The Three Tensions

An Optimization Tool innovation for Abortion-Minded women.

COMPASSCARE
ERASING THE NEED FOR ABORTION

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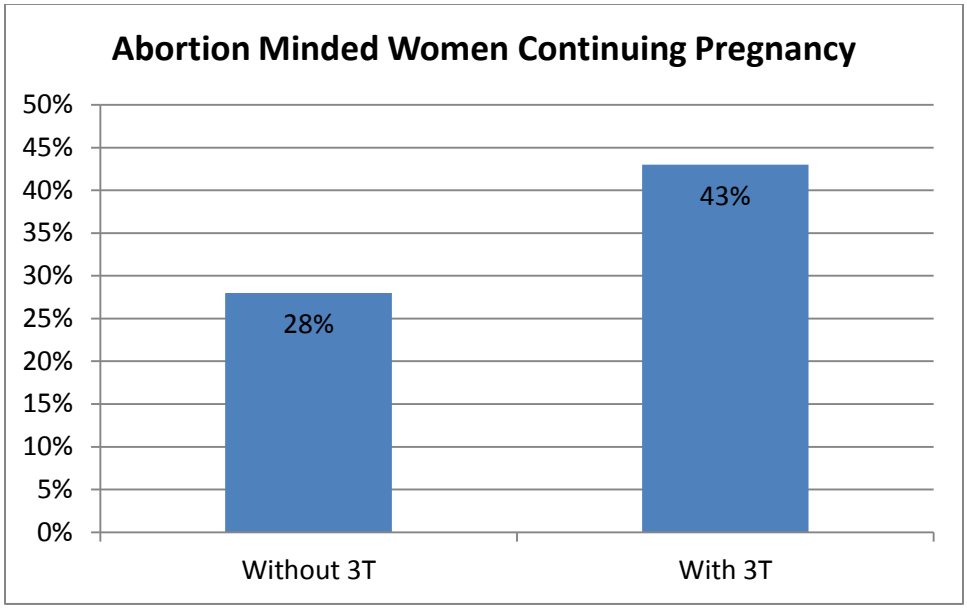
Introduction

CompassCare has a decade-long history of effectively reaching and serving abortion-minded women in Rochester and across the U.S. Early in 2013 we noticed a drop-off in effectiveness with the most abortion-minded group of patients. By the beginning of 2014 only about 28% of our abortion-minded patients in Rochester were continuing their pregnancies, well below our tolerance range of 45-65%. Something had to be done.

Our recognition of this downward trend coincided with the introduction to the concept of the three Tensions research funded by the Vitae Foundation. After careful analysis of the research, CompassCare developed new scripts and steps for the patient service process. Upon implementation of this innovation, effectiveness with abortion-minded patient went back up to 43% in only three months (see Figure 1). That was more than a 50% increase in effectiveness with the most at-risk women! Bottom line, 50% more women choose to have their babies, and the effectiveness rate is holding!

The remainder of this document will discuss the details of the Three Tensions innovation, and address some common questions surrounding its implementation.

Figure 1



The Three Tensions

The Vitae Foundation funded research in 2011 by the Right Brained Group which evaluated how women facing unplanned pregnancies make the decision to have an abortion or carry to term. An analysis of this research revealed that there are three primary internal tensions that women at-risk for abortion experience.

1. My Life vs. the Baby's Life
2. Bad Life vs. No Life
3. Shame vs. Guilt

Every woman has at least one tension, often multiple. Typically there is one tension that ultimately drives her decision.

The **My Life** tension is the most common, at least in the northeastern United States. Women experiencing this tension feel as though someone must die, either themselves—their life as they want it or planned it—or their baby's. To put it simply, if the value of the baby's life is perceived as more significant than her own life, the mother will choose to continue her pregnancy. If her own life is perceived as more valuable, she will abort. This could be the single woman who is finishing college or beginning her career; it could be the married mother who already has the two children for which she planned.

The **Bad Life** tension stems from a twisted sense of compassion. Women fear that they won't be able to provide the standard of living or a stable family for their baby (or their current children) if they continue pregnancy. In a sense, they feel their baby is better off dead than being born into the current circumstances, or having a bad (substandard) life. Women with this tension tend to be women with lower income, and are usually not in a stable relationship with the baby's father.

The **Shame** tension is often hidden behind one of the other tensions. This tension primarily exists with women who have or whose parents have a strong faith background. She feels that she must choose between the private guilt of an abortion, which violates her values or convictions, and the public shame of an unplanned pregnancy. The shame may stem from pregnancy out of wedlock (for those with very strong faith or cultural taboos), or pregnancies that are the result of adultery.

The Innovation

Patient autonomy only exists absent coercion. It is the role of medical providers to reduce or insulate women from coercive pressure in order to ensure her decisions are truly free. Latent within all three tensions are coercive pressures that hinder a woman's true autonomy. CompassCare has developed scripts and tools to leverage the realities of the three tensions to help more women choose to continue their pregnancies. The basic strategy is to *identify* and *clarify* the patient's primary tension early in the appointment, allowing the patient to *confront* the tension within herself after the ultrasound, and finally *offer resolution*. This helps the patient understand the coercive pressures she faces and make a truly free choice about the outcome of her pregnancy.

Identify

During patient intake, CompassCare's Optimization Tool has used the question, "How do you feel about potentially being pregnant?" This is the first time that the patient will begin to open up about the reasons she is pursuing an abortion. To further identify her primary tension, a follow-up question was added: "What makes the idea of being pregnant difficult for you?" The nurse must pay very close attention to the patient's words or take a few notes in order to recall them later in the appointment.

The nurse may follow-up on vague answers with a gentle probing question, such as "Why is that?" *This entire exchange typically takes less than two minutes.*

As the patient responds, the nurse can use the simple, objective tool in Figure 2 to identify the patient's primary tension. When any of the factors in the first column match with who the patient is or what she says, the nurse circles the number in that row. Then, all the circled numbers are summed by column. The column with the highest score will indicate the patient's tension with >95% accuracy.

Figure 2

Tension: / Tension Factor	My Life	Bad Life	Shame
White	1		
Suburban	1		
Urban		2	
In College / Pursuing Career	2		
Unemployed / Poverty		2	
Strict Religious/Cultural Background			1
Pregnancy Result of Infidelity			3
"Bad Timing" or Similar	4		
"Can't support baby" or Similar		4	
"Can't tell relatives/friends" or Similar			4
Sum			

Figure 3 shows a matrix that has been completed for a Pilipino-American patient who lives in the suburbs, who is about to finish her degree and has said that this baby doesn't fit with her plans. Her parents are nominally Catholic. They know about the pregnancy and are disappointed, but will support her no matter what she decides. The father of the baby is out of the picture. Her primary tension is My Life (vs. the Baby's Life).

Figure 3

Tension: / Tension Factor	My Life	Bad Life	Shame
White	1		
Suburban	1		
Urban		2	
In College / Pursuing Career	2		
Unemployed / Poverty		2	
Strict Religious/Cultural Background			1
Pregnancy Result of Infidelity			3
"Bad Timing" or Similar	4		
"Can't support baby" or Similar		4	
"Can't tell relatives/friends" or Similar			4
Sum	7		1

The tension factors were specifically selected and correlated for the northeastern U.S., and other regions with similar cultural dynamics. For an in-depth look at developing a similar matrix for other regions, an addendum to this document is available upon request.

Clarify

Upon initial identification of the patient's primary tension, it is helpful for the patient to hear clearly what her primary tension is. The nurse will take one additional minute to clarify that tension with the patient, by repeating the patient's words back to her using the following script outline:

> *So would you say that…*
>
> [My Life] *Being pregnant right now conflicts with the plans you set for your life?*
>
> [Bad Life] *OR Your current financial state means you feel unable to adequately take care of a baby?*
>
> [Shame] *OR You're scared to tell your parents because of how they would react?*

The nurse will choose the two tensions that best fit the patient's situation, and give the patient the choice between the two. For the example illustrated above, the nurse might say, "So would you say that being pregnant right now conflicts with the plans you set for your life? Or are you mostly afraid to have disappointed your parents?"

Clarification is an essential step in the diagnosis process. Without an accurate diagnosis, the medical provider cannot effectively protect the patient's autonomy and insulate her from the coercive pressures that threaten it. At this point early in the patient's appointment the clarification process also accomplishes two additional objectives. First, if there are other issues that the patient has yet to bring up, this affords her another opportunity. Second, it communicates to the patient that her nurse is actively listening to her and wants to understand her, thereby building rapport.

Following clarification, the nurse maintains leadership of the appointment and transitions to the next step with the following script:

Ok. We can definitely help you with that. The first thing we need to do is get a urine sample for a pregnancy test. If it's positive, I'll have a few questions about your health, and we'll do an ultrasound exam. After that, we'll talk through your options.

Confront (Intensify)

Following the ultrasound exam, the patient is most open to the reality of her baby's life. The nurse uses the following script to shed more light on the tension that the patient is experiencing, and allow her to confront the decision that she is truly making. A heightened level of moral tension is a positive, because patients with more tension are more likely to choose positive outcomes. This is a critical step in the medical provider's ethical obligation to insulate the patient from coercive pressures.

1. *How are you feeling about what you saw today?*

   Wait for answer and draw out her underlying thoughts. The question, "Why is that?" is particularly helpful.

2. *Earlier you mentioned that what made the idea of continuing your pregnancy difficult was…* (refer to patient's specific comments at intake.) *It seems there's some tension you're feeling and it's pulling you in two different directions. It's important to get a clear picture of what you're dealing with in order to make the wisest decision. What is pulling you in the other direction? (Why don't you want to have an abortion? OR Why do you want to continue your pregnancy?)*

   Here it is very likely that a patient will respond with something related to her belief that abortion is wrong, or something related to the life of the baby. This is a significant moment, where she often finds herself speaking words aloud that she never thought she would say. Give her a minute to wrestle with that. Again, the question, "Why is that?" or "Why is that important to you?" can help her further explore and turn up the heat on the internal tension she feels.

3. *You have these two tensions you're dealing with*. Name the tensions again, holding one in each hand as if weighing them (i.e. your life as you planned it vs. your baby's life right now). *What you want to consider then, is which of these two issues carry the most significance for you.*

   Give her time here. Do not require an answer. Often she is in a state where she needs some time to consider things further, which is exactly what you can offer her next. Remember, time is the friend of good decisions.

4. *It seems that you're feeling pressured by your circumstances to make a decision that is in conflict with what your heart is compelling you to do. Making such an important life decision contrary to your own heart's belief has the potential of being very detrimental to you.* (Here

you can sight statistics regarding the emotional impact of abortion from CompassCare's Abortion Brochure.[1] "Women who have abortions increase their risk of an adverse mental health diagnosis by 81%."[2])

5. Finally, give her permission to consider her decision. *It's important to take some time and carefully consider your decision. Can we agree to take a strategic delay, take one week to step back, breathe a little bit, and think things over?*

Offer Resolution

The patient is experiencing a high level of tension, and feels caught between two options, neither of which she is comfortable with right now (abortion and parenting). This is the perfect opportunity to present adoption. Because adoption has negative cultural connotations, we avoid the word *adoption* in beginning of the script.

1. *There is an option we should consider that allows you to continue your pregnancy as well as continue your current plan for your life AND provide a way to bless a young couple unable to have children of their own.*
2. Present the "10 Questions" brochure from Bethany Christian Services.
3. *What are your thoughts/feelings about this sort of arrangement?* Listen. Probe. Get to the "why" behind any objections and refute misconceptions with evidence.
4. *Making an adoption plan to provide a loving home for your baby is very flexible. You can choose a plan that allows you to have contact with your child or no contact at all. Choosing to make an adoption plan shows a great deal of maturity. It can be a very responsible, loving parental decision, because you're choosing to give your child the very best of life possible.*
5. *If you're considering this option, I'd encourage you to contact Jennifer of Bethany Christian Services. Her contact info is on the back of this brochure.*
6. *Do you have any questions about your adoption options right now?*

There are several benefits to placing the adoption presentation after the tensions discussion. First, patients are much more open to the conversation than they are at the start of the appointment. Adoption now becomes a more meaningful way of relief from the tension she feels—a source of hope, rather than a source of fear and complication. Second, and perhaps more significantly, the fact that adoption provides a way to achieve both sides of her tension (especially for My Life and Bad Life cases) holds the patient accountable. She can no longer justify an abortion to herself by saying "I had no other choice."

Following the adoption presentation, the appointment continues with the Personal Resource List and the Gospel Presentation.

[1] http://www.prcoptimizationtool.com/store/products/abortion-brochure-bundle-of-100/
[2] Coleman PK (2011). Abortion and mental health: Quantitative synthesis and analysis of research published 1995-2009. Br J Psych; 199: 180-6.

Common Questions

Why did you use these particular factors to determine tension?

For example, why is 'white' in your list but not 'black'?

The simple answer: math. For a detailed description of the process for developing the Tension Matrix, an addendum to this document is available upon request. The specific factors that correlate with each of the tensions may vary based on the culture and demographics of each service area. For the Rochester tension matrix, we found that being white was correlated to a My Life tension, while being of another race did not correlate specifically with another tension. Living in the city (urban) was an even stronger correlation for a Bad Life tension.

Is this innovation a return to client-centered counseling?

The Optimization Tool has always been a problem-centered Linear Service Model. This sounds a lot like the counseling we used to do in a client-focused Global Service Model.

It is easy to understand why this innovation, at first blush, can seem like client-focused counseling. However, the conversational elements introduced with the three tensions innovation are tightly scripted and designed around diagnosis, specifically helping the patient diagnose the mental, emotional, and spiritual conflict that has her feeling that abortion is her only way out. As stated in the Medical Pregnancy Resource Center Code of Conduct,[3] "All patient care team members including non-medical staff must be dedicated to seeing the patient as a whole person by understanding a patient's past health history, current socio-economic circumstances, personal beliefs, and future health goals." By exploring with the patient the internal and external pressures that are pushing her to abort or continue her pregnancy, we are merely fulfilling our ethical obligation as medical clinicians to insulate her from coercion and protect her autonomy.

It may be helpful to recall the two features which primarily distinguish a Linear Service Model from a Global Services Model: (1) the nurse drives the service encounter, not the patient; and (2) the services are provided in the same way with each patient, for purposes of accountability and measurability. For more detail on these distinctions, see our Benchmarks for Success[4] (PDF) white paper.

Both distinctives are maintained in the three tensions innovation. The nurse maintains leadership of the conversation at all points, and serves each patient the same way using predetermined questions and scripts. How each patient answers and how each nurse follows up on those answers will vary. That latitude has always been a part of the Optimization Tool process, which includes several "How do you feel…?" questions.

[3] http://www.physiciansforreproductiverights.org/medical-prc/prc-code-of-conduct/
[4] http://www.prcoptimizationtool.com/wp-content/uploads/2012/07/Benchmarks_for_Success_08.21.07.pdf

Unfortunately, it is possible for a nurse to revert to a talk-therapy styled conversation in those areas of latitude. That is why it is essential that pregnancy center personnel are appropriately trained and held accountable to avoid talk therapy, and instead engage an ethical and guided diagnostic process.