

NON-DIRECTIVE COUNSELING

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In today's secular society, non-directive counseling is practiced for mother of fetuses with birth defects, for genetic counseling, for high risk pregnancies, and for any situation where abortion is an option. The aim of non-directive counseling is to present facts and options non-judgmentally. Non-directive counseling offers continuation of pregnancy and abortion as two 'reproductive options'. The non-directive counselor does not advise one option or the other.

Non-directiveness is felt to be an ethical imperative. The putative moral obligation to practice non-directive counseling is 'necessary' to prevent the counselor from impressing his/her values/beliefs on the patient. Non-directiveness is so well entrenched that it seems to have become the established state religion-everyone is obliged to believe and practice non-directive counseling. There are problems with non-directive counseling from a Catholic medical-moral perspective. These problems require a Catholic or pro-life alternative.

Non-directive counseling is not itself non-directive, since offering abortion implies approval thereof. Tone of voice and facial expressions may expose beliefs (Simpson, J.L. 1991). Non-directive counseling has biases which are not disclosed (Thorpe, et al 1995). One rarely hears about post-abortion syndrome, long term physical complications of abortion, or mortal sin in non-directive counseling (Hilgers, 1972; Rue, 1994; Ney, 1994). Is abortion really so good? If not, then non-directive counseling then serves to introduce a pro-choice agenda without any counterbalancing pro-life argument.

Non-directive counseling is offered in some situations but not in others, revealing underlying biases. It is not usually promoted to encourage fetal sex selection. Fetal sex selection is rightly seen as discriminatory to women. To the extent that non-directive counseling promotes abortion, it is harmful to affected fetuses. Current application of non-directive counseling in cases where fetuses have abnormalities reveals a bias against fetuses who have disabilities.

Theoretically, the non-directive counselor can counsel both pro-life and pro-choice patients. This is problematic because the doctor/counselor and patient may have different agendas. The doctor may offer abortion as a way to avoid lawsuits. Doctors may paint a bleaker picture of the babies prognosis before birth, while abortion is still an option, than after birth. Some counselors or doctors may feel abortion of babies with birth defects (or of babies whose mothers are poor) may reduce the costs to society in taxes, insurance costs and medical expenses. This outlook is utilitarian.

The mother's agenda is often quite different. She is usually concerned about her responsibilities to her child and her family, and she may fear the unknown stresses of a baby with an abnormality. She is often pro-life about her particular baby, which moves within her abdomen, even if she is not pro-life in general. The mother is not well served when she is counseled according to an agenda different from her own. Mothers should be able to request a pro-life counselor.

The non-directive counselor/doctor presents different options but doesn't tell the patient which one he thinks is best. This reveals a fundamental dishonesty in non-directive

counseling. The doctor who does not indicate which is the better option is not being forthright with the patient.

To make this point more graphically, let us use a hypothetical example. A patient has appendicitis. Hypothetically, the two therapeutic options are surgery and acupuncture. Assume that acupuncture has minimal therapeutic effect on appendicitis. The doctor presents these two options as having equal merit, and does not advise one over the other. The patient chooses acupuncture because it is cheaper and easier. The patient dies of ruptured appendix shortly thereafter.

The doctor who presents these two options as being of equal merit has not been completely honest. The doctor would certainly never counsel his own daughter in this way. The doctor can not care deeply about his patient, and yet care not at all about what his patient chooses. If the doctor really believed that abortion was best, he would have an obligation from honesty to tell his patient so. Non-directive counseling would then be immoral from the pro-abortion perspective.

Indeed, some have stated that non-directive counseling is not non-directive at all, and has never been. One rarely hears about post-abortion syndrome, long term physical complications of abortion (Hilgers, 1972; Rue, 1994; Ney, 1994), or mortal sin in non-directive counseling. Is abortion really so good that it has no significant medical complications? If not, then non-directive counseling then serves to introduce a pro-choice agenda without any counterbalancing pro-life argument.

Among the considerations above WE HAVE FORGOTTEN SOMEONE. Fetuses are not allowed informed consent for abortion. Since fetuses cannot give informed consent for abortion, it should never be performed on them. The baby, no matter what his condition, has a right to maternal love. No matter how short his or her life, he deserves and has earned at least one maternal embrace after spending nine months cooped up in a womb. Some postulate as to the future quality of life that a given baby may have. Such considerations are speculative. If a baby could talk back, he/she might say, "you cannot predict my future happiness."

Non-directive counseling ignores the traditional obligation of doctors to the fetal patient. In honoring his duty to the fetal patient, the doctor would have a moral obligation to advocate for the fetus and discourage abortion. Non-directive counseling is thus immoral from the pro-life and the fetal perspectives as well.

If non-directive counseling is immoral, what alternative can be offered by Catholic medical care? In the example above regarding appendicitis, many would consider the doctor immoral for not advocating surgery over acupuncture. The Hippocratic Oath contains a number of moral imperatives, including a proscription against abortion. The practice of medicine is inherently moral, and it is anomalous to try to remove morality from medicine. Catholic medical care should offer a moral alternative.

When the non-directive or pro-choice counselor offers a choice between abortion and continuation of pregnancy, the mother sees a tragic situation over which she has little control. She may look ahead to a painful pregnancy, followed by the tragic death of her baby, a journey of sorrow and misery. If the baby will live with a disability, she may wonder if she give the baby all the care it needs, and whether society will accept and appreciate her baby. She may feel that she can not shoulder all this by herself. She is left with two choices, both of which seem terrible.

In the Gospel of Life, the Holy Father offers guidance on euthanasia which could be profitably applied here. "The request which arises from the human heart in the supreme concentration of suffering and death, especially when faced with the temptation to give up in

utter desperation, is above all a request for companionship, sympathy, and support in time of trial. It is a plea for help to keep on hoping when all human hopes fail.” (Evangelium Vitae, 67). This is the support the Catholic or pro-life physician should provide, along with the family, friends, and parish. This is the third choice—a good choice. This way has been called the way of “love and true mercy” by the Pope (Evangelium Vitae, 67).

His Holiness Pope John Paul II reaffirms “every man is his brother’s keeper” (Evangelium Vitae, 34). Some situations are worsened, he states, by the “culpable indifference and negligence of those who in some cases could remedy them” (Evangelium Vitae, 10). Neutrality in abortion is neither licit nor legitimate. To provide loving, responsible and compassionate care we should encourage mothers to keep their babies and to love them.

The Catholic or pro-life physician should advocate for the fetus and against abortion. He/she should provide any treatment available. He should be eager to invent or devise a new treatment if one is not available. He should rally support from the family, parish, and/or community. He should encourage prayer. He will administer the greatest amount of healing when he supports both mother and child.

The Catholic or pro-life physician would do well to remember the example of St. Joseph. When the life of Jesus was threatened by Herod, St. Joseph took Jesus to Egypt. If Herod decreed that all infants should die, how could he enforce such a law? Such a law could only be enforced under pain of death. For St. Joseph and Mary to flee to Egypt, they were risking their lives for their child. It is not unreasonable to make an extra effort for fetuses in difficult situations. This must be done judiciously, and heroic treatments are not sensible in many cases. On the other hand, we can remember a relevant teaching of our Savior: “Whatever you did for the least of these, that you did also for me” (Mt 25:40).

The baby is the mother’s own flesh and blood. Whatever the doctor does for the baby, he/she also does for the mother. Whatever he does for the mother, he also does for the baby. **YOU CAN’T HELP A MOTHER BY HARMING HER CHILD.**

Decision-making in obstetrics has long focused on the baby’s interests versus the mother’s interests. We should not pit the mother’s interests against the baby’s interests as if they were opposing parties locked in gladiatorial combat. Here we can profitably quote Pope Pius XI. He notes: “Upright and most skillful doctors strive most praiseworthy to guard and preserve the lives of both mother and child; on the contrary, those show themselves most unworthy of the noble profession who encompass the death of one or the other, through a pretense at practicing medicine or through motives of misguided pity.” (Casti Conubii, P 64). We could reduce the wisdom of His Holiness to a simple terse medical commandment: **WE MUST SAVE BOTH.**

Non-directive counseling is not truly non-directive, is not entirely honest, is not fair to the fetus. It is problematic because the mother may be counseled according to an agenda which is different from her own. It is not consistent with Catholic medical ethics. Instead, the doctor should offer a “way of love and true mercy”, supporting the mother in her time of trial. The doctor should help the mother care for her baby, who is her own flesh and blood (**YOU CAN’T HELP A MOTHER BY HARMING HER CHILD**). The Catholic physician should be guided by what is best for both mother and baby (**WE MUST SAVE BOTH**). This would be true compassion.

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