VALUES CLARIFICATION WORKSHOP

modified from a workshop designed by Vicki Breitbart and Jini Tanenhaus of Planned Parenthood of New York City

The Values Clarification Workshop outline below is structured for a two-hour time slot and works best in small groups where everyone has the opportunity to participate. However, the Reproductive Health Access Project has used this workshop in a modified format for use during a 40-minute staff meeting, one-hour lunch break, or spread out over several sessions. By shortening each section or by selecting only some of the exercises, it is possible to fit this valuable material into a shorter period of time, without compromising the important messages being imparted. Values Clarification Workshops are best led by individuals with training in mental health and group process. Use this workshop curriculum in an in-person or virtual setting with videoconferencing.

VALUES CLARIFICATION WORKSHOP

Goals: To provide an opportunity for staff who are new to the provision of abortion care to assess their attitudes and beliefs regarding the issues surrounding abortion.

Objectives: After this workshop, staff will be able to:

1) identify the myths and reality *surrounding* the provision of abortion care in this country and the people who have abortions.

2) identify their own beliefs and attitudes towards the provision of abortion care and the people who have abortions.

3) separate their personal beliefs from their professional role in the provision of abortion care.

Materials:

In-Person:

- markers
- signs with "agree" and "disagree" written in large, bold letters
- sign with ground rules
- printed copies of abortion fact sheet
- printed copies of sentence completion forms
- index cards
- pens, pencils

Virtual:

- Google Jamboard or other "whiteboard" platform
- electronic copies of abortion fact sheet
- electronic copies of sentence completion forms
- breakout rooms enabled
- Google form
- slide with ground rules

I. Introduction — 5-10 minutes

Invite participants to go around and introduce themselves, their role in the health center, and something they are looking forward to in this workshop. Facilitator describes the goals and the objectives for the session.

II. Establishing community guidelines and norms — 5 minutes

Use this time to establish ways of working together. Facilitators present ideas and welcome participants to share their own ideal guidelines. Facilitators can take notes on board or on a slide shared on the facilitator's screen. Participants in this workshop will be discussing very sensitive, challenging issues and they need a non-judgmental, brave, safe-to-fail environment. Examples: Keep everything confidential, welcome multiple viewpoints, actively listen even if we disagree, there are no wrong answers, step up and step back, take risks: lean into discomfort, notice and name group dynamics in the moment, challenge with care. Facilitator's can review RHAP's Community Guidelines and AWARE-LA's communication guidelines for creating a brave space for ideas.

III. Breaking the News — 5-10 minutes

Facilitators ask participants to pair up for a role play (or assign breakout rooms in pairs). One partner plays the "clinician" and the other the "patient." The clinician tells the patient that they are pregnant. The "patient" doesn't want to be pregnant. After one minute, the roles are reversed and the other partner plays the clinician breaking the news.

After, the group comes back together to debrief. Facilitators ask participants to describe the most helpful aspects of the way the "clinician" broke the news. Take note of participants' answers on the board or on a virtual whiteboard (example answers may include: "non-judgmental", used sympathetic body language, etc.)

(Use this exercise as an alternative to IV "establishing empathy" that follows.)

IV. Establishing empathy — 20-25 minutes

Exercise 1: A Time When You Needed Help

Facilitators ask the group to think of a time when they were in trouble, had a problem, or were in a crisis and went to someone for help – it could have been a friend, a teacher, a family member, someone from your place of worship, a counselor, etc.

Participants are then asked to choose someone sitting near them or will be assigned to breakout rooms in pairs. One member of each pair is asked to talk to their partner

about what it was like to ask for help. After two minutes the other person is given a chance to talk about their experience asking for help.

Before the pairs break out, the facilitator should stress that when participants are listening to their partners, they can use what we call "minimal encouragers, things like "uh huh" or "mm" to indicate their active listening, but they are not to ask questions or give any verbal response to their partner.

After the allotted time, the facilitator asks the group to come back together to discuss the following prompts, taking note of responses on a board or virtual whiteboard.

What did you hear it was like for that person to ask for help?
What was your partner's message about what was helpful?
What was your partner's message about what was NOT helpful?
What are the important values in dealing with someone in a crisis?

Exercise 2: Stand Up/Sit Down

The facilitator asks everyone to stand up or to turn on their video and introduces this exercise by saying:

We all do things that we "know better" not to do even though we know the consequences.

Now sit down/video off if you smoke.
Now sit down/video off if you eat too many snacks.
Now sit down/video off if you J-walk.
Now sit down/video off if you work too hard or too many hours.
Now sit down/video off if you spend too much time on social media.

The exercise ends when no one is left standing/with their video on.

The facilitator points out that:

We have all done something we know isn't good for us even though we know what the consequences could be. One of these things could even be having sex without contraception at a time when we did not want to become pregnant. We all have the right to do things that, sometimes in hindsight, we realize we probably should not have done. Some people may view those things as "bad choices. "How do we provide a service without imposing our judgment on others? There is nothing we do in life that doesn't invoke judgement from ourselves or something else. What we should strive for is to separate the personal from our professional responsibilities and to relate to clients' experiences and needs in their own terms.

V. Myths About Abortion 15-20 minutes

Ask participants to share what they have heard about abortion -- what myths, stories, uncertainties do people say about abortion and people who get abortions? For instance, maybe they are "selfish," they didn't use birth control and that's why they got pregnant, abortions cause breast cancer, etc. The facilitator lists the responses on a board or virtual whiteboard, or collects them on the Zoom chat.

After brainstorming a list of stereotypes and myths, hand out the factsheet or send a virtual copy via the Zoom chat and share information about the reality of abortion in the U.S. Discuss the different points and invite participants to share how these facts challenge what they have heard people say about abortion.

VI. Values Clarification 30 minutes

The facilitator asks the group to stand and explains that they are going to read statements about abortion. They have designated one side of the room for people who "strongly disagree" by posting a sign on the wall and the other side of the room for people who "strongly agree." In a virtual platform, you can either use a Jamboard with labels "strongly disagree" and "strongly agree" on either side of the Jamboard and create miniature icons in the center. Invite participants to choose an icon and move it along the Jamboard to express their feelings about the statement. Alternatively, in a virtual environment invite participants to "raise their hand" if they agree or remain as is if they disagree or are uncertain.

The facilitator explains that after each statement is read, people will move to where they think they are on the continuum. They can either move to where the sign is or anywhere else in the room (or Jamboard) that designates where they believe they fit. The middle of the room/Jamboard is neither agree or disagree, close to the sign that reads "strongly agree," but not directly under it, would be "somewhat agree."

To warm folks up, the facilitator explains that the first example is not related to abortion but will give people the experience of moving to a place in the room/Jamboard that best represents their response to the statement. For instance:

I love chocolate cake, or
I love to travel

Then the facilitator reads one of the statements on the Value Clarification Statements list below. After the group stops moving to their positions, the facilitator invites a few people to explain why they moved to/chose where they are. The participants invited to speak should be

chosen from various different positions in the room/Jamboard. After, if there is time, open the floor to general discussion and reactions to the different ideas that were expressed.

VALUES CLARIFICATION STATEMENTS

- Every person has the right to choose to terminate a pregnancy.
- Parental notification should be required for any teen requesting an abortion.
- People who have more than one abortion are irresponsible.
- It does not matter why someone wants an abortion.
- Partners should have the right to be part of the decision about terminating a pregnancy.
- Abortions should be legal only up to a certain gestation.

VII. Worst Fears 10-20 minutes

The facilitator asks the group to write on an index card or via anonymous Google Form the questions or statements they are most afraid a patient might ask them regarding abortion and/or your worst fears about providing abortion care in practice. The questions are not signed but are collected. The facilitators go through the questions, answering some of them and opening up the discussion of the answers to the group.

Some examples a patient may ask: "Can I see the baby after you do the abortion?" or "Don't you feel like you are a murderer for doing abortions?" or "Do you think I'm a bad person?"

VII. Sentence Completions 5-10 minutes

As a closing exercise, pass out or electronically send the following worksheet on Values Clarification Sentence Completions. Invite participants to take 5-10 minutes to reflect and fill out their responses to these statements. If there is time, you can also invite participants to share out some of their sentence completions (verbally or in the chat if on a virtual platform) and reflect on how their responses may have been different prior to the values clarification workshop.

VALUES CLARIFICATION SENTENCE COMPLETIONS

1. Abortions are:

2. People who have abortions are:

3. A person facing an unwanted pregnancy should:

4. With a patient who has an unwanted pregnancy, the role of a primary care clinician should be:

5. My biggest concern about introducing abortion care into our practice is:

6. If we provide abortion care here, I am afraid that:

7. Providing abortion care here is:

8. In this country, abortions should be:

Myth Busting: Facts About Abortion

The majority of the following statistics report specifically on women's experiences with abortion care. However, many transgender and non-binary patients also experience pregnancy and abortion. Data regarding these patients' care is alarmingly limited; most nationwide studies overlook these demographics entirely. More research must be conducted to analyze transgender and non-binary patients' unique healthcare experiences and, more generally, to comprehensively report on reproductive healthcare in America.

Abortion Overview

Abortion Statistics

- 1 in 4 women in the United States will have an abortion by age 45. [2014]
- In 2020, 930,160 **abortions were performed** in the United States, down from 862,320 in 2017. Altogether, about 1 in 5 pregnancies ended in abortion. [2020]
- In 2014, fifty-one percent of women getting abortions reported that they used contraception during the month they became pregnant. [2014]

Unintended Pregnancy

- Each year almost 50% of all pregnancies among American women are unintended. [2011]
- At least half of American women will have an unintended pregnancy by age 45. [2013]

Abortion Patient Demographics

Patients who have abortions are from all racial, ethnic, and religious backgrounds [2014]

- White women account for 39% of abortions, black women for 28%, Latinx women for 25% and women of other races for 9%
- 30% of women obtaining abortions identify as Protestant, 24% identify as Catholic, and 34% reported no religious affiliation

Patients have abortions at different times in their lives [2014]

- 12% percent of American women obtaining abortions are teenagers
- Women in their 20s account for more than 60% of all abortions
- About 59% of abortions are obtained by women who have 1 or more children
- Women who have never married and are not cohabiting account for 46% of all abortions

Low-income patients are more likely to have an unintended pregnancy [2011]

- 49% of women obtaining abortions have incomes below 100% of the federal poverty level ($11,670 for a single woman with no children) [2016]
- 26% of women obtaining abortions have incomes between 100–199% of the federal poverty level [2016]

Types of Abortion

Abortion Procedure

- Surgical abortions are generally well-known in US popular culture. They are relatively quick procedures which occur in a clinical setting [2022]
- Surgical abortions are both safe and effective, having a 99% success rate [The Reproductive Health Access Project, 2022]

Abortion Pills

- Medication abortions typically involve a combination of two medications, mifepristone and misoprostol, which can be provided safely and effectively in the US up to 11 weeks gestation [2022]
- Medication abortions are safe, accessible, and effective, working 98-99% of the time [The Reproductive Health Access Project, 2022]
- Medication abortions are central to US abortion care, accounting for more than half (54%) of all US abortions [2022]

Self-Managed Abortion (SMA)

- Self-sourced medication abortions, in which pills are obtained by person instead of being directly provided by a clinician or in a clinical setting, are known as "self-managed abortions" [2022]
- There are many reasons why someone may choose SMA; because it is the most accessible option to terminate their pregnancy, to avoid discrimination and stigma in the health care setting, and even because it can feel more private, "natural," or empowering [2022]

Safety

- Studies demonstrate that self-managed abortion is safe and effective when patients can access accurate information on how to use the pills (mifepristone & misoprostol, and misoprostol alone) and when to seek help [Abortion On Our Own Terms, 2022]
- Fears of "coat-hanger" or "back-alley" abortions date back to a medical and sociopolitical landscape predating *Roe v. Wade*. Today, medication abortion makes self-managed abortion care a safe option for patients [2022]

Medication Abortion Reversal

- There is no evidence-based study to support George Delgado's claim that medication abortion is reversible, and the American Congress of Obstetricians and Gynecologists say the chances of "reversing" an abortion after mifepristone administration is the same (30-50%) as taking the mifepristone alone, not taking the misoprostol and waiting it out [ACOG].

Abortion Complications (or lack thereof)

A first-trimester abortion procedure (which account for 92% of all abortions) is one of the safest medical procedures and carries minimal risk – less than .05% – of major complications that might need hospital care [2018]

Abortion and Mental Health

- According to numerous major studies over the past 50 years, there is no significant scientific evidence that the rates of mental health problems for patients with an unwanted pregnancy are any different if they had an abortion than if they gave birth. [The American Psychological Association, 2022; Turnaway Study]
- What psychological research does demonstrate is that denying someone an abortion that they want is a detriment to their physical and mental health [The American Psychological Association, 2022; Turnaway Study]

Abortion and Cancer

- Research has shown that patients who have had an abortion are no more likely to develop breast cancer than patients who have not had an abortion; there is also no indication that abortion is a risk factor for other cancers. [The American College of Obstetricians and Gynecologists, 2021]

Abortion and Infertility

- There is no scientific evidence which demonstrates that patients who have had an abortion are at a greater risk of infertility than patients who have not had an abortion. [The American College of Obstetricians and Gynecologists]

Abortion Access

Abortion among Teens [Advocates for Youth, 2022]

- Teenagers are disproportionately affected by restrictive abortion policies because they are less likely to be able to take time off of school, afford travel expenses, or maintain privacy over their personal healthcare decisions
- Though most pregnant minors choose to tell their parents, many young people cannot tell their family about their pregnancy status
    - 20% of pregnant minors have experienced physical abuse by a parent or caretaker
    - 30% of pregnant teenagers who did not tell their parents about their abortion reported fearing violence or physical displacement
- Teens are more likely to experience delays in having an abortion until after 15 weeks of pregnancy, when the medical risks associated with abortion are significantly higher [2013]

Legal Barriers for Teens [Advocates for Youth, 2022]

- The majority of US states require that minors notify or receive consent from their patients to terminate a pregnancy
- These parental involvement laws:
    - delay or prevent abortion care entirely, leading to more expensive and later-term abortion procedures or carrying an unwanted pregnancy to term
    - can put young people's safety at risk
    - disproportionately affect undocumented youth
- Research demonstrates that parental involvement laws have no clear impact on abortion rates and almost no impact on a young person's decision to disclose their pregnancy status to their guardian

Judicial Bypass [Advocates for Youth, 2022]

- "Judicial bypass" allows minors to receive abortion care without involving a legal guardian. Acting as another barrier to access, the policy requires that young people receive court approval to have an abortion
- More details on state-specific parental involvement and judicial bypass policies can be found on the Guttmacher Institute's "Parental Involvement in Minors' Abortions"

Legal Barriers Nationwide

Across the United States, restrictions on legal abortion vary widely. These differences are becoming even more stark since June 24th, 2022, when the Supreme Court of the United States struck down *Roe v Wade*, no longer guaranteeing Americans a constitutional right to an abortion. With a rapidly changing reproductive healthcare landscape, resources tracking state-specific, day-by-day changes to abortion policies can be found at the following:

- Interactive Map: US Abortion Policies and Access After Roe (Guttmacher Institute)
- What if Roe Fell? (The Center for Reproductive Rights)