

# Curbside Consultation

## Counseling Patients with Unintended Pregnancy

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Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous. Send scenarios to [afpjournals@aafp.org](mailto:afpjournals@aafp.org). Materials are edited to retain confidentiality.

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### Case Scenario

A 23-year-old woman presented to my clinic with an unintended pregnancy. It is her second pregnancy. She has a toddler at home by a different father who is no longer around. The patient works in the same building as the current father. He does not know she is pregnant, and she says he recently threatened her. Because of this intimidation, she does not want him involved in her child's life. She is considering adoption for her current pregnancy. What are some techniques for counseling women with unintended pregnancy, and how should I counsel this patient?

### Commentary

Nearly one-half of all pregnancies in the United States are unintended.<sup>1</sup> Risk factors for unintended pregnancy include limited access to contraception, less than a college education, poor social support, age between 20 and 24 years, and black race.<sup>2,3</sup> Family physicians are often the initial medical contact for women with unintended pregnancy. Pregnant women have three options. They can carry the fetus to term and raise the child, carry the fetus to term and place the child for adoption, or undergo an induced abortion. Although the list of choices is short, the decision can be very difficult. Several principles can aid physicians in providing quality care.

### PREVISIT

Unintended pregnancy can present ethical and moral challenges, not only for patients, but also for their families and the physicians caring for them. It can bring the patient face-to-face with issues such as abortion, teenage pregnancy, and single parenthood. Although physicians have a right to withdraw from cases that raise personal moral conflicts,<sup>4,5</sup> office visits are not an appropriate platform to argue the morality of one choice over

another. Physicians with moral opposition to specific therapies should have referral processes in place, whether to colleagues or to outside sources. Importantly, ethical care includes timely and affordable care. Referrals should not be made to facilities that place undue burdens on patients, such as long wait times for appointments, and long-distance traveling should be avoided when possible. Patients deserve care that is unbiased and meets established medical standards. Specifically, they should generally not be referred to crisis pregnancy centers or pregnancy resource centers, which frequently use manipulative tactics and deliver biased and medically inaccurate information.<sup>6</sup>

### INITIAL INTERACTION

Unintended pregnancy is not synonymous with unwanted pregnancy. About 60% of women with unintended pregnancy carry the fetus to term and raise the child.<sup>7</sup> Making assumptions about the intentions of the mother is a common pitfall. Do not assume, for example, that any woman who is married desires the pregnancy or that any single woman's pregnancy is unwanted. Physicians can approach counseling with a sympathetic, nonthreatening tone, realizing that unintended pregnancy causes stress and anxiety for many women. A neutral question like, "How do you feel about the pregnancy?" should be used as an alternative to statements like, "Congratulations!" or, "Are you happy about the pregnancy?"<sup>8</sup> Other questions, such as, "Do you know what your options are?" or, "What are your thoughts about parenting/adoption/abortion?" can help the physician further assess the situation.<sup>9</sup>

Inquiring about a patient's social support system can identify women who may need additional resources. Women can be asked who knows about the pregnancy, what the

reactions have been, and whom they may tell in the future. Questions about intimate partner violence should also be standard, because patients who experience abuse before pregnancy remain at risk during pregnancy.<sup>10</sup> Knowing the patient's social dynamic can reveal whether she is at risk of coercion from the father or from other family members or friends. It should be clear to the patient that, although others may be affected, it is her choice to make, and she should not be forced into a decision. Adolescents should be asked whether their parents have been informed, not only to assess their support network, but specifically if abortion is being considered, because most states require parental consent or notice for minors.<sup>11</sup>

Close follow-up can be useful for patients who have not made a decision or who need time to process or gather more information. Ensure the patient knows that follow-up is always available and that she can change her mind during the course of pregnancy, with the caveat that choosing abortion may require more time-sensitive decisions.

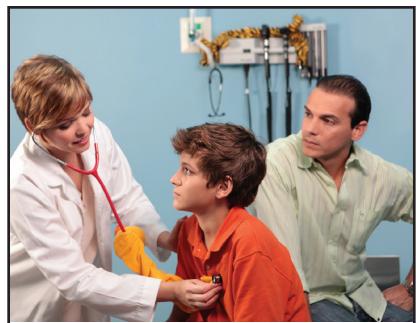
#### OPTIONS COUNSELING

Physicians are not only responsible for providing medically accurate information, but also for practicing nondirective counseling. This can be challenging if the patient is exhibiting a pattern of poor or questionable decision making. Frustration with the patient's prior choices and a mistrust of her ability to make sound decisions moving forward are a form of objective countertransference.<sup>12</sup> Recognizing that many reasonable persons can experience these feelings will help temper negative emotional reactions.

Although physicians help patients make informed decisions, it is likely that most patients enter the encounter having already made a decision.<sup>13</sup> Some women may not desire further information, particularly when they have chosen abortion. In one study, only 18% of women answered "yes" to the question, "Would you value further discussion about abortion?" Additionally, answering "yes" to the question, "Are you certain that you do not want to continue this pregnancy?" had a high positive predictive value that the woman would complete the abortion.<sup>14</sup> Still, physicians are responsible for ensuring that patients are making informed decisions. By probing for the reasons a patient has chosen an option, the physician can clarify misconceptions, offer additional resources, and provide suggestions to appropriately plan during the course of pregnancy.

Options counseling is also an opportunity to discuss prevention of unintended pregnancy and sexually transmitted infections in the future. Discussion of contraceptive options should be routine for women with unintended pregnancy. In the case of adoption, or for women who plan to raise the child, this conversation can reasonably be postponed until later in pregnancy. For women who choose abortion, the initial interaction may be the only opportunity to provide or prescribe contraception for future use or to arrange follow-up for longer-term options, such as long-acting reversible contraception or permanent sterilization.

A sound approach to the patient in the case scenario above would include assessing her values on alternative options to adoption, recommending resources for all options with an emphasis on adoptive resources, and most importantly, gaining a clear picture ►



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of her familial and social support network. Paternal rights in situations of potential domestic abuse can be difficult to navigate. If available, a practice's legal counsel is a valuable resource for determining whether the patient has an obligation to inform the father or if any legal action may be needed to protect the patient's wishes.

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