper advertisements, posters, notices in churches or from GPs. The extensive network of Cura centres meant that many women had a centre local to them and had heard of the service locally, rather than through national-level media.

Some of the 3-option crisis pregnancy counselling services incorporate other reproductive health care activities into their services and were known to women because they are clients of these other services. These services had shop-front premises, some in a prominent location in Dublin, and had come to women's attention in this way.

Some women had heard of counselling services from the nurse or doctor who confirmed their pregnancy. This ranged from being told the name of one agency verbally, through being given a written note with one or more names of agencies to being given the 'Positive Options' leaflet, which lists all crisis pregnancy counselling services in receipt of funding from the Crisis Pregnancy Agency. One woman attending the antenatal clinic in the West was put in contact with the on-site crisis pregnancy counselling services by staff in the clinic. One woman was admitted to a general hospital with acute pregnancy-related nausea and staff there put her in contact with a local Cura counsellor.

A number of women heard about crisis pregnancy counselling services from friends. A number of women in the abortion group referred to having a friend who had travelled for an abortion previously. This friend then provided the woman with information on Irish services, as well as on abortion service providers in England.

- *'Positive Options' campaign*

The data collection for this study coincided with the launch of the Crisis Pregnancy Agency's information campaign entitled 'Positive Options'. Over one-third (16) of the women interviewed were aware of the campaign. Most (9) had become aware of it through television adverts while each of the following sources were mentioned by one woman: radio, magazine, posters on buses, posters on toilet doors, posters in college and word of mouth. One woman was given the Positive Options leaflet by her GP.

About half of those who had been exposed to the advertisement felt it was an effective campaign because the imagery or language resonated with them:

I actually remember it not because of the music or anything, I remember it because of the wall, the shadow on the wall, the wee figure. That's how I remembered it but, ye, something, you know, that makes sense.

[Antenatal Group H]

The advertisement in the television it says, you know, 'uncertain about', do you know, and to text for your options. Like, that was obviously an option.

[Abortion Group L]

Two-thirds of those who heard of the service did not contact it. Three of the women in the antenatal group were exposed to the campaign later in their pregnancy when they felt their need for such a service had passed:

It was only recently there was an advert on the telly: some number you text and Positive Options; that was it. And I was saying to myself, 'I could have done with them before', you know, at an earlier stage. But it wasn't to be; it wasn't to be.

[Antenatal Group T]

In contrast to those who felt the campaign was effective, there was a minority of women who had noticed the advertisement but who had not connected it with their needs:

You know the way you see signs, toilet door, bathrooms or whatever? But other than that I never used to pass much remark on this kind of thing.

*Is it clear, what it means?*

Well it's just if you're pregnant, I think, do you know, and you weren't expecting it. It doesn't actually tell you that there are counsellors or anything like that.

(Abortion Group R)

I remember seeing it and hearing it but I actually ended up having to look up the Golden Pages for the local family-planning clinic. Like I knew, I knew there was something out there, but, again, I didn't know what a Crisis Pregnancy Agency were able to offer.

(Abortion Group V)

It didn't really register, you know? I don't know. I just thought I was pregnant and I would go through with it, you know?

(Antenatal Group G)

In two cases women did not contact the service because they were fearful of connecting with a 'rogue agency'. One had attended a 'rogue agency' earlier in the pregnancy while the other had heard of them through word of mouth:

I heard on the ads, you know on 98FM, like, they were saying for Crisis Pregnancy, text 'LIST'. I didn't want to ring any of them but, but they were saying text 'LIST' and you get a load of lists but I didn't go by them. ... I sent the text and I got a long list of agencies ... [My mother] rang me [aunt in England] instead of going to any of the agencies again, in case the same thing happened again.

(Abortion Group B)

Even though it's a very good ad and everything, probably trying to put across that they are more positive, I'd still be like, 'Ah no they are just doing that to get you in the door.' I would.

(Antenatal Group A)

Two further women who were aware of the service did not contact it because they had had their needs met through other sources. In one case, the woman had decided on abortion and acquired information on services in England through a magazine. The second woman, who wanted counselling to help her come to a decision, had her needs met by her GP.

Three of the sixteen women sent a text message to the service but did not proceed to attend a counselling agency. In one case this was because she was unable to locate a 3-option agency in her area through the service:

Well, I think you text the first two letters of each and they tell you what the organisations, about these things and I was ringing the ones that offered counselling, yeah, and they didn't have anywhere in Munster.

(Abortion Group J)

The other two women did not pursue this avenue because they felt the information provided in the text message was not sufficiently clear in communicating that there were 3-option services available:

Well, I texted for the list and they gave me the number and, I had a bit of a problem to actually get any more information or anything. So I texted them, I think it was Cura, I think, that I texted then for information on, and they didn't, they kind of. The information they gave about them was it was open Monday to Saturday, 9 to 5, or whatever, and I'd a number to ring and it gives, I think, free pregnancy testing and counselling or something, you know? I think that's it ... I thought they'd tell you about the services they give, not 'open 9 to 5'.

*You wanted to know if they included the option of abortion or not?*

Yeah, because it was the one thing I knew I was looking for, but it was awful hard to find.

(Abortion Group I)

Of the sixteen women, two had contacted counselling agencies through the Positive Options text-messaging service and were very satisfied with it. One of these women had seen the advertisement on a bus poster, the other was given the Positive Options leaflet by her GP:

I seen the poster on the bus ... and it had the number if I needed to text and that sent me out Cherish<sup>5</sup> and all the different numbers and all the rest. So it was pretty straightforward ... So, better than having to ring people all the time and all the rest. I find it's better cause you're not talking to any receptionist ... You hear things on the radio, and that, as well but I don't really pay too much attention to them. But that just stood out and that was it and it was handy, you know what I mean?

(Abortion Group O)

Well, when I went in to my doctor I was asking him about the different stages of pregnancy, and that, and he gave me a leaflet about Options. It's on the television now, like, or whatever. So he gave me a leaflet about that and it had all down about if you are having a termination or if you are going having adoption or abortion or whatever. All the advice was there and the numbers.

(Antenatal Group U)

- *Use of telephone directories and the internet*

Where women were not immediately familiar with a crisis pregnancy counselling provider they often consulted the telephone directory to locate a service when seeking help with a crisis pregnancy. The directory most often consulted by the women interviewed was 'The Golden Pages'. However, women highlighted difficulties in establishing the nature of the services provided and, in particular, whether a service included the provision of information on abortion based on the entries:

Because that's what girls did years ago and it's just been carried through me. I just went straight to the telephone book.

(Abortion Group A)

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<sup>5</sup> Cherish was renamed One Family in 2004.



Even with looking through the yellow pages and all, I found that it was kind of, like, about the termination it was a real kind of hush-hush, you know?  
[Antenatal Group E]

- *Alternative sources of information on abortion services in Britain*

The 23 women in the abortion group who took part in qualitative interviews illustrated the key role support networks of friends and relatives played in helping them through the crisis. As noted earlier, a number of women in this group referred to having a friend who had travelled for an abortion previously. Some women knew this already and went to that friend for information, advice and support on discovering they were pregnant. In other cases a friend or relative came forward to share their experience with a woman when they realised she was going through a crisis pregnancy. While some relied exclusively on these informal sources to contact an abortion service, others attended a counselling service or GP as well.

For some, friends or family members resident in England formed a source of information on how to contact abortion service providers directly.

Among the sources women used to get contact details of abortion service providers in England were international directory enquiries services, the internet and, in one case, a glossy women's magazine. Despite the development of web-based information on counselling services in Ireland over the past year, internet searches were more likely to yield information on abortion service providers in Britain than crisis pregnancy services in Ireland.

In some instances women who got contact details of British abortion service providers and called them directly were told by booking-line operators about counselling services in Ireland.

- *Overview of women's knowledge of services*

In the qualitative interviews women reflected back on their capacity to immediately identify a crisis pregnancy counselling service when faced with a crisis pregnancy. Many commented that while they are exposed to information through television or radio advertisements or posters in colleges and pub toilets, this did not mean they had the information to hand when they needed it. When they referred to a facility such as the Positive Options text service or, in particular, the telephone directory, they found it difficult to determine the nature of services. In these situations their information needs remained unmet. Those women who were migrants were least likely to know about crisis pregnancy counselling services in Ireland. Migrant women, in turn, were most critical about the lack of advertising of these services.

#### 4.5 Overview of women's needs and expectations of counselling

When faced with a crisis pregnancy, women described needing someone to talk to who would allow them to air their views in a safe environment. This would include articulating their fears and conflicting emotions. Women need counselling to act as a forum where these views can be aired freely without having to worry about how they are impacting on the person listening, as would be the case with a partner, family member or friend. Women also needed to know that these feelings would be acknowledged and

respected and not disregarded, as they might expect if they voiced them to someone close to them. This is a role they attributed to a trained, professional counsellor.

Another role women saw as unique to counselling was a capacity to ask the right questions and 'tap into' women's full range of emotions. They felt this could facilitate them in coming to terms with the pregnancy and making a sound decision. Women also needed counselling to provide answers to them by giving full, detailed information about the options they were considering so they could make as informed a decision as possible.

For some counselling was necessary for them to come to a decision, and so it needed to cover all options for resolving a crisis pregnancy without being directive. Women described how such an approach enabled them to broaden out their thinking so as to consider all possibilities and then arrive at the outcome that was best for them. Women placed a strong emphasis on the need for counselling to be non-judgemental. They also sought reassurance from counselling as to their ability to cope in the future with whatever outcome they decided upon.

Women who decided on abortion needed practical information on abortion service providers overseas. In addition, they needed to have it provided by an agency they trusted, so that they were reassured and confident of the credentials of that service. As well as information on abortion service providers, women in the abortion group set out clearly other, very detailed, practical information needs they had. Information they needed included a comprehensive account of the abortion procedure, the sequence of events in the clinic, options for anaesthesia, fasting requirements, recommended clothing and sanitary items, and costs, including the procedure, flights and related expenses. Women also wanted advice on travelling, including directions on how to reach the clinic from the airport and suitable convenient accommodation, and other information such as whether to expect protesters and what the actual clinic looked like. They also needed advice on how they could expect to feel physically and emotionally immediately after the procedure, in anticipation of making the return trip to Ireland.

Women continuing to motherhood needed detailed information in relation to the antenatal care system: how it works and what to expect on attendance at a clinic. In anticipation of motherhood they needed advice on supports for parents (including financial assistance, social-welfare entitlements, work-related protection and supports) childcare options, and support and advice on managing the relationship with the father.

They described needing counselling to continue to play a role through many stages of the pregnancy and afterwards. Women saw a need to have counselling available in an ongoing way, as well as at the decision-making stage. Also, they saw a need for counselling services to extend to partners and parents.

Both groups of women emphasised that at all times women need a crisis pregnancy counselling service to provide support, advice, reassurance and empathy in a non-judgemental way.

As for expectations, in general women expected crisis pregnancy counselling to provide them with information on all options available to them, allow them to come to their own decision and provide support for whatever decision they reached. This was in keeping with their needs from counselling. Women who expected crisis pregnancy

counselling services to meet their needs anticipated it would be supportive, would cover all options fully without being directive, and be non-judgemental. It is interesting to note that a number expected to hear about other women's experiences through the counselling process.

However, the detailed interviews with women illustrate that some women expected counselling services would seek to influence them in making their decision. Some attributed certain 'agendas' or stances to individual organisations. These expectations in turn shaped their decisions as to whether or not to attend such agencies. Women imputed meanings to organisations' names and expected that the type of counselling service provided would correspond to these meanings. Unprofessional practices of some 'rogue agencies' fuelled these expectations, as accounts of experiences with 'rogue agencies' were shared among women.

While some women were accurate in their understanding of the situation pertaining to the provision of information on abortion, there continues to be a lack of clarity on the provision of information on abortion. A small number of women expected counselling service providers could refer them to abortion service providers overseas. Others expected all counselling services would include the option of abortion. When women had this expectation they were sometimes left at a loss after attending a 2-option service, and they then experienced difficulties in accessing the information on abortion services without delay or distress.

Conversely, a few women did not expect any organisation to provide information on abortion services and so avoided attending counselling for this reason.

Some women associated counselling primarily with providing emotional support, rather than having any role in the provision of practical supports and information. One view expressed was of counselling being associated with psychological distress and being tailored towards unsupported, distressed young women, as opposed to meeting the needs of every woman who considers their pregnancy is a crisis.

When asked about their knowledge of crisis pregnancy counselling services, most women knew about the 2-option counselling service, Cura. Around one in two women knew of the 3-option counselling service, Well Woman, and 43% knew of the 3-option service, the Irish Family Planning Association.

Women cited a range of sources of information on counselling services including advertisements, doctors or nurses who confirmed the pregnancy, hospital clinic staff and friends who had previous experience of crisis pregnancy. The advertisements for the Positive Options campaign were launched contemporaneously with this research. Almost a third of women interviewed had heard of the service. The message conveyed in the campaign seemed to resonate with most women. Two-thirds of those who heard about the service did not contact it. Reasons women gave for not contacting it included hearing about it late in the pregnancy, having needs met by other sources, being fearful of connecting with a rogue agency or not connecting the service with their needs. Of the five who did contact the service, three did not proceed to attend any of the agencies listed. In one case this was because there was no local service. In the other two cases the women were critical of the service for not communicating clearly the nature of the supports and information each of the crisis pregnancy counselling agencies listed have

to offer. Two women contacted the service and felt it was very effective in connecting them with a counselling agency that met their needs.

Women used a range of directory resources to help them access crisis pregnancy related services including classified telephone directories, directory enquiry services and the internet. This yielded information on both crisis pregnancy counselling services in Ireland and abortion service providers in England. The nature of the information listed in directories on counselling services in Ireland was often insufficient to satisfy women that the service could meet their needs. Some women who accessed information on abortion service providers in England contacted them directly, without attending an Irish crisis pregnancy counselling service. In some instances the booking line of the abortion service provider informed women about the presence of crisis pregnancy counselling services in Ireland.

Women reflected back on their capacity to immediately identify an appropriate service when faced with a crisis pregnancy. They commented that while they were exposed to a range of information this did not mean they had the information to hand when they needed it. Some did not feel enough exposure is given to such information. In particular, women who had recently migrated to Ireland emphasised this view most strongly.

## 5.0 The role of general practitioners

### 5.1 Introduction

This chapter will explore women's perceptions of the role of their general practitioner (GP) in supporting them through a crisis pregnancy. GPs are an important component of the package of support and care services available to women experiencing a crisis pregnancy. While both the Medical Council and the 1995 Regulation of Information Act allow for GPs to exercise a conscientious objection to providing information on abortion services, GPs are deemed to have a duty of care to women experiencing a crisis pregnancy. This entails providing informed support and advice for every stage of the pregnancy and afterwards, without causing any delay that might increase the medical risk to a patient.

The role of GPs was only explored in the qualitative interviews and so there is no survey data to report in this chapter. When asked about contact with their GP, about half of the 46 women interviewed in-depth for the study reported having attended a GP at some point during this pregnancy. Women were most likely to consult their usual GP in relation to the crisis pregnancy. In some cases women sought out a GP other than their regular GP because of concerns about confidentiality. Women considering abortion were more likely to seek out an alternative GP, usually because of a perception that their regular GP would not be willing to discuss this option.

However, GPs were not always perceived to be a source of care, assistance and support for women going through a crisis pregnancy. Women based their decision about attending a GP on their expectations of how their doctor was likely to respond to a disclosure of crisis pregnancy and how supportive they were likely to be.

### 5.2 Barriers to consulting general practitioners

#### 5.2.1 *Concerned about being judged*

When considering consulting a GP, women took into account their doctor's potential reaction to the pregnancy. Some had concerns that their doctor would chastise them for being irresponsible in becoming pregnant.

In general, women who wanted to explore all three options or who were considering abortion had the most concerns about how their GP would react to the pregnancy. Fears that a GP would be judgemental about unintended pregnancy or would view a woman seeking abortion negatively acted as barriers to women attending a doctor for help and advice with a crisis pregnancy.

#### 5.2.2 *Unclear about GP's position on providing abortion information*

Where women considering abortion believed it was illegal for doctors to provide advice or information on the option of abortion this acted as a barrier to them consulting a GP.

#### 5.2.3 *Preference for a specialist crisis pregnancy service*

Finally, some women preferred to attend a specialist pregnancy counselling service, as opposed to attending a GP, because they did not attribute the skills they needed to their doctors:

I'd be worried that it would change his opinion of me. Like, you know, because you don't know, everyone has different views on abortion so you don't know, and just even getting pregnant and just like, you know, like stupidity basically.

[Abortion Group A]

I think they might be a bit, 'Well, there's contraception there and why didn't you get a new prescription [for the pill]?'

[Abortion Group L]

*And in choosing a doctor, did you go to your own, your usual doctor?*

No, no. I did not go to my usual doctor because, em, I heard, now, I cannot say exactly. I heard she would be anti-abortion and the doctor has their right, apparently, to give you the information. So I said that, 'Ok, my local doctor, I'm not going to go to her.'

[Abortion Group B]

### 5.3 Needs of women when consulting a GP during a crisis pregnancy

#### 5.3.1 Confirmation of pregnancy

First and foremost, most women consulting a GP sought confirmation of their pregnancy. In many cases women had not thought they were at risk of pregnancy and so were finding it difficult to believe they had become pregnant. In some cases women presented with symptoms they did not connect with pregnancy and the GP was the first one to raise this possibility. To emerge from the consultation with a positive confirmation of pregnancy was very shocking for most women.

#### 5.3.2 Medical advice and information

Women who approached their doctor for help with making a decision on how to resolve the crisis pregnancy were looking for advice and information. They wanted answers to questions they had about their pregnancy and advice on their options. Women who had queries about health implications arising from being pregnant or associated with abortion were looking for information, advice and reassurance from their GP:

I went to my GP and I said 'I am nearly 14 weeks' and said 'What is the risks [associated with abortion]?'

[Antenatal Group V]

#### 5.3.3 Compassion and understanding

Women were looking for their GPs to respond in a caring and compassionate way, as well as to meet their needs for medical advice and practical information. In this they needed GPs to provide them with emotional support. These needs required GPs to have some of the skills associated with a counsellor. The kind of help women envisaged a GP being able to give them in making a decision included sitting down and talking through the situation facing them and discussing the available options.

In some cases women also sought referrals to specialist services that could help them further with making and implementing their decision:

I was kind of trying to see would she be able to give me any, well, say to me 'You can go and talk to somebody'.

[Antenatal Group T]

I think it would be more personal, even if they referred you to a counsellor or if they took it on board themselves, and if they organised counselling instead of you.

[Abortion Group B]

#### 5.3.4 *Practical information and help*

Some women had already decided whether to continue the pregnancy or have an abortion when they approached their GP. In such circumstances what they wanted most was help in carrying out that decision. For women who had decided on abortion a key need was to get full information on the abortion procedure and related aspects, such as what to bring with them to the clinic or fasting requirements.

In addition, one woman who was travelling for an abortion specifically sought a letter of referral from her GP to provide to clinic staff, detailing her health status and any conditions she suffered:

[My GP] gave a referral letter just saying basically that I had no allergies or allergic reactions. Now, my sister asked for that.

[Abortion Group B]

A small number of women described needing a certificate of sickness from their GP for absence from work due to morning sickness or recovery after an abortion. In all instances they did not want the certificate to disclose that the condition was related to pregnancy and they relied on their GP to support them in concealing the pregnancy.

### 5.4 *GPs' responses to women presenting with a crisis pregnancy*

Through their interviews, women who attended GPs gave descriptive accounts of the response they received. Responses can be characterised in four ways:

- *Presuming there is no crisis* – Pre-judging women's reactions with an assumption that the pregnancy is welcomed or at least does not present a crisis.
- *Evasive response* – Not taking any stance on the situation facing the woman or playing any role in helping her resolve the crisis.
- *Unhelpful response* – Actively withholding information, advice or even support from a woman who discloses that the pregnancy is a crisis and requests help.
- *Helpful* – Providing women with information, advice and/or support when they disclose that the pregnancy is a crisis, including being pro-active and taking the lead in providing what women themselves regarded as helpful assistance.

Accounts of women who met with each response are presented below, as they are the best illustrations of the character of each response type.

#### 5.4.1 *Presuming there is no crisis*

This response is characterised as pre-judging women's reactions with an assumption that the pregnancy is welcomed or at least does not present a crisis. This had the effect of the woman not engaging with the GP and resulted in a missed opportunity by some doctors to link women with a crisis pregnancy with a medical or pregnancy counselling service.

For example, the following participant attended a GP attached to her workplace two days after she confirmed the pregnancy. She attended primarily for a certificate to say she was unfit to work due to pregnancy related illness. At that point she was in the midst of the crisis and was astonished by the doctor's reaction. She did not approach him for any help with resolving the crisis:

I told him about the pregnancy and he immediately – he was a young man, he was in his 30s or late 30s – and he immediately launched into this 'Oh, so you're going to have to buy a house and do this and do that.' And I'm kind of going 'I found out 2 days ago' and he was asking me about mortgage prices and where I was going to give birth and like 'Where would I tell you to have the delivery, [Hospital A] is the best place for delivery'. And I'm still going, 'I found out 2 days ago.' And I kept playing it fairly politely, like, 'This is news on me, it's barely sunk in' and he was asking me where I wanted to have the delivery! I got what I wanted, I got the cert for work but I just thought 'You're a young man – cop on!'  
(Abortion Group G)

#### 5.4.2 *Evasive response*

This response is characterised by not taking any stance on the situation facing the woman or playing any role in helping the woman resolve the crisis.

For example, the following participant described how her doctor did not communicate any sense to her that she was willing to enter into a discussion with her on her intentions regarding the pregnancy:

She was, like, to be honest with you, she didn't go through any options with me or anything. She just kind of said to me, 'It could be worse, I could be telling you you had cancer.'

*And how did that make you feel?*

No, it wasn't really, like, any help.

*Did you expect anything else?*

Well, I would have expected her [GP] to have asked me was I going to keep it or what, like, but she didn't. She didn't ask me my situation or anything whatsoever, like.  
(Abortion Group U)

#### 5.4.3 *Unhelpful*

Some women described their GP as unhelpful, and this can be characterised as actively withholding information, advice or even support from a woman who discloses that the pregnancy is a crisis and requests help.

For example, the extract below describes how a participant made an explicit request for information on the option of abortion from her GP; he responded that he could give her no information on this. He proceeded to treat her as though she was going to continue the pregnancy and arrange her hospital antenatal care in the face of her insistence that she had not decided on which option to pursue and that she was actively considering abortion:



*Did you find the doctor, kind of supportive, or...?*

No, I wouldn't say. They just started to write it into my file, basically. I didn't know what I was doing. They were writing into my file when I was to come to the clinic next and go and get blood taken; they even told me when I was due.

*So they assumed that you were going to go ahead?*

But I, like, said, 'There's no point in writing that all down, I don't know if I'll keep it or not, I have to decide' ... They said they couldn't talk about abortion and they had to go ahead with the paperwork and then would have to get an appointment in case you were keeping it.

(Abortion Group N)

#### 5.4.4 Helpful

Doctors described as being helpful can be characterised as providing women with information, advice and/or support when they disclosed that the pregnancy was a crisis. This included being pro-active and taking the lead in providing such help.

Doctors who acknowledged the crisis nature of the situation facing the woman and responded with understanding, empathy and kindness were considered helpful by women even where they did not provide the information sought by the woman.

Women seeking abortion described different ways in which their GP took the initiative in meeting their specific needs, ranging from acknowledging her decision to have an abortion, through providing information, to helping women tell their parents. In some cases the GP took the initiative to offer to talk through all options, including explicitly stating their willingness to discuss abortion. There were also accounts of GPs providing a letter for the clinic in England on the woman's medical status:

I went into her [a recommended GP]. She was great; she gave me all the numbers I needed ... So she just said to me 'You've done the test' and she said 'Here's all the information you need.' And she just said to me 'If you need anything, when you come back, if you have any problems, any pains, even in the meantime, come straight and see me. There's no problem' she said.

*And what, in terms of giving the options, did she talk to you about how you were feeling and give you the information, or was it just the information, or how did you feel she had responded to you?*

Well, she was very, she was very kind. She did ask how I was feeling. 'It must have been a terrible shock', she said, and 'It's very unlucky that the morning-after pill didn't work', and, she was, she was really, really nice ... She gave me numbers of Crisis Pregnancy, Marie Stopes [Dublin] and something like Cherish.

(Abortion Group T)

### 5.5 Strengths of GPs in crisis pregnancy care

The aspects of GP care that women commended and appreciated illustrate how importantly GPs are positioned in relation to meeting the needs of women with a crisis pregnancy. The positive encounters women described with their GP demonstrated some examples of good practice in this area.

### 5.5.1 *Provided reassurance*

Having a GP express an understanding for the situation facing a woman seemed to offer valuable reassurance for women. Some doctors had particular strengths associated with their own approach to the consultation. A GP who reassured one woman that she wasn't alone in experiencing such a crisis or choosing abortion among her community eased her mind greatly. One woman explained how her doctor brought in aspects of her own personal life, which the woman found very effective in achieving the goal of having her see all sides of her options.

I was explaining my difficulties in making my decision and [my GP] goes 'No-one would ever fault you on making a decision that was, like, so difficult.' And he was just so nice.

*OK. And was that helpful to you, do you think?*

Yeah, it was. It was very, very helpful to me.  
(Abortion Group A)

Where medical concerns were factors in the crisis nature of the pregnancy women needed trusted medical advice so they could make an informed decision. They tended to look to a trusted GP for such advice:

I said 'I'm really upset, like, and I'm worried about the [morning-after] pill: does it affect the baby now already, like? It could be maybe it's going to have different problems.' And she said 'No, it's, like, the pill there won't be any problem like that at all.' Then I said 'Look I had a caesarean section would I be, would it harm me or if I had the baby would the stitches burst or the wound or whatever?' And she said no, that I'd be grand and you'll be fine and she made me feel much better so I decided no, I wasn't having an abortion.  
(Antenatal Group R)

GPs, in general, are trusted sources of referral for a range of medical and health services. Therefore, women were more at ease and confident about an abortion service provider they had heard about through their GP, as opposed to having to rely on an informal source.

### 5.5.2 *Offered continuity of care*

As described above, women tended to go to their usual GP and this had enhanced benefits for them, as the GP was often aware of the context in which the pregnancy occurred. This enabled them to relate to women's decision-making and made women feel particularly supported. Continuity of care after the pregnancy was another benefit in relation to medical check-ups and contraception:

She knows me well. And she knew it because we were actually talking about coils beforehand ... She's a lovely woman, you know? She would kind of feel for you, and she sat down beside me and she said 'What are you going to do?' and 'Is your mind made up?' ... And she said 'I'll support you, I'm telling you now, when you come home, now, come up to me' and I'm going up to her, and she just wants to check me out and that, and she wants to put me on antibiotics.  
(Abortion Group F)

### 5.5.3 *Supported women disclosing pregnancy*

Some younger women, in particular, avoided attending a GP who was the family physician. However, doctors in this situation can play an important role in helping women to tell their parents. One woman described how she wanted to tell her parents but had not had the courage to do so herself. When the GP did so with her permission the outcome was that she went on to get vital support from her family.

### 5.6 Role of GPs in post-abortion care <sup>6</sup>

Finally, the role of GPs in post-abortion care was explored specifically in the analysis. Where a woman attended a regular GP during the crisis pregnancy the strength of her attachment to the doctor enhanced the likelihood that she would attend for a post-abortion medical check-up and contraceptive advice. In general, women who found their doctor helpful when they presented with a crisis pregnancy seemed happy about the prospect of returning to them for post-abortion care.

Where women attended a GP and found them unsupportive they were less likely to consider attending their GP for a check-up and, by implication, less likely to attend for a check-up overall. This would be the case for doctors coming under the headings 'presuming there is no crisis', 'being evasive' or 'being unhelpful'. By these responses GPs missed a valuable opportunity to link women with a crisis pregnancy into a system of care and support through crisis pregnancy counselling services and primary medical care.

### 5.7 Summary and conclusions on the role of GPs

Doctors were considered to be helpful where they were supportive, empathetic and willing to assist women with the practical information they needed, irrespective of the decision they made. Engaging with the emotional aspects of the crisis pregnancy, in particular, meant a lot to women. Where these aspects featured in women's experience of consulting with their GP they considered their doctor fulfilled the role of a crisis pregnancy counsellor. Notably, doctors who were emotionally supportive, even without providing women with the information they required, were considered to be more helpful than those who provided information but did not address the emotional issues.

Other features of GPs' responses described as helpful included: taking the initiative in raising women's options with them; providing contact details of one or, most usefully, a number of crisis pregnancy counselling services; providing letters detailing medical information for the abortion service provider; providing letters certifying women were unfit to work without disclosing the pregnancy and helping women tell their parents about the pregnancy.

Doctors who made an assumption that women were happy with the pregnancy and intended to continue, or who were non-committal and evaded the possibility that the pregnancy represented a crisis, did not alleviate the sense of crisis for the woman. Crucially, they missed a valuable opportunity to link women with dedicated services and to foster an attachment between the woman and medical and counselling services. Such an attachment may have had a positive impact on the woman's behaviour in relation to attendance for ongoing care, including antenatal care, post-abortion medical check-up and post-pregnancy contraceptive advice. The accounts of women, presented above,

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<sup>6</sup> Post-abortion care will be discussed in more detail in Chapter 7.

demonstrate that meeting with an unhelpful or evasive response from a doctor can discourage women from attending a doctor for such care.

Lack of consistency or coherency in approach between doctors was a marked feature of women's accounts. It appeared to be a matter of chance as to how women were responded to by their GP. In such a context the potential for women to have their needs met by doctors is compromised. This is particularly the case where women are constrained in their choice of doctor because there is no local alternative GP or women are registered with one GP through the GMS<sup>7</sup> system. Where GPs did not succeed in meeting women's needs the most detrimental outcome was that women experienced a delay in implementing the decision they ultimately made. This may entail later presentation for abortion or antenatal care.

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<sup>7</sup> General Medical Scheme

## 6.0 Evaluation of services attended

### 6.1 Introduction

This chapter presents women's views on the extent to which the services they attended met their needs. Women who attended services are very well placed to know what makes for a 'good' service in terms of meeting the particular needs of women going through a crisis pregnancy. The strengths women highlighted from the services they attended can inform the development of a good practice model in crisis pregnancy counselling. Similarly, women highlight issues of bad practice among some service providers, indicating a need for action to address such issues. In addition, some deficiencies in services attended are also noted.

### 6.2 Analysis of survey data on evaluation of services

We saw earlier that of the total group of 400 women surveyed, 110 or 28% had attended a crisis pregnancy counselling service. Women were asked to rate how well the service met their needs on a five point scale ranging from very well to very poorly and their responses are presented in the table below. For this part of the analysis the services are grouped according to whether they were 2-option or 3-option crisis pregnancy counselling services.

**Table 6.1 Women's evaluations of how services they attended met their needs**

Type of service attended	Very well		Well		Partly		Poorly		Very poorly		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
2-option	11	35%	7	23%	6	19%	1	3%	6	19%	31	100%
3-option	24	57%	8	19%	2	5%	3	7%	5	12%	42	100%
Other	7	70%	1	10%	0	0	1	10%	1	10%	10	100%
Total	42	51%	16	20%	8	10%	5	6%	12	15%	83	

Of the 110 attendees at counselling, 83 replied to the question asking them to evaluate the service; 27 cases were missing. The commentary below refers only to the 83 women who replied to this question.

Overall, over half (51%) of women attending any service felt it met their needs very well. Those attending 3-option services were more likely to say it had met their needs very well (57%) compared with those attending 2-option services (35%).

One in five of all women felt the service they attended met their needs well. Slightly more of those attending 2-option services (23%) were of this view, compared with 19% of women who attended 3-option services.

One in ten women felt their needs had been partly met by the service they attended. When this is broken down according to what type of service women attended, 20% of those attending 2-option services said their needs had been partly met. This compares with only 5% of those attending 3-option services.

A low 6% reported that their needs had been poorly met, comprising one woman attending a 2-option service (3%) and 3 women (7%) attending 3-option services.

15% of women felt the service they attended had been very poor in meeting their needs. Almost one in five women (19%) who attended a 2-option service gave this response. Almost one in eight (12%) women who attended a 3-option service said the service had been very poor in meeting their needs.

Comparing the two services overall, the 3-option services were evaluated more positively than the 2-option services by the women surveyed.

### 6.3 Analysis of the qualitative data on evaluation of services

Of the 46 women interviewed for the qualitative element of this study, 21 had attended a counselling service. In their accounts they discussed the strengths of those services, as well as their shortcomings.

#### 6.3.1 Strengths of services

The aspects of counselling services identified as strengths by interview participants were classified into strengths related to the emotional support provided, strengths in the range of supports provided and strengths related to the structure and organisation of the service.

- *Strengths related to emotional supports*

The study participants described how they had a strong need for emotional support. Counselling offered women a safe space to fully explore their emotional response to the pregnancy and each of the options open to them. Counselling may have been the only forum in which women felt able to raise doubts, fears or conflicting feelings, as they tended to protect those close to them from the most acute or confused emotions. Those women interviewed who felt the counselling service they attended had met their needs highlighted this as a particularly valuable aspect of crisis pregnancy counselling.

Often women described how they did not find articulating their feelings and emotions very easy. The skills of a trained, professional counsellor in being able to 'tap into' the full breadth and depth of women's feelings was highly valued by women. They described how counsellors seemed able to ask the right questions or 'pick up' on those issues that were particularly pertinent to them.

The ability of counsellors to help women put the event into perspective, rather than seeing it as overwhelming, was an important strength of the services. Another was their capacity to reassure them that they would be ok. Women described how a counsellor could put them at ease so that they felt they were talking to a trusted confidante.

Even those women considering abortion who attended a 2-option service and did not have their needs for practical information met, evaluated the service positively when their emotional needs were met.

The strength women emphasised most in relation to services was that they did not make them feel judged. Given how the fear of being judged inhibited women from attending counselling this was very important to them:

Having that little care for emotion, maybe that someone else cares, that someone cares or, you know, that they come across in that caring way. It's better than just saying 'Right, this is what you have got to do, ring that number, ring that number.'  
[Abortion Group T]

You can just say what you really think about, and how you really feel about it and when [it's your partner] you are watching your p's and q's and trying not to upset them ... It was nice to be able to say to someone 'It was a pregnancy I didn't want.'  
[Antenatal Group Q]

[The counsellor] made me feel I would be ok, whereas before that it seemed like a much bigger deal in my mind.  
[Abortion Group Q]

[The counsellor's] approach was, she was just brilliant, she spoke, like, as if we knew each other for years.  
[Abortion Group R]

I think that's why you need a counsellor, you need somebody who can tap into how a person is feeling ... It's so important: suddenly you're talking to someone who you feel is not judging you.  
[Abortion Group M]

- *Strengths in the range of supports provided*

Bringing women through all possible outcomes of the pregnancy in the context of their particular situation was welcomed by many women. This allowed them to broaden out their thinking to encompass options they may have previously dismissed. This was the case even where women described feeling quite certain about what outcome they would pursue when entering the counselling session. The benefit of such an approach seemed to be in the presentation of alternatives so that women felt they were making a choice, as opposed to feeling they had only one option open to them.

Women considering abortion expressed strong anxieties about accessing the information they needed to organise this. For these women the provision of information on reputable abortion service providers was a crucial aspect of good service delivery. They also valued a counsellor who gave them a clear and thorough account of what the abortion procedure would entail. They then knew what to expect and were able prepare for all aspects of the procedure. This included fasting, how to dress, what sanitary items to bring and how they could expect to feel afterwards. For some women the trip to the clinic was their first time travelling to the particular city or area; for a small number it was their first trip outside of Ireland. Their accounts of the conditions under which they travelled demonstrated that they often had little time to spare, were on a tight budget and were generally under significant pressure over the course of the trip. Counselling services that were cognisant and considerate of this, and provided women with information to help them in this journey, were very much appreciated by women.

Women interviewed for the study described how some services invited them to return there for further care. They welcomed this and, in most cases, intended to return for further pregnancy-related care and/or contraceptive services. Crisis pregnancy counselling is designed to meet the needs of women in the midst of a crisis. The

majority of women interviewed believed it was possible for this to be achieved in one contact between the woman and the service. However, some women reported that there is also potential for services to support women beyond the pinnacle of the crisis in many important ways. Women continuing with their pregnancy expressed the need for emotional and practical support at various stages throughout the pregnancy. In particular, those who were considering placing the baby for fostering or adoption expressed a strong need for continued support. Women taking on the role of mother anticipated needing support in adjusting to this new role, as well as needing information and advice on practical issues. Women in the abortion group anticipated needing a post-abortion medical check-up and/or counselling.

Women who had more than one session with a counsellor described how having the time between sessions to reflect on what the counsellor said and what the woman herself thought and felt during the session was a key benefit. Some services extended to providing counselling for partners. Women who gave an account of this considered it to be a strength of the service. This was either one-to-one counselling for partners or couple counselling, where they counsellor saw the woman and her partner together:

I know now there's four different options to pregnancy: Keep the child, foster the child, abort the child or adopt the child. I know that now but, you know, before this ... you're sitting there going 'Help!' because there's nothing there for you.

[Abortion Group E]

It was helpful; she went through what was going to happen, because I thought I was going to be butchered, like, you know?

[Abortion Group V]

The counsellor is very familiar with where you're going, and they give you a lot of details about your journey.

[Abortion Group C]

And we've had a few one-to-one sessions and I've had a few sessions where my partner has been with me and it was kind of nice.

Well, we still see, we [woman and counsellor] keep in contact and we see one another now and again but it's just that there are so many feelings there of uncertainty it's nice to be able to talk to her about it. And get her opinion on it and then go home and think about the whole lot and it makes it easier that way to make a decision.

[Antenatal Group Q]

- *Strengths related to structure and organisation of the service*

Flexibility in the format of service provision was highlighted as a strength. Some organisations women contacted had a helpline staffed by a counsellor. This enabled women to benefit from the support of counselling in situations where attending a service for a face-to-face session was impossible. Services that operated on an outreach basis were highly praised by women who attended them as they overcame a range of barriers such as travel, fear of being recognised entering a premises, and childcare issues.



Being able to offer some flexibility in appointment times was another strength participants valued. Women often felt under significant pressure when they made contact with services and many had a strong preference to attend the service quickly.

Concern for confidentiality was central for all women. A service that was presented in a discrete format facilitated access and allayed women's concerns about being seen entering the building. Examples of a discrete format mentioned were a doorway in a quiet location, a shared building or a multi-purpose facility. Women valued those services with centres throughout Ireland as they appreciated having a local service they could attend. Crisis pregnancy counselling services in receipt of statutory funding are free of charge. All women praised this aspect and some highlighted how it had enabled them to attend.

I suppose they were just so helpful, really. They were just 'Whereabouts are you? We'll find out where the nearest place is to you and I can arrange for an appointment for this time.'

[Abortion Group T]

[The service] is very well concealed, where it is, it's kind of in a little square and there's a lot of different, I don't know what the other organisations are but it is, you know, the side of the building so you could have people confused. All in all, I'm very positive about it, but if it was somewhere on the open street I wouldn't have gone in, I think, because, I mean, at that time I didn't want anyone to know, apart from the people I told.

[Abortion Group J]

Most of all what was best was that I didn't have to travel to Dublin, which is bad enough, you know. The fact that it was accessible.

[Abortion Group M]

### *6.3.2 Deficiencies in services that did not meet women's needs*

Women who attended services that they felt did not fully meet their needs highlighted weaknesses and gaps in these services. These are considered deficiencies in services and are discussed below. There were also instances where women attended 'rogue agencies', whose overall practices were criticised by women. These will be discussed separately later.

#### *• Not providing information on abortion services*

While 2-option crisis pregnancy counselling services will counsel a woman on all her options they do not provide information on abortion service providers. Women seeking abortion who attended 2-option services were critical of this because it caused difficulty for them in accessing the information as early as possible. Most of those in the abortion group who attended 2-option services found their needs had been met in every other way. However, from their perspective, failure to provide information on abortion services was a key deficiency:

[2-option agency A] was good as well, you know what I mean? It always felt, like, if they offered more information ... They give you your options but they don't give you the advice to go with the options: the practical. They just tell you 'You can do this, you can do that, that's your options, that's your choice', like, you know?

(Abortion Group E)

I think it's a pity that [2-option agency A] don't have the information. Like, they would have been a very complete service, then, for me anyway. ... Even if they could say 'Well look, we don't have this information, but if you check out this website...' All you need is just a starting point, you know, because it's so frustrating, it really is.

(Abortion Group J)

- *Poor response of front-line staff*

Women highlighted the importance of the approach of front-line staff in organisations offering crisis pregnancy counselling. Front-line staff were primarily receptionists, and nurses who performed pregnancy tests. Two main criticisms were made in relation to front-line staff in 3-option services. Firstly, women in the abortion group criticised staff in 3-option agencies for failing to reassure women that the service would provide information on abortion as part of the counselling process. A number of women who contacted 3-option services and asked this question found the responses confusing:

I tried asking them on the phone about what types of options were available, 'Did they talk, would they give me information on abortion and stuff?' And they kind of, they didn't really answer me that clearly on it. They didn't sound like they would have given me the information I wanted on the abortion because they didn't feel, like, they didn't sound like they could speak freely about it.

(Abortion Group I)

Reception staff also came in for criticism for failing to be sensitive to the anxiety and vulnerability of women contacting the service:

I was asking her, like, 'Could ye make appointments for...' whatever, and she goes, 'Well, we can't give out that information over the phone, it's illegal...' Some of them, the [3-option agency D], when I rang up first she was a snotty bitch, God forgive me. She was really snotty on the phone, like, no way helpful at all like.

(Abortion Group R)

As described in previous chapters, one of the main things women wanted from a counselling service was a non-judgemental approach. One interview participant in the abortion group felt that she met with a judgemental response from a 2-option counsellor she spoke with on the telephone:

This particular lady was making quite strong comments about, maybe, that I ought to try, like, she actually said to me 'This is your child.' ... I wish I hadn't called them, because it was more or less trying to say to me 'Don't.' Not actually coming out and saying 'No, don't go and do that!' but the comments that she was making was trying to obviously make an impression on me to say 'That's not the right thing to do.'

(Abortion Group T)

- *Inadequate information on abortion procedure*

As previously highlighted, women in the abortion group expressed a strong need for detailed information on the policies and procedures of the abortion service providers they planned to attend, as well as on the abortion procedure itself, as part of the counselling process. Some women who attended 3-option counselling were critical that their needs in this regard had not been met. They described how this led to anxiety or confusion for them during the procedure.

This criticism was most pronounced in relation to the issue of anaesthetic options:

I went into [the 3-option agency] and the Dublin doctor told me that conscious sedation is better and I said 'Ok, we'll go with that'. And when I got here this morning, they said 'Oh, we don't do conscious sedation on Saturdays, you'll have to have a general anaesthetic. Why don't you want a general anaesthetic?'. And I goes 'I don't know, because I was told' and it was more expensive than the other anaesthetic and I hadn't really brought the huge amount of money with me that I needed.

[Abortion Group G]

I actually did discuss my concern and my worry about going and having a general anaesthetic. Yes, and [the counsellor] didn't even say to me that there is other options, which I find strange.

[Abortion Group D]

- *Absence of scanning equipment to confirm gestation*

Some women in the abortion group encountered difficulties because they were unclear as to the stage of gestation of the pregnancy. They needed to be as accurate as possible about their stage of gestation in order to book the appropriate medical treatment. Given that crisis pregnancies are often unplanned and unintended it is likely that women may not be able to accurately identify the gestation of the pregnancy:

The doctor [in 3-option agency] couldn't even tell me, roughly, how long I was, because they took no scans or nothing, you know the way? So it wasn't until I actually had the scan here today. Because they're, like, people don't, you know the way you don't be keeping an eye on your periods and stuff like that, you don't. So they thought I was 7 weeks, so that would have meant when I went up for my appointment that I was 10 weeks according to them up there, going by my dates roughly, and that. And then coming over today I thought I was about 12. It would have meant I could have gone to Birmingham then, not here, like, to Liverpool.

[Abortion Group R]

Staff in the abortion clinics where the research took place confirmed that this arises fairly frequently as a problem for Irish women. Attaching scanning facilities to non-directive crisis pregnancy counselling services would overcome this.

#### 6.4 Issues of bad practice – case studies of 'rogue agencies'

Four of the 46 women interviewed for the qualitative component of the study had attended a 'rogue agency'. They were all considering abortion when they attended the service. They described how these agencies actively tried to dissuade them against abortion using fear-inducing tactics. These strategies included the provision of spurious

information about both the abortion procedure and the medical and psychological effects of abortions. They sought to delay women accessing abortion by giving them a false expectation that they would provide them with the information they needed in the future.

Two women proceeded to travel for an abortion but felt they had been delayed in doing so by these practices. Another woman maintained contact with the service under the false impression that she would be given information on abortion services. Eventually she reached a stage of gestation at which abortion was no longer an option. The woman then presented very late for antenatal care.

Women attended these services seeking help with the crisis they were facing. They expected to attend a service that was focused on helping women by providing counselling and helping them work through their decision and the options open to them. Rather, the sole focus of such services was to deter and prevent women from accessing abortion services. Their practices caused women distress, anxiety and harm and prevented them from accessing help and support during and after the pregnancy. Furthermore, as their reputation becomes known to other women, they act as deterrents to other woman accessing any counselling when facing a crisis pregnancy.

In all, four women attended 'rogue agencies'. All four had decided on abortion before attending the service and were hoping to access information on abortion services from the counsellor. Two of the four went on to get the information elsewhere and travelled for an abortion. One woman decided against abortion having attended for counselling. The fourth woman was misled by the rogue agency into thinking they would eventually give her information on abortion services. She waited so long to receive the information from them that in the end the gestation of the pregnancy was so advanced as to rule out abortion.

#### 6.4.1 Case study one (Antenatal Group W)

I had an interview with a counsellor called 'C' up there, which wasn't too bad. She asked a few questions, you know, basic background questions, and that, and then she left me to watch a video. Now, the first video wasn't too bad. It was just about your different stages of pregnancy and what the foetus and the baby is at certain stages. So that was fine. I was there for about maybe an hour, which wasn't too bad, and she arranged for, I had to have a scan done. So they arranged actually for me to have a scan done just to determine exactly how far I was gone which was in [a private] hospital in Dublin and I had to pay 95 euros for that. It is pretty expensive.

I arranged for my next counselling session to be on the same day [as the scan]. So I went to, I had the scan done and then I went on to the [agency] to have my next counselling session. And I seen a man, I can't even remember his name. I don't know what it was. But I was brought down into a small little room kind of in a basement. There was no windows or nothing there and I'd say I was in there for two hours with just himself and myself. He left then as well to let me watch another video.

*And what went on in the two hours?*

Just he talked about religious side of things. To me it kind of, I mean from the very beginning, 'C', the lady that I seen first, she was lovely now, she was. She made it clear that they are not trying to influence me one way or the other. But I didn't get

*Continued overleaf*

that impression from the man. They talked about religious reasons and would you be able to live with it on your conscience and God looking down on you and this kind of thing. He also showed me photographs of women that had, first of all decided to have an abortion and then decided not to, and of their babies now and how they are so happy and all this. He showed me, that second video was terrible. It actually showed a termination. It showed a woman, I don't know whether she woke up on the table or wasn't properly anaesthetised. That was desperate now. Actually on the video as well it showed pictures of the babies that were aborted at, dead babies, like, that were after twenty weeks were aborted. It was rotten now, it really was.

I didn't really say a whole pile. I was doing most of the listening, to be honest, and he was getting his point across.

No, I found him horrible, now. That whole experience was rotten. I left that day, like I said I was still determined but they, between the weeks I was due then to go back up maybe in another two weeks' time for another counselling session. I mean the weeks were slipping by at this stage and I knew there was a time limit. They left me and left me and left me for weeks and weeks and weeks. I rang the [agency] three times a week every week, if not four, and nobody got back to me until after the twenty weeks or twenty-one weeks when it was too late.

Like I said the second counselling session was a nightmare. I mean, two hours in a room without a break, you know? A small little room down in a, not even quarter the size of this kitchen and with a television and him. I mean, when he started with the religious side of things and they went through as well health risks.

*That would be if you had an abortion is it?*

Yeah, if there's a history of cancer in your family or a history of liver problems, liver cancer in your family, which there actually is on my family, and that your risk is greater at developing cancer after a termination or liver disease.  
(Antenatal Group W)

#### 6.4.2 Case study two (Antenatal Group E)

Well, I watched a tape on, you know, the type of things that, the tools that would have been involved in the termination, the size the baby would be. You know when, then she was speaking to me, long-term effects of it, physically and mentally. About the effects of the family and the partner as well, obviously 'cause he knew.

*Were there medical risks as well?*

Yeah, yeah. Things like, you know, later down the line about cancer and things like that. If something went wrong, you know, with your organs while you're there. It's only a clinic once you get over there, and that, you know? They're not able to treat you if anything went wrong in there, you'd have to be sent to a hospital or something. Things like that.

I was a little bit freaked out when I went in. When she showed me, like, you know, that the baby is this size, but I think I needed to know all that kind of thing. 'Cause

if I had have went in and found out later that that was the size of the baby, the baby had feelings and it definitely could feel pain, and that, they, you know, that they were using a thing that's pretty much like a Hoover to take this baby out. If I had of found all that out later, I don't think I would have been able to forgive myself for, you know, having it. I still would have regretted it. But I mean, she told me basically everything that was, you know, involved in that. They showed tools and that kind of thing. Whereas if you go in blank and, like that, and you see the things then later. She was saying as well, you know, it's a clinic, you know, they're not surgeons. They're trained in that field of, you know, terminations, or whatever. It doesn't necessarily mean, though, that they'll be able to help you if they sucked out the wrong organ or something like that.

*What do you mean?*

If anything went wrong, like, the people in the clinic, if you were over there and, you know, weren't going to be able to.

*That they wouldn't be trained, is it?*

Yeah. Well, pretty much. You know, if something very bad went wrong. Plus, as well, I mean, you don't, I don't think you get time to recover over there. But I mean having to get your clothes on and get out of there and then head home wouldn't be...

(Antenatal Group E)

#### 6.4.3 Case study three (Abortion Group B)

I went to a counsellor, which kind of put me off for a while then; then I felt, like, she showed me photos of aborted babies and the whole thing.

She was trying to persuade me not to, you know, and that was the impression I got, was that, eh, you know, I could die and the baby feels pain and all this, and that really put me off for a good while.

She was showing me scans of a baby, and telling me all baby development. Like I can't do it now, you know? I felt really guilty. She was reading out all the, you know, what could happen, you know, that you would feel pain and all that.

She was really convincing me that I could have a risk of cancer from you know, my body calendar.

[Afterwards] I couldn't, I wouldn't have been able to speak, you know? It was only when I got home my nerves were calmed. I didn't even say that, I just said 'Ah no, it was grand, it wasn't that bad.' I didn't even really tell my Ma or [partner]. Then, as I kind of went on, I was kind of thinking she thought she was probably trying to help me but she was actually really putting me off. And then I said that to my Ma, and she goes '[A], I knew, because you don't go in there hoping to get an abortion and you come out changing your mind', you know?

(Abortion Group B)

#### 6.4.4 Case study four (Abortion Group A)

I was talking to a male counsellor and he started asking me, like, he was just like, I explained my, sort of, my moral obligation, and then my not wanting to be pregnant and basically not knowing what to do and he was like 'Oh, well, I definitely think you're not suited for abortion.'

He asked me, like, he did this questionnaire. He was like 'What's pregnancy?' and then he goes 'Well, otherwise termed as having a baby.' So I said 'The begetting of new life.' so he's like 'Right, well, ok'. And he goes 'So what's abortion?' and I was like 'Well, it's stopping that life in its tracks.' And he was like 'Right, is there any other way of putting it?' So I put it in another way and then he goes 'Ok, I'm going to probe a bit further' and he goes 'Is there another way?' And I was like 'What, like, so it's killing the baby?' And he was like 'Yeah, that's what I'm looking for.' And then he goes 'So is this right or wrong?' and I was like 'Well, I know in my moral mind it's wrong but it doesn't make me want it any more'.

And then he showed me pictures of fetuses and he showed me pictures of abortions and he was going to show me a scan but he didn't because I had already had one, and, like, you know, he said to me, he was like 'Oh, I can just, no, I don't think you should have one' and like. I could see through it because I'd read and because when I went on the internet for abortion organisations and they said it's important to get counselling, but be careful because some of them say they're not pro-life when they are. And so I could see through it.

*And how did you feel coming out from the counselling?*

Eh, like, towards the end, it sort of got, like, entertainment. You know, he was just trying to pull anything to get me out of having an abortion and I could see through it so I wasn't traumatised. I mean, the only time I got upset was when he was showing me the fetuses but apart from that, no, I was fine, like, only because I could see through it. I just thought it was, it's just awful for other girls. It must be just terrible. Like girls who are honestly looking for advice and don't know where to go and then to be getting that, it's just terrible.

...

*So the role of counselling for you was to help you?*

Yeah, and, you know, he was just, like, it was just like, totally one way and it was just like, it was unhelpful and it didn't actually affect me.

*But the outcome was that rather than you getting this help in making your decision, was that you were left then to make your decision on your own?*

Yeah. It was like, I'd got, it didn't help me one bit. I'm lucky that it didn't influence me but it also did not help me one bit.

(Abortion Group A)

### 6.5 Summary of evaluation of services

Over 70% of women who attended a crisis pregnancy counselling service felt the service met their needs well or very well, while 21% felt their needs had been poorly or very poorly met. Women identified a range of strengths relating to three main aspects of crisis pregnancy counselling: the emotional support provided, the range of supports provided, and structural and organisational aspects.

Strengths associated with the emotional support provided included the service being non-judgemental and the ability of counsellors to 'tap' the full depth and breadth of women's feelings. A counsellor's ability to put women at ease and acknowledge and understand conflicting emotions was considered to be a strength, as was offering a safe space to explore these. Overall, women felt that such strengths enabled them to get a perspective on the crisis and facilitated them in coming to the best resolution for them.

Other strengths identified related to the range of supports provided. The strength most emphasised under this heading was the inclusion of all options in the counselling process. Other strengths cited were providing information on abortion services, giving a thorough account of what the medical procedure of abortion entails, providing detailed directions on how to reach the clinic in England, the ongoing availability of counselling during the pregnancy, the provision of post-pregnancy care options and extending counselling to partners.

Finally, the strengths highlighted in relation to the structure and organisation of the services included flexibility in the format of the service, such as telephone counselling, outreach provision and flexible appointment times, presentation of the service in a discrete format and the provision of counselling on a no-fee basis.

In discussing the criticisms women had of services it must be borne in mind that almost three out of four of the women surveyed had not attended counselling. Of those who took part in interviews, only one in two had attended counselling. Many of those who had not attended counselling were critical of the barriers they encountered to accessing services. The criticisms of those women who attended services should be read together with the discussion on barriers to get a full picture of the weaknesses associated with crisis pregnancy counselling by the entire study group.

The criticisms women made of services attended reflected both deficiencies in service on the part of 2-option and 3-option agencies and bad practice on the part of 'rogue agencies'. Overall, 2-option services were criticised by women in the abortion group for not including information on abortion services. The outcome of this for some women was that they were left at a loss as to how to access such information.

3-option services were criticised for being unclear in communicating to women that their service included the provision of information on abortion and for failure on the part of front-line staff to give due consideration to the anxiety women felt when contacting an agency. Deficiencies in the extent to which women are prepared for the policies and procedures of the abortion clinic and the absence of scanning facilities to confirm the gestation of pregnancy were also criticised. One woman in the abortion group was critical of a 2-option service she had contacted, which she felt had acted judgementsally towards her.



Issues of bad practice were highlighted in relation to 'rogue agencies', which presented themselves as crisis pregnancy counselling services. All of the rogue agencies women attended were operating without the support of funding from the Crisis Pregnancy Agency or any other statutory body. Case studies of women's accounts of attending rogue agencies illustrated that they were not focused on helping women. Rather, their sole focus was on deterring and preventing women from accessing abortion services. The strategies used in an attempt to dissuade women who were considering abortion from that option include the provision of spurious information about both the abortion procedure and the medical and psychological effects of abortion. Their tactics extended to lies, threats and misrepresentation. The outcome of such practices was that women were left distressed and worried and did not access the kind of help and support they anticipated would be provided through crisis pregnancy counselling. Three of the women presented late for either abortion or antenatal care. In turn, these women were less likely to access post-abortion or ongoing care services during the pregnancy and post-natally.

## 7.0 Care issues after a crisis pregnancy

### 7.1 Introduction

When dealing with a crisis pregnancy, support in making and implementing a decision was crucial, but for most women their help and support needs did not end there. Timely attendance for post-abortion care and antenatal care is considered necessary in the interests of the wellbeing of the woman. This is emphasised to women by counsellors and staff at the clinics in England. Early attendance at antenatal care is also important to optimise the wellbeing of the baby. In the study we explored women's needs and intentions regarding further counselling and medical care related to this pregnancy.

### 7.2 Post-abortion care

As is the case with all medical procedures, it is recommended that a woman have a post-operative medical check-up within two to six weeks of undergoing a procedure for an abortion. It is envisaged that a GP will usually perform this check-up. Other aspects of post-abortion care include post-abortion counselling and advice on contraception. Post-abortion support groups – which involve women coming together to discuss their crisis pregnancy and abortion experiences – emerged in Dublin as a self-help initiative in the late 1980s. The Irish Family Planning Association became involved in facilitating these groups and now facilitates a post-abortion support group in each of its counselling centres around the country.

#### 7.2.1 Analysis of survey data on post-abortion care intentions

Of the 99 women in the abortion survey group 68 gave an indication of their intentions regarding post-abortion care. Just over half of the 99 women surveyed (52%) intended having a post-abortion medical check-up. One in four women intended to seek contraceptive advice from a medical professional. 14% intended to seek post-abortion counselling services while a small number (4%) intended to seek out a post-abortion support group.

**Table 7.1 Post-abortion care intentions**

Post-abortion care intentions	Number	Percentage
Post-abortion medical check-up	52	52.5%
Contraceptive advice	24	24%
Post-abortion counselling	14	14%
Post-abortion support group	4	4%
Missing	31	31%

#### 7.2.2 Analysis of interview data on post-abortion care intentions

From the interviews with the 23 women in the abortion group it was clear that abortion service providers in England strongly advise women to attend for a post-operative check-up and contraceptive advice and prescription. In order to minimise the risk of post-operative infection all women were prescribed a seven-day course of antibiotics following the procedure. The clinic gave women referral documentation to present to

their doctor when having a post-operative check-up. Both of the service providers who facilitated this research are pro-active in facilitating Irish women's access to a service in Ireland that will attend to their post-abortion care needs. Women attending Marie Stopes were told about Marie Stopes Reproductive Services in Dublin as a possible facility to attend for post-abortion care. Women attending BPAS were given a leaflet about post-abortion care at the Irish Family Planning Association, which has centres in Dublin and in a number of regional locations.

Qualitative interviews with the 23 women in abortion clinics in England explored specifically their intentions regarding post-abortion care. Women's knowledge of post-abortion care services and the factors shaping their intentions regarding post-abortion care were considered in the analysis.

- *Post-abortion medical check-up*

The high proportion (52%) of women in the survey group who intended to have a post-abortion medical check-up was confirmed by analysis of the interview data.

Where women had attended a crisis pregnancy counselling service or a GP who provided them with support and help in their decision to have an abortion, they usually also received advice on post-abortion care. This included advice on recommended post-operative care, as well as details of where to access such care. GPs women described as supportive were, without exception, pro-active in encouraging them to return for a post-operative check-up. Women were very appreciative of this. Some of the 3-option counselling services women attended included an in-house medical team that provided post-abortion check-ups and contraceptive advice and prescriptions. Women who attended these services for counselling were always advised of this. In most cases they intended to return there for post-abortion care:

[My GP] said 'I'll support you, I'm telling you now, when you come home come up to me.' And I'm going up to her, now, tomorrow, or not tomorrow, Monday. And she just wants to check me out, and that, and she wants to put me on antibiotics.  
(Abortion Group F)

*The recommendation about a medical check-up, do you think you'll take that up?*

I'm going to take that up, yeah. I'd go back to the nurse at [3-option agency], they asked me to come back. They said come back 2 weeks after. I said I would. So I can do it there; the privacy and everything is better.  
(Abortion Group I)

In addition, hearing about the availability of a dedicated service for post-abortion care from abortion service providers strengthened the resolve of some women to act on the advice to attend for a post-operative check-up. Women who wished to keep the abortion confidential from their regular or local doctor commented that such facilities meant they were reassured that medical care would still be available to them:

When I was told that I would be able to go back into the clinic in Dublin, that they would be able to mostly look after anything, that was a huge relief.  
(Abortion Group G)

Women who expressed the intention to attend for a post-abortion check-up seemed highly motivated to do so, even where this would entail a substantial journey and/or having to take a day off work. In general, women intended to have a post-operative check-up so as to satisfy themselves that no complications had emerged since the procedure and they were fully recovered.

Those women who did not envisage attending for a medical check-up gave reasons such as feeling uncomfortable about gynaecological check-ups in general. Women who attended a doctor and met with an unhelpful response were also likely to dismiss the prospect of attending any GP for a medical check-up in case they encountered such a negative response again. It is interesting to note a case where a doctor exercised her right not to provide a woman considering abortion with any information on abortion service providers but specifically invited her to return for post-abortion care, should she pursue her decision. The woman was not inclined to return to her for a check-up:

She was just in no way helpful, information-wise, she didn't give any information whatsoever, she just was really... She just gave me the [name of a 3-option agency], that was it, that's all she said to me, and she told me that if I wanted to go back to her she'd get it checked out, if I ever, if I did decide it, that was no problem, she said. Even if you do go ahead with it, she goes, I'll be your doctor no problem.

*Right, and would you go back to her now?*

Not, no, I don't think I would, not as quick. I'd have to be dying, being honest. She wasn't really helpful, like.

[Abortion Group R]

Some women, particularly those who had not accessed a crisis pregnancy counselling service before travelling for an abortion, had residual fears about how to deal with any post-operative complications. Women who had not attended counselling were more likely to express such fears. Those who had not attended a counselling service in Ireland were only informed about the nature of the procedure and any attendant risks on arrival at the clinic. In contrast, those who had attended counselling had usually been fully informed of the procedure and post-abortion care options. As a result attendees were aware of the recommendations for a check-up and usually knew of potential local providers of post-abortion care. This usually diminished their concerns that any complications might arise. However, some women expressed concerns that the Irish health services may be neither skilled in nor receptive towards treating a woman who presents with post-abortion medical complications, and this was a source of anxiety for them:

Do I have to travel all the way back here if something major went wrong with me? Am I going to go up to my local hospital, my general hospital and say 'Sorry, I'm after being to England', you know, and all the rest of it, and them looking at me going 'What?' ... I wouldn't know whether I could go to see, like, the general or local hospital or what I'd do. I haven't a clue. So what would you say to them, like, you know what I mean? So it's confusing, you don't know who you can turn to or where you'd go.

[Abortion Group E]

- *Post-abortion counselling*

Most women had not formed a firm intention about attending for counselling after the abortion. They were more inclined to wait and see how they would feel in the weeks and months ahead. Again, this confirms the low 14% of women in the survey group who expressed an intention to attend for counselling. In general, women felt they were clear about their decision and had a network of people they could talk with and so did not expect to feel a need for post-abortion counselling. Two women did not intend to seek post-abortion counselling because they did not consider their personality type as being amenable to talking as a therapy or as a means of resolving something:

I think because I'm very clear about the decision I'm making, I don't think that counselling afterwards is that important.

[Abortion Group M]

I find to keep talking and talking about things, you're just churning them over and over and over instead of saying 'Right, this has happened, this is how I feel, I do feel like this but I have to move on now.' That's how I'd feel, that's the kind of person I am.

[Abortion Group T]

Women who were contemplating attending for counselling included both those who had attended a counsellor before travelling and those who had not. Among those who had not attended a counsellor before travelling for an abortion, one woman was of the view that counselling is more relevant after the abortion than beforehand. Those who attended counselling in either 2-option or 3-option services were usually advised of post-abortion counselling and/or support groups offered by the service.

The reasons women mentioned that would prompt them to attend for counselling were feelings of guilt, or the experience playing on their mind. Another reason mentioned was to deal with the issues raised by the crisis pregnancy itself and the reasons why women felt compelled to decide on abortion. One woman was of the view that the abortion itself could not be a panacea for all of the issues raised by a crisis pregnancy. Rather she expressed a need to sustain contact with a counselling service to continue the work on resolving these issues:

We've [woman and counsellor] got a good relationship now. The counsellor does post-abortion counselling as well so I'm going to meet up with her at least two or three times after ... But honestly, I mean, it's not going to just finish here today, you know?

[Abortion Group J]

A few women mentioned how they would like to talk with an experienced pregnancy counsellor about their feelings after an abortion to establish if these are 'normal' and common among other women. They would be attending for reassurance and support:

You might be feeling a bit emotional and need to talk about it. Maybe you want to know about what other women's experiences are like and how you're feeling, like, 'Is this ok, is this normal?'

[Abortion Group K]

### 7.3 Motherhood group's ongoing support needs

Women who were continuing to motherhood were asked how they thought crisis pregnancy counselling could help them through the pregnancy and after the birth, now that they had chosen this option.

#### 7.3.1 Analysis of survey data on motherhood group's views on what services would be helpful

Of the 301 women surveyed in antenatal clinics, 158 women indicated that some ongoing support would be helpful for them during the pregnancy or after the birth of the baby. Their views are presented in table 7.2 below. Some women indicated that more than one type of support would be helpful.

**Table 7.2** Motherhood group's views on services helpful to women continuing pregnancy

Services helpful to women continuing pregnancy	Number	Percentage
Support preparing for childbirth	101	33%
Support preparing for motherhood	96	32%
Post-natal counselling	88	29%
Parenting information	77	25%
Mothers' support group	71	23.5%
Provide practical information	46	15%
Provide support to parents	32	10.5%

One in three women in the antenatal group saw a role for counselling in supporting them as they prepared for childbirth and motherhood. 29% were of the view that post-natal counselling would be helpful for them. One in four women said parenting information, and around the same number expressed the view that a mothers' support group would be helpful. 15% felt that a counselling service providing practical information on issues such as accommodation options and welfare entitlements would be helpful. Around 10% of women considered counselling could be helpful for their parents.

#### 7.3.2 Analysis of interview data on motherhood group's views on what services would be helpful

Those in the antenatal group felt that counselling could play a supportive role in the short term by advising them on the antenatal care system and informing them on supports for parents. Women expressed a need for information on how they might cope with their first child or an additional child in their family in relation to meeting the costs of rearing a child, combining work and motherhood and accessing childcare. For most women in this group the role of counselling would be to provide practical support, as opposed to emotional support:

It would be nice to talk to somebody about practical things ... About benefits, about what do I do now, about what options are open to me, do I put the baby in a crèche, school. I mean, you, I'm not saying you want somebody to take over but I'm just saying, just, it would be lovely just to have somebody to say, you know, this is a,b,c.  
[Antenatal Group H]

Meanwhile, a small number in the antenatal group did see a role for counselling focusing on the emotional aspects of the pregnancy. Some women continuing to motherhood did not feel that the factors that contributed to the pregnancy being a crisis were resolved when the decision to continue the pregnancy was made. They felt counselling services could continue to have a role beyond the decision-making stage to provide women with support and help on issues such as their relationship, fears around parenting, disclosing the pregnancy and dealing with other people's reactions. Where the crisis was primarily related to health concerns regarding the mother and/or the foetus, women saw a need for counselling to deal with the emotional worries and anxieties this generated.

Those in the antenatal group who expressed an ongoing need for emotional and practical support felt this should also be available after the birth of the baby. Concerns were expressed that the emotional turmoil women experienced in the early stages of the pregnancy could put them at greater risk of post-natal depression after the birth of the baby:

After I have the other baby how will I feel? I'm worrying about that as well. How am I going to feel? I feel great now but will I be very upset? Will I be depressed? I'm worrying about will I be depressed? Because I felt so depressed in the beginning, will I feel depressed then?  
[Antenatal Group R]

Three women in the antenatal group were contemplating placing the baby for fostering or adoption. All felt a need for ongoing access to counselling during the pregnancy. This would provide support and help with coming to a decision and practical information on what placement entails, including contact options for mother and child. Again, these women anticipated a need for counselling to be available to them after the baby is born:

If I went ahead with my decision to give it up when I have it, it would be tough to come to terms with it afterwards.

*Do you think the counsellor would have a role there as well?*

I'd say so yeah, because if a woman has to give up a baby after birth, their body is going through all the emotions having the baby and your body craving for the baby when you give it up. Did I do the right thing or did I do the wrong thing?  
[Antenatal Group Q]

Some women also highlighted post-natal contraceptive advice as a need they anticipated after the birth of the baby. One woman was critical of how contraceptive advice was dealt with after her last pregnancy, which led up to this crisis pregnancy event only eight months after giving birth.

Women were aware of a range of supports beyond crisis pregnancy counselling that could meet their needs in relation to preparing for childbirth, parenting support, advice

and information. However, they highlighted how these services do not attend to emotional needs a woman may have adjusting to the pregnancy and motherhood.

#### 7.4 Summary of post-pregnancy care needs

When women are dealing with a crisis pregnancy, support in making and implementing a decision is crucial, but for a significant group of women their help and support needs do not end there. Post-abortion, antenatal and post-pregnancy care services are all considered important by health providers. Timely attendance for post-abortion care and antenatal care is considered necessary in the interests of the wellbeing of the woman. Early attendance at antenatal care is also important to optimise the wellbeing of the baby.

Of the women surveyed who decided on abortion and gave an indication of their intentions regarding post-abortion care, just over half intended having a post-abortion medical check-up. One in four intended to seek contraceptive advice from a medical professional. 14% intended to seek post-abortion counselling services, while a small number (4%) intended to seek out a post-abortion support group. Those who had attended crisis pregnancy counselling were usually informed about post-abortion care services. In addition, abortion service providers appear to be pro-active in alerting Irish women to a service in Ireland that will attend to their post-abortion care needs. Hearing about the option of attending a dedicated service for post-abortion care seemed to strengthen the resolve of some women to act on the advice to attend for a post-operative check-up. Women who attended a crisis pregnancy counselling service or a GP and found them supportive usually intended to return for post-abortion care.

Women who attended a doctor and met with an unhelpful response were likely to dismiss the prospect of attending any GP for a medical check-up in case they encountered such a negative response again. Another reason given for not planning to attend for a medical check-up was feeling uncomfortable about gynaecological check-ups in general.

Women, particularly those who had not accessed a crisis pregnancy counselling service before travelling for an abortion, had some residual fears about how to deal with any post-operative complications. They expressed concerns that the Irish health services may be neither skilled in nor receptive towards treating a woman who presents with post-abortion medical complications; this was a source of anxiety for them.

Most women had not formed a firm intention to attend counselling after the abortion. Many were more inclined to wait and see how they would feel in the weeks and months ahead before deciding on this. Most women did not envisage a need for counselling as they felt they were clear about their decision and had people in their own support network to talk to. All of those who attended 2-option or 3-option services had been offered the option of returning for post-abortion counselling. The reasons women mentioned that would prompt them to attend for counselling were feelings of guilt, or the experience playing on their mind. Another reason cited was to deal with the issues raised by the crisis pregnancy itself.

One in three women who were continuing to motherhood expressed a need for ongoing support from crisis pregnancy counselling services as they now prepared for childbirth and motherhood. Most women felt practical help would be important. This included



advice on the antenatal care system, and practical information on issues such as accommodation options and welfare entitlements, as well as post-natal counselling – including parenting advice.

A small number of women in the antenatal group felt that counselling providing emotional support would be helpful. This could help with issues such as managing their relationship, fears around parenting, disclosing the pregnancy and dealing with other people's reactions. Where the crisis is primarily related to health concerns for the mother and/or the foetus women need counselling to deal with the emotional worries and anxieties this generates. Women anticipated a need for such counselling both during the pregnancy and post-natally. Some had concerns that the emotional turmoil they felt in the early stages of the pregnancy would put them at greater risk of post-natal depression after the birth of the baby.

Women who were contemplating placing the baby for adoption were in particular need of ongoing access to counselling during the pregnancy. This was both for support and help with coming to a decision, as well as for practical information on what placement entails.

## 8.0 Conclusions

### 8.1 Introduction

The aim of this research was to develop a greater understanding of women's counselling and information needs when they are faced with a crisis pregnancy. The focus of the analysis has been on understanding women's perceptions and experiences of counselling and identifying the potential to better support women in this situation. This chapter presents the conclusions of the study, organised under three headings. Firstly, we look at the factors shaping women's attendance at counselling. Secondly, the factors shaping best practice in crisis pregnancy counselling are drawn from findings relating to women's needs and expectations, as well as the strengths women identified in services they attended. Finally, deficiencies identified by women attending services are considered, followed by a discussion of the practices of 'rogue agencies'.

### 8.2 Factors shaping women's attendance at counselling

A range of factors shaped women's decisions about attendance at counselling. Analysis of the qualitative data facilitated an in-depth understanding of these factors. It also demonstrated that these factors converged in different ways for each woman according to her individual situation. Key factors in women's decisions on attendance at counselling related to their levels of knowledge about the presence and nature of services, their orientation to counselling and the role of their support network. The role of GPs in meeting the needs of women who disclosed a crisis pregnancy was another factor in whether or not women attended dedicated crisis pregnancy counselling.

#### 8.2.1 *Women who attended counselling*

Survey findings showed that attendance at counselling varied significantly according to the outcome a woman decided on. Over half of the women who decided on abortion (54%) attended counselling, compared with less than one fifth (19%) of those continuing to motherhood. Within the groups, women in the abortion group were most likely to attend 3-option counselling services whereas those continuing the pregnancy attended both 3-option and 2-option services in equal numbers. Mahon et al. (1998) found that just over one-third (34%) of the women in their study who decided on abortion had attended counselling. The findings from the current research indicate that counselling services are reaching a higher proportion of Irish women travelling for an abortion.

Women attended counselling for the support it offered in coping with the stress of a crisis pregnancy. Some women attended counselling for help with making a decision on how to resolve the pregnancy. Being able to explore the available options, even while 'leaning' towards one particular option, also featured in women's decision to attend counselling. However, most of those who attended counselling had made a decision and wanted practical help and advice in carrying it out. This was the case whatever decision women made – abortion, motherhood or adoption. This confirms findings of Mahon et al. (1998), as well as earlier findings of O'Hare et al. (1983) and Flanagan and Richardson (1992). All of these studies found that women going through a crisis pregnancy contacted support services primarily for practical help and advice. Alongside their need for practical help, women emphasised the importance of emotional support in coping with the stress of a crisis pregnancy.

While most women received support from within their own network, there were a small number who did not. In cases where no other support person was available to the woman, access to crisis pregnancy counselling was vital. Those who did find support often reported that this meant more than the support of a counsellor ever would. However, many still saw an important role for crisis pregnancy counselling alongside this support system. Crisis pregnancy counsellors were often viewed as having some skills and information women did not expect would be available from members of their support network. Women outlined a range of situations where counselling was viewed as an important resource, alongside the support they had from their own network of partner, family and friends. Women described how they acted to protect their partners, family and friends by holding back on the full depth or range of emotions they were feeling. As counsellors do not have a close, personal relationship with the woman and as they are professionals, skilled in dealing with crisis and emotions, they represent someone who can cope with hearing about everything the woman is feeling. There were cases where women's decisions on how to resolve the pregnancy conflicted with the views of members of their support network. Women sometimes felt that those in their support network could not fully comprehend the sense of crisis they were experiencing in response to the pregnancy. Counsellors, on the other hand, were seen as experienced and skilled in the area of crisis pregnancy and better able to relate to how the woman was feeling.

### *8.2.2 Women who did not attend counselling*

Across both groups, women's general attitude to counselling was a key factor in whether or not they attended a crisis pregnancy counselling service. Women who were doubtful about the inherent value of counselling did not attend. Those who usually resolved a difficult dilemma without canvassing other people's opinions took the same approach to resolving the pregnancy. These women discounted contacting a counselling service regardless of what option they were considering. Where women had made contact with a 'rogue agency' they were reluctant to contact another agency because they feared they might meet the same negative treatment again.

Within the antenatal group, women who had been through a pregnancy before and those who had the support of their partner or family were less inclined to attend a counselling service. In particular, women who were older, in stable relationships and/or had children already tended not to consider counselling as relevant to them. In general, those who had not considered the option of abortion also tended not to consider attending counselling. For a number of women in the antenatal group, health concerns relating either to themselves or the baby were factors in the pregnancy being a crisis. These women sought out the advice of a doctor rather than a counsellor. In all cases the doctor they attended met their needs. Meanwhile, a number of women in the antenatal group felt that counselling could have provided them with key support during the pregnancy. This group reported lack of knowledge of counselling services as the key barrier inhibiting their access to counselling. This barrier was particularly acute for women who had recently migrated to Ireland.

Women in the abortion group were more likely to report experiencing barriers to accessing counselling than choosing not to do so. Of those in the abortion group who did not want to attend a counselling service some simply felt that they did not need counselling to help them with their decision. Some believed that counselling would

entail an attempt to persuade them to continue the pregnancy. Women avoided counselling where they perceived it would involve them giving an account of how the pregnancy occurred or a defence of their decision. They resisted having to talk through these issues because they feared it would confuse their thinking, believed it would be upsetting or because they could not see any benefit counselling could offer.

### *8.2.3 Barriers women encountered to accessing counselling*

A common barrier for women in both groups was a lack of knowledge of who provides crisis pregnancy counselling and what such counselling entails. When reflecting back on their capacity to identify a crisis pregnancy counselling service immediately when faced with a crisis pregnancy, women commented that while they were exposed to information through television or radio advertisements or posters in colleges and pub toilets, this did not mean that they had the information to hand when they needed it. Migrant women in the study were particularly at risk of not knowing of any services. Those for whom English was not a first language argued for better awareness-raising of such services using media targeted at non-national communities. These women felt that information about the services should be available in a number of languages. Women from rural areas felt that public information campaigns about pregnancy counselling services were less visible outside of Dublin.

Other barriers common to both groups were difficulties accessing services due to limited contact hours and inadequate geographical spread. Delays in getting an appointment were also cited as a barrier. Women usually wanted to attend counselling very soon after making contact with an agency so a delay in getting an appointment often resulted in women ultimately failing to attend the service. Finally, fear of being recognised entering the premises of a crisis pregnancy counselling service was also mentioned by women from both groups.

For women in the abortion group lack of clarity on the regulations governing the provision of information on abortion had consequences for their ability to access services. Not knowing whether a service would discuss the option of abortion or provide contact information on abortion services was the most commonly cited barrier to accessing counselling among this group. It must be borne in mind that women are seeking information and access to services in a crisis situation, where they are under stress and worried. Some women expected counselling services would seek to influence them in making their decision. Some attributed certain 'agendas' or stances to individual organisations and these expectations shaped their decisions as to whether or not to attend such organisations. Women may interpret organisations' names as advocating one option over another and they expect that the service provided will correspond with their interpretation. Unprofessional practices of 'rogue agencies' have fuelled these expectations, as accounts of experiences of counselling are shared among women.

Women who were not immediately familiar with any service used a range of directory resources to locate one, including classified telephone directories, directory enquiry services and the internet. Women reported that the details on what the service entailed were often insufficient to satisfy them that abortion would be discussed or that contact information on abortion services would be provided as part of the counselling process. They found the language and terminology relating to crisis pregnancy counselling services unclear and confusing. The failure of crisis pregnancy counselling providers to

communicate clearly the nature of the supports and information they offered was strongly criticised by women.

### 8.3 Shaping good practice

To determine the factors that would shape good practice in crisis pregnancy counselling services, findings relating to the needs and expectations women had of counselling and post-pregnancy care services are combined with the strengths women highlighted of the services they attended.

#### 8.3.1 *Shaping good practice in crisis pregnancy counselling*

Women needed counselling to be a forum where they could talk freely about their feelings, fears and conflicting emotions in a safe environment. They needed to know that these feelings would be acknowledged and respected and that the counsellor would respond with a caring attitude. Women needed counsellors to have the skills to 'tap into' their full range of emotions, thereby facilitating them in coming to terms with the pregnancy and making a sound decision.

Women placed a strong emphasis on the need for counselling to be non-judgemental. They also sought reassurance from counselling about their ability to cope in the future with whatever outcome they decided upon. In addition, women saw a need for counselling services to extend to partners and parents. At all times women needed a crisis pregnancy counselling service to provide support, advice, reassurance and empathy in a non-judgemental way. It is interesting to note that a number of women expected counselling would include accounts of other women's experiences.

- *Non-directive*

For some, counselling was necessary for them to come to a decision and so needed to cover all options for resolving a crisis pregnancy without being directive. This enabled women to broaden out their thinking to consider all possibilities and then arrive at the most appropriate outcome.

- *Provides full information*

Women need counsellors to provide them with full, detailed information about the options they are considering so they can make as informed a decision as possible.

Women who decided on abortion needed practical information on abortion service providers overseas and needed to have it provided by an agency they trusted so that they were reassured and confident of the credentials of that service. As well as information on abortion service providers, women seeking abortion set out clearly other, very detailed, practical information needs they had. This information included a comprehensive account of the procedure, the sequence of events in the clinic, options for anaesthesia, fasting requirements, recommended clothing and sanitary items, costs (including the procedure, flights and related expenses), advice on travelling (including directions on how to reach the clinics from the airport) and suitable convenient accommodation. Women wanted to know whether to expect protesters and what the actual clinic looked like. They also needed advice on how they could expect to feel physically and emotionally immediately after the procedure, in anticipation of making the return trip to Ireland.

Women continuing the pregnancy needed detailed information in relation to the antenatal care system: how it works and what to expect on attendance at a clinic. In anticipation of motherhood they needed advice on supports for parents, including financial assistance, social welfare entitlements, work-related protection and supports, childcare options, and support and advice on managing the relationship with the father.

- *Communicates clearly the nature of their service*

While some women were accurate in their understanding of the situation pertaining to the provision of information on abortion, there continues to be a lack of clarity about this matter. Some women expected counselling service providers could make referrals for them to abortion service providers overseas, others expected that all counselling services would include the option of abortion. These women were left at a loss when their expectations were not met, and they then experienced difficulties in accessing the information without delay or distress.

- *Flexible in design*

The strengths highlighted in relation to the structure and organisation of the services included flexibility in the format of the service (such as telephone counselling, outreach provision and flexible appointment times), presentation of the service in a discrete format, and the provision of counselling on a no-fee basis.

### 8.3.2 *Shaping good practice in post-pregnancy care services*

For most women their help and support needs did not end when they had come to their decision. Timely attendance for post-abortion care and antenatal care is necessary in the interests of the wellbeing of the woman. Early attendance at antenatal care is also important to optimise the wellbeing of the baby.

- *Post-abortion care services*

Of the women surveyed who decided on abortion and gave an indication of their intentions regarding post-abortion care, just over half intended having a post-abortion medical check-up. One in four intended to seek contraceptive advice from a medical professional. 14% intended to seek post-abortion counselling services while a small number – 4% – intended to seek out a post-abortion support group.

Women who attended crisis pregnancy counselling were usually informed about post-abortion care services. In addition, both of the abortion service providers who facilitated this research were pro-active in alerting Irish women to a service in Ireland that would attend to their post-abortion care needs. Women who attended a helpful and supportive crisis pregnancy counselling service or GP usually received advice on post-abortion care and, in most cases, expressed an intention to return there. Women, particularly those who had not accessed a crisis pregnancy counselling service before travelling for an abortion, expressed some fears about how to deal with any post-operative complications. They were concerned that the Irish health services may be neither skilled in nor receptive towards treating a woman who presents with post-abortion medical complications; this was a source of anxiety for them. At the point of going through the procedure for an abortion most women had not formed a firm intention to attend post-abortion counselling. They were more inclined to wait and see how they would feel in the weeks and months ahead. The reasons women mentioned that would prompt them to

attend for counselling were feelings of guilt, the experience playing on their mind or dealing with issues raised by the crisis pregnancy.

- *Antenatal and post-natal care services*

One in three women who were continuing the pregnancy expressed a need for ongoing support from crisis pregnancy counselling services as they prepared for childbirth and, in many cases, motherhood. Support needed included a counselling service that would provide advice on the antenatal care system and practical information on issues such as accommodation options and welfare entitlements, as well as post-natal counselling, including parenting advice. In particular, women who were contemplating placing the baby for adoption needed ongoing access to counselling during the pregnancy. This would provide both support and help with coming to a decision, and practical information on what placement entails – including contact options for mother and child. Women continuing the pregnancy also envisaged a role for counselling beyond the decision-making stage to provide them with support and help on issues such as their relationship, fears around parenting, combining motherhood and work, disclosing the pregnancy and dealing with other people's reactions. Where the crisis was primarily related to health concerns for the mother and/or the foetus women felt counselling could have a role in helping them cope with the emotional worries and anxieties this generated. They anticipated a need for such counselling both during the pregnancy and post-natally.

#### 8.4 The role of general practitioners

The role of GPs in supporting women through a crisis pregnancy had an important bearing on what women needed and expected from crisis pregnancy counselling. A GP who was supportive, empathetic and willing to assist women with the practical information they needed to proceed with whichever option they were considering met most of women's needs. Doctors who responded supportively and empathetically were considered helpful by women, even when they did not provide practical information. Engaging with the emotional aspects of the crisis pregnancy in particular meant a lot to women. When emotional concerns were addressed in the consultation, women tended to feel their doctor had fulfilled the role of a crisis pregnancy counsellor. Notably, doctors who met these emotional needs even without providing women with information they required were considered to be more helpful than those who provided information but did not address emotional issues. Other features of GPs' responses described as helpful included taking the initiative in raising women's options with them, providing contact details of one or, most usefully, a number of crisis pregnancy counselling providers and providing letters detailing medical information for the abortion service provider. Providing letters certifying women were unfit to work for medical reasons related to their pregnancy, without disclosing the pregnancy, and helping women tell their parents about the pregnancy were other important facets of the GP's role.

Doctors who either made an assumption that women were happy with the pregnancy and intended to continue to motherhood, or who were non-committal and evaded the possibility that the pregnancy represented a crisis did not alleviate the sense of crisis for the woman in any way. Crucially, they missed a valuable opportunity to link women with dedicated services and to foster an attachment between the woman and medical and counselling services in dealing with the pregnancy. Such an attachment may have a positive impact on women's behaviour in relation to attendance for ongoing care,

including antenatal care, post-abortion medical check-up and post-pregnancy contraceptive advice. Where women meet with an unhelpful or evasive response from a doctor this can discourage women from attending a doctor for such care.

### **8.5 Addressing deficiencies and bad practice in crisis pregnancy counselling**

In discussing the criticisms women had of services it must be borne in mind that almost three out of four of the women surveyed had not attended counselling. Many of these were critical of the barriers they encountered to accessing services; these were discussed earlier. The criticisms of those women who attended services should be read together with the discussion on barriers to get a full picture of the weaknesses women associated with crisis pregnancy counselling services in their current format. The criticisms women made of agencies they attended reflected both deficiencies in service on the part of some agencies and 'bad practice' on the part of others.

#### **8.5.1 Deficiencies**

Deficiencies highlighted related to both 3-option and 2-option services. Overall 2-option services were criticised for not providing information on abortion services to women. The outcome of this for some women was that they were left at a loss as to how to access such information.

3-option services were criticised for being unclear in communicating to women that their service included the provision of information on abortion. Women found the language and terminology relating to crisis pregnancy counselling services unclear and confusing. Some 3-option counselling services appeared to be very guarded in how they described their service and, in particular, their treatment of abortion information to women over the telephone. Women were left unclear as to whether the agency could meet their needs. The response women received when they first made contact with a service played a key role in whether they proceeded with making an appointment and attending for counselling.

Women were also critical that front-line staff, in 3-option agencies in particular, lacked empathy. They felt front-line staff were not always sympathetic to the plight of women who contacted them enquiring about crisis pregnancy counselling. Another criticism of 3-option agencies was a failure on the part of some to prepare women fully for the policies and procedures of the abortion clinic. The issue of choice and availability of anaesthetic was highlighted in particular. In addition, the absence of scanning facilities to confirm the gestation of pregnancy in 3-option services caused difficulties for some women when organising the appropriate abortion procedure. Women also highlighted how constraints on agencies making direct referrals for Irish women to attend an abortion service provider in another state placed a very stressful burden on women.

#### **8.5.2 Bad practice**

Issues of bad practice were highlighted in relation to 'rogue agencies'. All of these services operated without the support of funding from the Crisis Pregnancy Agency or any other statutory body. Women's accounts of these services illustrated that they were unethical in their treatment of women who presented to them seeking help. These services were not 'client centred' and consultations were not conducted in a manner that sought to meet the best interests of the woman in distress. Rather, the sole focus of



these organisations was to deter and prevent women from accessing abortion services through manipulation and misrepresentation. The strategies used in an attempt to dissuade women who were considering abortion from that option included the provision of spurious information about both the abortion procedure and the medical and psychological effects of abortions. The outcome of such practices was that women were distressed and worried, presented late for either abortion or antenatal care and never accessed the kind of help and support they anticipated would be provided through crisis pregnancy counselling. In turn, these women were less likely to access post-abortion or ongoing care services during the pregnancy and post-natally.

## 9.0 Recommendations

### 9.1 Context for recommendations

Having analysed women's needs, expectations and experiences of support during a crisis pregnancy we have formulated a set of recommendations. The recommendations are underpinned by a concern to ensure that better support is available for women going through a crisis pregnancy. The central objective of crisis pregnancy counselling and support services should be to facilitate full consideration of all options and ensure a continuum of comprehensive support from the point of contact through to post-pregnancy care for all women, regardless of which outcome they decide upon.

Raising women's awareness of services, and communicating clearly the nature of supports available are key challenges in the development and delivery of these services. A further challenge is to ensure that all women who present with a crisis pregnancy are linked into the full range of support services. It is important that opportunities to foster an attachment between women and crisis pregnancy counselling and support services are optimised. Such an attachment will have a positive impact on women's access to ongoing care, including antenatal and post-natal care, post-abortion care and post-pregnancy contraceptive advice. Services should follow through with post-pregnancy care, counselling and support to address issues that were factors in this pregnancy constituting a crisis. Such a focus will reduce the possibility of women experiencing another crisis pregnancy in the future; this is a key part of the Crisis Pregnancy Agency's strategy.

### 9.2 Ethic of Care to underpin services

At the outset, we recommend that all crisis pregnancy counselling services should be underpinned by the principle of an Ethic of Care for women going through a crisis pregnancy, regardless of what outcome they are considering and ultimately decide upon. The Ethic of Care must be evidence-based. The evidence from this research is that women going through a crisis pregnancy need services to offer both a supportive environment and comprehensive practical information on whichever option(s) they are considering. The Ethic of Care should standardise the response to a woman who makes a disclosure of a crisis pregnancy. This should represent the minimum standard of care provided by any crisis pregnancy counselling or support service. In particular, it should apply to those offering crisis pregnancy counselling and to GPs.

#### 9.2.1 *Principles of an Ethic of Care for crisis pregnancy counselling*

A woman who makes a disclosure of a crisis pregnancy should be responded to with:

- a pro-active openness to fully exploring how she is feeling and the full range of options available
- an emotionally supportive environment, which provides help, advice, reassurance and empathy in a non-judgemental way
- full, comprehensive information on whatever option the woman is considering, including abortion, motherhood and adoption
- information on care services beyond the point of making a decision.

Where a counsellor or doctor is unwilling to provide contact information on abortion services they have a duty of care to refer women on to a 3-option counselling service, communicating clearly that this service will give the woman this information.

The implementation of this Ethic of Care involves three principal strands:

- A policy and regulatory framework, which could be led by the Crisis Pregnancy Agency.
- Good practice at the point of contact with women in the delivery of front-line services, which is the responsibility of service providers.
- A review of 1995 Regulation of Information Act to consider its capacity to impede women's access to crisis pregnancy counselling and support services.

### 9.3 Policy and regulatory framework

A clear framework for the delivery of crisis pregnancy counselling services is necessary to ensure consistency in the standard of care encountered by women going through a crisis pregnancy. Guidelines should apply to all front-line crisis pregnancy counselling and support services, such as crisis pregnancy counselling services and GPs, and other key services, such as antenatal-clinic staff. Under the current institutional framework this work should be led by the Crisis Pregnancy Agency, with ultimate responsibility for the development and implementation of the framework residing with the Department of Health.

The framework comprises guidelines, monitoring, dissemination of information, delivery of training and service development.

We recommend that the Crisis Pregnancy Agency should:

- Work towards the development of a Code of Practice for all providers of crisis pregnancy counselling and support services. This should reflect the Ethic of Care outlined above. The code of practice should govern both the promotion and advertising of services and the delivery of services.
- Continue to monitor advertising of crisis pregnancy counselling and support services to ensure adherence to the Code of Practice for crisis pregnancy counselling and support services.
- Continue to develop its public information campaign on crisis pregnancy counselling and support services to educate women on the role of counselling. This should be informed by the evidence in this research regarding misperceptions and misunderstandings about the nature of supports available.
- Develop and issue a simple and clear guide to the 1995 Act regulating the provision of information on abortion services. The Agency's plan to re-issue the guidelines from the Department of Health and Children on the application of the Act goes a long way towards meeting this recommendation.
- Investigate how support networks, particularly families and friends, of women with a crisis pregnancy could be resourced to encourage women's contact with crisis pregnancy counselling services.

- Implement its objective to develop services for specific ethnic groups. This should include a focus on media aimed at non-national communities to raise awareness of pregnancy counselling services among immigrant communities. 'Positive Options' leaflets should be produced in a range of languages.
- Proceed with current plans to develop and implement a best-practice manual and training module for crisis pregnancy counsellors. This should be aimed at all front-line services providing crisis pregnancy counselling. The manual should take into account the principles of the Ethic of Care outlined above. It should also be cognisant of women's demands for a service that is both emotionally supportive and provides quality information. A specific component of the manual and training module should assist 3-option counselling services to best meet women's needs for comprehensive information on abortion and abortion service providers. It should also include a template of a letter from a medical practitioner to an abortion service provider detailing relevant medical history and information.
- Continue to liaise with the Irish College of General Practitioners (ICGP) to ensure that:
  1. GPs are well informed about the available crisis pregnancy counselling and support services and the role of these services in supporting women
  2. GP training relating to crisis pregnancy counselling reflects the best-practice training module for crisis pregnancy counsellors.
- Explore how a system of certification for counselling services and GPs who participate in best-practice training for crisis pregnancy counselling could be developed.
- Continue to develop resource materials for all front-line services including:
  - Providing a comprehensive list of all 2-option and 3-option crisis pregnancy counselling and support services. The revised 'Positive Options' leaflets will address needs expressed in this research for a clear description of the nature of the services each agency provides. The imminent publication of this leaflet is very welcome.
  - Continuing to work in partnership with the ICGP on the 'Key Communicators' project for GPs, to develop GPs' capacity to respond to a woman presenting with a crisis pregnancy.
  - Continuing to work in partnership with the Southern Health Board on the 'Key Contacts' project to provide resources to persons or agencies that may be contacted by a woman with a crisis pregnancy. The template generated by this project should be promoted by the Agency for implementation by every health board in the country.
- Promote women's access to crisis pregnancy counselling and support services by:
  - Continuing to ensure equal regional spread of 2-option and 3-option crisis pregnancy counselling services and post-pregnancy care services.
  - Exploring the potential and effectiveness for delivering crisis pregnancy counselling in alternative formats, including counsellor-staffed helplines, outreach services and out-of-hours services.

- Recommending to the Department of Health that pregnancy testing and crisis pregnancy consultations by GPs should be included as part of the General Medical Services (GMS) contract.
- Forging links with abortion service providers in Britain to promote the practice of referring women to crisis pregnancy counselling services in Ireland when they contact the service to make a booking and to post-abortion care services in Ireland on discharge from the clinic.
- Develop crisis pregnancy counselling and support services to take account of the continuing needs women have beyond the point of making a decision. Women should be fully supported in whichever option they choose and they should receive the optimum support to encourage attendance at post-abortion, antenatal and post-natal care. This should include supporting women in dealing with issues that were factors in their pregnancy constituting a crisis, to reduce the possibility of women experiencing another crisis pregnancy in the future.

#### 9.4 Good practice in the delivery of front-line services

The conclusions presented in Chapter 8 set out the factors that would shape good practice in the delivery of crisis pregnancy counselling and support services. Drawing on these, the following recommendations are directed to front-line services – crisis pregnancy counselling agencies, GPS and other key services in turn.

##### 9.4.1 *Recommendations to counselling services:*

- The language used to describe the services, including counselling and information provision, needs to be clear – particularly in relation to whether or not contact information on abortion services is provided. This applies to information provided in both oral and written formats.
- Training should be provided to all front-line staff on the agency's policies in relation to the provision of counselling and information, on how to respond appropriately to a woman who is seeking help for a crisis pregnancy and on how to communicate clearly to women the nature of the service provided.
- The format of counselling should take into account the type of environment women indicated they need, i.e. supportive, reassuring, empathetic and non-judgemental.
- Women continuing to motherhood should be given full information and advice on:
  - the antenatal care system, including how it works and what to expect on attendance at a clinic
  - supports for parents, including financial assistance, social welfare entitlements, work-related protection and supports and childcare options
  - where requested, information and resources relating to placement of the baby for adoption
  - managing the relationship with the father.
- Where women have decided on abortion they should be given comprehensive information and advice on:
  - the procedure, including the sequence of events in the clinic, options for anaesthesia and fasting requirements

- recommended clothing and sanitary items women should bring
- the costs entailed, including the procedure, flights and related expenses
- travelling, including directions on how to reach the clinics from the airport
- suitable convenient accommodation
- whether to expect protesters and what the actual clinic looks like
- how women can expect to feel physically and emotionally immediately after the procedure, in anticipation of making the return trip to Ireland.
- 3-option services should look at strategies to ensure that women who are travelling for an abortion have as accurate an indication of the stage of gestation of the pregnancy as possible. One possibility to consider would be to make scanning facilities available.
- All 2-option counselling services should refer women seeking information on abortion to a 3-option service. The 'Positive Options' leaflet would act as an important resource in this.
- Access to services should be enhanced by developing alternative formats for delivery, including out-reach, drop-in and out-of-hours options, and the potential of a counsellor-staffed telephone helpline should be explored.
- Attention should be paid to the format of the premises from which the service is delivered, in light of women's concerns for confidentiality. A discrete format could include a shared building or a multi-purpose facility.
- The offer of counselling should be extended to include partners and parents of women going through a crisis pregnancy. At present some services do so; this should be extended to all.

#### 9.4.2 *Recommendations for general practitioners*

The ICGP has recently published guidelines for its members on responding to women with a crisis pregnancy; these are welcomed for addressing many of the issues highlighted in this report. In the implementation of these guidelines we recommend that:

- The ICGP and the Crisis Pregnancy Agency are engaged in a 'Key Communicators' project to update the 'Training Programme and Information for General Practitioners (in response to the Termination of Pregnancy Information Act 1995)' (Crisis Pregnancy Agency 2004: 53). All GPs should participate in such training. The revised training project should address the following issues:
  - non-threatening strategies to encourage women to discuss how they are feeling when they have a pregnancy confirmed
  - how to respond in a sensitive way to distressed women presenting with a crisis pregnancy
  - the practical information required, particularly by women seeking abortion
  - the legal situation governing the provision of information to women seeking abortion
  - post-abortion care provision.
- GPs should state clearly in surgery brochures whether they provide 2-option or 3-option pregnancy counselling. Where 2-option counselling is offered GPs should refer women seeking information on abortion to a 3-option service. The 'Positive Options' leaflet would act as an important resource in this.

- GPs should provide pregnancy testing, and crisis pregnancy counselling and information free of charge with funding from the Crisis Pregnancy Agency.

#### 9.4.3 *Recommendations for other key services*

- Antenatal clinic staff should be resourced to refer women to on-site or local crisis pregnancy counselling services where necessary. The development of the 'Key Contacts' project by the Crisis Pregnancy Agency and the Southern Health Board is an important initiative here. All health boards should take the initiative to develop such a resource for maternity hospitals and units in their area.
- The Crisis Pregnancy Agency has proposed forming a partnership with the obstetrics and gynaecology professions. This partnership should develop guidelines for Accident and Emergency departments of maternity and general hospitals on how to respond to a woman presenting with post-operative complications after an abortion. While the incidence of this is less than 1%, it is important that staff respond in a caring manner and have the skills to provide the necessary care.
- Abortion service providers in England already take some steps to meet the specific needs of women travelling from Ireland. These should be implemented by all abortion service providers in England and include:
  - informing women calling from Ireland to make a booking for an abortion about the availability of crisis pregnancy counselling and supports services in Ireland
  - informing Irish women about services providing post-abortion medical and counselling care in Ireland at the point of discharge.

### 9.5 **Review of 1995 Regulation of Information Act**

The findings of this research highlight the lack of clarity among women and some service providers on the situation pertaining to the provision of information on abortion services. It appears that the issue of advocacy of abortion, as set out in the Act, may impede the ability of non-directive counselling services to clearly state that they do provide women with the information they need to enable them to contact abortion providers directly and to book a consultation with them. To address the difficulties described by women seeking abortion in accessing services as early as possible in their pregnancy we recommend that:

- the Crisis Pregnancy Agency thoroughly examine the legislation and produce a clear guide for non-directive service providers on how they can communicate the nature of their services within the conditions of the legislation
- if necessary, the legislation should be amended to allow non-directive counselling services to clearly advertise that they provide such information
- the legislation should be amended to allow services to refer women directly to abortion service providers outside the State in the interests of continuity of care for women.

### 9.6 Recommendations for further research

The reluctance of young women under the age of twenty to participate in this research was evident to the researchers during the data collection process. This was confirmed when we analysed the data, particularly relating to the age profile of the sample. Comparison of the age profile of women participating in the survey with that of all women resident in Ireland having an abortion in Britain demonstrates this in relation to the abortion group. Researchers' observations are the strongest evidence for this among the antenatal group.

Younger women's reluctance to participate shows that a research design targeting the general population of women is unlikely to attract this potentially more vulnerable group. Therefore, we recommend that a dedicated research project – focusing on the support needs of young women with a crisis pregnancy – should be undertaken. The design of this study needs to pay very detailed attention to the issue of sensitivity and stigma, as well as the issue of consent for this group



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## Appendix 1

### Abortion Clinic Information Sheet and Questionnaire

#### *Crisis Pregnancy Counselling in Ireland: Women's Views*

I am Catherine Conlon from the Women's Education, Research and Resource Centre (WERRC) at University College Dublin. Together with my colleague Joan O'Connor I am carrying out a study for the Crisis Pregnancy Agency on women's views of crisis pregnancy counselling and I would be very grateful for your help.

About 10,000 Irish women every year have a crisis pregnancy and need support. This study aims to explore and describe women's needs and expectations with respect to crisis pregnancy counselling in Ireland and to assess their experience of it. The study began in July 2003 and will finish in June 2004. It is intended that the Crisis Pregnancy Agency will publish a report of the study.

Every Irish woman attending the clinic between October and December is being asked to fill out a questionnaire that will take about 10 minutes. All information collected by the questionnaire is anonymous. Your name will not be attached to any of the information collected.

We are also asking women to take part in an interview lasting about half an hour. This can take place in the clinic today. In all 50 women will be interviewed for the study. The interview is confidential and anonymous and is just like a conversation.

Questionnaires and records of the interview will only be seen in full by the researchers and will be stored securely in my office. Information from the study will be grouped together in reports so that no one woman can be identified. All information collected will be destroyed 12 months after the research is completed.

Taking part in the study will place demands on your time – filling in the questionnaire will take about 10 minutes and taking part in the interview takes about half an hour. By taking part you can help the Crisis Pregnancy Agency better understand what kind of counselling and support women need when faced with a crisis pregnancy so that better services can be put into place.

Your participation in the study is completely voluntary. Any questions you do not wish to answer can be left blank. Feel free to ask the researcher any questions you wish at any time during the interview. You are free to withdraw from the study at any time and all information collected at that point will be destroyed.

Your care at the clinic today will not be affected in any way by whether or not you take part in this study.

If you have any questions about this study at any time please feel free to contact me, Catherine Conlon at WERRC, UCD, Belfield, Dublin 4, Telephone 01-\*\*\*\*\* [number provided].

Thank You For Your Help

**Pregnancy Counselling: Women's Views**

**Please note all information given on this form will be completely confidential and will be seen only by the researcher named below.**

1. Date of Birth: \_\_\_\_\_
2. What County in Ireland do you live in: \_\_\_\_\_
3. Do you live in a:  
☐ City      ☐ Town      ☐ Rural area
4. What is your marital status:  
☐ Single    ☐ Married    ☐ Separated    ☐ Divorced    ☐ Widowed
5. How would you describe yourself:  
☐ Not currently in a relationship      ☐ Engaged  
☐ In a casual relationship      ☐ Co-habiting  
☐ In a long-term relationship      ☐ Married
6. What is your level of education to date:  
☐ Primary education      ☐ PLC Course  
☐ Some second level      ☐ College Certificate/Diploma  
☐ Group/Inter/Junior Cert      ☐ College Degree  
☐ Leaving Cert      ☐ Postgraduate level  
☐ Other (please write in) \_\_\_\_\_
7. Are you now:  
☐ At School      ☐ Working in the home  
☐ At College      ☐ Part-time employed  
☐ In Training      ☐ Unemployed  
☐ Full-time employed  
☐ In receipt of state benefits (e.g. One Parent Family Payment,  
☐ Back to Education Allowance, Disability Allowance)
8. Please state your current or last job, if applicable:  
\_\_\_\_\_
9. What is your current income per year, before deductions for tax, PRSI etc.:  
☐ Less than €5,000      ☐ €10,000 – €20,000      ☐ €30,000- €40,000  
☐ € 5,000 – €10,000      ☐ €20,000 – €30,000      ☐ €40,000+

10. Other than children, who do you live with:

- ☐ Live alone                      ☐ Live with parents  
☐ Live with partner/husband   ☐ Live with sisters/brothers  
☐ Live with friends                ☐ Other (*please specify*)
- 

11. Please describe your Citizenship:

*If you have citizenship in more than one country please give all of them.*

- ☐ Irish                      ☐ Other Citizenship, *please write in as many as apply*
- 

13. Please describe you ethnicity:

- ☐ White   ☐ Traveller   ☐ Black   ☐ Asian  
☐ Other ethnic origin (*please specify*) \_\_\_\_\_  
☐ Mixed ethnic origin (*please specify*) \_\_\_\_\_

13. If you have children already, how many do you have?: \_\_\_\_\_

Please give their age(s):

14. About how many weeks pregnant are you now?

15. Have you discussed this pregnancy with any of the following: *Please tick **all** that apply*

- ☐ Your mother                      ☐ Your father                      ☐ Your partner  
☐ Your sister                      ☐ Your brother                      ☐ Your friend  
☐ Another relative                ☐ A counsellor                      ☐ A telephone counsellor  
☐ A Social Worker                ☐ Your regular GP                      ☐ Another GP

Another person (please state) \_\_\_\_\_

16. Did you consider attending a Pregnancy Counselling service?

- ☐ Yes                      ☐ No

17. What did you expect from Pregnancy Counselling? *Please tick **all** that apply*

- ☐ You are allowed come to your own decision  
☐ Your decision is influenced You are supported whatever your decision  
☐ You are judged  
☐ You are given information on **all** options  
☐ You are listened to

- ☐ You are given information on **some** options
- ☐ You are advised on future contraceptive use
- ☐ You are given practical help to carry out your decision

☐ Other \_\_\_\_\_

18. What could a Pregnancy Counselling service have provided for you?

*Please tick **all** that apply*

- ☐ A supportive listener
- ☐ Information on pregnancy care
- ☐ Help with telling others
- ☐ Information on supports for parents
- ☐ Talk through all your options
- ☐ Information on adoption
- ☐ Help with making a decision
- ☐ Information on abortion

☐ Other \_\_\_\_\_

19. Where did you get the information you needed to arrange this appointment?

*Please tick **all** that apply*

- ☐ GP
- ☐ Magazine
- ☐ Counselling Service
- ☐ Friend/Relative
- ☐ Internet
- ☐ Telephone book

☐ Other \_\_\_\_\_

20. Did any of the following stop you or make it difficult attending counselling?

*Please tick **all** that apply*

- ☐ No local service
- ☐ Delay in getting appointment
- ☐ Not knowing of any service
- ☐ Fear of being recognised
- ☐ Money issues
- ☐ Unsure what information agency provided

☐ Other \_\_\_\_\_

21. Which of the following Pregnancy Counselling services have you heard of??

*Tick **all** that apply*

- ☐ Cherish
- ☐ Life
- ☐ Cura
- ☐ PACT
- ☐ Irish Family Planning Association (IFPA)
- ☐ Well Woman

Another counselling service (please give details) \_\_\_\_\_

22. If you attended for counselling at any of these services, how well did the service meet your needs?

*Please circle one response for each of the services you attended.*

	Very Well	Well	Partly	Poorly	Very Poorly
Cherish	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cura	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IFPA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PACT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Well Woman	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Give reasons for your answer(s) \_\_\_\_\_

24. Whether or not you have attended pregnancy counselling before today, do you intend to have contact with a service when you return to Ireland for any of the following: *Please tick **all** that apply*

- ☐ Post-abortion medical check-up    ☐ Post-abortion counselling  
☐ Contraceptive advice    ☐ Post-abortion support group

**Taking Part In An Interview for The Study**

I would like to talk to you to find out more about what support services, if any, you would have liked and/or used for help and support in dealing with your crisis pregnancy. The interview lasts about thirty to forty minutes and is like a conversation. I can talk to you today here in the clinic or arrange another time that suits you. The interview is completely confidential and the information collected will only be seen by the researchers. By taking part in this study you can help us understand what kind of services would be helpful to Irish women facing a crisis pregnancy. This will assist the Crisis Pregnancy Agency putting better services and supports in place for women. If you would consider being interviewed please tell the receptionist and we can meet to talk about it.

**Please seal the questionnaire in the envelope and return it to the receptionist letting her know if you would be willing to meet me to talk about an interview.**

Thank you very much for your help.

Catherine Conlon

## Appendix 2

### Antenatal Clinic Information Sheet and Questionnaire

#### *Crisis Pregnancy Counselling: Women's Views*

I am Catherine Conlon from the Women's Education, Research and Resource Centre (WERRC) at University College Dublin. Together with my colleague Joan O'Connor I am carrying out a study for the Crisis Pregnancy Agency on women's views of crisis pregnancy counselling services and I would be very grateful for your help.

The study aims to find out women's needs and expectations of crisis pregnancy counselling services in Ireland and to evaluate their experience of it. The study began in July 2003 and will finish in June 2004. It is intended that the Crisis Pregnancy Agency will publish a report of the study.

Over the next few weeks women attending the ante-clinics are being asked to fill out a questionnaire that will take about 10 minutes. All information collected by the questionnaire is anonymous. Your name will not be attached to any of the information collected. We are also asking some women to take part in an interview lasting about half an hour. This can take place in the clinic today after you have seen the doctor or at another time that suits you. The interview is just like a conversation and in total 50 women will be interviewed for the study.

What you tell us will be kept confidential unless something arises that we consider necessary to refer to a member of the hospital medical or social work team. This is to protect your interests and safety (for example if you are at risk of medical complications, domestic violence, or self-harm) and to protect the safety of someone else (for example if a child is at risk of injury or harm). Questionnaires and records of the interview will only be seen in full by the researchers. The information will be kept securely in my office and all information from the study will be grouped together in reports so that no one woman can be identified. All information collected will be destroyed 12 months after the research is completed.

Taking part in the study will place demands on your time – filling in the questionnaire will take about 10 minutes and taking part in the interview takes about half an hour. By taking part you can help the Crisis Pregnancy Agency better understand what kind of counselling and support women need when faced with a crisis pregnancy so that better services can be put into place.

Your participation in the study is completely voluntary. Any questions you do not wish to answer can be left blank. Feel free to ask the researcher any questions you wish at any time. You are free to withdraw from the study at any time and any information collected at that point will be destroyed.

**If you decide not to take part in the study, your care in the hospital will not be affected in any way. Whether or not you decide to take part, should you need help with issues related to your pregnancy you should make contact with the hospital Social Work department who can help you.**

If you have any questions about this study at any time please feel free to contact me, Catherine Conlon at WERRC, UCD, Belfield, Dublin 4, Telephone 01-\*\*\*\*\* [number provided].

Thank You For Your Help



### Pregnancy Counselling: Women's Views

**Please note all information given on this form will be completely confidential and will be seen only by the researcher named below.**

1. Date of Birth DMY \_\_\_\_/\_\_\_\_/\_\_\_\_
2. What County in Ireland do you live in \_\_\_\_\_
3. Do you live in a  
☐ City    ☐ Town    ☐ Rural area
4. What is your marital status  
☐ Single    ☐ Married    ☐ Separated    ☐ Divorced    ☐ Widowed
5. How would you describe yourself  
☐ Not currently in a relationship    ☐ Engaged  
☐ In a casual relationship    ☐ Co-habiting  
☐ In a long-term relationship    ☐ Married
6. What is your level of education to date  
☐ Primary education    ☐ PLC Course  
☐ Some second level    ☐ College Certificate/Diploma  
☐ Group/Inter/Junior Cert    ☐ College Degree  
☐ Leaving Cert    ☐ Postgraduate level  
☐ Other *(please write in)* \_\_\_\_\_
7. Are you now  
☐ At School    ☐ Working in the home  
☐ At College    ☐ Part-time employed  
☐ In Training    ☐ Unemployed  
☐ Full-time employed  
☐ In receipt of state benefits (e.g. One Parent Family Payment,  
☐ Back to Education Allowance, Disability Allowance)
8. What kind of paid work do you do or have you done in the past  
 \_\_\_\_\_
9. What is your current income per year, before deductions for tax, PRSI etc.  
☐ Less than €5,000    ☐ €10,000 – €20,000    ☐ €30,000- €40,000  
☐ € 5,000 – €10,000    ☐ €20,000 – €30,000    ☐ €40,000+

10. Other than children, who do you live with
- ☐ Live alone ☐ Live with parents
- ☐ Live with partner/husband ☐ Live with sisters/brothers
- ☐ Live with friends ☐ Other (please specify) \_\_\_\_\_

11. Please describe your Citizenship
- If you have citizenship in more than one country please give all of them.*
- ☐ Irish ☐ Other Citizenship, please write in as many as apply
- \_\_\_\_\_

12. Please describe you ethnicity
- ☐ White ☐ Traveller ☐ Black ☐ Asian
- ☐ Other ethnic origin (please specify) \_\_\_\_\_
- ☐ Mixed ethnic origin (please specify) \_\_\_\_\_

13. If you have children already, how many do you have? \_\_\_\_\_
- Please give their age(s)

14. About how many weeks pregnant are you now?

15. Which of the following phrases best captures your response to this pregnancy
- Please read the list and then tick ONE.**

- ☐ 'As planned' ☐ 'Unexpected' ☐ 'A personal crisis'
- ☐ 'A shock' ☐ 'Long awaited' ☐ 'Pleased'
- ☐ 'Didn't know what to do' ☐ 'Pleasant surprise'

Please tell us more \_\_\_\_\_

**If your response to this pregnancy was either 'shock', 'unexpected', 'a crisis' or 'didn't know what to do' please continue to the end of the questionnaire.**

**Otherwise please return the questionnaire to the researcher.**

16. Who did you look to for support? Tick **all** that apply

- ☐ Your mother ☐ Your father ☐ Your partner
- ☐ Your sister ☐ Your brother ☐ Your friend
- ☐ Another relative ☐ A counsellor ☐ A telephone counsellor
- ☐ A Social Worker ☐ Your regular GP ☐ Another GP

Another person (please state) \_\_\_\_\_

17. Did you consider attending a Pregnancy Counselling service?  
☐ Yes      ☐ No
18. What do you think happens in Pregnancy Counselling? *Tick **all** that apply*  
☐ You are allowed come to your own decision  
☐ Your decision is influenced  
☐ You are supported whatever your decision  
☐ You are judged  
☐ You are given information on **all** options  
☐ You are listened to  
☐ You are given information on **some** options  
☐ You are advised on future contraceptive use  
☐ You are given practical help to carry out your decision  
Other \_\_\_\_\_
19. What should a Pregnancy Counselling service have offered you? *Tick **all** that apply*  
☐ A supportive listener      ☐ Information on pregnancy care  
☐ Help with telling others      ☐ Information on supports for parents  
☐ Talk through all your options      ☐ Information on adoption  
☐ Help with making a decision      ☐ Information on abortion  
Other \_\_\_\_\_
20. Which of the following Pregnancy Counselling services have you heard of?  
*Tick **all** that apply*  
☐ Cherish    ☐ Life  
☐ Cura      ☐ PACT  
☐ Irish Family Planning Association (IFPA)  
☐ Well Woman  
Another counselling service (please give details) \_\_\_\_\_
21. Were you in contact with any of the following Pregnancy Counselling services?  
*Tick **all** that apply*  
☐ Cherish    ☐ Life  
☐ Cura      ☐ PACT  
☐ Irish Family Planning Association (IFPA)  
☐ Well Woman

Another counselling service (please give details) \_\_\_\_\_

22. Did any of the following stop you or make it difficult for you to attend counselling?

*Tick **all** that apply.*

- ☐ No local service                      ☐ Delay in getting appointment  
☐ Not knowing of any service   ☐ Fear of being recognised  
☐ Money issues                      ☐ Unsure what information agency provided

Other \_\_\_\_\_

23. If you attended for counselling at any of these services, how well did the service meet your needs?

*Please circle one response for each of the services you attended.*

	Very Well	Well	Partly	Poorly	Very Poorly
Cherish	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cura	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IFPA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PACT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Well Woman	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Give reasons for your answer(s) \_\_\_\_\_

24. How could pregnancy counselling services help you through the rest of your pregnancy and after the birth?

*Tick **all** that apply*

- ☐ Support preparing for motherhood                      ☐ Parenting advice  
☐ Support preparing for childbirth                      ☐ Post-natal counselling  
☐ Provide support to your parents                      ☐ Mothers support group  
☐ Give practical information (e.g. on accommodation, allowances etc)

Other \_\_\_\_\_

### Taking Part In The Study

We would like to talk to you to find out more about what support services, if any, you would have liked and/or used for help and support with your pregnancy. We can talk to you today here in the clinic or arrange another time that suits you. The interview lasts about forty minutes to one hour and is like a conversation. The interview is completely confidential and the information collected will only be seen by the researchers. By taking part in this study you can help us understand what kind of services would be helpful to women during their pregnancy. This will assist the Crisis Pregnancy Agency in planning and promoting better services and supports for women.

Would you be willing to take part in an interview for this study:

☐ Yes

☐ No

When would you prefer to be interviewed:

☐ Today at the clinic

☐ Later this week at home or at another agreed place

If you would prefer to be interviewed later this week at home or elsewhere please fill in your details below so that we can contact you to arrange this.

Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone \_\_\_\_\_