THE CREATION AND IMPLEMENTATION OF A MARRIAGE, FAMILY, AND CHILD COUNSELING PROGRAM IN A FAMILY PLANNING AGENCY

A Thesis Presented to the Graduate Faculty of California State University, Hayward

In Partial Fulfillment of the Requirements for the Degree Master of Science in Counseling

By
Randolph Fuller
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ABSTRACT

This study presents a model for implementing the skills of a Marriage, Family, and Child Counselor into Family Planning agencies. The model has been derived from the author's own experiences as a counselor in a Family Planning agency.

This study argues that Family Planning agencies are deficient in their services by not including on their staff professional counselors. This study then illustrates ways professional counselor's services can be integrated into existing Family Planning programs.
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Approved:

Date:

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PREFACE

In August, 1974, I was a graduate student at California State University, Hayward, in Educational Psychology. I had finished the course and field work for the Master's degree in Marriage, Family, and Child option, and I was looking for employment while I worked on my thesis. By chance I drove by a Family Planning agency in Newark and when I saw the sign I impulsively stopped and went inside.

I had heard of Planned Parenthood and I knew that such agencies dealt in population and birth control. Beyond this basic knowledge I knew little or nothing about Family Planning, or the services it provided. I went inside. I told the receptionist that I was interested in learning about her agency, what the services were, and some of the details of their operation. Her supervisor intervened in our discussion and enquired politely about my visit. I told her that I was a Counselor in the area of marriage and family, and that I had seen their sign and decided to come in and enquire about the nature of their services. Either she was very perceptive or I was very obvious because she replied that she did not think there was a job for me in Family Planning as they "only provided birth control services and medical examinations."
I persisted with my enquiries, so she suggested that I might like to talk to the Director. I asked whether the Director would be available in an hour for a brief talk as I had a very busy schedule and my only free time was that afternoon. Actually I had as much time as it took me to find a job. I suspected that the Director was residing in an office behind the wall and if I persisted enough I might get a chance to speak with him. Somewhat to my surprise the supervisor picked up the phone and dialed a Union City number and asked for Nell. She told this person that a Marriage Counselor was in her office looking for work and would like to talk with her. The supervisor said "just a minute," looked up from the phone, and asked me if I would consider volunteering. My immediate reaction was "volunteer for what"? I did, however, want to talk with the Director, especially since she had not immediately said no when the supervisor spoke about me. I replied that volunteering might be a possibility but we would really need to talk about it. I was given an appointment for the following day at the "main clinic" in Union City.

By this time I had decided that if she only wanted a volunteer I would try to arrange this as a field site to finish my intern hours toward the Marriage, Family, and Child Counseling license. In return I would ask for a Clinical Supervisor, either a Clinical
Psychologist or a licensed Marriage Counselor. The Director began the conversation by telling me that for some time she had recognized the need in her agency for a professional Marriage Counselor but she had always lacked the funds to employ one. From this gambit we began upon what became an intense four hour conversation. We explored the agency's needs, what she conceived a Marriage Counselor to be, my responses to her needs, how I thought I could serve her agency, and finally we made some salary agreements. By the meeting's end, contrary to all my expectations, I had not only found a position in my field, but I had actually helped to create a new one. That is to say, when I sat down with the Director to talk about using her agency to collect hours toward my license, the position of Marriage Counselor* did not exist in hers or any other Family Planning agency in the country. By the end of our conversation we had created a position that we both conceived of in the same way, we had conceptualized how the Marriage Counselor would function within the agency, and we had laid a general design for implementing the Counselor into the existing Family Planning services. We had also arranged for a licensed Clinical Psychologist to supervise me.

*The actual position created was "Teen Services Coordinator" since I could not legally be titled "Marriage Counselor" until I received a license from the state.
Since that meeting according to my research the position of Marriage Counselor in a Family Planning agency is unique. This thesis will relate my experience of trying to create and implement a Marriage, Family, and Child Counseling program. I will also make deductions and generalizations from my experiences as to the applicability of a Marriage, Family, and Child Counseling service in similar agencies. In many ways this thesis will read like a narrative, detailing the specifics of how I began a Marriage, Family, and Child Counseling service at Tri-City Family Planning, Inc.
ACKNOWLEDGEMENTS

The author wishes to thank Nell Randall, Executive Director of Tri-City Family Planning, Inc. This thesis owes, in large part, to her belief in the need for a Marriage, Family, and Child Counselor in her agency.

Also, thank you Dr. Dorlesa Ewing, for genuinely "advising" me with this thesis. Any mistakes in the text are due only to my error. The order and clarity of the text, however, is due to your suggestions and corrections.
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Race/Ethnicity of Tri-City Family Planning, Inc., Clientele
Chapter 1

THE PROBLEM

Statement of the Problem

Family Planning agencies, and specifically Tri-City Family Planning Inc. are federal and state supported agencies. They were created to give ready and expedient access to contraception for median and low income families.

Tri-City Family Planning has become, in the seven years of its existence, a resource center to its community for numerous needs, not all specifically dealing with contraception. When individuals and families come to Family Planning for contraceptive services, they often seek help that involves counseling them about their's and their family's behavior. In other words, Family Planning centers are, as a matter of routine, called upon to provide individual, couple, and family counseling of a psychological nature.

To date Family Planning centers have not dealt adequately with this situation in that they have not attempted to meet the counseling needs of their clients. One finds that in Family Planning centers clients are treated with an umbrella approach: they all need family planning counseling. Family Planning personnel do their best to counsel people about their problems. They are
limited, though, by their lack of training (they are not professional counselors) in matters other than contraception. They will attempt to deal with the problem presented them not because they are competent to do so, but because they have not been trained to recognize safe limits for their ability and training. Family Planning staff often feel compelled to at least try to help when they are asked.

This is a hazardous situation both for the public and Family Planning. If Family Planning personnel were trained to deal with the emotional and psychological needs of individuals and families, then there would be no problem. Unfortunately Family Planning personnel are not trained at all in psychological counseling. The average Family Planning staff has had a high school preparation with an on the job training in health matters related to family planning. Unfortunately the only professionals Family Planning agencies hire are doctors and nurses. A lay staff conducts the remainder of family planning business, including counseling needs.

The author has also found that Family Planning does not begin to deal adequately or competently with individuals and families who require counseling for problems other than contraception. Over the past year the author has found numerous cases of individuals being
misguided and even psychologically confused by well intentioned staff who are unaware of their own limitations. This is the problem to which this thesis addresses itself. This thesis argues the need for a trained professional counselor in a Family Planning agency. It also presents how a professional counselor can function in the agency to remedy the situation of untrained personnel performing counseling to the hazard of the client and agency.

Background of the Problem

Family Planning centers came into existence during the late sixties when Congress began to recognize the problem of overpopulation. Congressional appropriations, channeled through state and federal agencies, allowed the creation of numerous family planning agencies throughout the United States.

Congress disbursed family planning monies through the then Office of Economic Opportunity (OEO). Regional OEO offices in turn disbursed funds through Community Action Programs (CAP agencies) and county health departments.

What is now Tri-City Family Planning began as an outreach program of the Oakland Planned Parenthood in Union City in 1968. By 1970 Planned Parenthood withdrew its program, which then became a Family Planning agency
under OEO control and the local CAP agency.

For three years Tri-City Family Planning operated under the auspices of the Alameda County Health Department in conjunction with OEO and CAP. The impact that the Health Department had on Family Planning was to codify its operations according to department standards for public health programs. In essence, the Health Department system called for treating consumers of Family Planning services as "patients" who were seen by doctors and educated by nurses.

Unfortunately this operational approach proved convenient for Health Department administrators but inadequate for the personnel of Family Planning (who were not doctors and nurses) and for the consumers (who were not necessarily patients). Regulations designed for patients with illness and disease proved disruptive and obtrusive when applied to people seeking birth control or related information.

In 1973 Family Planning incorporated and won a direct grant from the Department of Health, Education, and Welfare (HEW). Though this ended control by the Health Department its influence did not immediately cease. Many of the Health Department procedures imposed on Family Planning have taken several years to eradicate. The point that is pertinent to this thesis is that the Health Department began a system that conceptualized
family planning consumers as patients whose bodies needed tending to by doctors and nurses. With the departure of the Health Department went the notion that only nurses could or should inform people about contraception. What has lingered to this day is the notion that the major thrust of Family Planning is to provide medical and health related services which tend to people's bodies.

The consequences of this notion are in part what this thesis addresses itself to: Family Planning has not given adequate attention or recognition to the emotional needs of their consumers, nor have they given adequate recognition or attention to hiring or training personnel who are qualified to deal with the emotional problems of their clients. This thesis describes in detail the daily need for a trained professional counselor to deal with a variety of problems that arise in every Family Planning agency. This thesis also describes in detail how a Marriage, Family, and Child Counselor can function in a Family Planning agency and deal with those problems to the benefit of client and agency.

Operational Definitions
2. Marriage, Family, and Child Counselor - That person
who performs, or holds himself out as able to perform, counseling of a psychological nature for individuals, couples, families, and children. Such persons hold a Master's degree, and are licensed to counsel by the State Board of Behavioral Science Examiners.

3. MFCC - An abbreviated form of Marriage, Family, and Child Counselor.

4. Professional Counselor - A term for an individual who holds a Master's degree in counseling. He may or may not be an MFCC.

5. Tri-City Family Planning, Inc. - Refers to the Family Planning agencies in Newark and Union City California where the author is employed.

6. Family Planning - Refers to a larger context of Family Planning agencies in general.

7. family planning - The lower case form refers to the concept of planning the number of births in a family.

7. sexual dysfunction - The term identifies individuals or couples whose ability to perform sexually has been impaired in some way, either physically or psychologically.

Research Questions

1. Can the services Family Planning provide benefit by a Marriage, Family, and Child Counselor?
2. How can a Marriage, Family, and Child Counselor benefit the service of providing information about contraception?

3. How can a Marriage, Family, and Child Counselor benefit the service of counseling about contraceptives?

4. How can a Marriage, Family, and Child Counselor benefit the service of pregnancy counseling?

5. How can a Marriage, Family, and Child Counselor benefit the service of abortion counseling?

6. How can a Marriage, Family, and Child Counselor benefit the service of sterilization counseling?

7. Can a Marriage, Family, and Child Counselor benefit services for teenagers?

8. How can a Marriage, Family, and Child Counselor benefit a teen rap?

9. Is there a need for a Marriage, Family, and Child Counselor to represent Family Planning for establishing contacts with school counselors?

10. Do teens have the right to confidentiality?

11. Do teens require special sensitivity from Family Planning personnel?

12. Can a Marriage, Family, and Child Counselor working in a Family Planning agency train the staff in effective communication?

13. How can a Marriage, Family, and Child Counselor assess staff training needs?
14. What are the in-service training needs for a Family Planning staff?

15. What criteria should a Family Planning agency consider for hiring a Marriage, Family, and Child Counselor?

16. What qualifications should the Marriage, Family, and Child Counselor have?

17. What approach might an agency take to seek funds for a Marriage, Family, and Child Counseling program?

18. How will a Marriage, Family, and Child Counselor benefit the broadening of Family Planning's services?

Significance of the Problem

Family Planning agencies across the country provide the major public resource for people seeking information and service for family planning and related matters. This fact is especially true for low and median income families who cannot afford the services of private doctors or clinics. To date, the attitude among those in Family Planning about how best to meet the needs of its consumers have produced working models totally oriented toward medical ends. Nowhere is this fact more dramatically evident than in literature dealing with any phase of family planning. The vast majority of family planning literature in one way or another deals with some aspect of medical services, and how an agency should provide
them. The literature accurately reflects the attitudes among those in power in Family Planning organizations: how can we improve our medical services to better meet the needs of the public?

Research, as well as my own experience, has shown that the problems men and women deal with around family planning issues are overwhelmingly of an emotional and psychological nature. Seldom, if ever, can it be shown that men and women are directly affected in their decisions about family planning by the availability of Family Planning agencies. This is not to say that the existence of Family Planning agencies makes no difference, since obviously if no agency existed then neither would a consumer public. Rather the point is that once a Family Planning agency or program exists in a community, what exactly moves people to seek or avoid its services. The predominate answer in Family Planning organizations would be the quality of the health care. This idea is incorrect.

Aside from the research, I think any objective minded person could spend a week in any Family Planning agency, and if that person could have access to the people who come and listen first hand to their stories, he would find they seldom come seeking—or needing—only what a doctor and nurse can provide. Their needs are emotional and psychological very frequently, though they
will not express these needs directly, very often, because they have not been told to or allowed to express them.

The body of this thesis illustrates the psychological and emotional needs of Family Planning consumers. It also points out that there is no one in Family Planning organizations to meet these needs. In the author's opinion, the situation is reaching staggering proportions as the number of Family Planning agencies is rising. The numbers of consumers whose needs are not being met are equally rising. To meet this crisis, this thesis presents what the author considers to be the only realistic and viable means to do so: to include a Marriage, Family, and Child Counselor on the staff of Family Planning agencies.

**Thesis Statement**

This thesis asserts that Family Planning agencies do not include in their services any type of professional counseling, particularly Marriage, Family, and Child Counseling. It then attempts to illustrate and to prove that the service of Marriage, Family, and Child Counseling is a service that is critically needed in Family Planning agencies, and that the addition of this service is viable and practical as well as a professional asset.

Without being able to cite published statistics or articles, the author is nevertheless aware that with
a single exception there are no Family Planning agencies that employ Marriage, Family, and Child Counselors as part of their service programs. The only exception is Tri-City Family Planning, Inc. in Newark, California where the author is himself employed.

Due to the lack of statistics, and the uniqueness of the Marriage, Family and Child Counseling program that the author is developing in a Family Planning agency, this thesis will examine parts of the author's own program to argue its need and viability. This thesis, then, will present how a Marriage, Family and Child Counseling program can be created and implemented in a Family Planning agency by way of the author's own experiences. By way of illustration this thesis also means to argue the difficiency of Family Planning agencies for not having Marriage, Family, and Child counseling programs, and their need to implement them.

As it is understood in family planning literature, by definition family planning refers to the distribution of contraception and related medical services such as PAP smears, plus educational material about contraception. To date, and to the author's knowledge, no one in Family Planning has publicly suggested a need for any type of psychological services in Family Planning agencies. Consequently, no literature exists discussing possible needs for Marriage, Family, and Child counseling programs.
in Family Planning agencies.
Chapter 2

A REVIEW OF LITERATURE

Introduction

This literature review is intended to be somewhat polemical in nature in that it means to illustrate two points as well as relate the findings of other authors. A central purpose in this thesis is to argue the need for the inclusion of Marriage, Family, and Child Counselors in Family Planning agencies. In the literature review one will find that the need for a Marriage Counselor, and the services he can provide, has been almost totally neglected by those writing in the field. One will also find that the scant literature relevant to this thesis clearly reveals the urgent need for the services of Marriage Counselors in Family Planning. As will be seen, the need is illustrated by omission rather than specific discussion, since no one has written about the inclusion of Marriage Counselors in Family Planning agencies.

Though the literature lacks this specific discussion, the review directs the reader to an extremely important point. For a large segment of Family Planning consumers, their decisions about family planning and birth control have little or nothing to do with the
quality or availability of medical health care or contraceptive information. To the contrary, many (if not most) Family Planning consumers' decisions about contraception are the primary result of their attitudes toward their own sexuality.

The importance of this point cannot be overemphasized. Today, at all levels of Family Planning organizations, services are predicated upon the notion that consumer needs are best served by giving quality medical care and contraceptive information. This is most often provided in the form of doctors giving pelvic examinations and nurses (or others) describing the various methods of contraception. Clearly, as this thesis in part means to illustrate, this is a totally deficient model to meet the needs of Family Planning consumers. People do not seek the specific service of medical examinations from Family Planning, nor do they avoid it. They do, however, seek and avoid help with their sexual growth and maturity, which in part takes the form of medical care. Examinations alone can no more meet the needs of consumers of Family Planning than can an I.Q. test meet the needs of the slow learner who is undernourished.

Sanger et. al. (1931) published the symposium contributions to the seventh International Birth Control Conference held in Zurich in 1930. Today the volume has little but historical significance. As one might expect,
nearly all of the contributions are by doctors, whose writing styles are highly polemical and obtuse; i.e.,

The scourge of abortion is nothing more than the necessary consequence of a lack of birth control, and vice versa, an ideal solution of the latter problem would, by the same means and methods, rid the world of abortion. (p. 175)

The focus of the symposium seems to urge the contributors to pronounce judgments about their notions of birth control and the medical profession.

Wilhelm Reich contributes one article (p. 271) in which he urges individual and public meetings for recipients of birth control because "The mental effect of such community instruction is very great." Reich also urges that special instruction be given the young. Reich, like his colleagues, lends many moralistic prescriptions. Unlike his colleagues, however, Reich finds moral responsibility for the doctors as well as the partient to find enlightened attitudes about sexuality: "It is also necessary morally to aid all those who are still imbued with the official viewpoint that sexual intercourse is permissible only for the production of children." (p. 271) It is not surprising that Reich's viewpoint is not illustrated anywhere else in the symposium.

Berelson et. al. (1965), in a two volume compendium of articles about issues in Family Planning, dramatically exemplifies this field's inattentiveness toward the need for professional counseling among its
services. One article (Hsu) summarizes what the author believes are the personnel needs in a Family Planning organization: 1) administrators; 2) medical professionals; 3) para-professional health workers; 4) non professionals (clerical and volunteer). Neither this article, nor any of the others, ever recognize a need for professional counseling services in Family Planning, though quality service is often mentioned as a goal. These articles hold a priori notions that by providing expert medical services for women seeking contraception, that Family Planning organizations will meet their full responsibilities.

In 1968 the American Public Health Association published a guide for state and local Family Planning agencies. The purpose for the publication was to describe and define what Family Planning meant, both as a concept and as a working agency. In 1968 Family Planning had been recognized by the federal government for only a year as a funding priority. Thus many of the ideas in this publication are awkward or outmoded. For one example, Family Planning is constantly referred to as a service for couples. Today most Family Planning literature reflects a consideration for the individual.

This particular document is especially worth noting because it contains a reference to the possible need for Marriage Counseling in a Family Planning program.
In a section entitled "Program Content," areas of services are enumerated: "And a variety of other counseling services may be properly incorporated in family planning services—for example, social work, cancer detection, marriage, genetic, or religious counseling." (p 74)

One has difficulty accepting the seriousness of this passing remark, but at least the remark is made. At this period in Family Planning history, this book reflects the many who initially conceived Family Planning programs, and their ideas about the nature of services. Since 1968 this slight reference to marriage counseling has been forgotten and neglected. It is of worth to note, however, that the seeds for marriage counseling programs in Family Planning agencies were there from the beginning, if only in a very small way.

The death of counseling and psychological services has been observed in many phases of Family Planning programs and organizations. Pohlman (1969) observes that modern psychological research has revealed much about American's needs and expectations when buying a television, while we know very little about why men and women have children.

Pohlman attempted to fill this void by reviewing the scant research on the topic. He also explored modern cultural notions about child rearing in the light of psychoanalytic theory.
Pohlman never speaks directly to the issue of providing professional counseling services in Family Planning agencies. His book, however, is a testament to the critical need for implementing psychological services into Family Planning programs at all phases of development. Indirectly Pohlman supports the contentions in this thesis by his comments on the "Psychological Affects on the Unwanted Child," on "Marriage Relationships," on "Parents," and on "Pregnant Women." He cites these topics as direly needing the closer attention of psychologists. The question Pohlman leaves unasked and unanswered is: "Who is to deal with these psychological effects?"

Bogue (1970) attempted to answer the question "What are the most serious problems facing Family Planning today." In an international workshop held in Seoul, South Korea, he polled the group for their most pressing problems. He asked for answers according to the following categories: 1) Informing the Public; 2) Provision of Medical Service; 3) Training of Workers; 4) Improving Productivity; 5) Improving Administration.

Curiously, Bogue does not report his results. He only presents his own questions to the group. There is a possibility that under his second category there may have been discussion of counseling needs, but this must remain a guess. The overall theme Bogue presents is one of medical and administrative cost effectiveness as it should
apply to Family Planning. No mention is made about counseling needs, for either training a staff or providing professional counselors.

Among those who have noted the need for psychologists to enter the field of demography, Back (1973) proposed a new research orientation to the psychology of population. His approach includes analyzing the developmental and social psychology of a group, such as a group's attitudes toward contraception and family planning. What is particularly noteworthy about this study is the fact that in 1973 a psychologist needs to propose a new research methodology for the field of population psychology that examines individual attitudes about family planning. Once again evidence comes to the fore that the field of psychology and family planning concepts and programs have for too long remained separate.

Back concludes his paper by defining one of the overall purposes of population psychology: to show how interpersonal and cultural conditions are affected by basic drives (sex). No one would dispute that there is a connection, which again points up the need for counseling psychologists to take up these issues in Family Planning.

A report by the Group for the Advancement of Psychiatry, Committee on Preventive Psychiatry (1973), discusses the social, economic, and humane considerations in population control. The findings in this report concur
with Back and Blacker. That is, a family's psychosocial development as well as individual neurosis is directly related to and affected by the individual's and family's family planning, and by their surrounding population density. The report distinguishes between population control and family planning, the latter being self control freely exerted by individuals to control their family numbers.

The report focuses upon unwanted pregnancies as being one of the foremost precipitating factors toward mental illness in modern society. The report clearly states the need for neighborhood comprehensive health services, easily accessible, and providing a full range of medical psychological services around family planning.

Blacker (1973) examines the current world population crisis from a psychiatrist's perspective. He summarizes many of the findings of social and behavioral psychologists who have illustrated the patterns of human stress generated by dense population. Blacker concludes that demography should be a major concern of psychiatrists since he feels most of the neurosis psychiatrists deal with are the direct and indirect result of over population. He proposes that psychiatrist's join together to find ways and means to deal with over population. Unfortunately, Blacker remains general about his conclusions and suggestions, though one might see where international
Family Planning organizations could be a medium to implement a discussion of his ideas.

Danzinger (1973) contributes his ideas about the training needs of a Family Planning staff. Using an I.E.C. model (information, education, and communication), he urges that full time trainers "must receive a high priority" in Family Planning organizations. These full time trainers should train Family Planning staff around: 1) trainee's job description; 2) task analysis; 3) training objectives fulfillment; 4) evaluation; 5) other principles of learning and teaching.

Danzinger's article is particularly disturbing in that it places total emphasis on research and educational training for a staff while totally neglecting the need for teaching basic counseling skills. When Danzinger uses the term "communication," he seems to mean the ability to relate facts clearly and accurately. As with the article as a whole, his notion of communication reveals a shortsightedness that is amazing--yet typical--among articles about Family Planning organizations. He never acknowledges that a staff "counsel" (i.e., communicate) with clients about birth control, and that communication in this sense of the word also deserves attention when considering training needs.

Hubbard (1973) discusses the need for "Good [abortion] counseling [that] assures that psychological
aftereffects will be non existant, or, at worst, minimal."
Hubbard goes on to say that a counselor for a woman
seeking an abortion should possess a combination of
knowledge and human warmth. Also, "Formal training in
psychology or psychiatry is not necessary; yet this is
not to say that such training lacks value in this area."
(p. 115) What Hubbard does not say is how or where an
abortion counselor should be trained, and trained in what,
if formal training is not necessary.

Kane (1973) conducted a clinical study of 99
single women who had abortions and 33 single women who
completed their pregnancies. In a highly refined methodo-
logical study, Kane found that variables such as knowledge
of contraception, sex education, or availability of birth
control were minimal factors contributing to their preg-
nancy. Instead, they found that emotional factors such
as guilt about sexual activity, and severe acting-out
character disorders contributed to pregnancy in both
groups.

Kane's findings shed a profound light on goals and
priorities in Family Planning. Kane confirms what has
long been suspected, that early unwanted pregnancies are
most often the result of psychological and emotional
problems. Today Family Planning programs direct their
priorities toward medical care and health education to
prevent unwanted pregnancies. Such an orientation completely disregards Kane's findings that the real problems are emotional, not physical and educational.

Monsour (1973) conducted a follow-up study of 20 women who had abortions. They were interviewed about their post abortion experiences to determine any appreciable change in their social attitudes, behavior, or attitudes toward self. The study revealed no appreciable psychological effects during a seven month follow-up, including guilt reactions about their abortions. Over seventy per cent of the women had not been using contraception during that seven month period, even though they knew about it and were apparently sexually active (cf. Kane and Schwartz). Monsour attributes this to what he terms a "conspiracy of silence," or the woman's fears to acknowledge their sexual activity by using birth control. This finding correlates perfectly with Kane's that emotional factors such as guilt about sex are the primary reasons for not using contraception, and thus for becoming pregnant.

Monsour takes his sample from a hospital, but does not say whether these women received any type of counseling before or after their abortions. An important question relevant to Family Planning arises: if these women were counseled following their abortions, and seventy per cent still did not use birth control, then clearly Family
Planning organizations need to reevaluate the effectiveness of their goals and methods for abortion counseling.

Rogers (1973) presents what at first appears to be a definitive study on communication and Family Planning. In his highly technical book, Rogers "summarizes and synthesizes what is known about communication strategies in family planning, . . . and to point out directions for future research." What is pertinent to this thesis is that no one seems to know a great deal about the communication that happens directly between staff and client. Rogers makes no mention of communication in the sense of an exchange between a Family Planning client and staff member during typical counseling sessions. Rogers, like so many, is very concerned about establishing a communication network between international agencies. And perhaps we do need to know how many IUD's are being inserted in India as compared to China. On the other hand, one still wonders about the skill and quality of the day to day communication which comprises the essential core of Family Planning services, about which no one seems to have much to say.

Schwartz (1973) conducted an interesting clinical experiment in which he tested the hypothesis that "guilt generated anxiety raises arousal past the optimum level necessary for efficient recall performance." To translate,
Schwartz had half of a group read sexually erotic passages, and the other half neutral passages. Following the reading, he lectured the entire group about birth control, and then examined them on the lecture. He found that those individuals in both groups whom he labeled as having high sex-guilt anxiety cored the lowest on the examinations. He also found that women retained more information than men.

Indirectly, his experiment gives evidence to the notion that the efficient use of birth control depends upon individual's notions about their own sexuality, and has little to do with the accessibility of medical services, whether good or bad. The question, then, is who will help people to resolve their "guilt generated anxiety" about their own sexuality.

The Secretary of the Department of Health, Education, and Welfare (Weinberger, 1973), submitted to Congress a five year plan for Family Planning services in the United States. The document is divided into two sections. The first section reviews the current research conducted throughout the country on Family Planning. Included in the research findings are cost projections for national and local levels; biomedical research; the role of the Food and Drug Administration in Family Planning programs.

The second section supposedly charts the nature
of Family Planning services, delineating strengths and weaknesses in current programs. The report emphasized the need for more medical staff, especially public health nurses. The report suggests that Family Planning agencies should provide part-time positions for public health nurses as the best method for providing quality care to consumers.

In a subsequent section entitled "Community Services Administration," the report reads: "A program directed to sexually active minors will reach young males as well as females. Counseling and information about family planning methods will be available . . . ." (p. 64)

After declaring the need for counseling and its immediate availability, the report makes no further mention on this topic. How counseling should be made available and by whom is not mentioned. What we find, then, is that the same ambiguity exists at the highest government level as with the lowest agency level: counseling is needed, but what exactly does counseling mean; who will do the counseling; what will be the qualifications of the counselor; etc.

As if in response to Pohlman, Thompson and Newman (1974) conducted a workshop for psychologists in which they attempted to educate the participants about population psychology. Their paper generated by this workshop proposes a post-doctoral curriculum for psychologists to
study in the population field.

Of interest to this thesis is the idea that psychologists are not trained in population psychology, but they should begin to seek this training at the post-doctoral level. The authors do not elaborate the manner in which psychologists will employ their newly developed skills, once they learn them. Presumably, however, either in private practice or in a Family Planning agency, psychologists trained in population psychology would be valuable assets to themselves and to the population they served.

Summary

This review of literature supports several of the contentions which this thesis presents:

1. There exists minimal attention in the field of demography, and in Family Planning organizations, toward the emotional and psychological needs of Family Planning consumers

2. There exists compelling evidence which reveals that women are not concerned with the availability of health services when considering contraception and sexual activity. The evidence indicates that women's choices about sexual activity and contraception are almost exclusively emotionally and psychologically motivated.
3. There exists compelling evidence, both theoretical and practical, to warrant the inclusion of a Marriage, Family, and Child Counselor in Family Planning agencies to meet the emotional and psychological needs of their clients.

This thesis presents a working model for the inclusion and implementation of a Marriage Counselor in a Family Planning agency. It is the author's contention that a Marriage Counselor is presently the only viable means in which Family Planning agencies can begin to deal with a critical deficiency in their organizations. That is, Family Planning does not presently tend to the emotional and psychological needs of their clients. In ignoring this deficiency, Family Planning threatens the well being of their consumers by denying their clients the professional services they clearly need.
Chapter 3

CONCEPTUALIZING A PROGRAM

My first priority for establishing the position of Marriage Counselor was to conceptualize in practical and workable terms exactly how a Marriage Counselor could best apply his skills in a Family Planning agency. Chapter 3 presents an overview of all the services Family Planning provides, and examines, with case illustrations, ways a Marriage Counselor integrates his skills into those services. The idea guiding my conceptualization was that the Marriage Counselor should compliment and function interrelatedly with the existing Family Planning services as well as provide a new and separate service. I, therefore, began with a detailed examination of the services already provided by Family Planning, looked at the problems each service attempted to cope with, and theorized about how the Marriage Counselor could best assist in dealing with those problems.

Determining the Need for a Marriage Counselor

Research Question One:

Can the services Family Planning provide benefit by a Marriage, Family, and Child Counselor?

It was apparent from the beginning that a Marriage,
Family, and Child Counselor could benefit Family Planning in nearly every phase of its clinical services; in fact, it became demonstrably apparent that professional counseling skills in some areas were imperative to guarantee competent professional services.

The services provided by Family Planning are as follows:

- Information about birth control and contraception
- Counseling whether to seek contraception
- Pregnancy Counseling
- Abortion Counseling
- Sterilization Counseling
- Medical Examinations
- Information and Counseling for Venereal Disease
- Sex Education
- Special Services for Teenagers

With the exception of the Medical Examinations (which physicians provide as a contract service at specified times), traditionally in Family Planning all services are rendered by a lay and para-professional staff. Staff training usually consists of word of mouth instruction by a fellow employee who may himself have been taught in the same manner, or who may have attended a two-day conference in pregnancy counseling. Since almost all Family Planning agencies are primarily funded by HEW, and as such operate under HEW charter guidelines (to provide the minimum
professionally acceptable service to the greatest number of people), until recently few agencies have found themselves handicapped for relying upon lay and para-professional staff. In recent years, however, the services of Family Planning agencies have been increasingly sought after by men and women of middle class incomes. This marks a major departure from the original Family Planning programs began in the middle sixties which were aimed primarily at serving the urban poor (Irelan, 1969). Most agencies were funded to serve a target population who exist at the poverty level index, usually an ethnic concentration in a specified geographic locale.

Today, in 1975, very few people conceive of Family Planning as a service agency for the poor, and quite correctly. For example, at Tri-City Family Planning, Inc. the ethnic and economic composition of the clientele are broken down in Table 1.

The importance of these statistics cannot be over-estimated, especially when one considers that when Tri-City Family Planning began in 1968, it was serving a clientele that was sixty per cent Spanish/Mexican heritage, and fifty per cent poverty level income. Since that time the clientele has steadily moved toward the white middle class to where it now constitutes the solid majority.

Returning, now, to the nature of Family Planning's services, one can understand how, when Family Planning
Table 1

Race/Ethnicity of Tri-City Family Planning, Inc., Clientele

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage of Total Clientele*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>1.1</td>
</tr>
<tr>
<td>Spanish/Mexican Heritage</td>
<td>17.0</td>
</tr>
<tr>
<td>Oriental</td>
<td>2.0</td>
</tr>
<tr>
<td>American Indian</td>
<td>.4</td>
</tr>
<tr>
<td>Other Minority</td>
<td>.8</td>
</tr>
<tr>
<td>White</td>
<td>78.7</td>
</tr>
</tbody>
</table>

*Percentage of total clientele at the Poverty Level Index. (Alameda County Census, 1974) 5.4

began, its primary objective was to provide a minimum standard of professional service where none existed before. Much of Family Planning's efforts had to be directed toward outreach work and public education in order to convince the then clientele of their need for family planning. Eight years later, however, no outreach work is needed, and few if any of the Tri-City Family Planning clientele need convincing as to the need for family planning. Consequently, the skills and direction of the Family Planning staff must be reorganized.
in a manner commensurate with the changing needs of a clientele that is entirely different from that with which Family Planning originally began.

The complexity of the problem caused by the significant clientele change and the need for a new orientation in Family Planning staff skills and training is far beyond the scope of this thesis. It should be recognized, however, that by creating the position of Marriage Counselor, Family Planning acknowledges the need for a new orientation for its services. At Tri-City Family Planning the inclusion of a Marriage Counselor and his attendant skills represent the first decisive step taken toward meeting the needs of a predominantly middle class white clientele.

Information about Birth Control and Contraception

Research Question Two:

How can a Marriage, Family, and Child Counselor benefit the service of providing information about contraception?

When Tri-City Family Planning began to operate in 1968, it began as an outreach program designed primarily to contact the Mexican poor in the Union City area. Outreach workers went from door to door, usually speaking in Spanish, attempting to educate women and men about the health and economic advantages of a planned family. The
outreach workers met consistently with fear and ignorance: fear of doctors and especially fear the doctor's examinations would reveal an unknown health problem; also, ignorance about birth control and the idea that you did not have to have a child one after the other. It is not an exaggeration to say that the average poverty level Mexican woman contacted in Union City in 1968 did not know that she could safely or easily control her number of births. The outreach program continued for four years, 1968 to 1972. The workers went from door to door, focusing upon four educational issues:

1. Ill health is the normal result of giving birth to too many children too close together. Medical experience has shown that a healthy woman normally requires about two years to recover physically from pregnancy and parturition.

2. The financial burden of attempting to raise more children than can be adequately cared for usually results in severe marital strain between the partners.

3. Financial strain which results from too many children normally results in undernourishment for the simple reason that family income is not enough to feed and care for the children adequately.

4. When any or all of the above factors exist in a family, children born into these circumstances
often meet with rejection from parents and siblings who regard them as additional burdens who will draw upon their already scarce resources. Outreach efforts proved reasonably successful. By 1971 the clientelle had tripled. The above issues helped more people to seek Family Planning services. One can also observe that in the above issues are found the origins for the need of a Marriage, Family, and Child Counselor. Essentially these four issues argue that the lack of adequate family planning destructively complicates marital and family relationships. What these four issues do not state is that merely giving a woman a diaphragm or a package of birth control pills will not solve her family and marital problems, though they may eliminate another unwanted birth.

In 1971 it became apparent that health and birth control services were inadequate to meet the needs clients presented. In many cases Family Planning reached families after they had already given birth to more children than they wanted or could afford. These families asked for help in coping with the numbers they already had as well as help in preventing further additions. For these families, marital and family strain brought on by financial difficulties already existed. A large number of unwanted or resented children were already displaying anti-social behavior. For families in these circumstances,
Family Planning and medical health care could only prevent worsening of the problem brought on by more children. Little could be done to cope with the existing problems operating within the marriage and the family.

Understanding the need for more in depth family problem solving is one thing; tending to that need is quite another. While it became readily apparent that many families using Family Planning services needed relationship and family counseling, the question remained who would provide this counseling, and in what setting. For several years at Tri-City Family Planning this question remained informal among the staff and consequently no plan or program developed. Staff members more or less took it upon themselves, attempting to advise or intervene in family affairs when clients would make their problems apparent. Outreach workers quickly learned, though, that there was little they could do for the woman who complained to them that her husband never came home on weekends, or that he abused her. The same held true for her adolescent children beyond her control, or her own problem with the fact that she hated them anyway. In like manner, staff in the office learned the hazards of advising the woman who came in for a PAP smear and revealed that she hated sex with her husband because she was afraid of him. Of course some staff members tried to cope with these issues, giving advice and making
suggestions when they thought they could help. Some staff had taken one and two day workshops in Human Sexuality or Pregnancy Counseling, and therefore felt they were the most qualified to speak to these people. And perhaps they were. All concerned, however, recognized that this was a problem, since no one had any specific training in Counseling or psychotherapy.

In most instances the logical alternative to the absence of professional counselors would have been to give clients referrals to the nearest mental health agencies. In the Tri-City area, however, Mental Health clinics are sparse, with long waiting lists and/or high costs beyond the average Family Planning consumer's ability to pay. Also, at the personal level, most of the Family Planning staff felt strongly that referring a client to another agency was somehow contrary to their own efforts of trying to get families to come to Family Planning. Thus staff remained motivated to deal with the problems of their clients themselves, even though they did not possess the education or training to do so.

In the year that I have been employed with Family Planning, I have spent an average of two to three hours per day in active consultation with people who drop by with the expectation that Family Planning can counsel them about their interpersonal problems. Most come for other Family Planning services at the same time, such as
contraception or pregnancy tests. Others come specifically to get help for family and relationship problems. The following case illustrations for each of Family Planning's services will demonstrate the frequent necessity for direct intervention by a trained professional Marriage, Family, and Child Counselor.

Counseling on Whether to Seek Contraception

Research Question Three:

How can a Marriage, Family, and Child Counselor benefit the service of counseling about contraception?

For many who will read this paper, the issue of deciding whether or not to seek birth control may not at first seem very problematical. One might feel that either a woman wants birth control or she does not; and if she does, then all she needs to do is to get on the pill. Unfortunately, for many women, such as those who come from poverty level backgrounds or repressive moral upbringings, the idea of seeking birth control often conflicts with their values. Thus they often distract or avoid Family Planning services. Often enough, for some segments of our population, merely suggesting that a woman decide whether to use birth control stimulates larger problems that are endemic to her cultural, social, and economic background (Irelan, 1969). Attempting to deal with those problems raises difficulties that are
beyond the scope of traditional Family Planning services. And yet, dealing with those difficulties is essential for providing adequate service.

A frequent problem Family Planning encounters in the Tri-City area involves Mexican/American women who find themselves at odds with their cultural surroundings and traditions. For example, for some Union City Mexican women, to use birth control means violating their religious and cultural standards which traditionally espouse that women should be pregnant. Giving Mexican women birth control sometimes offers them options about their lives, how they want to live, and under what circumstances. Often these options their husbands or their families are not prepared to allow them. In family matters that involve structuring roles and authority, especially for lower economic classes, Mexican women are traditionally passive, deferring decisions to their husbands (Irelan, 1969). If a husband is not convinced of the need for his wife to use birth control, then the wife ultimately ends up in a power struggle over who has authority in the family. If Family Planning has given the idea to the woman to begin with, then naturally enough she often looks to Family Planning to settle the matter for her and her husband. While Mexican women rather frequently complain of their marital problems to Family Planning staff, in reality rarely do they ever want advice as much as an ear,
and even rarer do they ever allow any kind of professional intervention in their family affairs. Most often Mexican women who have managed to come to a Family Planning clinic have decided one way or another that they would rather have contraception and the social problems that go with it than no contraception and the babies that go with that decision. Once having opted for contraception, however, they are likely to set firm and abrupt limits as to how far into their personal affairs they will allow Family Planning to go. Usually, no matter how much the hurt or the severity of the problems at home, Family Planning will only occasionally be allowed to listen, and then only covertly and in strict confidence from the spouse.

Ethnic and cultural complications are becoming less frequent due to the impact Family Planning educational efforts have had. Assisting Mexican women and their families with decisions about using birth control constitutes an important but minor portion of Tri-City Family Planning's counseling. A better, or at least more workable, case illustration of how a Marriage Counselor might intervene in a woman's decision making process about birth control involves a recently divorced thirty-four year old woman.

She married at nineteen. She was a virgin, and came from a poor but strict Catholic background. Her husband was five years older than herself, and when she
married him she knew she did not live him—she only knew him for a few months—but she thought she would change. He represented at the time what she thought would be her only chance to get away from a dreary homelife.

Her husband turned out to be impotent, except when he was feeling especially aggressive or when he was drunk. After a few years, the aggressiveness and drunkenness continued, but the sex stopped. They did manage to have three children, one of which was from an affair which her husband found out about several years later. This led to some ugly confrontations and their eventual divorce. This woman came to Family Planning coerced by a girlfriend. The girlfriend told the staff person at the front desk that her friend was too shy to speak for herself, but she was here because she wanted to go on the pill. The staff member felt that something was peculiar about a thirty-four year old being too shy to speak for herself so she was asked to speak with me. As it turned out the woman was not shy about talking but rather she was having a severe guilt reaction to the idea of birth control. She related birth control to her past extra-marital relationship, and also to the criticism her husband and his family had put on her. Her defense against that criticism was to remain absolutely chaste, and she equated birth control with unrestrained sexuality and being an immoral woman. Both labels she had taken and
accepted about herself from her husband's criticism. Fortunately, the woman was possessed of good reasoning capabilities, and in two subsequent counseling sessions she was able to decide that her sexuality need not cease to exist at the age of thirty-four.

This case illustration demonstrates the hazards of contraception dispensation without a better diagnostic procedure than most Family Planning agencies have. No doubt by the persistence of her girlfriend this woman would have eventually gone on some type of birth control pill. Had she not spoken with me, it is most likely that the pill would have been prescribed for her (after an examination) with no notice whatsoever taken about her confusion over sexual identity and guilt associations.

Pregnancy Counseling
Research Question Four:

How can a Marriage, Family, and Child Counselor benefit the service of Pregnancy Counseling?

Pregnancy counseling is a Family Planning service that is twofold in nature. The first step is to determine whether a woman is pregnant or not. The second is to determine what to do if she is pregnant. Women come to Family Planning after having made an appointment to have a Urine Pregnancy Test. The urine test is run by a Family Planning staff member who has had some basic training in
how to conduct the test efficiently and how to interview the woman regarding the test's results. Usually several staff members are designated for this job. It entails some sensitivity and basic communication skills, especially when a positive test arises for the woman who does not want to be pregnant. The counselor must then tell her the test results, bear with her through her reaction, and try to keep a calm head. At the same time she must be honestly empathetic, and try to counsel her about her alternatives for either keeping or aborting the fetus. This job in itself is not one that requires a trained Marriage Counselor. Planned Parenthood and Family Planning have been providing this service for ten years with few disastrous results. Quite to the contrary, they have been very successful at consoling pregnant women and advising them what they can do with their lives once they are pregnant.

Consolation and advice giving, however (as well as medical referrals for abortions or pre-natal care), are often of limited value for clients whose pregnancy either raises or are the results of family or relationship problems far beyond the capabilities or training of a Family Planning staff member. Two case studies can best illustrate this point.

A fifteen year old girl came to Tri-City Family Planning for pregnancy testing. Test confirmed her
pregnancy. The client opted for an abortion, and a staff member counseled her and then referred her to a hospital with one of its contract physicians. After the abortion, she was supplied with birth control pills from Family Planning. Several months later this same client came back to Family Planning, again pregnant, and again seeking an abortion. When asked if she had been taking her birth control pills, she replied "no." She eventually told the staff that her reason for not taking the pills was that she wanted to be pregnant again because she had been treated so well by the Family Planning staff. To be prized and treated well was apparently such a rare experience in her life that she wanted to have the whole experience again. If at that time Family Planning had had a Marriage Counselor on its staff, while he could not have affected the tragic home life that moved her to seek the dubious consolation of an abortion, had he interviewed her he might have been able to counsel her toward a more positive source of validation and affection. Unfortunately this case example is not the least exceptional. The fundamental pattern, a client who seeks pregnancy and/or abortion counseling as a remedy to a problematical home life, in too many instances returns to that same home life only to find nothing changed. What originally moved the client to seek health services is apt to repeat itself, leaving the client victim to her circumstances and unable
to initiate any change except to seek temporary relief through health services.

Another case illustration involves a twenty year old married mother of one who came to Family Planning for a pregnancy test. The results were positive. I was in my office at the time of the test. The staff member told her the results of her test and the client responded with an aggressive admonition that she wanted the child and that she was glad that the test was positive. The staff member was puzzled about her contradictory reaction and enquired if her husband wanted her pregnancy. She replied that she did not care if he did but that she was happy that she was pregnant. Though puzzled the staff member accepted this at face value and after the client left the staff member related the incident to me. Since the client had already left on the announced note that she was pleased to be pregnant, there was little to be done other than to suggest to the staff member some methods she might have used to make further enquiries. At the time it was also my feeling that this woman was strongly affected by her pregnancy because it might be an issue for contention in her marriage. Thus her aggressive reaction. I explained my thoughts to the staff member and also made some suggestions about either making a follow-up or how she might have consulted with me during the interview. Two days later this same client
called the agency, hysterically crying, and wanting to know how she could go about having an abortion. The staff member enquired why she now wanted an abortion and the client said she did not, but her husband was making her. At that point one could hear her husband yelling in the background. Since I was in the office, the call was transferred to me. After perhaps twenty minutes of talking both to her and her husband, they agreed to come in the next day for counseling. The presenting problem focused on the husband's attempts to coerce his wife into having an abortion, supposedly because she had had an affair with another man and the child was not the husband's. By the end of the first session the woman related to her husband that her pregnancy was by him. The woman had had an affair six months earlier, which the husband was still angry about. He had not yet settled the issue with his wife. By the second session it turned out that the wife wanted an abortion independently of her husband, even though her pregnancy was by her husband. She had been fighting his suggestions in order to have something to throw up at him when they fought, i.e., "you made me have an abortion." The woman did have an abortion, and the couple continued counseling, which focused on their mutual distrusts and insecurities. Counseling successfully separated the previous abortion issue from more significant marital problems. The counseling did not terminate
successfully, however, as the couple dropped out when they were no longer able to dredge up old issue to fight with. Presumably for this couple the prospect of meeting each other as people, and discovering who they really are, became too threatening.

One can easily begin to understand how the onset of pregnancy deeply affects the woman's relationship to her family and partner. Pregnancy counseling involves more than giving empathy and emotional support. When a woman learns that she is or is not pregnant, a counselor must inform her as to her alternatives. Also, he must help her to find the right alternative appropriate for the woman's home and family life, and interpersonal relationships. For most women, whether married or not, experience has shown that an unexpected pregnancy, though initially a shock, usually meets with cooperation, love and understanding even from partners, family, or parents who the woman thought "would kill me if they knew I was pregnant." For a significant number of other women, an unwanted pregnancy can introduce a family nightmare into their lives. These women and their disturbed families need some place to turn where they can receive professional and competent counseling that goes well beyond the scope of soothing feelings and educating the woman about abortion rights. Very few Family Planning staff members will attempt to cope in some way with family and social
complications brought on by unwanted pregnancies for no other reason than because they are the only person in contact with the woman, and there is no one else in their agency who can provide more help than they can. What one finds is a genuine dilemma whereby a staff worker cannot ignore the pain and distress a woman undergoes from uncooperative or punitive families or partners, and yet is untrained and unlicensed to handle the problem.

**Abortion Counseling**

Research Question Five:

How can a Marriage, Family, and Child Counselor benefit the service of abortion counseling?

Abortion counseling is a direct extension of pregnancy counseling. When a woman comes to Family Planning for a pregnancy test, if the results are positive, the counseling staff member will try to first determine whether she wants to continue the pregnancy or not. If the woman cannot decide, she is advised on the alternatives of either keeping or terminating the pregnancy. For instance, if she chooses to keep the pregnancy but has financial difficulties, she is advised as to how she can apply for welfare assistance, what kind of support she can expect, where she can obtain medical care, and so forth. She is also advised that if she had chosen to terminate the pregnancy she could have also applied for welfare to
pay for an abortion. If she is a minor she is told about "emancipated minors," that is her legal right to obtain medical care for her pregnancy without her parents knowledge or consent. The staff member makes every effort to educate the client as to her choices and then to allow her to make her own decisions. If she opts to have an abortion, at Tri-City Family Planning we will provide her with the necessary welfare forms if she wants them, and we will put her in contact with our gynecologist at his private office.

To date this has been the extent of Family Planning services for women seeking abortions save perhaps for much empathic support including crying with the individual when it seems appropriate or the staff member is so moved. As was discussed with pregnancy counseling, the possible family, partner, and social complications that come into play after the client has left the Family Planning center are many, and often well beyond the capability of staff members to deal with. And yet, particularly when a woman opts for an abortion, for whatever reason, how and where to have an abortion is often the least of the woman's problems. Once having made her decision, she must then cope with her family, her partner, the potential disapproval of her peers, her teachers, her religious leaders, and worst of all, her own guilt.
Our own records at Tri-City Family Planning for the past five years show that the average woman choosing to have an abortion is single between the ages of fifteen and twenty-two, with the median age falling to seventeen. Obviously, then, most of these women are teenagers still in school. A subsequent section will discuss teen services in detail. In this section we will focus on the difficulties any woman faces when choosing to have an abortion.

Making a decision to have an abortion almost invariably involves the woman in a confusing evaluation of how others will be affected by her decision, and how she will have to deal with those people. The most obvious other person involved in the woman's decision is her partner: how will he feel about her being pregnant; will he still love her; will he love her more; will he want to help her or leave her; will he want her to keep or terminate the pregnancy? It is almost impossible for a woman to avoid asking any or all of these questions. Seldom is the "other" person limited to the partner as most women have parents or family to whom they want to turn for help. At the same time they do not want them to know they are pregnant or involve them in their private lives. Often this dilemma results in withdrawal at school and home, or in unexplained aggravated behavior which
manifests itself in moodiness or short temper.

When a pregnant woman comes to Family Planning, the counselor is best advised to assume that her pregnancy is complicated by a myriad of problems. He should, therefore, take care to thoroughly explore with the client her background. He will want to know why she can or cannot talk to her parents about her pregnancy. He will want to know what are her fears. Some women fear that others will learn of their pregnancy and still others remain indifferent to the question. Others fear the change in their bodies and show minor concern about others knowing they are pregnant.

Counselors must learn answers to these background questions, but they cannot threaten the clients by appearing to pry. I have found it typical that teenagers fear their parent's criticism more than any other factor about their pregnancy. All they want is to have an abortion and eliminate the evidence. The counselor needs to explore the source of that fear, and how realistic it is. The assumption here is simple. It is always better if the woman can confide in a sympathetic family member. Some women clearly have no sympathetic members in their families. The counselor should explore this question thoroughly.

For a case in point, a mother of a seventeen year old high school student called and wanted to talk to
whomever could advise her. She had discovered that her daughter had been taking birth control pills. She was now afraid that her daughter was pregnant. I talked with the mother who said that for the past month her daughter had been behaving as a recluse from the family for no overt reason, and she was becoming very short tempered when the mother would try to ask her about it. One day when the daughter was at school the mother found in a top dresser drawer, her daughter's birth control pills, where the mother would normally put away some of the daughter's clothing. Later the mother confronted the daughter with her discovery, wondering if the pills had something to do with her moods. The relationship between the daughter and mother was not openly communicative since the daughter had never confided in her mother that she was sexually active or taking the pill. The daughter reacted hostilely to the mother, accusing her of snooping and trying to manipulate her life. The mother in turn reacted defensively, accusing her daughter of promiscuity and violating the standards that she was raised to believe in. At that point the daughter blurted out that she had not had a period in two months and that she was sure her mother could care less since she only wanted to moralize to her about sex. When the mother called Family Planning she was looking for someone to talk with her daughter and perhaps herself to try and help them through some difficult
feelings, especially concerning her daughter's possible pregnancy.

The daughter had left her pills in a conspicuous place where she knew her mother would find them. Though she did not explicitly tell her mother about her pregnancy, she still announced the fact to her. In this case an older daughter had become pregnant and had had an abortion, and this matter was still an unspoken issue that from time to time loomed ominously around family discussions. Everyone knew about the older sister but everyone knew it was too touchy an issue to talk about. All possible reference to the incident was conspicuously avoided. The second daughter was taking birth control pills secretly since she was sure her mother would never approve. She was also experiencing severe guilt about doing so. From time to time she would forget to take the pill, and apparently during one of these forgetful days she became pregnant. When she became aware that she was not having her periods, and that she might be pregnant, she wanted some help and consolation from her family but the issue of pregnancy and abortion was the foremost taboo subject in the household. Leaving the pills for her mother to find and then announcing her missing periods in an accusatory manner after her mother was objecting to her sexuality was her way of telling her family about her situation in as non-threatening a manner as she could manage. In this
case the intervention of a counselor cut short the double message family interplay that was taking place. By explaining to the family their fear to discuss pregnancy or abortion because of the oldest daughter, counseling helped clarify how the youngest daughter was trying to symbolically ask her mother's help while also trying to protect herself against her mother's condemnations by creating the side issue of her mother snooping in her room. Once the mother and daughter understood how they had been avoiding direct communication, they were then able to discuss non-defensively the daughter's pregnancy and the possibility of having an abortion. Eventually the mother took her daughter to have an abortion, and brought her back to Family Planning to resume birth control pills.

Another case illustration involves a fifteen year old girl who came in for pregnancy testing. Test confirmed her pregnancy. The girl indicated that she would keep the child and that she thought she and her twenty year old boyfriend would marry. The girl seemed sincere to the staff member counseling her so she told her that she was glad that she wanted the pregnancy and was planning to get married. The next day the girl's mother came to the center leaving the daughter in the car because she was too embarrassed to come in. I talked with the mother. When the daughter took the news home, she found out that her boyfriend was not anxious to marry
her and that her mother had given her some persuasive reasons for not having a baby. At the time the girl was having much difficulty in school and thought that if she got married she would no longer have to attend school. Upon reconsidering, she decided that an abortion was the best thing for her, but she was now embarrassed to come to Family Planning because a staff member had been so happy for her that she thought everyone expected her to have the baby. This case posed other complications in the form of an absent father and a step-father, both who were openly hostile to adolescent sexuality. This left both mother and daughter afraid of their reactions. In this case two family counseling sessions lessened the step-father's tendency to blame. The mother stopped her tendency to scapegoat her daughter. The boyfriend began to accept his ambiguous feelings; loving his girlfriend but not feeling ready to marry or have a child. The couple also realized that pregnancy was not the best introduction to marriage and that their chances for happiness rested on their continued single relationship until the girl finished school.

Perhaps the most significant manner in which a Marriage counselor can affect Family Planning's abortion counseling service is in helping women to cope with guilt reactions they face both before and after having an abortion. Typically a woman decides to have an
abortion once she concludes that an abortion would be the most rational solution to her unwanted pregnancy. Her rational decision, however, can and often does involve severe emotional trauma. Most often the woman will decide to have an abortion both financially and emotionally, her marriage status, her age, the social handicaps she would face, and so on. For those women who do not have the active emotional support of someone close and whom they trust, there remains unsettled feelings about whether they have acted selfishly for their convenience and disregarded what they "should" have done. This feeling often manifests in post abortion guilt with a strong tendency to either blame themselves or someone who advised them in their decision. One mother sought a counselor's advice because since her daughter had an abortion, which her mother had encouraged her to do, she had become cold and disdainful toward her mother. The girl was seventeen when she had become pregnant and at the time could not honestly determine who the father was. The mother had tried to talk to her daughter several times about who the father was. At the same time the mother had urged that she have an abortion. The girl reacted with guilt feelings about her sex life. She began to look upon her past sex life as promiscuous behavior. Having an abortion began to seem like a means to deny the proof of her promiscuity. At the same time the girl did feel
comfortable thinking she had been promiscuous. Rather than reckon with this dilemma, she was tending to blame the mother for "making" her have an abortion and for demanding to know who the father was. In this particular case neither the mother or daughter came for counseling after several phone conversations. Perhaps they were able to come to some mutual agreement to avoid the issue, or perhaps the syndrome of guilt and blame continued.

Sterilization Counseling

Research Question Sex:

How can a Marriage, Family, and Child Counselor benefit the service of sterilization counseling?

Sterilization counseling refers to both men and women who are seeking surgery that will permanently prevent any possibility of pregnancy. For men the operation is called a vasectomy. This operation entails cutting and tying the vas deferens. The operation, which lasts about half an hour, can usually be done in the doctor's office with a local anesthetic. For women the operation is not so simple. Women may become sterilized one of several ways, all of which require hospitalization. The least complicated surgical method of female sterilization is called a tubal ligation, or "having your tubes tied." This surgical procedure is always performed in a hospital and can be done one of
several ways. Essentially it involves cutting and suturing the fallopian tubes.

When a client comes to Family Planning seeking sterilization, he or she is first given an appointment for counseling. Very few Family Planning agencies have the on-site facilities to perform sterilization surgery. Consequently, counseling should result in a medical referral to a clinic or private physician well known by the agency for performing sterilization surgery. Before a client receives this medical referral, usually as per an agreement with the physician or clinic, the client will have been counseled to the satisfaction of the Family Planning referral agency that he or she has sound judgment and mature reasons for seeking sterilization.

Sterilization counseling does not necessarily require a trained professional. A mature staff member who receives competent supervision and who has received some basic training in communication skills can usually do a good job. Essentially the counseling consists of learning the client's motives for wanting to be sterilized and advising him or her about facts and contingencies that the client may not have considered.

The typical client or couple seeking sterilization is in their mid-thirties to forties, and has had two or more children. Typically they feel their child producing days are over, and thus, there remains no good reason to
continue the "hassle" of birth control. Counseling usually consists of helping them decide which partner will have the operation, and helping them to double check their feelings that they are doing the right thing. Not so typical, but common, is a client or couple who may be in their twenties, thirties, or forties, seeking counseling for the same announced reason as above. A brief session often reveals that they are sexually dysfunctional and have now scapegoated their sexual problems onto the issue of "fear of pregnancy" or the "mess of birth control." Sometimes lay staff counselors uncover these latent primary motivations of dysfunctional couples seeking sterilization. What to do for the couple once you have uncovered the latent motivation is quite another matter, usually beyond the competency of a Family Planning staff member. If the staff member is unaware of his lack and need for further training he will continue to talk to the couple relating in whatever manner he deems best. The probability that the staff member will add another complication to their dysfunctional relationship is high. The staff member who becomes aware of the couple's need for relationship counseling beyond what he can offer may refer them to a Marriage Counselor. A better alternative would be to call into the session your own staff psychologist or Marriage Counselor as a co-counselor. He could
then in subsequent sessions, if they were deemed necessary and the client(s) agreed, either supervise the staff member or handle the case himself.

As a case in point a thirty-seven year old successful businessman came to the Family Planning agency wanting a referral to have a vasectomy. I saw the client. He was a very trim and youthful looking man, poised and seemingly very mature in his judgment. He told me that he had talked extensively with his wife and they had concluded they both wanted him to have a vasectomy. They had two children, a girl and a boy. He said "they" did not want any more children, under any circumstances. He also stated that he had decided that it was best that he be sterilized rather than his wife since the operation for him was simpler and less costly. When I asked how his wife felt about this he replied that at first she had been against the idea but she later agreed. By this he might have meant that his wife had preferred that she have the operation, but further questioning revealed that up until a short while ago his wife had been completely against sterilization for either of them. With this fact established, what began as a model case for sterilization gradually emerged as a dysfunctional couple who had in desperation turned to sterilization in the hope it would alleviate their sexual and marital difficulties.

The client eventually revealed that for the past
five years his sex life with his wife "had been pretty bad" because his wife had had a very difficult pregnancy and delivery with their last child and she now very much feared having another. His wife had been raised a Catholic, an upbringing which had left her with a negative and ambivalent attitude about using birth control. She had in the past five years tried a diaphragm, an intra-uterine device, foam, and the pill. In each case she found either discomfort or annoyance with the method, and had moved onto something else. Over the last five years she had run out of methods and was now using nothing. For this couple using nothing meant they were having little or no sex.

When the husband originally suggested that he have a vasectomy, the wife resisted on the grounds that they might want some more children, even though a vasectomy would alleviate her fear of pregnancy. During the session the husband clarified to me that his wife feared pregnancy and delivery, but very much loved and cared for their children. The fact that she could not use birth control methods induced guilt: both that it caused so many problems in her relationship with her husband, and also she wondered whether having children was her way of placating her Catholic upbringing. That is, children were evidence that at some time she had not used birth
control.

As it turned out, I did refer this man for a vasectomy, but only after we had clarified his reasoning for having one and exactly what he hoped to achieve by it. In this case as it turned out, the couple's notion that they did not want any more children was sincere, even though they hoped for fringe benefits from the operation, and even though they had a myriad of secondary motivations for wanting sterilization. The counseling consisted mainly of helping them to understand how their sexual incompatibility had evolved, and the high hopes they were placing on the operation to change their sexual behavior. Since the couple never asked for marital counseling, further sessions were not scheduled.

Teen Services and Sex Education

Teen services includes all of the services described above, which is to say, all of the services Family Planning provides are included. Tri-City Family Planning, primarily due to my reorganization, distinguishes services rendered to teenagers as requiring special efforts to insure confidentiality. Also, Tri-City Family Planning operates under the assumption that providing family planning services to teenagers obliges special educational efforts as the only responsible course of action. Since Teen Services actually consists
of a major topic in itself, and relates inextricably with the role and services of a Marriage, Family, and Child Counselor, this discussion will be given to an entire chapter.
Chapter 4

TEEN SERVICES

With the acceptance of the position of Professional Counselor in September, 1974, I also accepted conjointly the position and title of Teen Services Coordinator. During the original negotiations with the director it became obvious to both of us that as a trained counselor I possessed skills that could be applied to their existing agency structure. Also, had this not been the case, it is unlikely that the position of Marriage Counselor would have proven viable. Once having established a clear and definite need on the part of Family Planning for more efficiently coordinated Teen Services, the Director and I were able to assign that task to me in conjunction with Marriage, Family, and Child Counseling. In this way we established an immediate working position that dealt with existing problems. Thus the new position had a focus toward old and new Family Planning duties.

It is important to realize the political and practical expediency for assigning a dual role and title. When I began with Family Planning no one could say with any certainty what the outcome would be for attempting a Marriage, Family, and Child Counseling service. While the Director—and I after a short while—could clearly
see the need, in the beginning it was very difficult to visualize beforehand how the public would respond. Also, we were uncertain how we would like them to respond. We were uncertain how to advertise the new service, what fees, if any, to charge, and so forth. Given the fact that this much uncertainty existed about the final direction a Marriage, Family, and Child Counseling Program would take, it became necessary to examine ways in which a Marriage Counselor could best apply his skills to already functioning programs.

At this time Tri-City Family Planning did not have a Teen Services Coordinator, nor did they have any firmly established policy or procedure regarding their services toward teenagers. There existed a separate clinic for teenagers, but since there was no one to oversee teen services most of the operations for teens only were poorly managed. The Director was too busy directing three agencies to attend to the teen services problems. The supervisors were too busy dealing with personnel matters. So the staff were left to deal with teens as they came in, with little idea about policy for the many problems that would arise.

Policy for Teen Services

Research Question Seven:

Can a Marriage, Family, and Child Counselor benefit services for teenagers?
In September, 1974, Tri-City Family Planning was operating three agencies, one in Fremont, Newark, and Union City. I was able to assess that teens comprised a large portion of the clientele (later I was to find that teens comprised the majority of the clientele). Teens were being asked to comply with different rules at different agencies, and then those rules would change from one week to the next, and no one could say why. Consequently the first order of business became to create standard procedures for all three agencies.

Two of the agencies were asking, but not requiring, teens to attend a once held weekly rap session to discuss birth control methods. The third agency did not ask teens to attend anything. Again everyone felt that teens ought to attend some sort of meeting, but no one was sure why, other than Planned Parenthood held weekly teen raps that they asked all of their teens to attend. So I found a procedure that was only sometimes implemented, and for the expressed reason that someone else was doing it, and therefore it was appropriate.

I eliminated the rap at one of the centers since as best as I could determine the average attendance fell between zero and four clients per session. Also, the person doing the rap was discussing sexuality with the teens, but had never attended a course or training session on any topic remotely relating to human sexuality. In
fact the person's expressed qualifications for doing the rap—a phrase that I was to encounter time and again—was that she was a woman relating to women. I then established a rap to be held once a week at one of the centers, and any and all teens who wished to receive birth control from Tri-City Family Planning had to first attend a rap session.

The rap was made mandatory for all new teens to attend for three reasons. First, I sought to consolidate the control of teen services at a single center. At this same center we would hold a once-a-week afternoon clinic in which teens only could attend. I wanted to consolidate the services for administrative efficiency, but also to be able to personally direct all of our educational attempts with teenagers. Finally, I made attendance at the rap mandatory for all new teens as I saw (and still see) an urgent need for effective non-judgmental education regarding teen sexual behavior and pertinent social issues. It has been my position from the beginning, that while a teen has the right to have birth control if she or he desires it, it is the responsibility of the dispenser to provide a professionally sound educational program which promotes and explores responsible behavior and mature judgment in human sexual relationships. For most teens who attend, the rap will provide the only instance in their entire lives where
they can sit with a group of people for the expressed purpose of discussing human sexual activity. For this reason alone I felt strongly that the rap deserves meticulous planning and implementation.

Numerous policy changes were made. All focused toward the notion that all of the services should be consistent between three centers, that teens should be guaranteed confidentiality the same as any adult, and that teens require a special sensitivity in dealing with them, particularly avoiding any hint of adult condescension. Some of the policy changes will be discussed below.

The Teen Rap

Research Question Eight:

How can a Marriage, Family, and Child Counselor benefit a teen rap?

Once having established the policy that all teens had to attend a rap once before receiving services, I then had to develop a rap format. I decided to conduct the rap myself each week with a female co-leader. This in itself represented a major change from the previous notion that Family Planning and sexuality belonged to women only. I instructed all staff to make a concerted effort to encourage teenage women to bring their male partners. A male and female co-leader doing the rap I hoped would model the notion that sexuality and birth
control is a matter of concern for partners, not just for women.

Actually I chose two staff workers to do the rap with me, and each would alternate weeks to co-lead. I began a series of training sessions for the three of us in which we first explored in-depth our own sexual attitudes, experiences, and viewpoints. This proved immensely rewarding for all three of us and successful for my goal which was to make us all aware of our biases and opinions about sex and sexual relationships. Whatever format we were to eventually decide upon for the rap, I wanted to be certain that we expressed what we thought we were expressing, and that we did not give double messages or unnoticed, embarrassed reactions to the group. We continued our self-exploration sessions several times a week for about a month until we knew and were comfortable with each other. That we could talk openly and intelligently about human sexuality before a group, and that we would not give off any double messages, was my primary goal for these sessions.

During this time we also worked out a format for the rap. We decided it could last two hours, once a week. We then agreed upon the following objectives:

- Teens would be encouraged to talk in a directed discussion on the following topics.
  a. The necessity for sex.
b. Masturbation.
c. Parents' attitudes and sex.
d. Sex and drugs.
e. Sexual myths and stereotypes.
f. Sexual concepts of self and others.
g. Sex and peer pressure.

- Teens would be encouraged to talk, but not coerced.
- Teens would listen to a 30-40 minute demonstration on safe and unsafe methods of birth control, and how to use them.
- Teens would be encouraged to bring up their own discussion issues which would be given priority over prearranged topics.
- The theme of the rap is to stimulate teens to think responsibly about sexual matters that affect their lives without making moral judgments.

We then decided upon a method to achieve these objectives. After a brief talk about confidentiality, the hours of the clinic, and excuses from school, we would give to each person a card with a question or statement on it to which they should write a brief reaction. The cards all dealt with the first objective above, such as "Is sex necessary," "Is masturbation normal," or "What should parents not tell their children about sex." After each person had written a brief reaction, for which he was told there was no right or wrong answer, the cards were
then collected and passed back out anonymously so that no one knew whose card they had. In this way we could ask each person to read the question and answer and to make a comment without embarrassment or fear of judgment.

Usually this format resulted in enthusiastic discussions. Teenagers often remarked to me that they liked the rap mostly for its openness, both for what they learned and what they could express without being judged.

After approximately ninety minutes of group discussion around social/sexual issues, we would then give a talk and demonstration about the various birth control methods and how to use them. During this part the leaders did most of the talking but again questions were encouraged. At the end of the rap teenagers were then given appointments to attend Teen Clinic for a medical examination prior to receiving the method of their choice. More than ninety percent of the women did not know there were other safe methods of birth control other than the pill. Even after the rap more than ninety percent chose the pill. We do not recommend any one method during the rap though we describe the side effects and rate of effectiveness for each method.

Most Planned Parenthood and Family Planning centers have teen raps, though most of them focus on methods, how to take them and their side effects, and
few make their raps mandatory for teens to attend. The rap at Tri-City Family Planning attempts to integrate a psychological and a medical approach to birth control information. When I first began at Family Planning I questioned at least a hundred teenage women who were current clients on what they remembered about the rap. Almost consistently the women remembered that it was boring, they did not like being there, and they talked about how to take the pill and "some other things they didn't remember." Whatever had been happening in the rap, for those who attended they took away a somewhat negative feeling and tended to remember only the part on how to take the pill.

With this information in mind, plus my own ideas about providing responsible education for teen Family Planning consumers, I concluded that a "methods rap" was definitely the wrong approach. First of all, I have found that teenage women seldom if ever become pregnant because they do not know how to take the pill. More to the point is that they know about the pill, at least in general, but for a multitude of reasons all having to do with their psychosexual and psychosocial development, they simply do not think in terms of receiving birth control. When a young woman begins to think about getting birth control for herself, she then must admit to the fact that she is sexually active by conscious choice, and that
she must now choose whether or not to become pregnant. For many teenage women this self acknowledgement is threatening and confusing as it often conflicts with values they have been presented with at home. For many of these women sex is an infrequent occurrence that "just happened because I love him." As long as they feel sex is just happening to them, and not something that they themselves are generating, then they avoid contending with psychological conflicts. It is for this reason that I feel strongly that a rap session should deal with the emerging sexual identity of teenagers, their social problems around sexual behavior, and some idea of responsibility for their behavior. Responsibility is taught not by telling someone how to take the pill (though they need to know this), but by urging them to be responsible for their own sexual identity and behavior, and by showing them the personal relevance of being responsible.

Community Contacts for Teen Services

Research Question Nine:

Is there a need for a Marriage, Family, and Child Counselor to represent Family Planning for establishing contacts with school counselors?

A common lack among many Family Planning agencies is their disregard for establishing active contacts and
cooperation with the community, especially the schools. Family Planning has business hours, with four or five evening clinics per month. Since the teen clinic is held on Wednesdays from one to four in the afternoon, and the teen rap on Monday's from three to five, this means that many students will have to miss school in order to receive Family Planning Services. Some agencies deal with this problem by holding their teen clinics on Saturdays, and others by ignoring the problem. I find both unacceptable on Saturdays, and others by ignoring the problem. I find both unacceptable as the former is administratively and fiscally impractical, and the latter is irresponsible. Since most teenage women would rather cut school to get their pills or come to a clinic for an examination, an ethical question arises as to whether Family Planning shares in the responsibility for the students missing school. I hold the position that teenage women are first of all young but responsible adults, and are responsible for their own choice and priorities about attending school. At the same time I feel that Family Planning should make a sincere effort to develop a cooperative plan with the schools to allow students to come to Family Planning without taking a "cut" at school.

When I began at Family Planning, the teen clinic began at 1:00 p.m. and all the teens had to arrive at the
same time. After rescheduling the clinic on the basis of fifteen minute intervals by appointment, some of the women whose appointments fell late enough did not have to miss school. Still others did. At this time I began a plan that I hoped would eventually lead to a contact with officials in every school. Hopefully they would cooperate with Family Planning to allow their students to be excused from school.

From time to time Family Planning is contacted by an enlightened School Counselor or teacher and asked to provide a speaker on birth control. I began to solicit from the schools more opportunities to speak, not just on birth control but related social issues. I usually handled all requests for speakers, and would go myself with one of the rap co-leaders. When at the school we would attempt to meet and achieve some degree of rapport with teachers and counselors. At the same time I was making formal contacts with school officials, mostly School Psychologists and Counselors about our new service of Marriage, Family and Child Counseling. On one occasion, after several months of effort, I was able to arrange, through the assistant Superintendant of a local school district, a meeting with all of the district's Counselors and School Psychologists. At these meetings I emphasized to the school officials the necessity for their cooperation in developing some sort of plan to
allow their women students to come to our services without being penalized at school, or having their parents informed of their absence.

It should not be forgotten that the success of my entreaties with Counselors and school officials was the result of my being a professional counselor. For several years Tri-City Family Planning had been trying, without success, to make contacts with school officials that would result in some cooperative plan to get students from school to Family Planning. Being a professional counselor talking to another professional greatly facilitated my task. It is no exaggeration to observe that most of Tri-City Family Planning's current school contacts are in fact unofficial contacts between myself and school counselors. After about four months I was able to provide for our staff a list that included one or more cooperative school personnel at every high school and most junior high schools in the Tri-City area. These individuals had agreed in their official capacities to allow us to send students from their schools to them, either to have a sympathetic ear or to arrange for them to be absent at a specified time to come to Family Planning.

Teen Confidentiality
Research Question Ten:
Do teens have the right to confidentiality?

According to California law (Civil Code 34.5), minors have legal access to contraception methods which do not require prescription, such as foam or condoms. Methods such as intra-uterine devices and diaphragms which require a physician's care, or birth control pills which do require a prescription, are a matter of legal debate throughout the state. Minors are given birth control throughout the state primarily by the authority of the Welfare Reform Act which was signed into law in 1971 and is contained in the California Welfare and Institutions Code:

> Family Planning services shall be offered to all former, current, or potential recipients of child bearing age, age 15-44 inclusive, and provided to those former, current, or potential recipients wishing such service. Such services shall be offered and provided without regard to marital status, age or parenthood.

* * * * *

Not withstanding any other provision of law, the furnishing of these family planning services shall not require the consent of anyone other than the person who is to receive them.

Since the law requires that minors be allowed Family Planning services without parental consent, it becomes the responsibility of the Family Planning agency to not only uphold the law but to insure that teenagers are given equally confidential treatment as afforded adults. This sounds simple enough but it often involves
some sticky questions.

Most teenagers who practice contraception do so without their parent's knowledge or consent, and most parents would object if they knew their teenagers were practicing contraception. On occasion parents either find circumstantial evidence that their daughter is taking the pill, or they learn from a friend that they think their daughter is going to Family Planning. Often an irate parent will call or come to Family Planning and demand to know if their daughter has been there or is taking the pill. When this happens the immediate question is who will deal with the parent(s) and in what manner. Ideally an agency should have a single person, such as a Teen Services Coordinator, who is clearly designated to handle such matters. Unless the agency has no concern for its public image and rapport with the community, that person should be not only thoroughly versed in the law regarding minors rights to contraception, but he should possess skills and experience in dealing with angry people in crisis situations that involve their family relationships.

For a case in point, one morning a couple came to Family Planning and told the staff worker that their daughter was pregnant, that she had run away from home and that they knew she had been here. They demanded to see our records and to have any information regarding their
daughter. The staff member sent them into my office.

The mother was crying and the father was visibly upset. They told me that for the past year their daughter had become a disrespectful and dishonest person, particularly toward them. They attributed her behavior to the influence of a boyfriend whom they had forbidden her to see. The girl continued to see him, and about three months ago the parents found this out and called the police to pick them both up. The police did, since he was eighteen and she was sixteen, and they both spent some time in jail. Since that time their relationship with their daughter had gone from bad to worse. Then last week their daughter had announced that she was six months pregnant. The parents righteously told me how after "spanking" their daughter they sent her to her room while they decided how they would punish her. The daughter climbed out a window and had not been seen for a week. They had the police looking for her, including a private detective they had hired. What they wanted from me was to know when I had last seen her, and also my cooperation in finding her. At this point both parents broke down and began to cry.

I told them that I did not know if their daughter had ever been to Family Planning but I acknowledged that we would have a record if she had. Also they were under the mistaken impression that their daughter would come to
Family Planning for pre-natal care. I explained that since their daughter already knew that she was pregnant, and for the time being did not need birth control, she would have no reason to come to Family Planning. Still they wanted to see our records. As it turned out, after some questioning on my part, they did not know for sure that their daughter had ever been to Family Planning, but they were guessing in a desperate attempt to learn some clues to her whereabouts. As it also turned out, the parents primary and only concern about their daughter was to get her home so they could punish her for lying to them about her boyfriend and for disgracing them in front of their neighbors by becoming pregnant.

After their motive for wanting their daughter's return became clear, I spoke with this couple for nearly ninety minutes during which they remained absolutely resolute to their position that their daughter deserved punishment, that that was all that mattered, even if their daughter did end up hating them for the rest of their lives, and even if their attitude did result in tremendous emotional trauma for their daughter. After all, they had five other kids for whom they had to teach a lesson.

Admittedly this is an exceptional example to illustrate a teen's right to confidentiality. When I told the parents that if the police were to come to me an
hour later, demanding to know if they had been there, and to see our records, that I would refuse them any information without a court order, they could not understand how I could be so lawless. Apparently this couple felt no more of a need for their own right to confidentiality then they did for their daughter; that is, until for an example I changed the policeman for a curious neighbor. When they thought about it in that light, the couple decided it was time to leave.

As strange as this case was, the appropriate behavior—to safeguard the files of that couple's daughter if she had ever been a Family Planning client—was always clear and easy to follow. A more common but much more difficult example took place the following day.

A mother called and wanted some hypothetical answers to some hypothetical questions about the rights of teenagers and parents. The call was switched to me for about five minutes we talked very abstractly about emancipated minors and their rights to services without parental consent. Then the mother switched tone and told me that she had found on her daughter's desk a form from our agency which confirmed her pregnancy and referred her to a physician for an abortion. She described the form, the name of the doctor, and the date of appointment. I checked our files, putting her on hold, and found that she was telling the truth. What the mother wanted was
some information regarding her daughter's emotional temperament, and to know if she was coping with her pregnancy. The daughter had made no mention of her pregnancy to her mother, and since her mother had found the form she said she only wanted to help her if she needed it, but she did not want to pry. In other words, she was willing to respect her daughter's wish for privacy, but at the same time she was concerned that maybe she needed some emotional support. Also, she wanted to know how her daughter was going to pay for it. The mother said she was very worried about how she would get the money and wanted to know if she could send the money to us and we could just tell her daughter that we would do it for free.

The feeling I got from this woman was genuine concern about the well being of her daughter and sincere motivation to want to help her daughter without intruding. I would not, however, give the mother any acknowledgement that her daughter had ever come to Family Planning, despite her good intentions. Once I had made it clear to her that my talking to her in no way admitted or denied that her daughter had ever been to Family Planning, I explored with her some of her feelings toward her daughter and suggested some overtures she might make to her daughter to open some communication. The daughter was scheduled to have an abortion the following week.
Later I mentioned the girl's name to one of our contract physicians who had done the abortion and asked him what kind of temperament she had been in when she came to his office. He replied, "Oh I remember her. Her mother brought her in and she even offered to stay with the daughter during the AB."

I am of the opinion that whenever family members contact Family Planning and want information regarding a possible client, these instances should be treated as a crisis and dealt with by a professional trained in crisis intervention. It is not enough to adamantly refuse any information to family members of clients, but it is potentially hazardous for the untrained individual to involve himself at length in conversations with family members, both for the inappropriate advice he might be inclined to give, or limited information he might become persuaded toward giving. The best way to insure professional handling of these instances is to have a trained individual, preferably a professional, to deal with all instances.

**Staff Training**

Research Question Eleven:

Do teens require special sensitivity from Family Planning personnel?

Most of what I have described in this chapter
would not be practical without a cooperative staff who themselves were knowledgeable about Family Planning and who were willing to be trained. Dealing with teenagers does require skills and sensitivity that are not necessary when dealing with average adults. Teenagers will often be irracible and moody, and vocally critical of anything from the way you comb your hair to the color of your office walls. They can be charming and poised and show mature adult behavior. When you tell them they need an examination before anyone will give them birth control pills, they may get angry, or they may volunteer their services after school. When teens display what appears to be hostile or angry reactions to your policies, one should first remember they are teens. If you tell a woman of twenty-five that you do not have a clinic with an opening for another week and she replies angrily that she should not have to wait that long, you can usually assume that that person has had a bad day, or she is normally of a nasty temperament anyway. Teens reply that way frequently, however, mostly to see what kind of response they will get. If you come back with a curt or authoritarian attitude, then that teen will come in only if they are desperate, and then they will probably give a false name and not be very cooperative.

Sensitizing a staff to the needs of teenagers and
to their own need for careful and controlled communication is a major undertaking that does not come about with a few talks. Teenagers want to be treated as mature adults, but often times they cannot behave themselves as the adult they would like to be considered. This is not, however, a sign of immaturity, as many people believe, so much as it is an indication that they are teenagers; people with adult bodies and expectations but who lack the experience and environment to achieve consistent adult behavior. Once a staff begins to understand this distinction, their potential for relating effectively with teenagers increases tremendously. How to achieve this result through in-service training will comprise the fifth chapter, and be considered within a larger context of training Family Planning staff to increase the quality of their general skills.
Chapter 5

IN-SERVICE TRAINING

With few exceptions, Family Planning agencies are directed and operated by women who come from medical and pare-medical backgrounds. In the past nine months while attending various conferences about issues in Family Planning I have met about fifteen to twenty agency directors and directors of Family Planning programs in related health service fields. All were women, and most either were nurses or had a background in nursing or public health.

In conversations with these people I have found them all dedicated people, highly motivated toward providing their consumers with first-rate medical care. The degree to which each saw their agency services as being primarily medical in nature varied with each individual, but all of the directors whom I talked with tended toward explaining their programs and planning their budgets according to medical models.

One can not argue with the basic fact that Family Planning first of all provides women contraception and for this service a doctor is required to perform a medical examination. There are, however, increasingly more people in responsible positions in family planning services.
arguing that not all women who want to take birth control pills need a medical examination. If a woman is thoroughly familiar with the symptoms and side effects that the pill can cause, some argue that a yearly PAP smear is enough.

Pill dispensation and medical examinations are not the extent of Family Planning services, though to examine the average administrative organization of any agency one would hardly know this. Remarkably few agencies (I can only estimate less than ten per cent), when they have the freedom to do so, place in their budgets any kind of social service that does not involve a doctor or a nurse doing some sort of examination.

No doubt most Family Planning administrators are facing the same financial crunch that most public service agencies are today facing, and they are forced to elect priorities. Given the fact that most of these administrators come from medical backgrounds, most therefore tend to establish priorities according to medical models. Also, most Family Planning agencies are funded all or in part by HEW, and HEW makes available on a limited basis training workshops that agency directors can send their staff to for such training as "Pregnancy Counseling," "Abortion Counseling," "Values Clarification," to name a few. Since HEW makes these workshops and training programs available on a limited basis, few if any directors think in terms of providing their own in-service
training for their staff.

Since being with Family Planning I have observed an interesting phenomenon regarding the "training" or workshops members of Family Planning agencies attend. I have attended five of these training sessions myself, and I have remained in correspondence with many people from other agencies whom I met at these sessions. I have come to the conclusion, from observation and enquiry, that it is very rare that one of these training sessions ever makes any difference in the job performance or professional behavior of the person attending the training. I have also discovered that this is not the result of the trainees, as they usually attend these sessions enthusiastically, with high self motivation to learn some skills. To the contrary they invariably learn skills that they do not have the freedom or the atmosphere to utilize when they return to their agency.

For example, I once attended a three day conference in "Values Clarification" held at Asilomar, California. All expenses were paid by HEW, and I attended this conference as one of two allowed from our agency. My own reasons for attending was first that my director had asked me to attend, and secondly that I had studied Sid Simon's books and I was interested in seeing how people in Family Planning were utilizing his methods. The conference turned out to be personally rewarding. I met
some very interesting people, including the leaders of the sessions, and I enjoyed the process. During the three days I had numerous conversations with most of the people attending (we were a group of about twenty), and all of us related how we were going to employ the values clarifications skills we were learning when we returned to our agency. This was the second conference I had attended while working for Family Planning, and I remember feeling enthused that people were eager to put into practice their newly learned skills.

Over the next several months, as I met some of these people again at other conferences, and corresponded with others, I began to realize that no one had ever implemented anything in their parent agencies regarding their training. I remember asking one person what had happened to her plan to devote one hour a week in her staff meetings to communications exercises and games using values clarification models. She gave me a simple answer. Nobody wanted to do that weird stuff and her director did not like the idea. I have faced this same dilemma, though I at least have some options to overcome staff and administrative resistance.

Fortunately for me and our agency, both my director and our Board of Directors saw a clear need for staff training in areas of communication and Family Planning counseling. While this director and Board were
perhaps more amenable than most toward encouraging their staff to attend training and then having them using their skills on the job, in reality they had come to the conclusion that training in the abstract for a two day period finally did very little to improve either the knowledge or counseling skills of most of their staff. Nearly everyone had learned to do pregnancy counseling not at a conference, but from watching another staff member do the counseling. When someone did attend a workshop, while sometime there was a noticeable difference for a short while, few of the staff seemed to retain any long term influence from these training programs, especially training that did not involve specific medical related skills, such as taking blood pressures, or how to aid the doctor during an examination. Most staff seemed to learn well basic medical skills but few demonstrated on the job that their values clarification training improved their counseling. Since I believe that "Values Clarification" (and other communication enhancing training) can improve substantially a person's communication skills in Family Planning, I must conclude that it is not the training material that has failed it is, rather, the reluctance of agency directors to allow new ideas to be incorporated into their clinic procedures.
The Marriage Counselor as Communication Trainer

Research Question Twelve:

Can a Marriage, Family, and Child Counselor working in a Family Planning agency train the staff in effective communication?

Whether or not Marriage Counselors have themselves mastered effective non-judgmental communication, they have at least been trained in the principles and techniques. They should have a theoretical understanding of the dynamics involved in a communication transaction, and as a practicing Counselor, they would necessarily possess communication skills. Given this fact, if a Marriage Counselor is part of a Family Planning staff, it is logical that the Counselor in some way become involved in training his fellow staff in some basic communication techniques and even fundamentals of counseling. First, we should examine some of the assumptions beneath this logical deduction.

Since HEW funds organizations to exist for the sole purpose of providing training events for Family Planning staff, some of which are non-medical in nature, one can assume that someone in HEW thinks it important that Family Planning staff know more than how to dispense contraception. Since agency directors give their staff time to attend these training sessions, and attend
many themselves, one can assume that some directors at least think it worthwhile that they and their staff attend some training that is non-medical in nature. Since Family Planning staff, including medical para-professionals (such as Women's Health Care Specialists) attend these training sessions and even talk about using their training in their jobs, one can assume that they sometimes think it worth their time to master the skills taught in the training. Finally, since (in spite of the interest in non-medical training at all levels of Family Planning), the effectiveness of the training offered is questionable, one can assume that a better means of training would be highly desirable.

Returning, then, to the notion that a staff Marriage Counselor can play an important role in training staff in communication and counseling skills, the question becomes how. Since I am currently involved in a training program for the Tri-City Family Planning staff, I will present the curriculum of this program as an example of how the Marriage Counselor as a Family Planning staff member can provide an indespensible service for staff training.

Assessing Staff Training Needs
Research Question Thirteen:
How can a Marriage, Family, and Child Counselor assess staff training needs?
Most of Family Planning staff duties involves dealing and relating with people. They are a service organization who exist to serve people. In the first chapter I have listed most of the services provided. One can see that all of their services in one way or another involves communicating with people about their social backgrounds, both impersonal and personal, such as their sexual behavior and how they relate to their partner.

The dispensation of contraception involves a modified form of counseling. Before a woman receives contraception from Family Planning she is interviewed about her social history (see appendix A for interview form). During this interview, which usually immediately precedes an examination, the interviewer is supposed to enquire about any relevant interpersonal problems, such as problems in her sex life. The interviewer then puts this information on the person's chart without upsetting the client. At the same time the interviewer encourages questions, and answers them, and also encourages the woman to take responsibility for keeping herself informed about contraception.

The urine pregnancy test also involves a modified form of counseling, and in fact, is most often akin to a form of crisis intervention. The woman is first given a form to fill out (see Appendices B and C) that enquires
about her background involving her possible pregnancy. The staff member then conducts the test, and then sits down with the client and discusses the results with her. In this situation the interviewer most often must deal with an intensely emotional woman or couple, and at once console them and inform them about their choices. At the same time the interviewer must remain clear headed but empathetic.

During both the interview for contraception and pregnancy testing, at Tri-City Family Planning the interviewers are asked also to remain alert for psychopathology in the client's interpersonal relationships that might be a precipitating factor for her coming to Family Planning. The interviewer is asked to make enquiries when they learn of unusual behavior that might be termed psychopathological, and then to make a referral for counseling if they deem it necessary.

Within these two areas, interviewing for birth control and pregnancy testing, there rests a large potential for staff training that is both professionally appropriate and administratively sound. Within each interviewing situation there exists the following dimensions that deserve specialized training.

The Interview For Birth Control:
- Taking a family history
- Taking a social history
- Taking a medical history
- Enquiring about relevant relationship problems
- Enquiring about sexual dysfunctions
- Encouraging the client's questions
- Noting and tending to client anxieties
- Making appropriate referrals
- Giving understanding to a client about their need for a referral

The Interview For Pregnancy Testing
- Taking a social history
- Exploring feelings about pregnancy
- Coping with stressful reactions
- Assisting in a resolution for the client
- Educating the client about alternatives
- Resolving initial trauma
- Avoiding transference
- Making appropriate referrals
- Giving understanding to a client about their need for a referral

These are the tasks to which the interviewer must address himself. It should be obvious that there is more involved than just the dispensation of a medical service, that in fact, Family Planning staff are asked to perform modified family counseling. At the same time, while a staff is asked to perform this counseling, and
are trained in how to perform a urine pregnancy test and to fill out an interviewer's form, seldom are they trained in communication or counseling skills to achieve these ends. When they are trained, it is either through workshops and training events as described above, or they observe for a period how somebody else has done the interviewing and they copy their style.

Many people in Family Planning would say to this topic, "Well they do the job, don't they, so why do they need training in something that they already do well without some professional telling them another way to do it." It has been my observation, both in the agency that I work in and from contacts with numerous Family Planning counselors, by any professional counseling standards one cannot accurately make the generalization that pregnancy and birth control counseling is done well within Family Planning. It has been my personal experience, again from both observation and conversation with numerous people in Family Planning, that excellent medical services and medical referrals are provided (such as a referral for abortion), but seldom does Family Planning achieve even an adequate degree of professional counseling: that is, counseling that accurately diagnoses areas of stress and dysfunction in their clients and then helps toward a resolution, or gives an appropriate referral for further counseling.
Seldom do Family Planning personnel recognize when a client needs professional counseling.

As an example, I have found at Tri-City Family Planning that one in seventeen women whom I interview for birth control will voluntarily mention that their primary sexual relationship is currently under stress due to a major sexual dysfunction, most commonly anaorgasmia, then dyspareunia, then premature ejaculation on the part of their spouse. When I counsel women during pregnancy testing, I have found that one in seven women are facing a major relationship crisis which they feel is completely overwhelming them and beyond their control to cope with. The most common is fear of an impending separation from their partner due to their pregnancy. This is followed by debilitating depressions caused by an impending forced decision about how to handle their pregnancy in relation to their relatives.

With the former example, one in nine will return for professional counseling about their sexual dysfunction for at least one session. With the latter example, I spend at least one counseling session with the client when she is in my office for pregnancy testing, and one in seven will return for at least two counseling sessions, usually with a partner or a relative.

My personal experience shows that the need for supplemental professional counseling in conjunction with
Family Planning services clearly exists. My personal observation in Family Planning circles also shows that this need is rarely met. In one respect the reason is simple. The average Family Planning staff member usually will not recognize these problem areas when they are covertly or overtly presented. When they are clearly presented the average staff member is likely to dispense with the problem quickly one of two ways: either make an authoritarian suggestion to the client, such as try relaxing the next time you have sex, and then drop the issue; or they will avoid the issue because they either feel there is nothing they can do anyway or they feel it is not important. If the agency is administered by people who share the latter opinion, then probably that agency will never recognize the need for professional counseling in conjunction with their services. If an agency is administered by people who recognize these needs of their clients, then they must at the same time recognize their own need to train their staff to deal professionally with these client needs.

There exists several other areas of Family Planning services which could be cited as requiring specialized training in counseling and communication skills: most notably dealing with a hostile public about such issues as abortion or teen services, or desensitizing yourself and your staff to the sensitive issues that
clients will daily ask you to deal with. For the purpose here these need not be illustrated in detail.

Aside from the need for supplemental training around an agency's existing health services, there remains two outstanding areas that require attention. Since I have tried to show that the existing training programs in the forms of conferences and workshops for Family Planning agencies are largely ineffectual, but not without redeeming qualities, there exists the need for agencies to provide in-service follow-up for their staff who have attended a conference. This would benefit the staff by reinforcing on the job their training, and it would benefit the agency by upgrading the quality of their personnel. The second area involves determining what are the professional requisites for their staff to advance themselves, and then to provide the necessary training to arrange to make that training available. Since most agencies try to fill personnel vacancies from within their own ranks, it only makes sense to have a training program available whereby an outreach worker could advance to the position of Family Planning Counselor, and the Family Planning Counselor could advance to supervisor or Woman's Health Care Specialist. Large companies can afford the luxury of having full time staff constantly operating schools for their executive's advancements. Family Planning agencies cannot afford
this luxury. They can, however, afford a Marriage, Family, and Child Counselor and include in his duties the function of trainer to meet these special needs of their staff.

A Training Curriculum

Research Question Fourteen:

What are the in-service training needs for a Family Planning staff?

At Tri-City Family Planning every Friday afternoon from twelve to five the agency closes to the public. During this time the agency holds staff meetings or training events when they are necessary, and for the rest of the time they catch up on their filing and clerical work. The following training curriculum is presented on Friday afternoons, usually on a pre-arranged twice a month basis. This leaves two or three afternoons per month for staff meetings and other business, but at the same time is an adequate distribution of time spent toward in-service training.

In developing a curriculum to date I have found five areas that I feel require training:

1. Developing within the staff an understanding of self in relation to Family Planning objectives
2. Refining staff interviewing techniques during birth control and pregnancy counseling
3. Learning to distinguish between Family Planning counseling and professional counseling of a psychological nature

4. Developing fluid and open staff interaction

5. Providing continuation training from workshops and conferences

This is not to say that these five training areas are the extent of what an in-service trainer might address himself to. They represent the five areas that in my experience at Tri-City Family Planning I have found relevant for pursuing with training. Another person in another agency might find some or none of these relevant to his agency, though I would think this highly unlikely. If an agency did not have a need to refine the counseling techniques of its staff, or to teach them to differentiate between psychological and family planning counseling, then they would have achieved a degree of sophistication in their personnel that I personally have not found in any Family Planning agency with which I have come in contact.

Training area one. I have found that the best way to approach the first training area is with Values Clarification games. For my purposes developing an understanding of self does not mean set up an encounter group. To the contrary, I think this method would be highly irresponsible on the part of the trainer unless he first made explicitly clear to the staff his intentions, and then
secured their free consent and willingness to participate. Since this type of training would be requisite for a person's job, it is reasonable to assume that some of the staff would not voluntarily opt to attend these training sessions. As such, the trainer has a responsibility to guard against unnecessary threatening situations for the staff during the training sessions. Values Clarification games, however, provide sufficient group interaction to allow a person to explore his own values without a threatening push from the group.

I have borrowed from Sid Simon's Values Clarification (1972) two exercises. The first is his popular "Aligator River" story:

PURPOSE

In this strategy, students reveal some of their values by the way they react to the characters in the story. Later on, in examining their reactions to the characters, students become more aware of their own attitudes. This strategy also illustrates how difficult it is for any one teacher to say, 'I have the right values for other people's children.'

** * * *

The Alligator River Story

Rated "X":

Once upon a time there was a woman named Abigail who was in love with a man named Gregory. Gregory lived on the shore of a river. Abigail lived on the opposite shore of the river. The river which separated the two lovers was teeming with man-eating alligators. Abigail wanted to cross the river to be with Gregory. Unfortunately, the bridge had been washed out. So she went to ask Sinbad, a river boat captain, to take her across. He said he would be glad to if she would consent to go to bed with him.
preceding the voyage. She promptly refused and went to a friend named Ivan to explain her plight. Ivan did not want to be involved at all in the situation. Abigail felt her only alternative was to accept Sinbad's terms. Sinbad fulfilled his promise to Abigail and delivered her into the arms of Gregory.

When she told Gregory about her amorous escapade in order to cross the river, Gregory cast her aside with disdain. Heartsick and dejected, Abigail turned to Slug with her tale of woe. Slug, feeling compassion for Abigail, sought out Gregory and beat him brutally. Abigail was overjoyed at the sight of Gregory getting his due. As the sun sets on the horizon, we hear Abigail laughing at Gregory.

PROCEDURE

The teacher tells either the X rated or G rated story of Alligator River, depending on the age of the students. Following the story, the students are asked to privately rank the five characters from the most offensive character to the least objectionable. The character whom they find most reprehensible is first on their list; then the second . . . (Simon et. al., 1972)

Employing variations on this story as you go along, this is an excellent technique to encourage the staff to discover and express their own opinions on our sexual mores. With a little creative thinking, you can make Abigail a virgin or a prostitute, a teen or an adult. You can make Ivan a Marriage Counselor, and Sinbad a dope dealer or a physician. The point is to present a provocative situation that will stimulate the staff to react to the story. As they react you make additions and deletions to the story causing them to re-evaluate their positions. Then following this game, which should last for about an hour, you lead a group
discussion exploring the values in the story, the re-
actions people have, especially if anyone changes their 

mind about a notion they might have about contemporary 
morals. In this exercise it is important to encourage 
spontaneous reactions and to safeguard anyone from being 
judged by another. Keep the focus on the story. If done 
with a creative and enthusiastic outlook, this game 
should provide an excellent gambit for the Counselor-
Trainer in his training program with his staff. 

The second of these exercises, an excellent game 
that can be used in this first training area, is the 
self revelation card. Pass out 5X8 cards to the staff. 
Then ask them to write on it your own variation of the 
following. In the upper left hand corner write your age, 
where you had your first sexual experience, how old you 
were, and whether or not you used a method of contraception. 
In the upper right hand corner write your favorite color, 
your favorite food, your favorite smell, and your favorite 
place to relax. In the lower left hand corner write the 
name of a person whom you like very much, the name of a 
person whom you dislike very much, the name of a person 
with whom you have unfinished business, and the name of 
a person with whom you would like to change identities 
for a day. Then in the bottom right hand corner write a 
reminder about a secret you have, then a reminder about 
sexual secrets you have, then the name of a person with
whom you wished you had either had or did not have sex with, and then a reminder of a fantasy. At this time the trainer should then spend some time reviewing the principles of the values clarification process, which prescribe a method for determining and then publicly avowing with some consistency your values. The trainer should be thoroughly familiar with Simon's book for this part. Then the trainer asks the participants to pin the card to their shirt and to walk around the room in silence and merely look at each other's cards. Then the trainer asks each of the participants to sit in pairs and to discuss one at a time one of their corners on their card. This can then be followed by a brief talk about reasons for choosing one section of the card to talk about; did the person wish to keep some parts private or did it depend upon whom he was talking with as to what part of the card he would share.

Throughout this exercise I recommend that everyone be given the option not to participate. Also the trainer should remain alert to keep the tone of the event loose and non judgmental. The first time I did this training, one of the participants cried vigorously during person to person sharing. She chose to discuss her first sexual experience by which she became pregnant. It had been more than twenty years since this happened and she seldom talked about it. The exercise had put her
in touch with many suppressed feelings and during the remainder of the exercise she ventilated many of them. The exercise turned out to be rewarding for her and the group. Had this woman not experienced this during training, she would probably have let go during a pregnancy counseling session and perhaps have added much confusion to a client already distressed about her own pregnancy.

This game can be repeated selecting different personal issues that relate to sensitive social issues that Family Planning staff constantly deal with, such as vasectomies or abortions. Following these games brainstorming sessions around a core idea are excellent exercises to surface from the more involved emotional interchanges of the self revelation cards, but if done properly they can continue to focus toward a self evaluation. For instance, following the above incident where the staff member ventilated her feelings about being pregnant, I asked the group to brainstorm about how a person might give off double messages during a pregnancy counseling session. I wrote ideas on a blackboard as fast as everyone threw them out. The staff quickly grasped the point, and eagerly discussed their own examples of how double messages can creep into pregnancy counseling.

Another method that can be used for this first
training area are readings and literature reviews, and
group discussions of current Family Planning issues:
anything from fiscal problems to men in Family Planning.
It helps if the trainer has a background in teaching for
this method, but it is not necessary. If he is sensitive
and sensible about leading a group discussion, and
provides topics and direction for the discussions (i.e.
brings zeroxed articles to discuss), this method can
prove highly informative for everyone and help to keep a
staff informed and critical in their opinions about
Family Planning issues.

In general I think it best that a trainer approach
his weekly programs, particularly when addressing himself
to the first training area, with the idea that these
sessions will provide for the staff an atmosphere that is
conducive to growth and learning. He should work
intently toward uplifting staff morale to participate in
these training sessions. He can do this any number of
ways, but finally his success will be determined by how
well he himself models the training he espouses. Facili-
tating people toward self understanding is never a matter
of games and exercises. Nothing in this chapter will
work if the trainer is not sincere in his efforts. This
means he must facilitate but not judge. Given a few
basic requisites such as these for the trainer, then
Values Clarification games of the sort described here
can assist the trainer in his objectives.

**Training area two.** I have found that the best way to approach training area two is to begin with a brainstorming session. Before you can actually work with a staff on their interviewing and counseling skills you need first to clearly establish what information must the interviewer obtain during an interview. Of course one can go to the forms that an agency uses, but this does not serve the purpose for training. Without forms ask the experts, (those who do the interviewing) what information they think they need to know about a client in order to do their interviewing and counseling.

Beginning with the interview for a woman who wishes to receive birth control, ask your staff to brainstorm their own ideas about what information they need to know. At the same time the trainer should record their ideas on a blackboard or large sheets of paper. Then take each item and compare their ideas with the forms that the agency actually uses to obtain this information from their clients. Be prepared to find that the forms may not ask the kinds of questions that the consensus of your staff think ought to be asked. During this process begin to group your staff's ideas into categories. For example there will be needs to know about menstrual history, and also about income level.
The two are entirely different types of information, so begin to sort out responses that go together. When you have placed all of the responses into categories, then ask the group to again brainstorm about problems they encounter when doing interviewing for birth control. Again categorize the responses. Typical responses might include uncertainty about how much time to take during an interview; how detailed a menstrual history should you take; how detailed a medical history should you take; suppose the client wants to talk about personal problems, should the interviewer listen; what about the client who is having side effects from birth control pills but is also having severe emotional problems that may be complicating them; what do you tell the client who wants advice about her sex life. There are many possibilities but all should be carefully listened to and dealt with since these questions are important to the staff and will certainly affect their counseling.

During this stage of training it is good practice to have your director involved, or whoever has the authority to make decisions about what can be dealt with in an interview, how much time can you take, etc. Also, if you and the staff find substantial flaws in the interview forms that you are presently using, you will undoubtedly need your director's cooperation for getting them changed.
After the trainer and the staff have established what the factual content of the interviewing sessions need be, which will probably take several sessions, the trainer can then begin to focus on techniques and skills for the interviewer. Since the techniques and skills an interviewer will need to learn will apply to other kinds of interviewing and counseling situations, such as pregnancy counseling, it would be best to repeat the entire process for each interviewing situation until everyone is clear and in agreement about the factual contents for all interviewing.

One can begin in the same way for pregnancy counseling. Ask your staff to brainstorm their ideas about what necessarily they need to know about a client, and then do a comparison process with your existing forms. At Tri-City Family Planning I have chosen to use the Pregnancy Counseling situation as the basis for more sophisticated interviewing and counseling skills and techniques. This is most appropriate since pregnancy counseling is the one service that demands the greatest skill on the part of the interviewer, and contains the largest possibility for distressing the client.

First I analyzed the forms our agency was using for the client and interviewer for a Urine Pregnancy Test (see Appendices D and E). I found that the form for the client contained a number of superfluous factual questions,
but contained critically few questions about the client's feelings about her possible pregnancy. I then rewrote our form with the guiding idea that when the Family Planning counselor sat down with the client to discuss the results of her urine pregnancy test, I wanted that counselor to have as much insight as possible into the client's feelings and state of mind about her pregnancy.

Next I rewrote the interviewer's form as I felt the old form offered the interviewer little or no structure for going about the interview. I rewrote this form with the guiding idea that the interviewer should have a structured form that caused him to focus on the client's verbal and non-verbal behavior, and then to be able to assess that behavior in some manner. My purpose was to help interviewers to pay attention to a person's verbal and non-verbal cues, and to be able to note when that client is saying two different things at once.

After rewriting the forms, I presented them in a training session and reviewed with the staff all changes in the forms and why I had made changes. I informed everyone that at least once during the week I would review with each staff member one of their pregnancy counseling sessions, and go over their forms and how they filled them out. Then every other week we would spend about an hour role playing one or two counseling sessions, and as a group review and criticize the
strengths and weakness of a particular person's counseling. As I told the staff, in this manner I hoped to eventually achieve continuity between all the counselor's for their procedural skills when doing pregnancy testing. Also, I hoped this format would help each to learn from the other.

Since I did not rewrite the form for the client who was coming for a second pregnancy test, after explaining my method and intentions, again using the brainstorming method I asked the group to rewrite that form. As it turned out, the group decided that the original form (see Appendix B) should be given every time someone came for a pregnancy test, and a new Counselor's form should also be used.

With the use of pregnancy forms, I have been able to begin to develop the counseling skills of the staff in a way that gives them constant on the job practice. I have found that when the staff can practice daily the idea and theory that you train in twice a month, their interest in learning remains high.

Certainly anyone can see that merely rewriting a few pregnancy forms has limited value for achieving any long term and substantial increase in staff counseling skills. I have found that for this phase of training it is realistic and desirable to have the group do some intensive reading of some counseling theorists. What a trainer decides upon is largely a matter of personal
choice depending upon his own background and with what he feels comfortable to teach. For my purposes I have selected material from Carl Rogers, Thomas Gordon, Berenson and Carkuff, Fritz Perls, and several others. From Rogers we read "The Helping Relationship" and explored his ideas about the fundamentals of a counseling process. From Berenson and Carkuff we read about their eclectic theory of four core dimensions in every counseling relationship. In all the discussions I was careful to relate ideas to cases we had talked about, and to constantly stress that theorists do not just talk hypothetically: that their ideas do have genuine applicability to the counseling situations at Family Planning. At Tri-City Family Planning this training is currently in progress, so the final paragraph to this section is yet to be written.

Training area three. The essential ingredient for this third training area is to teach the staff when a client is asking for counseling of a nature that exceeds his training and competency. I begin with a simple rule. Whether you are a Women's Health Care Specialist doing pelvic examinations, or a Family Planning counselor doing birth control interviews, there is an immediate service that you are providing that client: i.e., a pelvic and an interview to get the client birth control
pills. If when doing your exam or interview you find that the client is asking for something other than getting birth control, then you need to assess what that client is asking and why. Obviously if a client wants to know where to apply for food stamps you need not look excessively for problems that require a professional counselor. It is common in a public service agency to ask about other public services. On the other hand, if the client asks "Is it normal for the guy most of the time to climax before the girl is ready," then at this point the interviewer should ask some questions. Here again I offer another basic rule. If the client is genuinely asking a hypothetical question, then it is fitting and proper that you answer in an effort to help educate clients about their own sexuality. On the other hand, and most common, if the client really wants to know "Is there something wrong with my old man because he's always coming before I do; or is there something wrong with me and I would like you to tell me what to do about it," then the client is asking for a prescriptive suggestion about her behavior. I contend that anyone in or out of Family Planning who has not been professionally trained as a Counselor (and in this case specifically trained in sex therapy), has no business whatever making suggestions to this client other than to refer them. Unfortunately, the overwhelming tendency among Family Planning personnel,
especially para-medical staff, is to handle these situations themselves. The first Counseling case I had at Family Planning was a twenty-three year old woman who came to me for sex therapy. She had mentioned to a Nurse Practitioner at a local agency that she was non-orgasmic, and that person had urged her to buy a vibrator and masturbate. The results had been disastrous, inducing extreme anxiety. Her relationship with her partner was already tense, and when the vibrator did not produce orgasms for her she had defensively blamed him "for ruining her." She developed such intense suspicion and hostility toward men and after three sessions she felt she could no longer relate to me. Though I tried to get her to attend a Women's pre-orgasm group, she was totally repulsed at the idea of another woman telling her to masturbate and refused to attend.

A trainer can at his own discretion either focus exclusively on this third area of training or include it in other areas. If he wished to deal with it exclusively, then a combination of lectures, role-plays and case illustrations would be the most appropriate. His focus should be to present as many examples as possible of cases where the client needed the intervention of a professional Counselor, and discuss how the interviewer could have recognized and dealt with it. This will require some tact on the part of the trainer since he can expect that at
least some of the people he will be talking to will feel strongly that they are perfectly qualified to do exactly what he is asking them not to do. Consequently I think it best that the trainer decide in his own mind, before approaching the staff, exactly what his position on this issue is; how strongly he holds it, and what lengths he is willing to go to in seeing that the staff do not attempt to exceed their abilities. If the trainer is a licensed Marriage, Family, and Child Counselor, or working toward that license, he would do well to recall Title 16 of the Professional and Vocational Regulations, section 1845.b:

A counselor shall not permit a trainee or intern under his supervision or control to perform, nor to hold himself out as competent to perform, professional services beyond his current level of training.

Training area four. A Family Planning agency is the type of public service that for consumers will be a pleasure or an irritation. Seldom are clients indifferent. At Tri-City Family Planning in Newark, as I noted earlier the trend in consumers is toward an increasing white middle class. Many of these consumers have private insurance or could well afford to go to their own gynecologist. At first, one is inclined to say that Family Planning is more convenient, thus, a consumers preference to come here rather than to a clinic or
private doctor's office. Actually, this is not true. During clinic sessions women still have to wait an average of two hours during the examination and interview process, and they are required to fill out forms and answer questions the same as a clinic or hospital would require. When one asks people why they prefer Family Planning, almost without exception reply that they like the personal contact and how nice the people are. Stated simply, at least in part, people come to Family Planning because they like the people who work there.

It is no surprise to anyone that good public relations promotes the growth of any business. People appreciate and tend to remember places where they are treated well. Prior to the current fiscal year, 1975/76, Family Planning agencies have been amply funded by the federal and state government. This past year most agencies were cut in their budgets from between one and ten per cent, and were advised to prepare to become independent and self supporting within two years if President Ford's projected fiscal policies take effect. For the first time in Family Planning history, money is not available to support all of the staff they had a year earlier, and agency directors are having to eliminate some positions. As is always the case in matters of personnel and budget cuts, desecension runs high and morale runs low.
If Family Planning is to become fiscally independent within the next few years, it is crucial that they develop realistic and viable programs that will meet with an accepting public response. If in the past the public has chosen Family Planning agencies over doctors offices and hospitals because they like the people, the way they interact and the personal service they give, then more than ever it is crucial that they maintain high morale and open staff interaction. I think it not the least an exaggeration to say that the degree to which agencies succeed in this they will be successful in their attempts to become self supporting with a steady clientele.

A staff Marriage Counselor and Trainer will find himself constantly in the position of dealing with individual's and staff personnel problems. Few agencies can afford a personnel administrator, but few would want one anyway. Neither would the Marriage Counselor supplant a personnel administrator as no doubt that is the last position most Marriage Counselors would be interested in. In his position of "staff shrink," and leader of training events, he will be in a position to directly affect the level and quality of staff interaction. In this respect a Marriage Counselor who acts as a trainer can help to keep personnel problems to a minimum, and thus, help to promote the agency toward
Training area five. As I have described earlier, HEW makes available to Family Planning agencies training events. Much of this training even the most competent Marriage Counselor could not provide for lack of space, facilities, personnel, etc. Also, some of the medical training is beyond the competency of Marriage Counselors. I have argued previously that much of this training, though needed and valuable, has a limited impact upon the trainees. This is due primarily to the lack of continuity and reinforcement once the trainee returns to his agency. An in-service trainer could change all this.

The in-service trainer should make himself thoroughly familiar with all training events being offered to Family Planning personnel and he should actively work toward having as many of his staff attend as possible. At the same time he should orient his own training chronology to correspond with the training events his staff attends. With the assistance of the trainer, staff should be encouraged to give presentations when they return to their agency relating highlights of the sessions they attended. The trainer should then, with their assistance, devise methods for implementing into their job performance the training they have received. If, for example, two of the staff attended a
session on abortion counseling, at the next training session they could present for the staff what they had learned. Then the group could assess its applicability in their agency, and devise methods for implementing those skills. Then at the next session the group could evaluate their progress and make corrections and adjustments.

For me, this method seems so logical and reasonable that I can hardly believe that so few agencies practice it; and yet this is the case. Rarely does an agency provide for its staff any kind of in-service follow-up of the training events they have attended. This has been particularly surprising to me since for many of the training events the training agency will send out to the agency at no cost a team of trainers to present, on site, a program that an agency has requested. I have no specific figures for how often this is done other than at our own agency, but my impression is that it is rare. Most agency administrators feel that they need to spend their time giving out contraception rather than training their staff.

As an example of how well this arrangement can work, especially when an agency has an in-service trainer, I arranged with my director to have a team of trainers come to our agency for a morning and afternoon session for two Fridays. The topic was interviewing
techniques. The trainers knew that they had a limited amount of time to work with the staff, but they also knew me and the program I was trying to implement. Consequently, when they did their training they developed a program that they knew would continue when they left under my direction. Since the trainers knew that they did not have to try and present everything in too short of a time, they were able to select what material they wanted to present, and then to coordinate their efforts with myself to allow us to continue at our convenience what they had begun.
Prior to this chapter, the direction for this thesis has been to show the necessity for a Marriage, Family, and Child Counselor in a Family Planning agency, and to suggest some alternate roles that he might play within an agency. As yet I have not described how the Marriage Counselor is recruited, on what terms, and how he and the agency go about developing his position. Since I have already presented in detail how his position should develop in the direction of Teen Services and In-Service Trainer, I will now focus on how an agency might utilize his primary skills as that of a Professional Counselor.

Recruiting and Hiring a Marriage Counselor

Research Question Fifteen:

What criteria should a Family Planning agency consider for hiring a Marriage, Family, and Child Counselor?

Before recruiting a Marriage Counselor an agency would first need to determine what services they "think" a Marriage Counselor might provide. Since few agencies
would have experience in providing this kind of service, probably their original program conceptualization would undergo some modification once they actually began their program. Nevertheless, before talking with applicants an agency should first give some consideration to whether or not they want a full time Counselor. It should be decided where his position will fall in the agency's personnel hierarchy. What will be the salary arrangements? Will there be office space? What fees, if any, will be charged for counseling? Also, there should be some type of scheme for directing current clients to the new service. The agency might consider becoming a training site for graduate students in Marriage Counseling programs if they are so fortunate as to have in their vicinity a University which offers a program.

It is important to first decide whether your agency wishes a full or part time Marriage Counselor since the amount of time the counselor spends on the job will determine the extent of the services he is to offer. For example, if you offered at your agency Marriage Counseling appointments two mornings a week, and provided a Marriage Counselor a salary to offer this counseling, it is unlikely that he could devote any of his time to any other services or projects except counseling. Also, to offer the service of Marriage, Family, and Child Counseling on any basis less than half-time I believe
will make it impossible for an agency to utilize a Counselor to supplement their existing services. At less than half-time, all a Counselor would have time to do is counsel. If this became the case, then the whole purpose for having a Marriage Counselor in a Family Planning agency would be lost.

When deciding on the full-time equivalent for the Counselor one should remember that the Counselor will become a part of Family Planning and not an isolated service or a contract professional such as doctors who come certain times in the week. His position should be considered for allowing him enough time on the job to provide an integrated professional Counseling service that effectively integrates with all of the existing Family Planning operations.

When deciding on the full-time equivalent for the Counselor one will no doubt be influenced by what kinds of salary arrangements one intends to offer the Counselor. Before you do this, however, one needs first to decide whether or not you plan to offer to your public and current clientele Counseling for a fee. If previously all of your services have been free or at a limited cost, then perhaps an agency would prefer to keep the cost of Counseling in line with their other services. Or perhaps an agency would prefer to base counseling rates on a sliding scale relevent to a client's ability to pay, or
perhaps they would prefer to simply leave it up to the Counselor. Whatever the decision, the agency should calculate into their budget for the Counselor's salary whatever returns they expect to earn for his services.

There can be a number of mitigating factors in making this calculation. For example, if an agency opted to recruit a graduate student currently working toward his license, that agency would be required to provide the following supervision:

1836. Supervision of Unlicensed Counselors. Non-profit and charitable institutions and education institutions employing nonlicensed counselors pursuant to Section 17808 of the code shall provide the following supervision:

(a) For personnel obtaining graduate training leading to a marriage, family and child counselor's license, not less than one hour of supervision for each five hours of counseling performed. One half hour of such supervision may be in a group setting, but the balance thereof shall be individual one to one supervision by a licensed marriage, family and child counselor.

(b) For all other nonlicensed personnel, not less than one hour of supervision for each two hours of counseling performed. One-half hour of such supervision may be in a group setting, but the balance thereof shall be individual one to one supervision by a licensed marriage, family and child counselor (Laws Relating to Marriage, Family, and Child Counselors).

The agency could then calculate this supervision into the salary negotiations with a prospective graduate student. If the agency wished to recruit graduate students but did not want to provide supervision themselves for
their Counselor, then they should consider in their salary arrangements that the Counselor will have to obtain his own supervision at a rate prescribed above. An agency can consult local Marriage Counselors or a University to learn what rates they or a student would be expected to pay for supervision.

If an agency decides that it will charge fees for the service of Marriage, Family, and Child Counseling, that agency will need to establish a fee format. How the client will pay: to whom and when. What will the agency do when client's are unable to pay or are remiss in their payment? Also, there are laws that will come into effect for fees and advertising if the agency recruits an unlicensed Counselor. They should consult the handbook Laws Relating to Marriage, Family, and Child Counselors and Licensed Educational Psychologists with Rules and Regulations. This handbook can be obtained free for the asking by writing The Board of Behavioral Sciences, 1020 N Street, Sacramento, California, 95814. In fact, an agency should have this booklet when considering its plans for a Marriage Counseling service.

An agency will also need to decide where in its personnel hierarchy the new position of Marriage Counselor will exist. Will the Counselor be responsible to the staff supervisor, or will they exist on separate but equal levels? If the Marriage Counselor becomes the
Teen Services Coordinator and a Trainer, an agency will need to consider his job description in relation to other personnel. Should his duties overlap with other's, and if they do, who will arbitrate differences of opinion.

At Tri-City Family Planning, largely by "natural selection," all responsibility for the operation of teen services with the exception of hiring personnel falls to the coordinator. This includes scheduling clinics, making staff arrangements, and handling all problems that arise in a teen clinic. Thus, in effect, during the teen clinic the coordinator acts as a supervisor whenever it is necessary for him to do so. He also establishes policy, coordinating it with the Director, and computes cost per client ratios for the fiscally sound operation of his clinic. For the remaining family planning clinics the Teen Services Coordinator defers all responsibility to the staff supervisors. As Marriage Counselor and Trainer, he assumes all responsibility for those positions and coordinates his decisions only with the Director.

After deciding on the Marriage Counselor's responsibilities, an agency will then need to arrange for office space. As with all psychological services, the nature of Marriage Counseling requires total privacy. This can simply be a room with a door with some comfortable chairs. An agency would do well to keep in mind that the Marriage Counselor is their representative to the public.
for professional counseling. If an agency places their counselor in a back room that has no ventilation, cracked wooden chairs and pink wallpaper, then the client and the Counselor will extract from that setting your seriousness about providing a professional service. While it has been my experience that Marriage Counselors recently trained characteristically disdain large or fancy offices and usually prefer a simple decor, they do require some basic conveniences and a comfortable room. One need only to place himself in the position of the client to realize the importance of this matter.

Finally, after making all of these decisions, the agency will need to decide who the Counselor's clients will be, and how will they learn about him. In other words, will he serve only Family Planning clientele, or will he accept referrals from other agencies or general requests from the public? At Tri-City Family Planning all concerned felt it would be irresponsible and unwise not to advertise the service of Marriage, Family, and Child Counseling to other agencies and the general public, but at the same time it was felt necessary to first serve Family Planning clientele. Consequently, it was decided to make the counseling available to anyone who desired it, but to give priority to Family Planning clients. In the event that a waiting list developed, the agency would prefer to refer people to other counseling sources.
whenever possible. To date no problems have arisen from this procedure.

Training and Qualifications of the Marriage Counselor

Research Question Sixteen:

What qualifications should the Marriage, Family, and Child Counselor have?

The State of California provides for rigorous training for anyone to qualify for a Marriage, Family, and Child Counseling license. A person is required to have at least a master's degree in marriage counseling or in a related behavioral science, and

... at least two years' experience of a character approved by the board, under the direction of a person who holds the marriage, family, and child counseling license or at least two years' experience of a type which in the discretion of the board is equivalent to that obtained under the direction of such a person. (Laws Relating to Marriage, Family, and Child Counselors)

For an as yet unlicensed individual an agency would need to assess his education and experience, hopefully in consultation with a Marriage, Family, and Child Counselor. While I think it reasonable to depend upon the state licensing board to have already determined an individual's competency to practice Marriage Counseling, there remains some important considerations for the Family Planning agency.

Though a simplification, it is accurate to state
that all of Family Planning's services are related to sexual behavior. As I have already cited in previous chapters, a Marriage Counselor in a Family Planning agency will deal with a disproportionate amount of cases that involve sexual dysfunctions. The Board of Behavioral Science Examiners does not prescribe curricula or specific areas of training for Marriage Counselors, but instead depends upon the Universities to provide the necessary training. Some University departments that train Marriage Counselors provide training for treatment of sexual dysfunctions, some leave the training as an option for the student, and some do not provide any training. Consequently it is entirely possible for a person to become a licensed Marriage, Family and Child Counselor and never have studied or practiced current developments and techniques in sexual psychotherapy.

It is my opinion, based upon my experience and practice at Tri-City Family Planning, that a Marriage Counselor could not perform competently unless he had received some training in sexual therapy. While doing my graduate training at California State University, Hayward, in the department of Educational Psychology, it was not required that a student learn or study about sexual psychotherapy, unless the student was training for marriage and family counseling. In this case the student is required to take a course in the tenets of
sex therapy. For my own training, subsequent to this course, I studied privately with Dr. Zilbergeld who is the director of a sexual dysfunction out-patient clinic at the University of California in San Francisco. He also supervised part of my case load my first ten weeks at Tri-City Family Planning. Since that time approximately one third of my case load has involved clients with sexual problems.

If one wishes to review what sex therapy is, I suggest consulting Kaplan's *The New Sex Therapy*, (1974). It is not my purpose here to explain the theory or techniques involved in this specialized form of psychotherapy, but I do intend to argue that this training is a necessary prerequisite for a Marriage Counselor who wishes to work in a Family Planning agency. An agency, when screening prospective Counselors, should enquire into the training background of their applicants and satisfy themselves that the Counselor they hire will be able to meet the needs of their clients who wish counseling for sexual dysfunctions.

Another qualification for a Marriage Counselor in a Family Planning agency, though more helpful than necessary, is a background in doing training. Given the amount of training (if you accept this model) that a Family Planning Marriage Counselor will be required to perform, it would be extremely helpful if he had done
some training previously. At least theoretically a
background in training would better enable the Counselor
to deliver effective presentations to schools and groups
when Family Planning receives requests for speakers.

Funding for Marriage Counseling Programs

Research Question Seventeen:

What approach might an agency take to seek funds
for a Marriage, Family, and Child Counselor?

Though part of the purpose of this thesis is to
argue that a Marriage, Family, and Child Counselor should
be an integral part of Family Planning, and given equal
budget priority with traditional personnel, it is possible
to seek separate funding in the form of grants from
private foundations. This can be done one of several
ways.

If an agency is unable or unwilling to set aside
funds from its central budget, but still wants a Marriage
Counseling program, that agency could draw up a grant
proposal—using this thesis as an outline—emphasizing
the need to supplement existing services to guarantee
continued quality. A better method would be to hire a
consultant to write the proposal, tailoring it to the
agency's personal needs and expectations and again using
this thesis as a working outline.

Second to hiring a consultant, the next logical
alternative would be to hire a Marriage Counselor on a part-time basis and for a limited period having him perform Family Planning services, such as coordinating or training, or whatever the particular agency could accommodate. For the rest of the time the Marriage Counselor could offer his service for a fee, using the Family Planning agency as a source of clients. The agency could provide him office space and some advertisement plus some basic clerical assistance. In return the Marriage Counselor could himself develop and write a proposal, again using this thesis as a working outline. The agency could make an agreement to retain the services of the Marriage Counselor until they received word whether the proposal was accepted.

Where to send proposals is always a problem, but by no means an insurmountable obstacle. Essentially this problem requires some hours spent at a city or University library in the research section, tracking down names and descriptions of foundations and funding sources who would be amenable to such a proposal. The reason I suggest that first a consultant, and secondly the Marriage Counselor himself do the proposal writing is that they would already be familiar with research methods and would be in a position to locate funding sources. My rule of thumb has been, never be content
with sending only one proposal. Send many to different types of funding sources. Expect them to be rejected and be prepared to enquire why they were rejected, to make quick amendments and adjustments, and to then re-submit them. Be sure to gather as many supporting letters as possible to substantiate your claims. Try to get your Board of Supervisors or the Mayor's office to write a letter, do not be timid about asking for those letters. Tactful insistence will most often get you a letter.

Most importantly about proposal writing is knowing to whom you are sending your proposal, and what their philosophy for funding is. Never send your proposal to the name of a foundation, even if they give you a form to do so. Do some research and learn the name of someone and send the proposal to him. In this way you ask somebody to take personal charge of your correspondence. Then make some introductory statements to this person and to the foundation, stating briefly but clearly why you have sent your proposal to that source and not another. Try to convey an immediate sense that yours is not just another request for money, but a well researched and documented plan that has come to their attention on purpose, and not because you have taken their name out of a directory. No one can guarantee that this tact will get you money, but anyone who has ever sat on a funding
board will tell you that it will at least get your
proposal read—which, by the way, does not always happen.

*Special Projects*

Research Question Eighteen:

How will a Marriage, Family, and Child Counselor
benefit the broadening of Family Planning’s services?

Most knowledgeable people in Family Planning
circles would concur that the federal government intends
that Family Planning agencies develop broader and more
comprehensive services if they hope for any continuance
for federal support. Not surprisingly most agencies are
thinking in terms of comprehensive medical services,
such as vasectomy and pre-natal clinics or full time
doctors and nurses. While this thesis means in no way
to detract from those plans or deny the need for com­
prehensive medical services beyond birth control dis­
pensation, without commensurate professional counseling
services these programs will result in the same de­
ficiencies I have described in chapters 1 and 3. Medical
services are the answer for medical problems. When a
person breaks a leg, he goes to a medical doctor at a
hospital. Unfortunately, when a person is about to
divorce their spouse over severe marital tensions, or a
teenager is about to run away from home because he
thinks his parents hate him, this person is as apt to
ask Family Planning to help as they are anyone else. Commensurately Family Planning is equally apt to either send them to someone else or to have their doctor or nurse talk to them. Given the initial indication, it would appear that unless some attention is brought to this matter, Family Planning will expand its services on this same deficient model.

Individual agencies can reckon with this problem by the simple and expedient method of adding a Marriage, Family, and Child Counselor to its staff, and actively including his services in their program planning. At Tri-City Family Planning, the director is developing plans for the addition of a vasectomy and pre-natal clinic. At the same time, I am developing plans for an alcohol abuse program for Family Planning clientele, and a series of weekend workshops for families to receive training in communication and interaction. Neither my plans nor the director's are the products of our own wants. I developed a questionnaire in which I polled Family Planning clients opinions on what kinds of additional services they would like to see added, and from this poll I have begun plans to implement them. In other words, as part of my role of Marriage Counselor, I try to assess the needs of the community and clientele and see how Family Planning can provide for them.

If one wishes to consider this monetarily, suppose
that two to three years from now a Family Planning agency needed to be self-supporting. Workshops and public training events, when handled properly, do attract attendance and people are willing to pay for quality programs. As my own survey indicates, people are willing to pay for some types of workshops more than others, but the point is, they are willing to pay. I daresay, the same response would not be forthcoming if doctor's or nurses offered weekend workshops in what a family should do when someone breaks a leg, though admittedly, I have not conducted a survey on this matter.
BIBLIOGRAPHY


Appendix A
SOCIAL HISTORY FORM

TRI-CITY FAMILY PLANNING, INC.

DATE______

NAME

(First) (Middle Name)

ADDRESS

(Street) (City) (Zip Code)

PHONE #_________

HUSBAND'S NAME

DATE OF BIRTH_________

ETHNIC GROUP: (CHECK ONE)

PLACE OF BIRTH_________

CAUCASIAN__ MEXICAN__

BLACK__ ORIENTAL__

WHO REFERRED YOU TO US:

AM. INDIAN__ LATIN AM.____

ANOTHER PATIENT____

PHILIPPINO__ OTHER__

FRIEND/RELATIVE____ (Specify)

PUBLIC INFORMATION____

Number of Children:____

CLERGYMAN____

PRIVATE M.D.____

HEALTH AGENCY____

WELFARE DEPT.____

OTHER____

Have you ever been to any of our FAMILY PLANNING CENTERS
for the following services:

1. Pregnancy Test __ When ___ Where ___
2. Birth Control Methods When ___ Where ___
3. Birth Control Class When ___ Where ___

ARE YOU ON WELFARE NOW____

HAVE YOU BEEN ON WELFARE IN THE PAST TWO YEARS____

SOCIAL WORKER'S NAME____________________

COUNTY OF ______ CARD # ___________

Income: Husband Employed__ Self Employed__
Weekly Take Home $___ Seasonal Worker___

CATEGORY: RE-CERTIFY____________________

TYPE OF CONTACT: TELEPHONE: YES ____ NO____

MAIL: YES ____ NO____

OTHER: YES ____ NO____

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Appendix B

PREGNANCY INFORMATION FORM

Tri-City Family Planning, Inc. Date

CONFIDENTIAL: Pregnancy Information Form

NAME: ___________________________ Date (first day) of last period

ADDRESS: ________________________

CITY: ______________________________

PHONE: ____________________________

Date (first day) of last period

Age

Date of Birth

Marital Status:
(Circle One) S M D W L-T

L-T - Living Together

Can we call you at home? Yes No

If No, where and how can we reach you? ______________________________

Where did you hear about Family Planning? ______________________________

Have you ever been pregnant? Yes No

Have you any children living now? Yes No

If Yes, how many? __________________

Have you ever had a miscarriage? Yes No

Have you ever had an abortion? Yes No

If Yes, how many? __________________

When? ____________________________

Have you ever come to Tri-City Family Planning before? Yes No

If Yes, When? ____________________________

Why? ____________________________

Have you taken any drug in the past 72 hours? Yes No

If yes, What? ____________________________

Are you currently using any method of birth control? Yes No

If Yes, What? ____________________________

If birth control pills, What brand? ____________________________

Were you using that method when you think you became pregnant? Yes No

What, if any, OTHER methods of birth control have you used? ____________________________

If you are pregnant, do you feel you can talk to your parents about it? Yes No

Explain: ____________________________
Have you, or do you plan to discuss your possibility of pregnancy with your partner?  Yes  No
Explain: ________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
How old is he?  Does he work?

Do you want to be pregnant?  Yes  No

If you are pregnant, what is your main concern?

_______________________________________________________________________
_______________________________________________________________________

If you are pregnant, have you any plans?

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

SIGNATURE __________________________ DATE ______________
Appendix C

INTERVIEWER'S COUNSELING FORM

Tri-City Family Planning, Inc. Date

INTERVIEWER'S COUNSELING FORM FOR PREGNANCY TEST

Name of Client

Results of UPT Positive Negative Inconclusive

1. Describe the general mood of the client before you counseled her.

2a. If the results are positive: How did the client react when you told her the results of the test?

2b. If the results are negative: What did you counsel the client on regarding birth control?

2c. If the results are inconclusive: What have you advised?

3. What was the theme—or significant points—to the client's story?

4. What was the theme—or significant points—to your counseling?

5. What was the client's mood when she left?

6. What plans, if any, did the client have when she left?

7. What referrals, if any, did you make?

Signature of Interviewer Time of Client's Appt. Date

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Appendix D

PREGNANCY COUNSELING FORM

Tri-City Family Planning, Inc.

820 E Street
Union City, Ca. 471-3930

6214 Thornton Ave.
Newark, Calif. 797-1188

43000 Sumter Ave.
Fremont, Calif. 651-1033

PREGNANCY COUNSELING FORM:                     DATE_____________

NAME_________________________ DATE OF BIRTH_____________
ADDRESS_______________________ MARITAL STATUS:(CIRCLE ONE)
CITY___________________________ S M W D OR SEPARATED
ETHNIC GROUP: (CHECK ONE)
Caucasian_Portuguese
Black_Mexican
Am. Indian_Oriental
Filipino_Other

DATE_____________

HOME PHONE_____________
HOW/WHERE can we get in
touch with you_____________

First date of your last
menstrual period_____________

HAVE YOU EVER BEEN TO ANY OF OUR FAMILY PLANNING CENTERS
FOR THE FOLLOWING SERVICES?
PREGNANCY TEST____WHEN________________WHERE________________
BIRTH CONTROL METHODS____WHEN________________WHERE________________
CLASS____WHEN________________WHERE________________

HAVE YOU HAD ANY OF THE FOLLOWING?
ABORTIONS____(number)
MISCARRIAGES____(number)
LIVE BIRTH____(number)

ARE YOU TAKING ANY
DRUGS OR MEDICATION?
IF YES, PLEASE STATE
WHICH________________

CONTRACEPTIVE HISTORY
Of the following methods of birth control
check these methods which you know of and
those you have used:

<table>
<thead>
<tr>
<th>TYPE</th>
<th>KNOW ABOUT</th>
<th>HAVE USED</th>
</tr>
</thead>
<tbody>
<tr>
<td>PILL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONDOMS/RUBBERS</td>
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<td>DIAPHRAGM</td>
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<td>JELLY/FOAM/CREAM</td>
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<td>WITHDRAWL/PULLING OUT</td>
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<td>DOUCHING</td>
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Appendix E
PREGNANCY COUNSELING FORM

PLEASE ANSWER THE FOLLOWING QUESTIONS:

HAVE YOU DISCUSSED THE POSSIBILITY OF A PREGNANCY WITH YOUR PARTNER? YES NO

HOW DOES HE FEEL ABOUT IT?

IF YOU ARE PREGNANT, ARE YOU PLANNING TO TELL HIM? 

HOW OLD IS HE DOES HE WORK OCCUPATION 

WHAT ARE YOUR FINANCIAL RESOURCES 

IF UNMARRIED, CAN YOU TELL YOUR PARTNER?

SIGN ABOVE LINE

FOR INTERVIEWER ONLY:

TEST (UPT) POSITIVE NEGATIVE INCONCLUSIVE

COMMENTS:

Date Interviewer's Signature