Abortion: With Particular Reference to the Developing Role of Counselling

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SUMMARY

This paper suggests that counselling is a rapidly expanding field in which professional and para-professional workers might combine to produce an effective service, given appropriate selection and training procedures. Initially these are seen as being provided by professionally qualified social workers with relevant experience. The author has used her own social work experience in abortion counselling to exemplify the article and to discuss some of the existing problems for workers and clients alike.

The subject of abortion evokes issues of life and death and arouses emotional attitudes and religious and moral fervour. Fierce argument continues to rage between those focusing on the sanctity of life and the preservation of the foetus and those concerned with bringing relief to the woman wishing to terminate an unwanted pregnancy. Indeed, when reading the main protagonists on this highly emotive topic it is clear that a great deal of energy is spent on polarizing the debate rather than on making rational efforts towards finding a basis for discussion.

In 1974 The Lane Committee presented its report on the working of the 1967 Abortion Act: one of its specific recommendations was that 'appropriate counselling should be available for all patients'. As a social worker with experience of both family planning and termination counselling I should like to discuss some of the issues arising from that recommendation, and to suggest that one way of meeting the demand for the provision of a high standard of counselling would be to employ professionally qualified social workers who seem the most appropriately trained professionals for this role.

THE DEVELOPING ROLE OF COUNSELLING

Counselling reflects one aspect of the contemporary view that an
individual is entitled to improve the quality of his personal and social life as well as his material position. With greater expectations of achieving personal satisfaction, people are turning increasingly to professional services for support and guidance, which if available at all, was traditionally provided by the doctor, the clergyman or the closer knit family network. Counselling is now widely available in such diverse areas as the Marriage Guidance Council, the National Association for the Care and Resettlement of Offenders, Youth Advisory Services, in School and in Student Counselling. It is a field which continues to expand but which has not yet fully clarified its aims or limitations; this may be because it is still relatively new or because it is practised by people with different views, who are acting on behalf of a wide variety of agencies whose functions may inhibit the development of a common standard or style of work. It is hoped that the Standing Conference for the Advancement of Counselling which includes both professionals and non-professionals will be effective in providing a more unified approach to the question of counselling and attempt to clarify underlying theory.

The focus of this paper is abortion counselling which evolved on an ad hoc basis and in response to a growing demand for terminations largely unavailable on the N.H.S. As a result some private and charity based organizations were established and counsellors including some social workers were employed within the charity sector, both to assist with evaluation of the clients' needs and to provide information. Clients were first seen by a counsellor or social worker and then by an agency doctor; two medical signatures were required on the Certificate before termination could be performed (Fig. I).

Factors affecting the quality of counselling included the lack of any uniform training, experience, or supervision of counselling techniques. As a result, counselling skills and techniques varied from counsellor to counsellor, and from one agency to another. The emphasis might either be more clerical, based on detailed history-taking, on giving factual information, or focusing on a dynamic approach concerned with underlying motivation and personality factors.

It is not only in administrative arrangements however that agencies vary in their approach to women seeking termination, but more significantly in terms of the ethos and function of the particular institution. My own experience working in two widely different but highly responsible agencies, provided contrasting examples of differing agency approach. At Welcare the emphasis was on a caring function, coupled with considerable practical help
ABORTION AND THE ROLE OF COUNSELLING

IN CONFIDENCE

Certificate A

Not to be destroyed within three years of the date of operation

ABORTION ACT 1967

Certificate to be completed before an abortion is performed under Section 1(1) of the Act

1. \(\text{(Name and qualifications of practitioner in block capitals)}\)

of \(\text{(Full address of practitioner)}\)

and 1, \(\text{(Name and qualifications of practitioner in block capitals)}\)

of \(\text{(Full address of practitioner)}\)

hereby certify that we are of the opinion, formed in good faith, that in the case of \(\text{(Full name of pregnant woman in block capitals)}\)

of \(\text{(Usual place of residence of pregnant woman in block capitals)}\)

1. the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated;
2. the continuance of the pregnancy would involve risk of injury to the physical or mental health of the pregnant woman greater than if the pregnancy were terminated;
3. the continuance of the pregnancy would involve risk of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman greater than if the pregnancy were terminated;
4. there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

This certificate of opinion is given before the commencement of the treatment for the termination of pregnancy to which it refers.

Signed \(\text{...}_...\)

Date \(\text{...}_...\)

Signed \(\text{...}_...\)

Date \(\text{...}_...\)

FORM H.S.A. 1.

Fig. I
leading to a girl continuing her pregnancy and either keeping the baby or giving it up for adoption. On the other hand the Pregnancy Advisory Service was most likely to facilitate the process of termination allied with good physical care unless there were definite contra-indications usually of a physical nature. Despite legally sanctioned conditions for termination, I must concur with Sims (1973) that 'the woman who is contemplating abortion will get different treatment informed by different values according to where she applies for help'. It may be argued that soon after the 1967 Act
was passed women seeking terminations outside the National Health Services were unlikely to be well-informed about which agency to approach, however now that almost a decade has elapsed many women are more aware of what help specific agencies are likely to offer and clients are therefore less likely to meet with disapproval or undue pressure.

Undoubtedly within the Health Service, women remain dependent on the differing exercise of medical discretion by both G.P. and hospital consultant (Fig. II). It was because of the continuing demand for terminations, together with the inequitable use of inadequate existing facilities in the National Health Service that private registered charities such as the Pregnancy Advisory Service and others were established. In abortion counselling, the woman's stage of pregnancy imposes strict limits on the period during which a decision to terminate can be made. Women seeking a termination need the opportunity for a reasonable period of discussion with a counsellor, bearing in mind the serious nature of such decisions and their long-term implications. 'Even in day care procedures where operative procedures seem simple surgical matters, the speed and simplicity should not be reflected in the time taken for assessment in pre- and post-operative counselling'. My own experience and observations as a counsellor led me to believe that a major factor affecting the quality of counselling was the limited amount of time agencies allowed for interviewing. In the Pregnancy Advisory Service in which I worked, counsellors were then routinely expected to see six clients each three-hour session, and sometimes even seven. The majority of my colleagues agreed that it was difficult to see that number and remain alert, maintain a reasonably neutral approach and work effectively. Indeed this seems self-evident since the process of counselling involves several stages, defining the problem, understanding the situation, interpreting feelings, establishing facts and explaining options before a decision is made.

AIMS OF ABORTION COUNSELLING

During the brief period of interaction and communication between client and counsellor, the latter is responsible for gathering and giving information, and for creating an atmosphere conducive to the discussion of intimate and painful feelings between two strangers. She relies on her capacity to empathize with the client and to convey informed interest and concern, and yet maintains her separateness in order to make a realistic assessment. Sutherland has suggested that 'counselling is a process of help located firmly
within the personal relationship between the counsellor and the person in need. I did not feel that it was always possible to establish a positive relationship whereby each client could use the opportunity to the full not only because of some clients' reluctance to do so, but also because of the exigencies of time and the fact that the counsellor is inevitably vested with the authority of the agency, empowered to give or to withhold the client's request. One can only try and use the client's reactions to oneself as indicative of her responses in other dependency situations. Paradoxically the counsellor has to both focus on the termination issue and yet learn as much as possible about the client in order to better understand her dilemma. The more experienced worker is also aware of the dangers of evoking an emotional reaction in the client which she cannot then contain; in other words the counsellor has to recognize the limitations of her role, and of the agency's function, she must also maintain a clear focus and refer a client elsewhere if she feels further help is needed. One of the frustrations and disciplines of having a very brief contact with a client is having to acknowledge the limited scope of therapeutic intervention possible. Clearly the assessment will be affected by the counsellor's sensitivity, her training, experience and knowledge of existing services as well as her capacity to recognize normal and pathological behaviour. Above all counsellors may be tempted to make a decision for their clients on the basis of their own and the agency's ethical stance. There are however inherent dangers in 'advising' clients to adopt any one particular course of action, indeed perhaps the major result of a good counselling experience is that the client, once she is aware of the various possibilities open to her, is then able to make her own decision. Where a counsellor is drawn into making a decision on behalf of the client she may unwittingly be reinforcing the latter's particular behavioural patterns. An opportunity to help the client make a rational and mature decision and avoid a similar situation recurring in the future may be lost. Hopefully, as a result of counselling, the client also gains some insight into why the unwanted pregnancy occurred. In my view there is little doubt that women who are considering an abortion should have the opportunity to discuss not only the practical aspects but also the emotional implications of termination.

A decision whether or not to terminate a pregnancy made without adequate consideration and advice may be a source of regret and distress to a patient and may result in lasting harm to her. ¹

From two years' experience in the field the writer sees the aims of abortion counselling as including:
(a) the provision of factual information regarding both the process of termination and a knowledge of available resources to assist those clients who decide to continue with their pregnancy;

(b) an ability to free the client to express her inner doubts and wishes freely and to provide some psychological support for whichever decision is made;

(c) helping the client differentiate her own wishes from those of her family, boy friend, husband or other salient figures;

(d) helping the client understand the extent to which she may have colluded in becoming pregnant—in terms of both her choice of partner as well as in her attitudes to pregnancy and to link this with factual information regarding future contraception. Many patients are very resistant to any discussion of this topic and are unrealistic about their contraceptive needs in the future. In these cases it is essential that before they leave the agency they be given specific information regarding contraceptive services available in their area;

(e) establishing the basis of aftercare. Patients should routinely be given not only a medical follow-up but also a post-termination interview preferably with the original counsellor. A recent study has suggested that an abortion can be the turning point in the practice and continuing use of contraception (Potts);

(f) enabling the client to use an adverse experience as part of a maturing process through responsible decision making;

(g) attempting to recognize those patients who appear to be markedly disturbed and in need of specialist treatment. This final point requires further attention; there are some types of psychological or psychiatric disturbance which may well be identified by the perceptive and experienced counsellor but there are others of a less overt nature where it seems likely that a counsellor, untrained in psychiatric work, might be unable to make an accurate diagnosis of personality disturbance. As a result, in my opinion, statistics of those clients referred to psychiatrists should be viewed with some scepticism.

The following case exemplifies recognition of psychiatric disturbance which although noted could not be referred for specialist assessment. (All cases reported were interviewed by the writer whilst employed as a counsellor at the Pregnancy Advisory Service, London.)

*Case A*

A Scottish girl of twenty-four, of markedly low intelligence was
dressed like the stereotype of a prostitute. She had come down to London with her boyfriend in order to arrange for an abortion. He was quiet, calm, not very insightful but very concerned about her. Miss E. was almost paralysed with anxiety, at first unable to speak and moving in a jerky, unco-ordinated fashion. Both social worker and doctor felt that though clearly highly disturbed this client could not tolerate delay in assessing her need for a termination. She was therefore not referred for a psychiatric assessment. Despite efforts to assist Miss E. and her boyfriend with practical guidance and to ensure that she received an early termination, it must regrettably be recorded that they returned to London two years later for a repeat termination.

As previously mentioned one of the great difficulties in assessing whether a client fulfils the legal conditions for termination is the importance of speed in reaching a decision. ‘All available psychological and medical research points to the need for early abortion’ (Potts). It has been noted by Balint and Sandler that women seeking an abortion are generally in a state of panic with only one conscious aim in mind, which is to persuade the counsellor and doctor to agree to the abortion which they desperately want. Because their need is indeed urgent it may be very difficult to differentiate between a ‘normal’ degree of panic induced by the situation and one reflecting a highly neurotic personality. Balint and Sandler found that practically all patients seen by a working group of G.P.s considered their pregnancy as a disastrous accident which must be removed as soon as possible. The authors found to their dismay that the doctors tended to accept the woman’s point of view considering the pregnancy as ‘the illness’ and not looking deeper for underlying psychological disturbance. Within the abortion counselling situation, as indeed with marital therapy and certain social work situations, it may well be advisable to support clients through the immediate crisis, helping them to recognize their difficulties and not exposing them to problems with which they are unable to cope without ongoing support. The abortion counsellor must therefore be alert to the psychological indications suggested in the highly psycho-analytically oriented paper mentioned above and yet bear in mind that there is no foolproof method of contraception which can be used by all women, that few women have access to insightful psychological help and that there are also cultural and social reasons why some people are unable or unwilling to use available contraceptive help.
CLIENTS

Despite the common factor of their pregnancy, experience suggests that clients who receive abortion counselling vary enormously by virtue of their circumstances, personality and needs. To make categorical statements, as many writers do, suggesting either that every unwanted pregnancy reflects an existing inner crisis or alternatively that there are many women who have little need for counselling, seems unconstructive. A brief review of a few typical categories of clients seeking termination may serve to emphasize how important it is for counsellors to be well informed, flexible and sensitive to the needs of the individual client.

1. OLDER OR HIGH PARITY WOMEN

It is generally accepted that after age thirty-five risks of childbearing to the health of the woman and the unborn child increase considerably. The proportion of women accepted for termination within the N.H.S. is highest in the over forty age group. Despite the assertion in the Lane Report that abortion is usually readily available for the woman of over thirty-five years who has a family already in their teens, personal experience has not borne this out. All too often geographical inconsistency in facilities offered reflected the prevailing influence of the consultant gynaecologist (cf. Fig. II).

Case B

A patient was referred to the Pregnancy Advisory Service by her G.P. who sent both a covering letter and a signed Certificate. This patient had been refused termination by her local N.H.S. hospital. She was a State Registered Nurse, aged thirty-six, married to a policeman; they have four children. The family was under considerable financial pressure and their accommodation was already proving inadequate. Mr. and Mrs. F. both felt that another child would strain the family beyond its limits. Mrs. F. had recently come off the pill, intercourse taking place during the safe period. She was desperate to have a termination and had already decided on a more reliable method of contraception. In assessing this case the counsellor focused on the immediate problem but also felt that a follow-up, which was not arranged, would have been desirable to ensure that there were no underlying problems which would later require social work support.

In this example as in others I encountered, there were clear indications that many clients might have benefited from referral to
other agencies. During my period at the Pregnancy Advisory Service each client was seen by both a doctor and a worker designated 'social worker' regardless of training, or experience. At that time only one full-time professionally qualified social worker was employed, and no supervision was given. As a result standards of work varied, reflecting the interviewers' limited experience and knowledge of existing facilities. Much of the interviewing was standardized in order to fill in a lengthy information sheet and as a result did not reflect the needs of the client. I felt that valuable opportunities were lost to help clients at a time when they were emotionally accessible and more amenable to help.

Counselling follow-up of clients was not built into the system and as a result rarely occurred; although many clients were resistant to subsequent involvement with the agency after termination, arrangements could have been made for clients returning for post-operative checkups to be seen by a social worker. Limited efforts by some staff members to retain a counselling rather than a clerical role was not supported and as a result the agency focus became one of through-put. I must add that during this period this agency was one of the very few providing safe terminations in good physical and medical conditions at a reasonable charge and as a result were under constant pressure from large numbers of women requiring termination.¹¹

2. RELIGIOUS AFFILIATIONS

Amongst many clients seen those with strong religious affiliations often experienced a particularly intense sense of guilt but they were nonetheless strongly motivated towards termination. Counselling in these situations needs to take account of the client's very considerable moral dilemma and it is in these cases that a counsellor may not be able to help assuage subsequent feelings of guilt.

The proportion of Catholic women receiving termination was only slightly lower than among fertile women generally ¹² but we do not know whether a significant further proportion of Catholic women are inhibited by their religion from seeking a termination.

Case C

A thirty-year-old practising Catholic had a stable relationship for eight months with another Catholic whom she hoped to marry. Withdrawal was the only method of contraception used. On learning of the pregnancy the boyfriend deserted her. This woman
had lost both parents in the last two years and was clearly clinically depressed and lonely. Despite her acknowledged wish for a husband and child she felt unable to cope with a child by herself, since she had no outside emotional or financial support. She had been sent by her G.P. for termination to her local N.H.S. hospital and had been refused. Because of her relative isolation social worker contact might have been established.

3. WOMEN WHO HAVE EXPERIENCED CONTRACEPTIVE FAILURE

Where patients report contraceptive failures it is often difficult for the counsellor to know from a brief interview whether in fact this is the case, whether it is used to disguise the truth, or to cover up inhibition or ignorance of birth control methods.

4. GIRLS UNDER SIXTEEN

There has been an increase in the number of pregnancies and abortions in girls under sixteen, the legal age for sexual intercourse (Table I). This reflects not only earlier sexual experience but also the earlier onset of physical maturity. Despite these factors the report of the B.M.A. Working Party on 'The Age of Consent in Relation to Sexual Offences' took the view that only a minority of the adolescent population experienced sexual intercourse and there were insufficient grounds to justify a change in the age of consent. Michael Schofield in *The Sexual Behaviour of Young People* confirms that the majority of teenagers are both inexperienced and ill-informed. The Abortion Law Reform Association comments that despite regular newspaper headings proclaiming an increase in schoolgirl abortion, the numbers have remained remarkably constant when seen as a proportion of total abortions.

*Case D*

A fifteen year-old was sent to the Pregnancy Advisory Service by her sympathetic G.P. who sent along a signed Certificate. Both the girl and her mother were seen separately and then together. The girl was extremely immature and had just left school; she said she had been quite inexperienced sexually but a casual boyfriend had used a sheath. When interviewing this girl it was felt that she needed a great deal more support than her family could provide and that she needed an outside contact such as her own social worker to follow her up over time as the prognosis seemed poor. No such provision was made.
### Table 1: Live Births and Notified Abortions to Girls under Sixteen in Great Britain

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Source: O.P.C.S. and G.R.O. (Scotland)
Many girls in this group have been found to be emotionally disturbed or of very low intelligence; often they come from unstable backgrounds. As yet there is little preventive work being done outside social service provisions.

5. WOMEN WHO SEEK SUCCESSIVE ABORTIONS

Some of these women show definite personality disturbances and should therefore be referred for specialist help, always assuming that they will accept it. I am loath to generalize, however, especially when a woman experiences a long intervening period of time between two abortions and particularly if a permanent relationship has been established in the meantime.

Ingham and Sims\textsuperscript{16} have reported:

Nearly all the roughly seven per cent of patients who came into hospital for their second abortion had a cluster of other problems as well. These included family breakdown, V.D., mental disturbance, previous suicide attempts, epilepsy, and previous illegitimate children and abortions. This sub-group requires particular attention from the social services.

It may be that further studies carried out in different socio-economic hospital catchment areas may provide more information about women requiring more than one abortion. It should also be noted that many such patients may prefer to go to private or charity-based organizations and it would be interesting to compare the different groups. This category of clients presents a most important group for future research.

6. CLIENTS PRESENTING AS UNCERTAIN ABOUT THEIR DECISION

In some cases counselling enabled clients to reconsider their decision and to clarify their own wishes.

Case E

A happily married woman of thirty-eight; she already had three children all of whom were at school or working. She wanted termination for financial reasons because another baby would mean less time and material comfort for the remainder of the family. After discussing her real feelings about having a baby as opposed to those the counsellor felt she was projecting on to members of her family, it became evident that it was basically embarrassment at this unplanned pregnancy at her age plus her fears that it might be self-indulgent to have another child which had brought her for termination. After further discussion with Mr. I. and the counsellor,
it became clear to Mrs. I. that her husband was prepared to support her through another pregnancy and had only agreed to termination because it appeared to be what she wanted. Mrs. I. left smiling. No application for termination was made.

Case F
A sixteen-year-old. She was initially very uncommunicative and her mother became extremely anxious when the counsellor insisted on seeing the girl alone. There had been a stable relationship with a young boyfriend for many months but no previous sexual experience. Miss J. was quite adamant in private discussion that she did not want a termination and she was in fact already fourteen weeks pregnant; she agreed that her delay in telling her parents was not only because she was frightened but because she wanted to keep the baby. When both mother and daughter were seen together the counsellor felt that it was the former who was experiencing the greater emotional trauma and in fact some time was spent trying to help Mrs. J. clarify her own feelings. The counsellor felt that the pregnancy was in fact symptomatic of the extreme difficulties between mother and daughter when the latter was struggling to establish her own identity and sexuality. Both because of the girl's own wishes and the duration of the pregnancy the counsellor felt unable to recommend termination. She considered that referral to a sympathetic and well-informed voluntary or statutory body was essential to provide further practical assistance and emotional support for the family. Unfortunately, no such facilities were made through the Agency.

7. A TYPICAL PROBLEM
One of the dilemmas facing the counsellor is presented by the client who for psychological reasons may need to continue with the pregnancy but for whom it is nevertheless not realistic or pragmatically feasible to do so. Case C might also be included in this category.

Case G
A twenty-nine-year-old Asian woman was separated from her husband, who had already returned to East Africa. She lived alone, had no relatives in this country and was dependent on Social Security benefits. Her only child had died a few years previously and her marriage had been unhappy. She described Mr. K. as suffering from severe mental illness. This client was referred by a
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Welfare Officer after the G.P. had suggested a private abortion which she could clearly not afford. Despite this woman's need to receive and give affection the counsellor concurred that the practical difficulties with which she would have to contend over a long period of time would prove overwhelming.

I would like to stress the significant number of cases where I felt that further counselling or guidance was required. Throughout my experience with this agency, however, no such formal liaison procedures were established or encouraged and as a result clients seen at a point of crisis were generally neither followed up nor referred.

A positive example of how this can be done is the integrative service at King's College Hospital, London, where links are made between all aspects of pregnancy including termination; general practitioners, family planning clinics, the hospital and local health authority aim to provide an effective and humane referral system (Newton et al.).

PREPARATION FOR COUNSELLING

At present the role of the counsellor is practised by both professionals of various disciplines, such as doctors, nurses and social workers, as well as by lay personnel. As previously mentioned, the training and qualifications of workers in the various fields of counselling suggests that there are no standard methods of selection, no uniformity of outlook, training, supervision or agency function.

Evidence of the Lane Committee indicated that the greatest number of women seeking termination were seen by their G.P.s and did not receive any other counselling service. Indeed, Newton, Elias and McEwan suggest that abortion counselling, with an assessment of all factors involved, is best carried out by the G.P., but it is the widely differing exercise of medical discretion which has been such a frequent cause of complaint in the working of the 1967 Abortion Act. Even a cursory glance at the training of the average doctor will show that few practitioners have had the opportunity of learning about patients from a psycho-social point of view, there is little time in traditional medical training to teach counselling skills. The following cases exemplify situations in which a number of women have experienced unnecessary delays in obtaining a termination either because their doctor did not approve of abortion or because he was unsure of which consultants working in the N.H.S. hospitals were sympathetic to such requests.
Case H

This patient came to the Pregnancy Advisory Service when she was more than ten weeks pregnant—on her first visit to her G.P. she was told to wait until she was eight weeks pregnant and then return to see him; when she did so he merely confirmed her pregnancy and gave no further advice or help. Mrs. A. was a thirty-two-year-old African woman who had already had 4 children, one of whom was stillborn. Her husband was studying and the family had been living on her salary while she worked as a student nurse. This woman looked utterly worn out and both the Pregnancy Advisory Service doctor and I felt that the strain of a further pregnancy would not only be deleterious to her mental and physical health but would also have serious repercussions on the rest of the family. In our view this was a case which should have been dealt with promptly by the G.P. and should also have subsequently been referred to a local Social Service Department since this client was not even aware of her social security entitlement.

Case I

Mrs. B. was a divorced woman of thirty-four; her two-year relationship with her boyfriend was already deteriorating. Mrs. B. had to support herself and her three children on social security benefits; her middle child suffered from frequent and severe migraine and was clearly a permanent source of anxiety. This patient was very thin, looked unwell and was already struggling to cope with severe domestic and financial problems. Her G.P. was unsympathetic and offered no help or advice.

Case J

Miss C: In this case the G.P. would not advise or allow his eighteen-year-old patient to go on the pill: no medical reason was given. This very immature girl was engaged to a young boy and was quite clearly experiencing many problems in the relationship. They were both inexperienced sexually and he used a sheath occasionally. She had finally gone to the Family Planning Association and had been advised to go on the pill, by which time she had already conceived.

In contrast, in the following case the G.P. took prompt action to support his patient’s request:

Case K

Mrs. D., a woman of thirty-three, was temporarily separated from her husband, they had one child aged fifteen. Mrs. D. had become
pregnant whilst on holiday away from her family. She had a history of psychiatric illness and had also experienced difficulty in finding a satisfactory form of contraception. The IUD had caused infections and she was not able to take the pill because of medical complications. In this case the G.P. had been very sympathetic and sent her to the Pregnancy Advisory Service with an explanatory covering letter when she was only six weeks pregnant.

Recent trends in medical care have advocated a more generic approach to the patient and it is to be hoped that in the words of the Lane Committee's Report 'a person should be viewed in the light of personal, physical and mental health and social conditions and not merely as one suffering from a particular disease or condition requiring amelioration or cure'. The Seebohm Report advocated precisely this approach in social work.

In trying to clarify which, if any, existing group of workers had already been prepared for the kind of crisis intervention and longer term work involved in counselling, it was essential to consider selection, training and supervisory processes which in turn led me to a comparison with the kind of experience and opportunity that many professionally trained social workers already have. Selection is initially a self-selection process, not always indicating suitability as it is clear from the number of aspiring counsellors who are not accepted; a wish to work in a specific area may in fact reflect one way of coping with unresolved personal conflicts which could adversely affect the counselling process. Rigorous selection is needed at an early stage to avoid a worker's subsequent sense of rejection should she prove unsuitable, and also to avoid wastage of training resources. Whilst it is possible to devise systematic procedures for selection, it remains difficult to clarify why a person is selected unless one uses descriptive terms and acknowledges the subjective, intuitive aspects of the selector's assessment. Indeed the capacity of selector and potential counsellor to relate to each other and to use the interaction productively may be seen as indicative of their capacity to relate to clients. An effective counsellor should offer accurate empathy, non-possessive warmth or unconditional regard, and genuineness or self-congruence (Truax and Carkhoff) also intelligence and flexibility in order to cope with a variety of clients coming from different social, economic and cultural groups. Insight, objectivity and willingness to continue listening, learning and reappraising one's own views are also essential traits.

Counselling is, at its best, a constructive exercise aimed at providing emotional support and practical help, hopefully enabling
the client to cope more effectively in the future; at its worst, it can be didactic, superficial and have little or no positive effect on the client. There would be a considerable advantage in the establishment of a unified programme of training, which would include a basic course for all counsellors new to the field and subsequent brief courses aimed at specialist practice. Areas for consideration on the basic course might include human physical and psychological development, relevant legal knowledge, information about existing social services and advice bureaux, and a section on counselling techniques and difficulties. But above all a major aspect of such a training programme would be to encourage self-awareness in both client and counsellors since, as Sutherland\textsuperscript{20} says:

Counselling is a personal relationship in which the counsellor uses his own experience of himself to help his client to enlarge his understanding—and so to make better decisions. The process of counselling is an educational activity for both parties, and each encounter is unique. The training of counsellors is therefore designed to give them more understanding of themselves, an objective which relies on appropriate opportunities for them to share experiences. Intellectual knowledge of personality development does little by itself to equip the counsellor. Such knowledge has to be assimilated with recognition of the relevant processes at work in himself if it is to be of effective help in the counselling task.

This is a view much in evidence in some professional social work training courses in relation to casework. Although my own bias has been towards a non-directive, psycho-dynamically oriented approach to clients in abortion counselling, marriage guidance work and in psychiatric social work, I do appreciate that many people may prefer to use behavioural techniques in some situations—but it may be that there too the relationship between counsellor and client is an important factor. The basic course would include seeing clients in one or two agencies, rather as social workers do in placements; counsellors could then opt for the particular area of counselling in which they wish to work, having earlier been introduced to a wide variety of possibilities during their basic training. Courses would then be taken in order to gain specialist knowledge of the specific needs and problems relating to counselling in their chosen field.

For example, counsellors attending a special course on abortion work could expect to cover a survey of the literature and research findings and the work being done presently in both the private and public sector. They would learn about appropriate agencies for referral on matrimonial, contraceptive, legal, social and psychiatric problems. Clearly counsellors must have a working knowledge of relevant current legislation to be able to explain this clearly, as with procedures of termination and contraception. In addition to looking
very closely at the importance of the working relationship between counsellor and client, it is essential that the counsellor be aware of the considerable physical, psychological and social changes which every pregnant woman experiences, and to appreciate that the individual will respond to her new state with natural anxiety about the future. The client's reaction to the change will be, to some extent, indicative of the way in which she copes generally with stress, anxiety and disequilibrium.

In this context, I envisage supervision as an on-going process on a one-to-one basis prior to completion of the basic course and subsequently in a group with peers. The supervision would focus mainly on the counsellor's work with clients but also on the relevance and impact of her own attitudes towards her clients. This aspect of the learning process may be beneficial not only to clients but also as an opportunity for increasing personal insight. I would expect that after considerable experience in the field counsellors may become supervisors and selectors; for each of these stages, teaching groups with available consultation would be required.

The whole process is aimed at establishing a corps of well-trained counsellors capable of quickly adapting to changing needs in society. The individual counsellor would also benefit from a greater sense of recognition in her competence, and from a wider area in which to work. My own view is that once counselling is more clearly defined, its boundaries agreed, and standards established, it will not be too long before professionalization follows. Much of what I hope to see in terms of training and supervision already occurs in the sphere of professional social work education and much of the content and approach needed in a basic counselling course is taught in social work training. Many social workers already have a very wide variety of experience of working with clients with different needs. They also have case-work experience and a considerable amount of factual knowledge including an awareness of up-to-date statutory and voluntary provision. Many are used to working on a crisis intervention model as well as over a considerable period of time; they are expected to work with problems of isolation, interpersonal relations, mental and physical handicap, and social and environmental deprivation. Those who are interested in the development of counselling skills and have experience in this area might well provide the nucleus of a training body such as I have outlined above. The counsellor's role remains a complex one, reflecting as it does profound yet changing social attitudes. These in turn affect not only the patient's perception of herself but also the agency function and the counsellor's view of her work. It may well
be that the social worker, with her unique combination of practical and theoretical training, can make a significant contribution to the future development of counselling, both as a counsellor and as a teacher.

Owing to the limited focus of this paper, it is not possible to consider closely all the related issues; I would, however, like to comment briefly on two which need further study. First, far more research is needed into the effects of abortion, often seen as pathological by some psychiatrists who by virtue of their profession are seeing a biased sample; there is little consensus however amongst those working in this field as to the psychological sequelae of termination. Much more needs to be known of the early and subsequent medical, social and psychological histories both of women who receive termination and those for whom termination was refused. Horobin\textsuperscript{21} found in the Aberdeen study that ‘few patients regretted the operation; reservations related more to the procedures used, particularly on the second trimester abortions, than to the decision itself and its consequences’. Guilt and fear of stigma remained but were seen as consequences of prevailing social values which would be likely to be lessened as abortion became more widely accepted as a necessary and justifiable act. Second, assessment of the counselling process poses considerable problems of adequately controlled studies and agreed criteria. There are major difficulties in measuring the effectiveness of counselling (Maguire),\textsuperscript{22} but well designed follow-up interviews between the original counsellor and client might give some intimation of the client’s view of counselling and her subsequent reactions to it. I would also like to see a study of terminated women half of whom were counselled, with the remainder used as a control group; clearly they would have to be very carefully matched for other variables. The aim here would be to try and clarify factors arising out of the counselling process.

\textbf{CONCLUSIONS}

As Simms\textsuperscript{23} has shown, counselling is a growth industry, and more skilled workers are urgently needed. Many social workers, like G.P.s, nurses and health visitors, are already concerned in counselling situations; given the opportunity to follow a post-qualification course in counselling they could fruitfully combine with other disciplines to lay the foundations of an effective and creative service.

The professionally qualified social worker with both generic and
specialist qualifications in counselling can contribute to the initial selection and training of potential counsellors. As a first step this would lead to a combination of para-professionals and professionals working together. With the availability of more formalized and specific training, counsellors would be able to move from one area of need to another. Indeed uniform selection and training might lead to greater long-term career opportunities and ultimately to professionalization.

Counselling has arisen on an ad hoc basis largely because of the dearth of statutory provision; its seems good sense therefore to use the existing expertise of the trained social worker and other disciplines as a teaching and training resource to improve the quality of counselling. It is vital that liaison with other relevant agencies should not only be encouraged but built into the organizational structure of the counselling agency; too often links are tenuous and time too rarely allocated for establishing and fostering contact. Agencies could become far more flexible in their use and allocation of time for client/counsellor interviews even where this might be detrimental in terms of overall cost-effectiveness.

Because of the repetitious nature of the presenting symptom and the constant emotional demand of the work it would seem advisable that abortion counselling in particular be undertaken either on a part-time basis, possibly as part of a comprehensive pregnancy advice service, or as one facet of a social work or other counselling commitment.

For convenience only counsellors throughout have been referred to as female.

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REFERENCES

3. Lane Committee Report, op. cit.
7. Ibid.
10. Ibid., Vol. I, Table 12, p. 81.
11. Recent contact with the P.A.S. elicited the information that potential counsellors now work a minimum of 4 sessions with a senior counsellor present; and there is a 3-month probationary period. Less than one per cent of clients are specifically invited for follow up, of these one-third attend. No formal referral systems have been adopted.
20. Sutherland, J. D., op. cit.