An Evaluation of the Earn While You Learn Program at the Pregnancy Support Clinic/Options Now of Valdosta, Georgia

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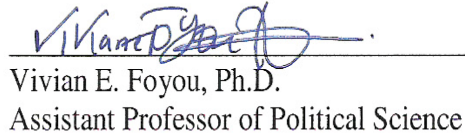

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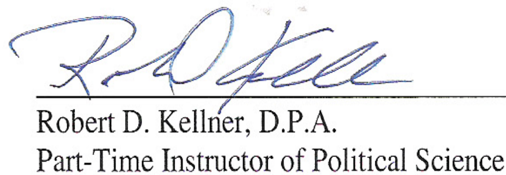

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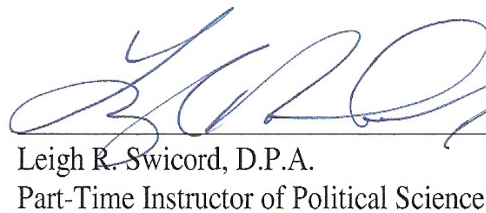

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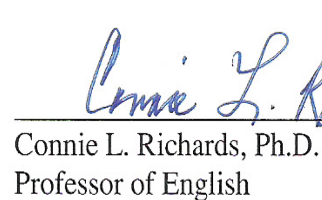

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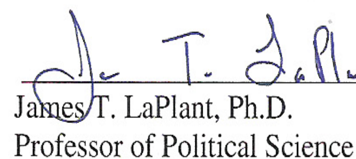

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ABSTRACT

This mixed-methods exploratory study examines the efficiency of the individual format of the Earn While You Learn (EWYL) program, as utilized by the Pregnancy Support Clinic/Options Now of Valdosta, Georgia. The EWYL program is provided to expectant teens in need of educational and material assistance to equip them for parenthood. This program has not previously been evaluated, an important step due to the widespread national use of this program within the Crisis Pregnancy Center community. Archival data collected over the years 2007-2011 was analyzed for this purpose. The total number of clients included in this study was 4,113, with 296 of them being participants in the EWYL program. Data from the two different formats of the EWYL program (the *individual* versus the *class* formats) were statistically analyzed for possible correlations. Data for the variables of time expenditure, cost expenditure, number of EWYL clients and appointments, and number of Abortion-Minded/Abortion-Vulnerable (AM/AV) clients were analyzed for correlations in relationship to the format type. Analysis revealed a positive correlation between format type and time expenditure, a negative correlation between format type and cost expenditure, as well as a positive correlation between format type and number of EWYL appointments. These findings demonstrate that the individual format directly results in an increased number of EWYL appointments as well as a corresponding decrease in cost expenditure. Further analysis also revealed an increase in client retention in relation to the individual format. Recommendations for future studies include the use of survey instruments on EWYL participants before and after participation in the program.

TABLE OF CONTENTS

I: INTRODUCTION 1
Statement of the Problem 9
Purpose of the Study 9
Research Questions 16
Importance of the Study 17
II: LITERATURE REVIEW 20
The Pregnancy Journey 20
Teen Pregnancy 22
The Life vs. Choice Debate 28
Pregnancy Support Centers 35
The Pregnancy Support Clinic/Options Now of Valdosta, Georgia 40
Education During Pregnancy 43
Earn While You Learn Programs 47
Group vs. Individual Format 48
III: METHODS 51
Research Hypotheses 52
Data Sources 54
Data Reliability 54
Research Methodology 58
Testing the Hypothesis 59
Study Procedures and Statistical Analysis 65
IV: RESULTS 67
Findings 67
Demographic Findings 67
Interview Findings 69
Results of Research Question One 75
Results of Research Question Two 76
Results of Research Question Three 77

Results of Research Question Four 80
Summary 81
V: DISCUSSION 84
Implications..90
Study Limitations 92
Recommendations for Future Research 93
Conclusion 95
REFERENCES 96
APPENDIX...104
Appendix A: Institutional Review Board Exemption Letter 105
Appendix B: Interview Questions.. 107

LIST OF TABLES

Table 1: Pregnancy Support Clinic of Valdosta's Client Statistics 2007-2010 4

Table 2.1: Teen Birth Rates World-Wide 23

Table 2.2: 1996 International Teen Pregnancy Rates 23

Table 2.3: 2010 Statistics for the Pregnancy Support Clinic of Valdosta 43

Table 3: EWYL Program Costs 2007-2011 65

Table 4.1: Racial Demographics of PSC Clients 2007-2011 68

Table 4.2: Age Data Breakdown of PSC Clients 2007-2011 69

Table 4.3: Variable Breakdown of Data 2007-2011 74

Table 4.4: Cross-tabulation of the Variables 75

Table 4.5: Bar Graph of Variables 2007-2011 76

Table 4.6: Comparison of Proportions of Total Clients who Participate in EWYL 78

Table 4.7: Number of EWYL Appointments Per Month 79

Table 4.8: EWYL and AV/AM Clients 2007-2011 81

Table 4.9: Red Rose Babies 2007-2012 83

LIST OF ACRONYMS

AM – Abortion-Minded

APT – Appointment

AV – Abortion-Vulnerable

CLT/CLNT - Client

CPC – Crisis Pregnancy Center

EWYL – Earn While You Learn

M – Mean or average

N – Total number of clients in the sample

n – Subsection of clients within a category of the study

P – Probability

PAS – Post Abortion Syndrome

PT – Pregnancy Test

PSC – Pregnancy Support Clinic/Options Now

PTSD – Post Traumatic Stress Disorder

SD – Standard Deviation

STI – Sexually Transmitted Infection

US – Ultrasound

GLOSSARY

Abortion-Minded. This term refers to the mental state of a woman who is pregnant. This indicates that she intends to abort the pregnancy and has expressed this desire to her intake counselor when seeking counseling services.

Abortion-Vulnerable. This refers to the mental state of a woman who is pregnant. This indicates that she is in a vulnerable situation and has a higher chance than average of choosing abortion due to her circumstances. There are specific criteria the intake counselors use to determine if a client is abortion-vulnerable, and only when a client meets the criteria is she categorized and logged as Abortion-Vulnerable.

Class. For the purposes of this study, this describes the format of the Earn While You Learn Program which is structured in a class format, teaching the curriculum to groups of clients at once.

Earn While You Learn. This is the curriculum which can be purchased by Crisis Pregnancy Centers for the purpose of educating and equipping young pregnant women in areas such as pregnancy, childbirth, caring for an infant, and parenting. This is the program being evaluated in this research study.

Individual. For the purposes of this research project, this describes the format of the Earn While You Learn Program which is structured in a one-on-one format, teaching the curriculum to the clients on an individual basis.

Post Traumatic Stress Disorder. A severe anxiety disorder that can develop after exposure to any event that results in psychological trauma. Symptoms include flashbacks or nightmares, difficult falling asleep, anger, and hypervigilance.

Post Abortion Syndrome. A form of Post Traumatic Stress Disorder believed to be triggered by the experience of an abortion. Symptoms include guilt, depression, anxiety, flashbacks and nightmares of the abortion event, suicidal ideation, drug and alcohol abuse, and eating disorders.

Red Rose. This phrase refers to any infant or child carried to term and born to a mother who had at one time intended to abort him or her. Regardless of whether this child is parented by his or her biological mother or is adopted out to loving parents, he or she is categorized by Crisis Pregnancy Centers as a “Red Rose” baby, or a life that was saved.

ACKNOWLEDGEMENTS

Special acknowledgement and my sincerest gratitude to Becky Deas, Executive Director of the Pregnancy Support Clinic, for so graciously working with me on this project. A special acknowledgement and special thanks to Pam Whitlock for so patiently and diligently collecting all the necessary data, which was quite a time-consuming process. Without the two of you, this research certainly would not have been possible! Thank you to everyone who participated in this study in any way—I hope that this work will be an important contribution to the steadfast battle to which you are so dedicated.

A special acknowledgement goes also to Dr. Leigh Swicord, Dr. Mary Eleanor Wickersham, Dr. James Peterson, and Dr. Bonnie Peterson for “pre-viewing” this project and giving me the confidence to move forward with it. I appreciate more than I can express the time you invested and the encouragement you gave me which propelled me to this point. You went “above and beyond” to help me reach this milestone, and I will be eternally grateful!

A special acknowledgement and note of appreciation to my entire committee, without whom this project, and this dream of mine, would have never come to fruition—thank you to Dr. Vivian Foyou, Dr. Robert Kellner, and Dr. Leigh Swicord, for your steadfast dedication, your endless patience, and your contribution of time and expertise. Your work “behind the scenes” does not go unnoticed!

Finally, I must acknowledge and thank the many friends, colleagues, and cohorts who participated in the reviewing process, lent words of encouragement during times of stress, supported me during this lengthy process, and spoke words of prayer on my behalf. You were an instrumental part of this work and my ability to complete it—THANK YOU!

DEDICATION

This work represents many hours of time spent pouring over academic journals, books, data, and analyses. The time spent on this dissertation was time sacrificed by my family. I do not take lightly this sacrifice, and know that my children sacrificed more than any others—without their support and willingness to allow me to do this, my lifelong dream would not have been realized. I dedicate this work and all that it represents to my four beautiful children: Daniel, Dawson, Kristann, and Drew. May this always stand as an example to you that no dream is too big, no mountain too high, and that it is never "too late" to pursue that which you are called to do. "With God, **ALL** things are possible!" (*Matthew 19:26 NIV*). May every dream you have come true!

Chapter I

INTRODUCTION

In today's society, abortion remains a very controversial issue. Because unplanned pregnancies are a regular occurrence, local communities have developed several methods for addressing this issue. For young women who learn they are expecting a child, there are three clear choices where they may seek assistance. The most obvious choice is an obstetrician, a physician who specializes in the care of women during pregnancy, as well as the care of women during the labor and delivery process. For women who absolutely are not prepared to become a parent, there are two other choices: abortion or adoption. Both abortion clinics and adoption agencies are in or near most communities, so an unprepared expectant mother may seek services at either facility. Unfortunately, all three of those facilities generally assume at the first appointment that the mother is certain of her choice, and rarely are any other alternatives discussed. For this reason, there have been women who have felt pressured into parenting, aborting, and adopting alike. Over time it became clear that there was a real need for a fourth option—one that would patiently assist such women with making a sound decision, after considering all options. With that realization came the formation of Crisis Pregnancy Centers across the United States (U.S.). Crisis Pregnancy Centers (CPCs) primarily seek to help women confirm pregnancy, first of all, and then educate women on their options

so that they are better equipped to make an informed decision. CPCs are usually non-profit agencies developed and supported by their own local communities as a result of the tremendous need that has already been observed. CPCs are governed by state and federal laws and also operate under the regulations of one or more of several overseeing national organizations, such as CareNet, Heartbeat International, and Birthright International (Family Research Center 2009).

The first network of CPCs was established in Canada in 1968 by Birthright International (Family Research Center 2009). Birthright subsequently served as a foundational model for later centers and is known as the world's first international crisis pregnancy service. Its international headquarters remain in Toronto, Ontario Canada, even today (Family Research Center 2009). Simultaneously, the first modern pregnancy center in America opened in California in 1968, expanding to nearly 70 such sites within the next three years (Family Research Council 2011). Following the legalization of abortion with the *Roe v. Wade* (see p. 28) court decision of 1973, the need for a service to educate a woman of her options and allow her to make an informed choice became even more paramount. In the *Roe v. Wade* case, the Court ruled that a woman's right to choose abortion fell under the right to privacy under the due process clause of the 14th Amendment, making abortion in the first trimester a legal option for women across America (*Roe v. Wade*, 410 U.S. 113, 1973). Seven short years later, the Christian Action Council (now known as CareNet) formed its first center in Baltimore, Maryland, in 1980, essentially the U.S.'s version of Birthright International (Family Research Center 2009). CareNet has since grown tremendously. For example, CareNet pregnancy centers saw

over 370,000 clients last year alone (CareNet 2011). Heartbeat International (formerly known as Alternatives to Abortion) was founded in 1971 (Family Research Center 2009). Heartbeat International centers have more than doubled in number over the last ten years, a testament to the exponential growth of CPCs within the U.S. There are over 4,000 CPCs in the U.S. today (as compared to under 750 abortion clinics) (CareNet 2011).

CPCs, sometimes also referred to as Pregnancy Resource Centers (PRCs), are typically non-profit organizations established for the purpose of preventing abortion. Although their primary purpose is to prevent abortion, they are regulated by laws and regulations so that they cannot legally pressure or openly discourage any client from choosing abortion. On the contrary, CPCs simply hand out brochures detailing common side-effects to the various abortion types and answer questions when asked about abortion choices. CPCs are very concerned about women who have previously had an abortion and are experiencing side-effects; so much so that most CPCs now have programs with the specific purpose of helping post-abortive women deal with the various side effects. Many CPCs now offer both post-abortion counseling as well as post-abortion support which focus on helping the women heal emotionally. CPCs primarily provide counseling related to abortion, pregnancy, and childbirth, but those that qualify as medical clinics also provide pregnancy testing, sonograms (ultrasounds), Sexually Transmitted Infections (STI) testing, and other services (Family Research Center 2009). In addition, they also offer counseling for women who have been raped, molested, or sexually abused, as well as women who are struggling with substance abuse.

In 1991, the local community of Valdosta, Georgia, resolved to address the vast number of unplanned pregnancies, particularly among teenage girls, by establishing a CPC, known as the Pregnancy Support Clinic. The Pregnancy Support Clinic (PSC) of Valdosta, Georgia, is an affiliate of CareNet and strives to maintain excellent standards in all areas. The PSC opened a satellite clinic called Options Now, also in Valdosta, in 2006 and adapted their name at that time to the Pregnancy Support Clinic/Options Now. This research project is a collaborative effort done in conjunction with the staff members of the PSC for the purpose of providing new, useful information to them. This research study is a basic program evaluation of the Earn While You Learn program utilized by the PSC. The PSC currently sees an average of 1,292 clients per year (this number is based on the total number of clients seen annually over a four year span), administers an average of 458 pregnancy tests per year (this number is based on the total number of tests given annually over a four year span), and administers an average of 239 ultrasounds (this number is based on the total number of ultrasounds given annually over a four year span). Table 1.1 (below) shows a breakdown of the data described above:

Table 1: Pregnancy Support Clinic of Valdosta's Client Statistics 2007-2010

Service Type	2007	2008	2009	2010
Ultrasounds	238	265	247	205
Pregnancy Tests	452	514	449	420
Clients Served	1364	1562	1187	1055

Pregnancy Support Clinic of Valdosta's Client Statistics 2007-2010, (*Pregnancy Support Clinic* (2012).

These statistics are reflective of Valdosta's local community only. All services offered by the PSC are free of charge to the client, allowing many low-income pregnant women to receive services they would otherwise not receive. The PSC also gives educational opportunities to many who are typically deprived of such opportunities.

Client Description

Literature suggests that the majority of young women in crisis pregnancy situations are young, aged 15-24, unmarried minority women living in urban areas. Demographic information obtained from the eKyros system (national CPC database) concurs with this summation. Of the 270 clinics across the nation who use eKyros, 54% were between the ages of 15 and 24; 66% of the 15 to 19 year olds in that year were unmarried (eKyros 2010). These numbers are consistent with literature on the age and demographics of crisis pregnancies (Kost, Henshaw, & Carlin 2010; United Nations 2011; Henshaw, Singh, & Haas 1999). From a national standpoint, CareNet centers alone (1,100 in number) saw 372,267 clients in 2009 (CareNet 2011). That figure computes to equal over 7,000 clients per week, a number far above the annual figure for the PSC (CareNet 2011). Including the figures of the PSC (because they are a CareNet affiliate), CareNet centers in 2009 relied on a team of more than 31,600 volunteers to provide pregnancy tests, counseling, ultrasounds, maternity necessities, and community education to the clients they served (2011). Ninety-five percent of their 372,267 clients chose to continue their pregnancies to term (either opting to parent or to adopt) rather than abort (CareNet 2011). Including other networks (other than just CareNet) in the figures, PRCs assist an average of 6,500 Americans (male and female, of all ages) with pregnancy and

sexuality related concerns each day (Family Research Council 2011, 31). The national abortion rate in 2009 tumbled 25% to a record "post-Roe" low—a trend that even *Time Magazine* credited in part to crisis pregnancy centers (CareNet 2011). This statement refers to a significant decrease in abortions in recent years, citing that it is at its lowest annual rate since the court decision which first legalized abortion in 1973, forty years ago. In essence, *Time Magazine* is attributing this drop to the diligent work of crisis pregnancy centers across our nation. These statistics are a powerful statement of proof of what centers just like the Pregnancy Support Clinic are doing all across America. One of the goals of this research is to aid the PSC in achieving excellence in their standards of service, and, in doing so, contribute in some small way to the battle to save unborn lives right here in Valdosta, Georgia.

Research Project Description

This is an exploratory study (due to the paucity of data) being conducted for the purpose of gleaning new information for the local crisis pregnancy center, the PSC. This study is representative of this particular clinic only and cannot be applied to any other clinic. The researcher in this case is an outsider working in conjunction with insiders (Herr & Anderson 2005). The process of determining the subject of research was a collaborative one. After a meeting with the Executive Director and other staff members, it was determined that a formal evaluation of the EWYL program would be beneficial to the clinic. The EWYL program has never been formally evaluated at any clinic, and this clinic in particular needs to know if there is a significant difference in efficiency between the class and the individual format of the program. The clinic staff and Board of Directors

continually evaluate and re-evaluate their programs and methods of service. A primary goal of the clinic is to meet their clients' needs in the most efficient way possible. The EWYL program is a curriculum that the clinic purchased to aid them in the education of the clients who choose the options of parenting or adoption. This curriculum teaches the client via video format, booklets, and worksheets in combination with client-counselor interaction. There are different segments of curriculum targeting the choice and the stage of pregnancy of the client. For those in the early pregnancy stages who are choosing to parent or place their child for adoption there is a segment which teaches about the changes a woman goes through during pregnancy and how to best care for herself and her baby. The client is also educated on the labor and delivery process and the options for pain relief that a woman has. These videos are appropriate for any client who will be going through this process. For clients who choose to parent, there are other curriculum packets to teach the client how to take care of a newborn baby, how to care for herself post-delivery, and also how to parent her child as he or she develops and grows. For clients who choose abortion, these videos are not shown as they are not applicable for them. Instead, educational material on possible side effects is given, as well as information about post-abortion counseling and support groups are offered. For women who choose to participate in this program, they earn "Mommy Money" for each worksheet and video segment they complete. They use the "Mommy Money" to purchase maternity clothing, infant clothing, diapers, strollers, other baby items, and even car seats. This helps alleviate the financial burden many of these women face and just knowing that these options exist often helps a client feel more confident that parenting could be an

option for her in spite of her perceived financial situation. This process lends itself well to the name "Earn While You Learn," as this is exactly what the clients are doing—earning essential items while learning the information they need to be adequately prepared for the pregnancy and parenting journeys. This is a great resource that the clinic is able to offer and is often viewed as a factor in the ultimate decision of the AM/AV client.

The EWYL program has been used at the PSC for nearly ten years, but during that time the format of use has been altered several times in an effort to find the most effective form of usage. Initially, the clinic utilized the one-on-one, or individual, format to teach the EWYL curriculum to its clients. However, after some time, it was decided that perhaps the class format would allow more clients to take advantage of the program benefits, while freeing up more of the counselors' time for regular pregnancy tests (PTs) and pregnancy option counseling, the primary focus of the PSC. After using the class format for approximately two years, it was then suspected that fewer clients were participating over time and its effectiveness was subsequently being diminished. After soliciting input from staff members, the Board determined it was prudent to revert back to the individualized teaching format. Over the last two years, staff and Board members have repeatedly examined the participatory numbers in an attempt to determine if the format change has indeed increased client participation. They suspect that the individual format has increased client participation, has decreased clinic time/cost expenditure, and has possibly even increased the number of AM/AV clients being seen at the clinic. However, the act of simply looking over the numbers alone is not a definite way of determining those factors with certainty. For this reason, the Executive Director

collaborated with the researcher to examine the data and make the determination of which format of the EWYL program is most efficient.

Statement of the Problem

In order to discover ways to address the problem of inefficiency of service, studies must be conducted on specific services within the PSC. The problem being investigated by this particular study is the comparable efficiency of the two different teaching formats of the EWYL program being utilized by the PSC. In order to ascertain which format is more efficient in terms of usage of the least amount of time and money, the cost and time factors of both formats must be examined closely. The time and money expended on each presentation format of the EWYL program will be compared to find out which is more efficient. Another problem being explored by this study is whether the format type of the EWYL program has any effect on the number of AM/AV clients coming into the clinic. This knowledge is very important because attracting and serving as many AM/AV clients as possible is the primary focus of the PSC. The other issue being examined is whether one format of the EWYL has an effect on client participation.

Purpose of the Study

The purpose of this project is to research a program utilized by a local non-profit service agency. This agency, The Pregnancy Support Clinic/Options Now, of Valdosta, Georgia, targets young, unwed women, particularly teens, who are experiencing crisis pregnancies. Their target population is school-aged and college-aged girls who think they may be or are pregnant. They first offer a free pregnancy test, to confirm or resolve pregnancy concerns. They then offer free ultrasound (to help determine if it is, in fact, a

viable pregnancy) and options counseling. Their primary focus is to help each client choose the best option for her individual situation—ensuring that she has access to information about all of her options before making a decision. For young women who choose to continue their pregnancy with the intention of parenting or adopting, they have the option to enroll in EWYL, an educational reward program.

The basic premise of this project is to conduct a program evaluation of the EWYL program utilized by the local non-profit organization, the Pregnancy Support Clinic/Options Now. This will be mixed-methods research which both seeks to examine exploratory questions as well as test specific hypotheses. The EWYL program has been used for nearly ten years but has been utilized in two different forms: the individual, one-on-one format, and the group or class format. The purpose of this project is to evaluate the effectiveness of this program in its varying forms with the ultimate intent of determining which format is more effective and which format uses the least resources. The clinic began entering client data into an internet-based database (known as eKyros) in 2006, during the time the class format was being utilized. At the time of this research, five years of data were entered in the system, three of which encompassed the class format and two of which encompassed the individual format. In order to give an even comparison of data within the archivally-available data, two years of data from each format will be analyzed comparatively to determine which uses the least amount of time and money as well as which attracts the larger number of clients. Particular attention will be given to clients who are labeled either AM or AV, as this is a primary target population for the clinic.

The principal reason for conducting this research is to determine which format of the EWYL program is more efficient in that it uses less financial resources and less actual employee time with equal or increased effect. Another is to determine if either format has had an effect on the number of AM/AV clients. A final reason is to determine whether the format type of the EWYL program has an effect on client participation in the EWYL program itself. Another aspect to consider, which may be revealed during this research, is whether the EWYL program is effective enough to justify continuing in its use or whether the PSC should implement a different program entirely. In order to help clarify these issues, several exploratory questions will be examined. First of all, this study will take a closer look at the clients of the PSC to determine the primary population of this research. This will lend validity to the study as well as give a clearer picture of who will ultimately be impacted by the results of this study and any subsequent recommendations. The question of the importance (or lack thereof) of education during pregnancy will also be addressed. The importance of prenatal education is critical to the importance of the program in question—if education is not important then the use of the EWYL program in any form may be unnecessary. This study will also address the question of the use of an "earn while you learn" program in general, to help determine whether the EWYL program itself has genuine merit and effectiveness. Finally, this study will address the question of which format is more effective through a thorough review of literature, examination of statistical analyses, and also through the interviewing of PSC employees as well as other clinics who are also familiar with the EWYL program.

Discussion of Terms

The most important goal of the clinic is to prevent as many abortions as possible. As Adrienne Kauffmann stated in her dissertation, the ultimate goal is always "to minimize the times that the choice of abortion needs to be made," (1999, 6). The second most important goal is to reach and aid as many young women (both pregnant and post-abortive) as possible. The third most important goal is to empower and equip as many pregnant young women as possible to make the best choice for themselves and to be prepared to parent if that is their choice. It is with all of these goals in mind that the PSC chose to purchase and implement a highly recommended program entitled "EWYL." The "EWYL" program (which will be hereafter referred to as EWYL) is advertised by its publisher as a tool to increase the number of AM and AV clients, as well as to efficiently equip and prepare women to parent. The terms AM and AV refer to the state of mind a young woman is in, in regard to her pregnancy intentions. If she is certain that she plans to abort and feels that is her best option when she first comes in to the clinic for services and/or counseling, then she is referred to as "Abortion-Minded." If she is, instead, more susceptible to an abortion decision because of her circumstances or prior history, or because she is being pressured to abort by someone close to her, then she is referred to as "Abortion-Vulnerable." Before being labeled in this way, a client must meet certain criteria. These criteria are attached to each intake form so that the intake counselor can easily refer to them while talking with the client. If the client meets the criteria, then she will be labeled as Abortion-Vulnerable and will be logged into the clinic database as such. Examples of the criteria include: having had a prior abortion, having inquired about

abortion options, and having a close friend, family member, or significant other who is strongly encouraging her to abort. These two terms are red-flags for the staff and volunteers of the clinic because this will mean they must be particularly careful with the terms they use when speaking with her (for example, in order to be sensitive to her state of mind it is best not to refer to a "baby" but instead to use the word embryo or fetus) and it will also dictate what material may be given to her (the importance of distributing factual information on various types of abortion will be much higher for these clients). When a client comes in for services and is AM or AV but ultimately carries her baby to term and either parents or chooses adoption, then that baby is celebrated and counted statistically as a "Red Rose" baby. Keeping up with this number is very important for several reasons. First of all, it lets the clinic know how many births they have played a strategic role in and represents actual lives saved. Secondly, it is important information for the supporters of the clinic (it is 100% privately funded by local businesses and individuals) as they want to know that the clinic is making a difference in their community.

The Earn While You Learn Program

The EWYL program is purported to increase the number of AM/AV clients a clinic gets, to educate young women on pregnancy, to educate parents on important principles of caring for infants and children, as well as to break the cycle of entitlement. As quoted from the publisher's own website,

> Giving things away free only enables our clients and fosters the entitlement mentality. With EWYL, clients come to you to learn how to be good parents. In the process, they form healthy bonds with their parenting instructors. In the end, they are able to walk out of your center with much

> needed items for their babies and a pride in their sense of accomplishment. The lessons they learn are crucial to the emotional and physical well being of their babies and break cycles of poor parenting, neglect and abuse. (Heritage House 2013, 1).

On the EWYL website they advertise that their program (among other things):

- Increases abortion vulnerable visits
- Increases abortion minded visits
- Increases donations
- Increases volunteers (www.ewylonline.com)

The publisher purports that the program is so popular that visits will increase by word-of-mouth advertisement. The promised benefits make purchasing the program very tempting for pro-life non-profits with a strong desire to be able to help the women and young girls most vulnerable to abortion. Heritage House sells this curriculum which is broken down into several different categories on their website, www.HH76.com. The PSC primarily uses only two of those offered, what is referred to as the Main Curriculum (geared toward first-time mothers who are just learning about what happens during pregnancy, how to have a healthy pregnancy, and what happens during labor and delivery) and the Parenting Pack (which focuses on parenting styles and how to discipline in a loving manner). For the purpose of this study these two types of curriculum will be examined. The Main Curriculum consists of nine modules and is sold by Heritage House for $1,295.00. The Parenting Pack consists of seven modules (35 lessons) and is sold for $969.95. Once purchased the clinic owns the DVDs and worksheet master copies outright and can use them as much and for as long as they desire. The advertising posters, pamphlets, and

other educational materials must be purchased for additional costs. The curriculum does get updated on occasion and that also is an additional cost to the clinics.

The PSC first began using this program in a one-on-one, individual format. The clients would make an appointment with a counselor and would watch the video the counselor felt to be most appropriate for her stage of pregnancy and current situation. For example, if the client was new to the program but was already six months pregnant, she would not be shown the “First Trimester” video, but would begin further in the series with the videos geared to her stage of pregnancy. If the client had to cancel her appointment for any reason she could easily reschedule and watch the same video at a later time. After using this format for several years, the clinic re-evaluated and decided to change the format. The clinic then switched to a class format and began offering scheduled classes on specific days and at set times. Clients were encouraged to sign up for the classes if they wanted to take advantage of the EWYL program. This was implemented in the hopes that it would allow more clients to be seen. Unfortunately, over time it was apparent that this had some disadvantages. First of all, the counselors noticed that many clients were cancelling on a regular basis and even dropping out altogether, primarily because of scheduling conflicts. The classes were always full, but each week the clients enrolled would be different. The classes also offered refreshments which resulted in the attendance of other family members (grandmother, aunt, cousin, etc.). Subsequently, a class of 15 may only include 7 actual clients, with the remaining attendants being extraneous family members. That made it difficult for counselors to build relationships with the clients and to really gain a good understanding of their

individual situations and needs. Because the counselors were busy with classes, pregnancy test appointments, and new client intakes, they also could not accommodate any rescheduling for those clients who had to miss class. This resulted in many clients not benefiting from the program, either educationally or materially, due to their inability to complete it. After a few years, the clinic decided to revert back to the original format in the hopes of being able to be more flexible to the individual clients. After this, the director began to suspect that their participant numbers and AM/AV client numbers might be increasing. She also suspected that the individual format actually costs less money and time, making it more efficient for the clinic as a whole. Without precise studying she could not be certain, and this is why she requested that this study be conducted.

Research Questions

The main focus of this study is the two different formats of the EWYL program that the PSC has utilized to date. These formats are:

1. Individual: allowing clients to work through the program at their own individual pace with one-on-one interaction with a counselor throughout.
2. Class: structuring the program in a class format so that groups of clients work through the program simultaneously, with little or no flexibility, with only one or two counselors per group (no one-on-one with a counselor). All discussions are held within the group and are held on specific days and times.

The research questions that are being asked are:

1. Which of the two EWYL formats expends the least in terms of time?

2. Which of the two EWYL formats expends the least in terms of cost?
3. Does the format type of the EWYL program have an effect on the number of clients participating?
4. Is there a correlation between the EWYL format type and the number of AM/AV clients coming into the clinic?

In addition to the answers to the above questions, the researcher also hopes to learn if there is an effect on client retention correlated to the program format type. The effectiveness of the EWYL program will be considered throughout the study, although that is not a primary focus of this research. The researcher expects to find an increase in the number of AM/AV clients as well as an increase in client participation that correlates with the implementation of the individual format. The researcher also expects to find a decreased time expenditure and a decreased cost expenditure correlated with the change in format.

Importance of the Study

This study will contribute greatly to the work of pregnancy resource clinics across the nation in several ways. First of all, there is little existing research that portrays the benefits of the outreach programs these clinics run. Much of the existing research is pro-choice biased and paints the pro-life clinics in a very negative light. This research seeks to instead highlight the many benefits such clinics offer their communities and the females who reside there. Even clients seeking abortions can still benefit from the free pregnancy tests, free counseling, options education, and even post-abortive support. Though the clinics do not hide their pro-life bias, they do not show any bias in the

clientele they serve or their desire to help all women, regardless of their beliefs or the choices they ultimately make.

The primary way that this research will benefit the work of pregnancy resource centers is through the scientific examination of the EWYL. As this study will demonstrate, this curriculum is the most widely used of its type in this country. Of the 4,000 or so clinics across America, the majority use this curriculum in one of the two formats examined. This curriculum also costs the clinics money to implement, to update, and to maintain. It will be to the benefit of every clinic that uses this program to know whether their money is justified and whether the program is, indeed, as effective as its publishers purport it to be.

The final way that this research is important is that, though this program is advertised as being an effective one, there is no published research which demonstrates it to be. Other than the websites of clinics across the nation which advertise their use of the program and the website of the publisher, Heritage House, which describes the program in an attempt to sell it to additional clinics, there are no resources which discuss this program at all. This research not only describes the program in detail and educates the reader in how it is used but it also goes further and examines scientifically how the use of this program affects client numbers, AM/AV client numbers, and client participation. This research also examines the program and these three factors in two differing formats. The results of this research will help clinics across America decide whether to continue investing money into this program, whether to begin investing money into this program, and whether to utilize one particular format or the other if they do use the program. This

research is treading new ground and opening doors for more future research of this kind. This study will aid the decision-making process of clinics everywhere and will add validity to an area that is inadequately researched.

In the following chapter, related literature will be reviewed in an attempt to give the reader a greater understanding of the clinic, its work, as well as to aid in the understanding of the current study and its importance. Chapter 3 will discuss the research methodology of the study. This study, designed to be exploratory in nature, entails collecting archival data and analyzing the data for statistical relationships and correlations. Employees will also be interviewed and/or surveyed to gain further understanding as well as to assist in answering the research questions. This study does have several limitations, including the use of archival data, the lack of access to the actual program participants, lack of demographic information, and a relatively small sample size. Because of these limitations the findings will only be directly applicable to the PSC, but will be informative to any clinic either using or considering the utilization of the EWYL program. Chapter 4 will discuss the research results and the implications of the results. Finally, Chapter 5 will further discuss the findings, implications of those findings, and make recommendations for future research.

Chapter II

LITERATURE REVIEW

There is very little literature directly pertaining to the program evaluation being conducted herein. Though multiple journals and databases were subjected to an exhaustive search, no research relating to the EWYL or any similar program within Pregnancy Resource Centers was found. As far as it is known, this particular program, though widely used throughout the U.S., has never been formally evaluated. Because the program is related to subjects such as teen pregnancy, crisis pregnancy counseling, the pro-life/pro-choice debate, education during pregnancy, earn while you learn programs, and the group versus individual format of teaching, the literature review consists of articles relating to these topics.

The Pregnancy Journey

Whether a female is thirteen or forty-three, there are many aspects of the pregnancy journey which can be stressful and overwhelming. A pregnant female's blood volume doubles, her energy and nutritional intake is redirected toward the fetus, and her bloodstream is flooded with hormones (Curtis 1997). And that is just the beginning! Common pregnancy symptoms are dizziness, nausea (with or without vomiting), fatigue, frequent urination, breast tenderness, taste and smell changes, and intense emotional feelings (Brown 1998; Curtis 1997). As Frederica Mathewes-Green stated,

> Even in a normal, much-desired pregnancy a woman must go through daunting physical changes, emotional stress, and a cataclysmic ending she

> may well approach with fear. How heavy these burdens must be to the woman whose pregnancy was unplanned and unwanted, (1991, 1).

The beginning of the pregnancy, when all of these changes are flooding the body, is also the time when the development of the fetus is most vulnerable (Curtis 1997). It is during the first twelve weeks of pregnancy that the most caution must be taken in lifestyle and diet—during this time there are many "safe" drugs and chemicals that are considered teratogenic and are likely to cause permanent developmental problems, and even death of the fetus (Curtis 1997). Regardless of a female's intention toward the pregnancy, early detection and education is crucial to prevent the mother from unintentionally causing harm to herself or the fetus. It is very important for a pregnant girl or woman to understand what things she must avoid, what things are safe in moderation only, and what things are necessary for health and wellbeing. In the case of an unplanned pregnancy, it is also important for counseling to be available to help her work through her emotions, thoughts, and life plans and to help her fully understand her options in regards to this important revelation. This support will lessen the stress the mother may be experiencing. Since stress has been shown to actually ". . . destroy fetal cells at any stage of pregnancy. . .," easing stress should always be an important goal (Curtis 1997, 96).

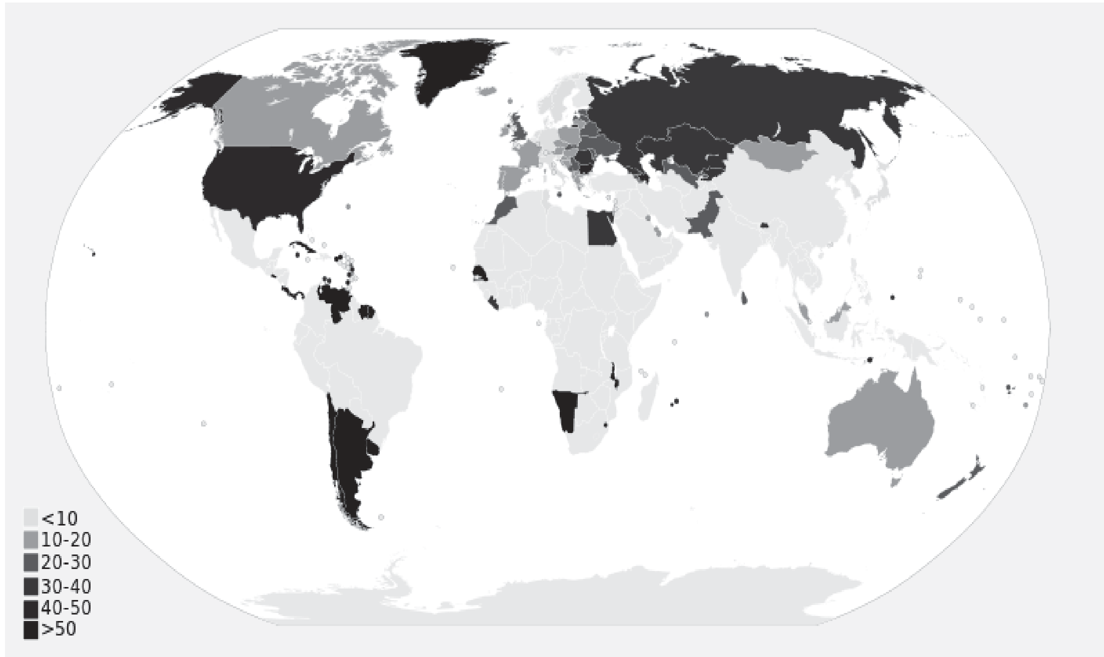
As women become older and more educated, some aspects of pregnancy may become common knowledge. For example, many women are told at their annual physical exam that taking folic acid daily is very important regardless of whether they intend to become pregnant. This is so that the brain of the fetus can be properly nourished regardless of whether a pregnancy occurs intentionally, or as often is the case, unintentionally (Curtis 1997). However, consider one of the nation's largest issues: teen

pregnancy. Imagine not a twenty-something married female, but instead a thirteen year-old unmarried middle school student facing the prospect of becoming a mother. In the case of a young adolescent or teen girl becoming pregnant, she very likely is not yet aware of the necessity of taking folic acid or the many other precautions one must take in the early weeks of pregnancy. She may or may not even be aware of the symptoms of pregnancy, how to prevent pregnancy during sexual intercourse, how to care for herself during pregnancy, or what her options are if she becomes pregnant. For these reasons, educating and assisting crisis pregnancies in teen girls is a dire need.

Teen Pregnancy

As recently as 2010, teen pregnancy, birth, and abortion rates in the U.S. were the highest of anywhere in the industrialized world (Foreman 2011). The statistics of the non-industrialized world are not really pertinent here since teenage girls in developing countries are usually married and pregnancy is socially welcomed by friends and family. Abortion is not considered an option for the vast majority because the pregnancies are wanted and accepted. To give a statistical comparison, though, 16 million children are born annually to women under age 20 across the world, over 95% of which are born to women in developing countries (United Nations 2011, 1). A visual depiction of the prevalence of teen birth rates internationally can be seen in Table 2.1, below (Freedom House 2009):

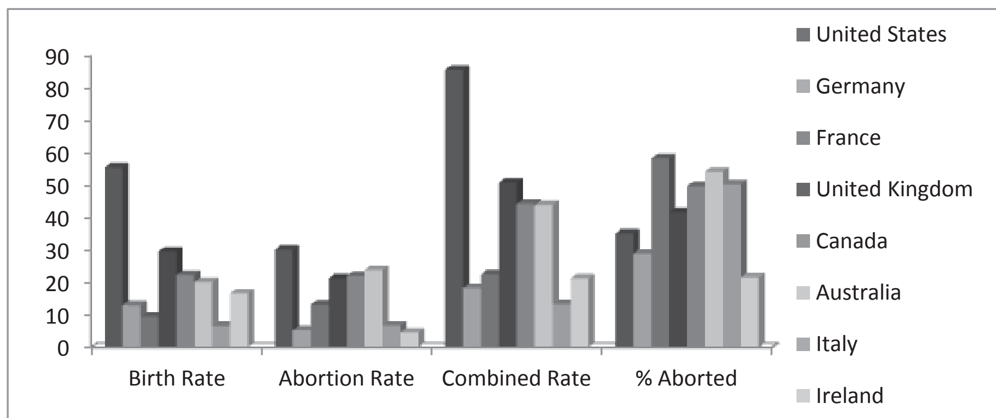
Table 2.1: Teen Birth Rates Worldwide:



(Teenage birth rate per 1000 women aged 15-19 worldwide, 2000-2009) *United Nations* (2011)

Among industrialized countries, the U.S.'s teen birth rates tower above its peers, as can be seen in the Table 2.2, below:

Table 2.2: 1996 International Teen Pregnancy Rates:



(Teen pregnancy rates per 1000 women aged 15-19) *Henshaw, Singh, & Haas* (1999).

The above chart (Table 2.2) is based on teen pregnancies in countries around the world and serves to illustrate the vast difference in the teen pregnancy rates in the U.S. in comparison to other, similar countries (Henshaw, Singh, & Haas 1999). The data, which shows 71.5 pregnancies per 1000 women aged 15-19, is based on the birth and abortion rates (per 1000 women) from the year 2006 (Kost, Henshaw, & Carlin 2010, 2). Though abstinence and birth control are options in all of these countries, the U.S.' teen pregnancy rate is substantially higher. Of the large number of pregnancies, teen or otherwise, that occur in the U.S., almost half of all pregnancies in the U.S. are unplanned; nearly half of those pregnancies end in abortion (Henshaw 1998). In one study of pregnant women in North Carolina, 62% indicated an unintended pregnancy, 44% a mistimed pregnancy, and 18% an unwanted pregnancy (Maxson & Miranda 2011, 1217). In this study, women with unwanted pregnancies had the highest depression, perceived stress, and the lowest social support scores of the group (Maxson & Miranda 2011). Among the nation's unplanned pregnancies, teenage pregnancies make up a large portion. Unplanned pregnancy is shown to be correlated with being younger than 24 years of age, unmarried, having less than a high school diploma, living in poverty, and being either on Medicaid or uninsured (Kost, Finer, & Singh 2012, 60-61). It makes sense, then, that limited opportunities and economic disadvantage are considered to be fundamental causes of adolescent pregnancy and childbearing (Miller 1991, 467). Of the 900,000 adolescent pregnancies each year, studies show that approximately 83% are unintentional (Mosher, Jones, & Abma 2012, 7). Teen pregnancy is related to many significant social and economic issues—including the educational level of teen mothers and their children,

poverty, child wellbeing, and lifetime income disparity for both the teen parents and their children (Foreman 2011). Teen mothers face many challenges, not the least of which are often interrupted or postponed education (Foreman 2011). Research shows that teenage girls as young as age 13 participate in sexual relationships with peers or older men, most without using any type of birth control for various reasons, one of which is lack of access to it (American Academy of Pediatrics 1999). Earlier initiation of sexual activity leads to an increased number of sex partners, meaning an increased chance of contracting sexually transmitted diseases as well as an increased chance of becoming pregnant (CDC 2000). As a result of this trend, over three million adolescents within the U.S. contract a sexually transmitted disease each year (Gold & Gladstein 1998). In 2006, a study conducted by Iuliano et al. (of over 3, 000 women) sought to gain a better understanding of safe sex practices during the teenage years. This study found that of the three groups of female participants (first sexual experiences, first unplanned pregnancy, and second/third unplanned pregnancy) the majority indicated that they had their first sexual encounter at 15 years or younger and did not use protection for fear their parents might discover their illicit activities (Iuliano et al. 2006). A smaller number reported that they did not use contraception because their first encounter was unplanned and they had little knowledge of contraceptive methods (Iuliano et al. 2006). Unprotected sexual intercourse is much more likely to result in pregnancy, thus explaining why the teenage pregnancy rate is so high, not just in our nation, but in the state of Georgia, specifically.

Georgia ranked 43rd in the country (with the higher number having the highest number of teen pregnancies) in the year 2000, averaging 95 girls per 1000 (ages 15-19)

experiencing pregnancy in that year (The Alan Guttmacher Institute 2004). Though this number has decreased slightly, Georgia still remains in the top ten in the nation, averaging 80 per 1000 (ages 15-19) in 2005 (Kost, Henshaw, & Carlin 2010, 2). This statistic does not take into account the estimated 13% of girls who experience pregnancy under the age of 15. According to The Guttemacher Institute, each year, in the U.S. alone, almost 750, 000 young women (ages 15-19) become pregnant (Kost, Henshaw, & Carlin 2004, 2). This number has dropped in recent years—in comparison, approximately 410, 000 teenaged women carried the pregnancy to term and gave birth in 2009 (Pazol et al. 2011, 1). The same age group, (ages 15-19), also have the highest unplanned pregnancy rates (Finer 2010, 1). The highest teen pregnancy rates are among the Black and Hispanic populations (126 per 1000 women, compared to only 44 per 1000 among non-Hispanic whites) (Kost, Henshaw, & Carlin 2004, 2-3). Georgia is in the top five in the nation for its Hispanic teen pregnancy rate, which was well over 185 per 1000 in 2006 (Kost, Henshaw, & Carlin 2004, 4). In a study conducted by Charles Basch (2011) intended to determine the percentage of teen births among minority students and the effect this has on education, Basch found that non-marital teen births were highly and disproportionately prevalent among school-aged urban minority youth and that it has a negative impact on their educational attainment. Approximately 82% of teen pregnancies are unplanned, accounting for a one-fifth of the total number of pregnancies nationwide (Brown & Eisenberg 1995, 31). One study on demographic factors associated with 581 abortion-minded females presenting to a crisis clinic in Ohio found that there are certain characteristics correlated with an abortion intention (Cote et al. 2009). This study found

that women who were abortion minded were more likely to be single, black, younger, with an income level under $10, 000, sexually active at a younger age, and having had previous abortions (Cote et al. 2009). This study indicates that teens that become sexually active, particularly African American teens from a low-income family, are much more likely to have an unwanted pregnancy and to at least consider abortion.

Seeing the problem of teen pregnancy years ago, Richard Barth attempted to address this issue by developing a workbook and program for teens to help build their skills in preventing pregnancy (1989). In an article by Joan Chesler and Susan Davis, they also attempt to call attention to the real problem of teen pregnancy by emphasizing the need for "social and medical services directed specifically at this high-risk group," (1980, Abstract). Of a like mind, the makers of the EWYL program (Heritage House) developed the video-based curriculum for free medical clinics across the nation.

Given the hard fact that teen pregnancy exists and is widespread in this nation, and given the fact that Georgia has one of the highest rates of teen pregnancy in the nation, it would seem clear that something needs to be done here, locally, to address this issue. According to Chesler and Davis (1980), a good means of intervention would be to establish social and medical services geared specifically toward the most vulnerable population. According to Guttemacher (2004), young girls ages 15-19 are the targeted population for this issue, with Black and Hispanic girls living in an urban area being by far the most vulnerable to this situation.

The Life vs. Choice Debate

When any female conceives a child it is, to some degree, her choice how the pregnancy will proceed. In a crisis pregnancy, in particular, she must consider her options carefully and make the best choice for her future. The three basic choices in a crisis (or any) pregnancy are: parenting, adoption, and abortion. Each pregnant female must choose one of those options. These options can be and often are broken down further into two choices: either carry the pregnancy to term or terminate the pregnancy. If a woman chooses to carry the pregnancy to term then she has nine months to decide if she wants to parent the child herself or to allow the child to be adopted. If a woman chooses to terminate the pregnancy then she seeks abortion services and continues her life relatively uninterrupted, with no further decisions at that point. The two basic choices every pregnancy presents have been condensed into a colossal war between those who support life (the pro-life group) or those who support choice (the pro-choice group). This war is known as the Life versus Choice debate.

The history of the Life versus Choice debate is a long one here in the U.S. One of the most memorable and most cited abortion-related cases is 1973's *Roe v. Wade*, a court case that legalized first trimester abortions nationwide (*Roe v. Wade*, 410 U.S. 113 (1973). Following this decision, the pro-life and pro-choice communities have been in a stiff race to put their beliefs into law. This is a heated issue that involves a diversity of actors, including health professionals, legal professionals, politicians, religious leaders, and businessmen/women. One politician, Ronald Reagan, was among one of the nation's political advocates of pro-life, having stated at a 1984 convention,

> The nation cannot continue turning a blind eye and a deaf ear to the taking of some 4,000 unborn children's lives every day. That's one every 21 seconds. One every 21 seconds…I believe no challenge is more important to the character of America than restoring the right to life for all human beings, (Public Papers of the Presidents of the U.S. 1986, 119).

Prominent fellow life supporters include Sandra Day O'Connor, George Bush, and George W. Bush. Over the years, various cases have attempted to expand the legal right to abortion and other cases have attempted to reverse and/or place restrictions on the *Roe v. Wade* decision. Legislation intended to make abortion less accessible and to protect the rights of the unborn include: licensing and reporting requirements, waiting periods, counseling requirements, fetal protection statutes, parental and spousal consent and notification laws (Coffey 2001). In 1989, *Webster v. Reproductive Health Services* upheld a woman's right to choose abortion, and in 1992, *Planned Parenthood of Southeastern Pennsylvania v. Casey* also upheld this right (*Webster v. Reproductive Health Services*, 492 U.S. 490 (1989); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). In 2006 and in 2008 several states attempted to introduce acts that would change the legal definition of life to include newly fertilized eggs, some calling it a Human Life Amendment (HR 536 in Georgia), but this did not reach the ballot (Manninen 2010). Also in 2008, attempts were made to reverse the right to abortion with few exceptions (such as cases of rape, incest, or health of the mother), but failed to pass (Manninen 2010). In 2010, several states, including Alabama, California, Colorado, Florida, Michigan, Mississippi, Missouri, Montana, Nevada, and Virginia also attempted to pass Human Life Amendments (Manninen 2010). The intention of these attempts is clearly to challenge *Roe v. Wade* and to open a door to its future reversal

(Manninen 2010). The President and Chief Counsel of the Thomas More Law Center, Richard Thompson, states (in reference to Georgia's House Resolution 536):

> The Human Life Amendment provides Georgia with the best legal means of overturning the central holding of *Roe v. Wade*. At the very least, it ensures that Georgia immediately becomes a pro-life state the moment the shackles of *Roe* are broken. . . The adoption of this amendment will place Georgia on the forefront of the battle to restore the sanctity of innocent human life (HLA Coalition Press Release 2008).

One of the biggest victories of the pro-life movement came in 2010 with the "Pain Capable Unborn Child Protection Act," which bans abortion after 20 weeks gestational age (with 19 weeks generally considered the "age of viability") (Manninen 2010). This ban passed on the grounds that a fetus can feel pain by 20 weeks gestational age (Manninen 2010). Individual states have regained, primarily through the *Webster v. Reproductive Health Services* and *Planned Parenthood of Southeastern Pennsylvania v. Casey* cases, their right to impose restrictions on abortion access—an opportunity that has been utilized (*Webster v. Reproductive Health Services*, 492 U.S. 490 (1989); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). Idaho, Indiana, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Nebraska, Ohio, Pennsylvania, South Carolina, South Dakota, Utah, and Wisconsin have all enacted laws which mandate pre-abortion counseling as well as a waiting period of 24 hours (Manninen 2010). The pre-abortion counseling entails having a state-specific prepared script read to the woman seeking the abortion, detailing the dangers of abortion including the physical, psychological, and emotional side effects that can result (Manninen 2010). These states require that the mother must wait 24 hours after hearing of these side effects so that she may have time to reconsider based on the new information. Other states, including

Alabama, Alaska, California, Connecticut, Delaware, Maine, Minnesota, Nevada, Rhode Island, and Virginia, also mandate pre-abortion counseling but do not mandate the 24-hour waiting period (Manninen 2010). There are also parental notification laws enacted which apply to minors in some states, including Alabama, Arkansas, Delaware, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Pennsylvania, and Rhode Island (Manninen 2010). Most recently, on January 12, 2013, the Alabama Supreme Court upheld the ruling of previous cases and specifically awarded personhood status to the unborn (with rights that should be protected by law), opening the gate for many new human life amendments to be passed (*Ex Parte Hope Elisabeth Ankrom v. State of Alabama* and *Ex Parte Amanda Helaine Borden Kimbrough v. State of Alabama*, 1110176 and 1110219, Ala. Code 1975, 13A-6-et seq (2013)).

While this issue has traveled in and out of courtrooms across America, it has simultaneously taken up permanent residence in the political arena, as well. This issue, which many people take very personally, has been taken up as one of the primary platform issues in the modern political Presidential race. Immediately following the *Roe v. Wade* decision, abortion became a core part of each presidential candidate's campaign platform. According to the detailed logs of the campaign platforms over the years compiled and published by Gerhard Peters and John Woolley, abortion was first explicitly mentioned as part of the campaign platform in the 1976 Presidential election (The American Presidency Project 1999-2012). Though abortion, if a topic of discussion, never previously entered into the political arena, from 1976 until today it has been a

heated debate that has become more and more of an issue in each subsequent presidential election. What was once a quiet, hidden, and frowned-upon practice has become a basic part of women's rights according to large portion of our nation. By the 1988 presidential election, abortion had become a major issue on which voters were basing their decision (Gerhard & Woolley 2012). It has increased in importance since, and as of our present time it is without a doubt the most important electoral issue of the 2012 presidential election. Based on current news reports, the abortion issue took "center stage" in the 2012 campaign (Ember 2012).

Historically speaking, the Democratic party has supported the woman's right to choose since the 1976 election and is very outspoken about their intent to not only maintain a woman's legal right to choose but also maintain that women who cannot afford an abortion will still have access to one through federally funded health care that pays for the abortion procedure (Gerhard & Woolley 2012). The Republican Party, on the other hand, is just as adamant that the human right to life at any stage, even pre-birth, should be paramount and is equally outspoken about their intent to reverse Roe v. Wade, making no exception in the case of rape or incest (Gerhard & Woolley 2012). This issue has become pivotal, such that many Americans cast their ballot based solely on the presidential candidate's stance on abortion. This issue is not as simple as it once was, however. In the beginning, it was not known at what stage in the fetal development the heart began beating and the brain began functioning. It was not entirely known, even, what the fetus looked like at various stages of development. With modern technology, though, it is now scientifically and medically proven that the heart begins beating in the

first two weeks after the fertilization of the egg (Nilsson & Hamberger 2003). The heart is pumping its own individual blood, often a different blood type from its mother. The brain waves can be detected as early as six weeks post-fertilization (Nilsson & Hamberger 2003). This is still before most women will have any pregnancy symptoms (including a missed period)—by the time most women realize they are pregnant the fetus has a beating heart and a functioning brain and ". . . the basic relationship between mother and child is forged," (Werth 2002, 7). Dr. Bernard Nathan, co-founder of an abortion-advocacy organization and the medical director of one of America's largest abortion clinics, stated:

> There is simply no doubt that even the early embryo is a human being. All its genetic coding and all its features are indisputably human. As to being, there is no doubt that it exists, is alive, is self-directed, and is not the same being as the mother—and is therefore a unified whole, (1996, 131).

The stages of development are seen in 3D ultrasound now and prospective parents are able to watch their little ones suck thumbs, kick their feet, and even give a thumbs-up at times. It is no longer a question of at what point life begins, insinuating that life is valuable at any point and to end a life is murder. In this belief system, which was dominant when *Roe v. Wade* passed, abortion was acceptable only because it was not yet considered a life. It has now become a question of the value of life at any point or is ending a life justified at specific "invaluable" stages of that life. It has become acceptable to end a known life at any point in pregnancy under certain circumstances and the real debate is now one between the rights of the mother versus the right of the fetus. This idea is substantiated by J.J. Thomson, an abortion advocate, who argues that one person's right to life does not entail the right to use another person's body for continued

sustenance (Manninen 2010). This belief is quite pervasive in legal policies in the US currently (Manninen 2010). It is the decision of the American voters now whose right will be upheld at the highest level, the mother's or her fetus'. So, as evidenced by both the political and the legal debate which is ongoing, the abortion issue is a vast one here in the U.S.

The pro-choice/pro-life debate has been explored by Adrienne Kaufmann (1999), who conducted research in order to develop conflict intervention designs. In this article, Kaufmann examines at length the evolution of the Life vs. Choice debate and determined that the pro-lifers she encountered spoke "with calm conviction, but without hostility," (1999, 4). Kaufmann noted in her dissertation that one possible hindrance to conflict resolution between these two groups is that the pro-choice supporters honestly do not realize that the pro-life supporters feel strong compassion toward the pregnant mother (1999, 5). They are less concerned with interfering with a woman's right to choice about her own body as they are concerned with the unborn baby's right to life and the negative effects the abortion may have on the woman (Kaufmann 1999). As the Executive Director of one pro-life clinic was quoted as saying, "Basically, [our goal] is to help women carry their babies to term, help educate women about abortion and what their options are in an unplanned or crisis pregnancy," (Weston 2008, 1). Clients are informed during the intake process of their first appointment of post-abortion support services, as well, so that they know they will be supported regardless of their decision.

Pregnancy Support Centers

With the *Roe v. Wade* decision came a splattering of pro-choice supported abortion clinics across the nation (Jones 2008). To counteract the influence of these clinics, pro-life proponents began opening crisis clinics (Jones 2008). Crisis Pregnancy Centers were birthed to serve those in crisis pregnancy by counseling them and educating them on their options, providing free medical services and material supplies, and also to counsel them in the process of carrying out their particular choice. These crisis pregnancy centers or pregnancy support clinics offered clients a variety of confidential services free of charge: pregnancy testing, STI-testing, counseling, referrals, education, and even ultrasound (Jones 2008). These clinics are staffed by a Director, trained counselors, and medically trained nurses, licensed sonographers, and sometimes even doctors (Jones 2008).

There are two primary reasons pro-lifers are so adamantly against abortion, and so pro-active in their establishment of resources centers: 1) they firmly and unequivocally believe that life begins at conception and that the unborn have as much of a right to life as those of us who are already born, and 2) they firmly believe that abortion is physically, mentally, and emotionally harmful to the pregnant mother and are trying to spare her possible irrevocable physical complications, possible death, and the emotional and mental anguish that often follows. There are numerous studies which support this belief. One study of post-abortion patients just eight weeks after an abortion found that 44% experienced nervous disorders, 36% experienced sleep disturbances, 31% had regrets about their decision, and 11% were prescribed psychotropic medication by their family doctor following the abortion (Ashton 1980, 1115). In this study, about 5% of all

participants had severe, enduring, long-term psychiatric disturbance following abortion and over half of all participants experienced at least short-term disturbances (such as guilt, feelings of regret) (Ashton 1980). Another study, conducted over a five year period, revealed that 25% of women who had experienced abortion sought psychiatric care, as compared to only 3% of the control group (Badgley, Caron, & Powell 1977, 1193). An additional study found that teenagers, divorced or separated women, and women with a history of more than one abortion were at a significantly higher risk of experiencing problematic side-effects (Somers 1981). A random study done by the Institute for Pregnancy Loss found that a minimum of 19% of post-abortion women suffer from diagnosable post-traumatic stress disorder (PTSD) as a direct result of having an abortion (Barnard 1990, Abstract). This study also found that 65% of all women who have had an abortion experience many symptoms of PTSD and between 39 to 45% showed high levels of stress in relation to their abortion experience; i.e., flashbacks, nightmares, or hypervigilence (Barnard 1990). Another study also showed that 65% of American women with a previous abortion experienced multiple symptoms of PTSD and these women consciously attributed these symptoms to their abortion experience (Rue, Coleman, Rue, & Reardon 2004). PTSD results in individuals who have experienced a particularly traumatic event that has overwhelmed their normal defense mechanisms, causing a hyperarousal of the “flight or fight” defense mechanisms (Reardon 1997). Many women focus on surviving and coping immediately after an abortion, numbing themselves to any negative feelings as a coping mechanism (Boulind & Edwards 2008). Years can pass before these suppressed feelings surface and psychological and behavioral problems

begin to emerge, causing many women to miss the link between their abortion and their subsequent symptoms (Speckhard & Rue 1992). This also makes definitive research into the after-effects of abortion somewhat difficult. However, when examining abortion-related literature, it seems clear that abortion does not come without an emotional price. As an example, the rate of suicide after an abortion was three times the general suicide rate and six times the suicide rate following a birth in 1996 (Gissler 1996). Though there is an ongoing debate surrounding the after-effects of abortion, there is ample research supporting the existence of severe emotional side-effects.

Abortion may be experienced by women as a traumatic event for several reasons: many are forced to have an abortion against their wishes by others or extraneous life factors, the termination of the pregnancy may be perceived as killing their own child (traumatic, to say the least), and many women report that the emotional and physical pain of the abortion procedure itself feels identical to rape (Francke 1978). When the stressor leading to PTSD is abortion, the disorder is referred to as Post-Abortion Syndrome (PAS) (Zakus 1987). Clinically, the symptoms of PAS include flashbacks, emotional numbing, interpersonal distrust, helplessness, sadness, shame, guilt, hopelessness, suicide attempts/suicidal ideation, anniversary reactions, grief, anger, and sexual dysfunction (Speckhard & Rue 1992). In one specific case study on the treatment of PAS, the client presented for therapy for severe depression that she did not even recognize as being related to her previous abortion (Boulind & Edwards 2008). As is often the case, women who are post-abortive have symptoms of PAS but do not recognize that the symptoms are related to the abortion. This client presented to therapy with the criteria of Major

Depressive Disorder (Boulind & Edwards 2008). She also met criteria for PAS, PTSD specifically related to her abortion experience (Boulind & Edwards 2008). As described in the case study,

> . . . she felt upset when reminded of the abortion (re-experiencing), she systematically tried not to think or talk about it, felt less interested in activities, felt detached and estranged from other people (avoidance), and had hyperarousal in the form of sleep difficulties, and other anxiety symptoms recorded on the BAI in the first two sessions (feeling hot, faint, sweating, scared, afraid of dying, nervous, afraid of losing control, unable to relax) as well as at least one intense panic attack, (Boulind & Edwards 2008, 542).

Another study revealed that the conscious decision to abort actually co-exists with a profound sense of rejection at the deepest level (Kent et al. 1978). The abortion subsequently leaves behind deep feelings of "intense pain, involving bereavement and a sense of identification with the [fetus]," (Kent et al. 1978, 80). One author points out that even in the best of situations, a woman chooses abortion out of desperation:

> No one wants an abortion as she wants an ice-cream cone or a Porsche. She wants an abortion as an animal, caught in a trap, wants to gnaw off its own leg. Abortion is a tragic attempt to escape a desperate situation by an act of violence and self-loss, (Matthewes- Green 1991, 2).

Recognizing this tremendous issue, these clinics inform any clients considering abortion of the possible emotional side effects of an abortion, including PAS, and also offer counseling for women who are already experiencing PAS. Their primary concern is the wellbeing of both the female client and her unborn child. The Pregnancy Support Clinic of Valdosta, in particular, "stresses the importance of educating all clients considering abortion about the potential side effects (physical, mental, and emotional), so that they can at least make an educated and informed choice," (Personal Interview with

Becky Deas 2012). As the Executive Director of another, similar clinic, was quoted as saying, “Basically, [our goal] is to help women carry their babies to term, help educate women about abortion and what their options are in an unplanned or crisis pregnancy,” (Weston 2008, 1).

In a 2001 study conducted on Crisis Pregnancy Counseling in five different clinics, consisting of 1,820 counseling transcripts, Richard Wittenberg found that crisis clinics do not focus solely on the pregnancy decision itself, but are very attentive to the individual situations and needs of each client and offer advice on their pregnancies, their sexual behavior, financial issues, educational issues, and legal issues (2001). They are equipped with knowledge of local resources and are very adept at referring their clients to appropriate resources based on their decision and needs (Wittenberg 2001).

Another study on the counseling techniques of various pregnancy support centers examined the use of ultrasound as a tool to help women make pregnancy decisions (Jones 2008). Jones’ study examined clinics spanning seven different states, including interviews of 12 different directors and ultrasound personnel from each clinic included in the study, collecting qualitative data using research questions and performing rhetorical analyses of the interviews (2008). The results show that there are ten different themes found in the rhetoric of the sonographer/counselor to client dialogue (Jones 2008). For the purpose of this study, the researcher would like to highlight a few of these themes: it was found that centers provide professional health services, that clients come in primarily seeking information and a reduction of their uncertainty, that centers maintain a safe supportive environment, that personnel are trained to demonstrate sensitivity, that

ultrasound does serve to reify the pregnancy for clients, and that a primary center goal is to empower the clients to make their own decision (Jones 2008, ii-iii). This research demonstrates the truly client-centered mindset of many clinics. The employees and counselors at these clinics seem to understand that a woman who is facing an unplanned pregnancy feels isolated and alone as she makes a deeply personal decision. To overcome this, ". . . we must explode the shell of her isolation, making her problems our problems, building concentric rings of support from the mother-child dyad outward to all society," (Matthewes-Green 1991, 2). While the larger issue at hand is the controversial debate over life versus choice, regardless of the stance of the clinic, they must keep the needs of the client in mind first and foremost.

The Pregnancy Support Clinic/Options Now of Valdosta, Georgia

The Pregnancy Support Clinic/Options Now was developed specifically to serve and aid women and teens with unplanned pregnancies, and has been serving this very population since 1991. Their clinic is currently located close to the heart of the urban and low-income housing in Valdosta, specifically so that the most vulnerable girls can walk there if they need to. They offer a pregnancy-prevention educational program very similar to that developed by Barth (1989) and have been working to implement this within the school systems for years. They offer free crisis counseling, free pregnancy tests (administered by a licensed nurse), free ultrasounds (administered by licensed sonographer), information on STIs (Sexually Transmitted Infections) and STI prevention, and information on all pregnancy options (including abortion). This is a pro-life organization and is a non-profit, 501(c) 3 organization funded solely by supporters in the

community. It is run by an Executive Director and a Board of Directors, a full staff, and a team of faithful volunteers. The crisis counselors are very client-centered and listen first to each client's situation. Their focus is to inform the clients of their options and to educate them on the advantages and possible disadvantages of each option, always allowing the client to make her own decision and never presuming to know what is best for their situation. Because the state of Georgia does not mandate pre-abortion counseling, many women and girls who live in Georgia seek abortion without knowing the possible consequences, making the education of choices that the PSC does even more important. The head counselor is a marriage and family therapist, rather than simply a "lay-counselor" as is used at most Crisis Centers. All staff are fully qualified for their position and the clinic as a whole strives to operate in a caring, open-minded, and ethical manner. They are one of the primary supports that this community has to help prevent teen pregnancy as well as to aid the young women who are already pregnant.

Another service of the clinic is providing counseling services and educational services to young women even if they are not pregnant. Women who are pregnant may be the target population but they are certainly not the only clients who benefit from services. One study examined the clinician's approach to teens with negative tests and found that most staff are not trained to work with adolescents and fail to address the problem of unsafe sex practices in the teen population (Moriarty Daley et al. 2004). This study demonstrated the need for medical services to be readily available to teens, to be free of cost if possible, for staff members to be trained to work with adolescents, and for educational services about safe sex practices, abstinence, and birth control to be provided

at every opportunity (Moriarty Daley 2004). Having these services accessible and available, taking advantage of the opportunity to educate, will potentially decrease the current pregnancy rates among teens. An important challenge put forth by this study was to attempt to offer the same level of importance of services to teens with negative tests as one would to teens with positive tests (Moriarty Daley 2004). This forgotten population of teens with negative tests was addressed by Eve Tushnet, as well: “Many of us were startled in our training …..to learn that clients whose pregnancy tests came out negative also need to be counseled,” (2003, 112). As Tushnet describes, the women who discover that they are not pregnant, after all, are all too often in emotional distress anyway and greatly benefit from the free counseling (2003). In addition to that, they also receive education about birth control, abstinence, and healthy relationships, hopefully helping them prevent future pregnancy scares (Tushnet 2003).

Though their primary focus is to prevent abortions, you would not immediately know that if you were a client. Clients who have been in to the clinic and used their services do sometimes choose abortion and later return. Counselors make it clear that they are welcome regardless of their choice, and that support is there for each option. Clients come in for educational resources, aid in getting the baby supplies they need, STI and abortion information, and post-abortion support and counseling. The clinic offers keyboarding classes, resume-writing seminars, and interviewing skill classes, all to help the young teens and mothers obtain secure employment. The overall support and encouragement they offer their clients is a source of comfort to many. For those who cannot afford to take an at-home test, this clinic offers valuable access to medical

services and allows them to confirm or negate pregnancy as early as possible and to begin making plans for their decision. For those who choose parenting, they have the option to begin learning about pregnancy, labor and delivery, and caring for a newborn immediately and to subsequently begin earning “Mommy Money” toward their material needs. To convey some idea of the number of women who benefit from their services, Table 2.3 shows some of their important statistics for 2010:

2010 STATISTICS FOR THE PREGNANCY SUPPORT CLINIC OF VALDOSTA	
TOTAL CLIENT VISITS	1085 CLIENTS
“**RED ROSE**”* BIRTHS RECORDED	136 BABIES
COMMUNITY EDUCATION	206,875 CLIENTS

Table 2.3: **“*Red Rose*”** refers to infants whose mothers intended to abort them prior to being seen at the clinic. *Pregnancy Support Clinic* (2012).

Notice the 136 “red rose” births, which represent babies who are now living because their mothers sought services at the clinic and were encouraged enough by the support offered that they decided to carry the pregnancy to term and either place their baby for adoption or to parent themselves. This serves as very clear evidence of the impact this small clinic is making.

Education During Pregnancy

Another issue to be considered for this study is the issue of education during pregnancy: is it important or not? If so, what issues should be covered during education? Many issues face an expectant mother as well as a new mother. Expectant mothers need to know how to properly care for their bodies as well as their developing babies during their nine month gestational period. New mothers need to know how to care for

themselves post-delivery as well as how to care for their newborn baby. So, the question here is how important is the knowledge of how to correctly do these things. Is it just as good for a mother to learn as she goes, by trial and error, or are there benefits to formal education? Let us look at an example here. During the gestational period there are substances and chemicals which are known as teratogens (harmful and potentially fatal to the fetus). A teratogen is defined as, "an agent, as a chemical, disease, etc. that causes malformation of a fetus," (Webster's New World Dictionary 1994, 1380). Essentially, teratogens are agents that have the potential to disturb the development of an embryo or fetus—with the possibility of death or birth defect in the child. Examples of this include radiation, maternal infections, chemicals, and drugs (including nicotine) (www.medterms.com). The type and extent of the defect are determined by the specific type of teratogen, the embryonic process affected, genetic predisposition, and the particular stage of development at the time of exposure. A smoking expectant mother who is uneducated on this topic and is approaching her pregnancy through trial and error may continue to smoke during her pregnancy out of ignorance, having no idea of the potential harm this could be causing the fetus. Potential side-effects of smoking during pregnancy include:

- Low birth weight
- Higher incidence of respiratory illness
- Greater chance of premature rupture of membranes
- Premature birth
- Perinatal death

- Placental abnormalities
- Bleeding during pregnancy (Simpkin, Whalley, & Keppler 1991).

If the expectant mother in question were to be informed that smoking could potentially kill her baby, she would possibly feel a strong motivation to stop, at least for the duration of the pregnancy. But, without that knowledge, she would have no reason whatsoever to stop smoking. One study examined the impact of prenatal education on behavioral changes toward smoking cessation, essentially looking at effects of imparting this knowledge through formal education during pregnancy on the decision of the expectant mother to stop or to continue smoking (Caine, Beasley, & Brown 2012). This study also examined the effects of prenatal education on the decision to breast feed post-delivery. Most participants (56%) were absent a high school or general equivalency diploma. This study found that program participants were more likely to initiate and even continue breast feeding than nonparticipants and that participants were also more likely to quit smoking than were nonparticipants, demonstrating that the act of providing education during pregnancy had a significant impact on their behavior (Caine, Beasley, & Brown 2012). This study, in particular, concluded that breast feeding and smoking cessation were modifiable risk factors that can be impacted by behavioral interventions through education (Caine, Beasley, & Brown 2012). This indicates that there is potential for the EWYL program (which also includes education on the benefits of breast feeding as well as the potential dangers of smoking during pregnancy) to have a significant impact on the behavior of the women who participate.

A study by Ateah (2012) examined the perceptions of participants of a prenatal parent education program offered in a group format. This particular program covered topics such as shaken baby syndrome, a safe sleeping environment, physical punishment, positive parenting, and development and safety (Ateah 2012). Using a survey questionnaire at the conclusion of the course, this study found that participants planned to use the information learned in caring for their infant, perceived the classes to be very helpful and useful, and even suggested that all expectant parents should have access to this information (Ateah 2012). This study indicates that not only is there a positive correlation between education and behavior, but there is also a desire and appreciation for this education during pregnancy found in expectant mothers and fathers.

Two studies conducted by Anne Broussard and Brenda Broussard demonstrate a need for effective teaching and support to help pregnant teens navigate the experiences of pregnancy, childbirth, and parenting (2010; 2012). In studying the different types of programs available, they determined that several criteria are more effective: hands-on activities are more effective than lectures, one-on-one contact was more desired by participants, material rewards are appreciated and encourage participation, and using a variety of learning approaches (such as games) was also found to be more effective (Broussard & Broussard 2010). Using a survey after the classes in the study, they also highlight specific things that the participants state they learned and plan to incorporate into their parenting techniques, such as: placing the baby on its back in sleep, not letting the baby sleep while holding a bottle, taking time and being patient with children, not shaking the baby, how to burp the baby, how to bond with the baby, not to get angry and

spank, and being less nervous in parenting (Broussard & Broussard 2012). These studies indicate that education during pregnancy is a valuable resource, that participants do gain important information, and that the style of teaching utilized by the EWYL program is an effective and appropriate one for the target population.

Earn While You Learn Programs

Although the researcher has been unable to find any competing program for the EWYL program being examined herein, it is not uncommon for clinics to utilize self-created versions of the EWYL program. They do not purchase a formal curriculum but instead develop their own. Within the existing research there are no studies examining this specific EWYL program, nor are there any studies examining any other curriculum within pregnancy resource centers. However, there are a few studies which examine other earn while you learn programs in unrelated fields. For example, the idea of apprenticeship allows individuals studying for a specific career to work under the supervision of an expert in that field while learning about the trade. Some apprenticeships offer paid programs, which are sometimes referred to as "earn while you learn" programs.

While the programs themselves are quite different from the EWYL program being studied here, they are comparable in that they offer money or other rewards as motivation while learning and studying a specific topic. An article on the earn while you learn program offered to up-and-coming firemen as well as an article on the advantages of an earn while you learn program in nursing both advocate the advantages of using this system in education (Dickson 2001; Hoban 2007). Both articles describe this as dually

advantageous—apprentices are more motivated to learn because of the added incentive not usually present in a traditional educational environment and their superiors gain an energetic student and assistant in one—eager to learn even at a lower paying wage than their counterparts (Dickson 2001; Hoban 2007). It truly is a dually beneficial situation, and while these programs cannot be directly compared to the EWYL program being studied here, they do have some merit in that they indicate that the inherent reward in an earn while you learn program results in a more motivated student. This suggests that the effectiveness of the educational aspects of such a program may be greater than other programs.

Group vs. Individual Format of Teaching and Counseling

There is a finite amount of research examining the differences between group versus individual teaching or counseling programs, the results of which are largely inconclusive. According to Panas, Caspi, Fournier, and McCarty (2003), the empirical evidence of which format carries the greatest benefit is scarce. One study examined individual versus group therapy specifically for children with anxiety disorders (Panas et al. 2003). The study found no statistically significant difference between therapy types, noting only that both groups showed improvement (Panas et al. 2003). The authors concluded, then, that the choice between treatment types would be best left up to pragmatic considerations such as therapeutic resources and child or parent preference (Panas et al. 2003). Another study on patient education concluded that neither format had a statistical advantage over the other (Wilson 1997). The evidence demonstrated that patient outcomes improved under both formats and that it is not possible to determine

which is better—they are essentially equivalent in effectiveness (Wilson 1997). In contrast, one study did demonstrate an advantage for the individual format of instruction (Dollahite & Scott-Pierce 2003). Analysis of behavioral outcomes in this study demonstrated a significant difference in the improvement for those taught individually over those taught as a group (Dollahite & Scott-Pierce 2003). Lorine Aughinbaugh (1969), asserts that staff shortages and funding restrictions forced most colleges and schools into utilizing group format counseling and teaching (1969). This study examined randomly assigned students to either group or individual counseling over a two-year period, testing for academic achievement, goal motivation, and other related factors (Aughinbaugh 1969). An analysis of covariance showed a significantly higher rating for students assigned to the individual group in the area of self-understanding, but no significant difference in persistence, academic achievement, or goal motivation (Aughinbaugh 1969). These studies reflect a lack of significance between group and individual format methods.

Purpose of the Study

As the literature review clearly demonstrates, the issue of crisis pregnancies, particularly in the teen population, is an enormous issue both in this nation and in this area of the southern U.S., specifically in Valdosta, Georgia. The researcher has demonstrated the diligent work that the Pregnancy Support Clinic/Options Now organization does to help alleviate and address this issue locally. This research project is designed to support their efforts in three ways: first of all, to legitimize the work that they are doing and to educate the academic community about their services, secondly, to aid

them in their work by giving them sound scientific evidence about the efficiency and effectiveness of their primary curriculum, and finally, to aid the entire pro-life community by adding research information in an area where there is a miniscule amount of information to be found. Having this research project published nationwide will help educate the academic world about the work CPCs across our nation are doing. This research will benefit not only the local Valdosta agency, but any crisis pregnancy center across the nation. The curriculum being examined in this research is the curriculum of choice for the vast majority of clinics nation-wide. These clinics have been using this curriculum in blind faith, with no way of really knowing if it is effective or efficient. The results of this research will answer their questions and will aid them in deciding if this specific program is a wise investment or if other programs should be utilized. Furthermore, this research will determine if one format of this program is more efficient than the other. Existing literature is generally inconclusive in regards to the individual vs. group format of counseling and teaching, with research supporting both methods as valid and effective. This project is important for its potential ability to shed light on the differences between formats, particularly for this particular program and population. Depending on the findings of this research, this could revolutionize the way that this program is used across the country.

Chapter III

RESEARCH METHODOLOGY

The methodology of this research consisted of statistically analyzing the efficiency of the two different formats of the EWYL, as utilized by the Pregnancy Support Clinic of Valdosta, Georgia. Specifically, this research examined which format used the least amount of clinic resources (time and money). The two formats of curriculum usage examined were the individual format and the class format. The variables examined were as follows: format of implementation of the EWYL program (individual vs. class), number of clients participating in the EWYL program, the total number of clients seen at the clinic, the number of AM/AV clients seen at the clinic, and the cost expenditure, and the time expenditure for each format. The time employees spend on each format was inclusive of both time and cost variables, as the counselors are paid hourly—thus time and cost are equitable. The costs examined in this study consist of general program costs for the EWYL program (absent employee pay) for each format implemented. The hypotheses and the methodology procedures used to examine the research questions are discussed. Interviews of the Executive Director and staff counselors were also conducted to obtain the time and cost data for the format types, as well as to gain a more thorough understanding of the EWYL program and how it is being used at the clinic. These interviews added to the research understanding of this curriculum but were not included in the statistical data other than the specific time and cost related variables obtained from

the interviews. The counselors were asked how much time they spend before and after each EWYL appointment under the individual format as well as under the class format and responses were analyzed.

Research Hypotheses

The most important question this research sought to answer was whether one format of the EWYL program uses less clinic resources than the other. It is the suspicion of the Executive Director of the PSC that the individual format is more efficient in terms of cost and time expenditure. In order to test this theory the researcher must first determine what clinic resources should be examined. A differentiation had to be made, as well, between the resources associated between the two program formats. Associated costs of the EWYL program use include: cost of the materials, employee salary, time expended on the program itself, and the cost of using the PSC facility. Being able to accurately calculate all of those factors, particularly for the years 2007-2009, was not feasible. It was deduced that the facility usage was roughly equivalent for the two formats. Accordingly, facility usage was not considered in this study. Under both format types the clinic hours remained the same—with counselors and staff available and the facility open for the same number of hours either way. In the matter of employee salaries, the Executive Director did not want to divulge that private information. However, she did point out that the counselor salaries were comparable (all counselors are paid the same hourly rate) regardless of program type and it stood to reason that the most important factor to examine was the amount of time the counselors spent on each program type. However, the individual format allowed for the use of volunteers, which do not receive a

pay and therefore do not add any cost. The class format, in contrast, only utilized two paid staff members. Additionally, the researcher was able to include the program costs for supplies and materials for the four years. Therefore, the focus of the time/cost expenditure comparison was time spent on the program type, with analyses also being performed on the basic program costs. Based on the beliefs of the Executive Director and on the primary need she has for this research, four hypotheses were formulated:

Hypothesis One: The individual format of the EWYL program uses less time than the class format.

Null Hypothesis One: The format type of the EWYL program has no effect on the usage of time.

Hypothesis Two: The individual format of the EWYL program uses less money than the class format.

Null Hypothesis Two: The format type of the EWYL program has no effect on the usage of money.

Hypothesis Three: The individual format of the EWYL program results in an increase in the number of clients participating in the program

Null Hypothesis Three: The format type of the EWYL program has no effect on the number of clients participating in the program.

Hypothesis Four: The format type of the EWYL program is correlated with the number of AM/AV clients coming into the clinic.

Null Hypothesis Four: The format type of the EWYL program is not correlated with the number of AM/AV clients coming into the clinic.

Data Sources

The data utilized in this study is quantitative, archival data contained in the internet-based database, eKyros, used by the PSC and 270 other clinics across the U.S. (www.ekyros.com). Prior permission was obtained from the Institutional Review Board for the collection of this data, exemption from the review process was granted (see Appendix A). With the consent of the Executive Director of the Pregnancy Support Clinic, archival data from the years 2007 until 2011 was utilized. All participants are female clients of the PSC with a wide variety of ethnic, racial, and age characteristics. No personal descriptive or demographics were examined for the purpose of this study because only limited demographics were provided based on data collections. However, demographics such as age and marital status were examined among the data submitted (though not considered in relation to the effectiveness of the program format type).

Data Reliability

The reliability and validity of a study's instruments, data, and measures are certainly important to its credibility. Though this is an original study not intended to be representative of all pregnancy resource centers and is applicable only to the center from which the data was obtained, its ability to be replicated is dependent on the accuracy and validity of the results. For the results to be important and useful to the PSC, as well as other clinics, when making decisions about which program to purchase and which format to utilize they must be confident in the accuracy of the results. The data collected by a staff member via the internet-based archive system is believed to be accurate and reliable because it pertains only to specific information which was not subject to interpretation

and was simply entered into a computer database. The archival data used for this study is automated data obtained from the clients and staff of the clinic, recorded into the eKyros system by counselors and other staff. The data has been confirmed through internal quality control measures which involve third-party review as well as cross-comparison of the original forms filled out by the counselors and clients to ensure accuracy of data entry. Variables such as individual format or class format not only were not subjective variables but were also restricted to specific years—if a client participated in the EWYL program during a specific year they only had one choice as to format type. Therefore, no mistakes in format type could be made. This makes the data very accurate and credible. A staff counselor or trained volunteer has a typed form for each client appointment which they fill out during the appointment with the client present. As soon as the client leaves they write their case note, describing what took place during the appointment, and then it is usually immediately entered into the database (specific data, such as date and appointment type—subjective data such as the counselor's narrative is not entered). Because data was not collected in regards to opinions, perceptions, feelings, or ideas, the data was specific, accurate, and easily accessible. The data is found to be reliable because it was systematically and carefully entered into a computerized database using a formatted template over the course of a four year period and is also systematically reviewed by a third party. During this time the data was reviewed by several individuals—the counselor who saw the client, the records personnel who monitor files and data entry, and the director who reviews all files after each appointment to ensure there are no errors. In order to increase validity, the data was also subjected to peer

review by multiple outside peer sources within the academic community and any errors discovered were immediately corrected.

The categorization of a client as either Abortion-Minded or Abortion-Vulnerable can be somewhat subjective. Because this was done on a case-by-case basis for many years, being completely left up to the counselors personal interpretation of the conversation which took place during the appointment, the classification of AM or AV was not a reliable one. The staff implemented measures to correct this error around 2005, creating an instrument as part of the intake process which would determine if the client was AM or AV based on specific criteria. This instrument is research-based and includes criteria shown to be associated with the decision to abort—such as having had previous abortions, being single, and being below the age of 17 (Cote et al. 2009). The presence of this instrument has greatly increased the reliability and validity of the classification of AM or AV, although it could be argued that there is still some room for error. Regardless, these variables are not related to the cost- or time-efficiency of the EWYL format, the primary focus of this research, and were not included in the analyses other than to determine if there is a correlation between format type and number of AM/AV clients at the clinic. The same counselors are making the AM/AV determination over the time period being examined in this study, so the classification process should remain consistent and relatively reliable for the purposes of this study.

Information gathered via survey or interview (see Appendix B) could certainly be subjective and biased and therefore was not included in the statistical analysis nor was it related to the hypotheses being examined in this study. Information was gathered using a

researcher-created interview which had no previously-proven reliability or validity, but that information was only used to further the understanding of the program, how it is used in other clinics, the perceptions of the program, and its perceived effectiveness in order to have some reference of comparison to the clinic being studied. The interview process did allow for some triangulation as it allowed the researcher to ask the same questions of multiple staff members to assess for accuracy. Four different staff members within the PSC were questioned on the time involved in an individual appointment as well as a class—the times given by all four individuals (interviewed separately so that no one's answers were influenced by the presence of another staff member) were identical, giving consistency and validity to the time expenditure figures used for this study.

Data Limitations

Limitations of this study include the availability of specific data—only archival data absent any demographic information was available. Therefore, ethnicity, race, geographic location, religion, and other factors were not included as part of the analysis of this study. This study cannot, then, account for any possible correlations which may be present with the results and these demographic attributes. Another limitation was the limited time-frame of the data. Because the internet database only contained information beginning in 2006, data prior to that year could not be used, allowing for only a four year time-span of data that was available for the EWYL program. Additional limitations include the fact that no client input was available for this study and that several important factors were not entered in as pertinent data and therefore not available for analysis.

Research Methodology

Data was collected on the total number of clients who came to the clinic each year during the four year span (2007-2011), the number of clients participating in the EWYL program for approximately two years using each format, and the number of EWYL appointments each year. Data was also collected on how many AM/AV clients came into the clinic during those years, how much time the counselors expended on the sessions using both formats, and how much cost the clinic expended using each format (including supply costs and employee wages by amount of time spent). Staff counselors were interviewed to determine the amount of time they spent and how much cost was involved, and the Executive Director was interviewed to determine the purpose of the EWYL program and her impression of its effectiveness. The researcher also interviewed directors of similar clinics within the state of Georgia who also use the EWYL curriculum in order to gain a more thorough understanding of the perception of the usefulness of the curriculum in general. After much discussion, it was determined that the salaries of the counselors were not needed because just examining the actual time spent would give the same value for comparison (the counselors employed during the timeframe of this study were all paid the same identical hourly wage). The usage of volunteers per format will be factored in because volunteers were only utilized for the individual format. Therefore, the costs of the materials was a one-time cost that applied to its use during classes as well as during individual appointments, so the cost of the EWYL program materials as well as the cost of maintaining the clinic will not be included in this study. However, the supply

and materials purchased outside of the curriculum will be included as basic program costs (this includes pamphlets, snack and refreshment costs, etc).

Employee Interviews

The interviews utilized for this study primarily focused on their perception of the usefulness of the EWYL curriculum. The researcher interviewed the clinic staff counselors and the Executive Director to determine the amount of time they spend and how much cost is involved with each of the two different formats. Questions were also asked of the Executive Director to determine the purpose of the EWYL program in her clinic, and her impression of its effectiveness. Additionally, interviews were conducted with the directors of several other clinics within the state of Georgia in order to gain information about their use (or lack thereof) of the EWYL program and their impression of the curriculum. This was done primarily to give a comparison to other, similar clinics.

Testing the Hypotheses

This research project encompassed four main objectives. These four objectives consisted of first determining the relationship (if any) between format type and time expenditure, then in determining the relationships (if any) between format type and cost expenditure, next in determining the relationship (if any) between the format type and client participation, and finally in determining the correlation (if any) between the program type and number of AM/AV clients. These objectives were broken down into four primary research questions:

1. Which of the two EWYL formats expends the least in terms of time?
2. Which of the two EWYL formats expends the least in terms of cost?

3. Does the format type of the EWYL program have an effect on the number of clients participating?
4. Is there a correlation between the EWYL format type and the number of Abortion-Minded/Abortion Vulnerable clients coming into the clinic?

From these research questions, four basic hypotheses were formulated:

Hypothesis One: The individual format of the EWYL program uses less time than the class format.

Null Hypothesis One: The format type of the EWYL program has no effect on the usage of time.

Hypothesis Two: The individual format of the EWYL program uses less money than the class format.

Null Hypothesis Two: The format type of the EWYL program has no effect on the usage of money.

Hypothesis Three: The individual format of the EWYL program results in an increase in the number of clients participating in the program

Null Hypothesis Three: The format type of the EWYL program has no effect on the number of clients participating in the program.

Hypothesis Four: The format type of the EWYL program is correlated with the number of AM/AV clients coming into the clinic.

Null Hypothesis Four: The format type of the EWYL program is not correlated with the number of AM/AV clients coming into the clinic.

The researcher focused first on answering question number one. In order to answer this, however, Hypothesis One must be tested:

H_1 = The individual format of the EWYL program uses less time than the class format. ($H_1 = x_1 < x_2$)

*where x_1 represents the time expenditure of the individual format and x_2 represents the time expenditure of the class format.

The first step in the testing process is to test the null hypothesis:

H_0 = The format type of the EWYL program has no effect on the usage of time. ($H_0 = x_1 = x_2$)

The null hypothesis was rejected and further testing was conducted to determine any possible statistical relationship. The researcher utilized several statistical procedures to confirm significance or lack of significant difference among the variables. The tests the researcher used were: *Pearson's correlation coefficient*, *t test,* and a *chi-squared distribution test*.

The researcher then examined the second hypothesis:

In order to do this, however, Hypothesis Two must be tested:

H_2 = The individual format of the EWYL program uses less money than the class format. ($H_2 = x_1 < x_2$)

*where x_1 represents the cost expenditure of the individual format and x_2 represents the cost expenditure of the class format.

The first step in the testing process is to test the null hypothesis:

H_0 = The format type of the EWYL program has no effect on the usage of money. ($H_0 = x_1 = x_2$)

The null hypothesis was rejected and further testing was conducted to determine any possible statistical relationship. The researcher utilized several statistical procedures to confirm significance or lack of significant difference among the variables. The tests the researcher used were: *Pearson's correlation coefficient*, *t test,* and a *chi-squared distribution test*.

The researcher then examined the third hypothesis:

H_3 = The individual format of the EWYL program results in an increase in the number of clients participating in the program. ($H_3 = p_2 > p_1$)

*where p_2 represents the number of participating clients in the individual format and p_1 represents the number of clients participating in the class format.

The first step in the testing process is to test the null hypothesis:

H_0 = The format type of the EWYL program has no effect on the participation of clients in the program. ($H_0 = p_1 = p_2$)

The null hypothesis was rejected and further testing was conducted to determine any possible statistical relationship. The researcher utilized a two proportion z-test to confirm significance or lack of significant difference among the variables. Using the formula for a hypothesis about two proportions, the two-proportion z-test, with $p_1 = 0.475$ (class) and $p_2 = 0.7003$ (individual), $p\text{^} = 0.573$.

The researcher then examined the fourth hypothesis:

H_4 = The format type of the EWYL program is correlated with the number of AM/AV clients coming into the clinic. ($H_4 = y_2 > y_1$)

*where y_1 represents the number of AM/AV clients who came in under the class format and y_2 represents the number of AM/AV clients who came in under the individual format.

The first step in the testing process is to test the null hypothesis:

H_0 = The format type of the EWYL program is not correlated with the number of AM/AV clients coming into the clinic. ($H_0 = y_1 = y_2$)

Unfortunately in this case the statistical testing failed to reject the null hypothesis, making further testing unnecessary. Although there was a small increase in AM and AV clients it was not shown to be statistically significant. Therefore, it cannot be assumed that this slight increase is in correlation to the change in format. More likely, the increase is simply due to chance.

The variables examined were as follows: format of implementation of the EWYL program (individual vs. class), number of clients participating in the EWYL program, the total number of clients seen at the clinic, the number of AM/AV clients seen at the clinic, the time expenditure, and cost expenditure for each format. The format of the EWYL program is clearly marked in the data as the staff themselves categorize which type of format was being used on the data entered—individual format referring to one on one teaching time and class format referring to teaching the curriculum to 10-15 ($M = 13$) clients at once in a classroom setting. The number of clients participating is also a concrete number which was obtained from the internet-based database utilized by the

clinic. Following each appointment, a staff member enters the appropriate data for that appointment into the database, specifying the appointment type and the format type. From this database the total number of clients seen at the clinic, the total number of clients participating in the EWYL program, and the total number of AM/AV clients were easily accessible. A staff member classifies clients as one of these two categories if they meet certain criteria; a client is considered AM or AV if at any point they meet certain criteria—this is noted on their chart and subsequently entered into the database in their file. Example criteria include: expressing the intent to abort, stating that they are being pressured by others close to them to abort, stating that they are considering abortion because of a difficult situation, and having a history of abortions. Time expenditure refers to the amount of time the counselor spends preparing for an EWYL appointment, the amount of time the counselor spends on the actual appointment, and the amount of time the counselor spends writing notes or entering data following the appointment. Because the counselor is being paid per hour for time at work, the amount of time spent is proportionate to the amount of money each appointment costs the clinic, giving a fair representation of which format type uses the most time and money. The only exception to this is when the counselor is an unpaid volunteer; the consideration of the cost from utilization of volunteers under the individual format has been accounted for. In addition to this inclusive time/cost factor, however, analyses on the basic program costs for each year has also been included, not including counselor salaries. These numbers can be seen in Table 3:

Table 3: EWYL Program Costs 2007-2011

Year	Program Cost
2007	1036
2008	1393
2009/2010	495
2010/2011	697

*Total program costs for the two-year span =1192 (individual) vs. 2429 (class). Data source: *Pregnancy Support Clinic* (2013).

Analyses were performed on these variables to determine the relationship between class format and time/cost expenditure, the relationship between class format and number of clients, the relationship between class format and number of EWYL appointments, and the possible correlation between class format and number of AM/AV clients seen at the clinic.

Study Procedures and Statistical Analyses

Multiple statistical analysis tools were used to analyze the data. *T* tests, Pearson's correlation coefficient, comparison of proportions, and other tests were run. Due to the relatively minimal consequences that could result from the results not being valid, a standard .05 or 5% alpha level was used when consulting the *t*-test significance table.

In using the above-described statistical analyses, this study is able to answer the research questions as well as the questions of the Executive Director so that she will be able to make a solid, empirically-based decision in regards to the future use of the EWYL curriculum. This research will also help inform the decisions of countless clinics across

our nation who are either already using the EWYL curriculum, or are considering purchasing the curriculum for their clinic. Because these clinics are non-profit organizations, they must be very careful how they spend their time, funds, and resources. This research will help them make the best, most cost-effective choices they can in regards to educating their clients. Without this research, this and similar clinics are left to their own guesswork and their own perceptions of effectiveness with no way of knowing if they are correct or if their faulty assumptions are costing their clinic precious time and resources.

Chapter IV

RESULTS

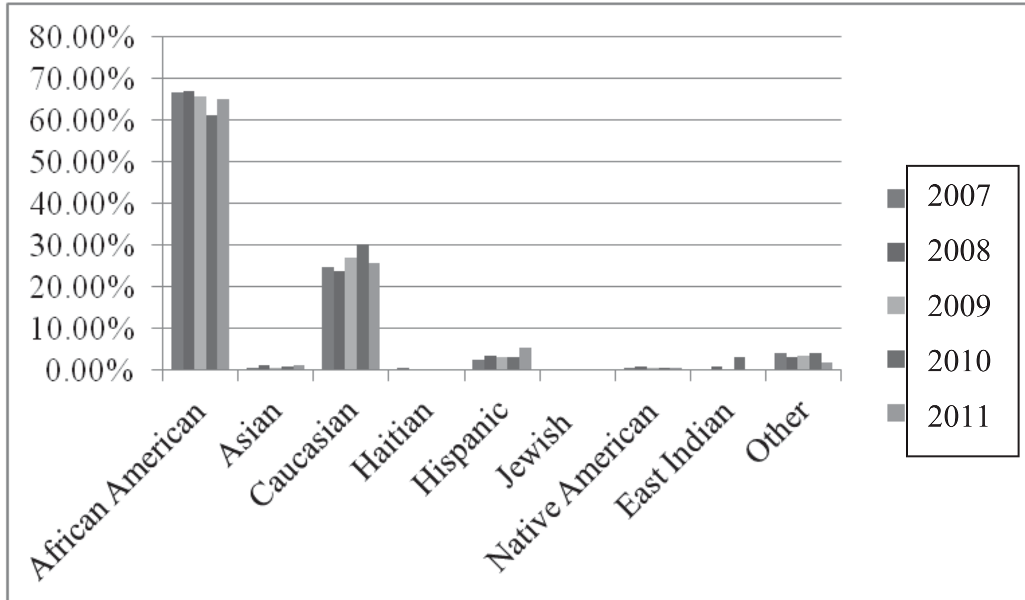
Findings

The findings of this exploratory study are not meant to be applicable to all pregnancy resource centers but are reflective of the PSC of Valdosta, Georgia, only. The participants of this study were 4113 pregnant females who reside in the Valdosta, Georgia area and are clients of the Pregnancy Support Clinic/Options Now. Of those, 296 chose to participate in the EWYL program, either attending the First Time Mom or the Parenting Module classes or individual appointments. The two EWYL program format types (individual vs. class) were the primary focus of this study. Analyses were performed on these figures to test for statistical correlations in relation to format type.

Demographic Findings

Although data was not collected on the demographics of the participants of the EWYL program for the years examined in this study, demographic information for the client population as a whole was provided. This data revealed that, just as the literature suggests, a majority of the PSC clients were aged 15-24 (74%) as well as African American (65%). The percentage of African American clients to other races was disproportionate to the general population, suggesting that there are racially or culturally related factors involved in the occurrence of crisis pregnancies. The racial demographics of the PSC clients from 2007-2011 can be seen in Table 4.1:

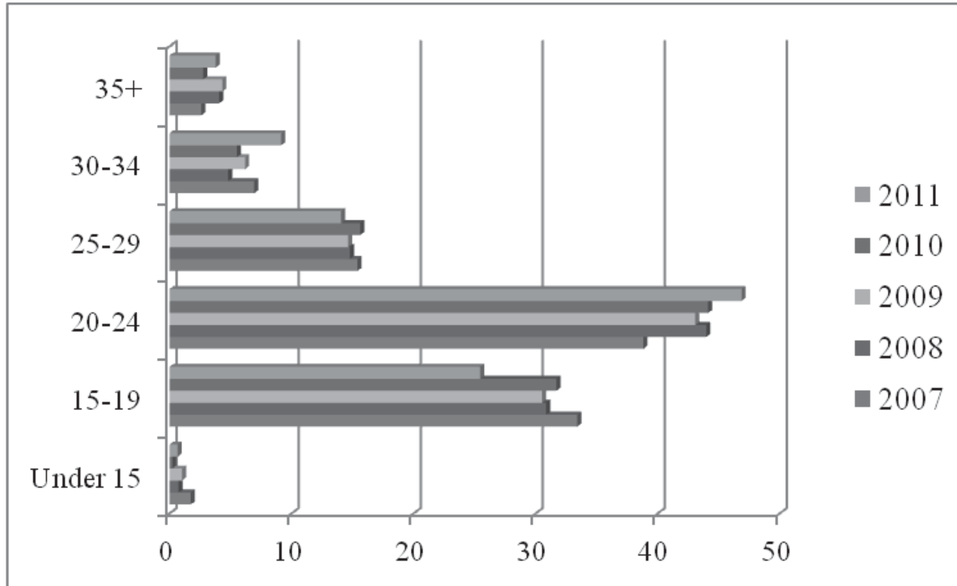
Table 4.1: Racial Demographics of PSC Clients 2007-2011



Data is representative of a percentage of the total client number. (*Pregnancy Support Clinic* 2013).

As seen in the table above, for all five years represented, the majority of the clients seen at the PSC were of African American race. Among the data presented, there were patterns in the age as well. Table 4.2 demonstrates the distribution of age among the PSC clients from 2007-2011, the majority of which do fall in the 15-24 age group.

Table 4.2: Age Data Breakdown of PSC Clients 2007-2011



This is representative of the percentage of the total for each age category. (*Pregnancy Support Clinic* 2013).

As can be seen in the above table, 74% of the clients who came into the clinic between the years 2007 and 2011 were aged 15-24. Again, this supports the literature findings discussed earlier in this paper. There were a larger number of clients in the 20-24 age-range, suggesting that the college population is likely also very vulnerable to crisis pregnancies. It is recommended that further, broader studies be conducted to validate this finding.

Interview Findings

The Executive Director gave a very positive description of the program, stating, "EWYL is a viable support program to offer women during pregnancy. Sometimes it is the difference maker in their pregnancy decision. The program lets the pregnant woman, many times in a crisis pregnancy, know that we are here throughout the pregnancy and

beyond.” Directors of similar clinics within the state of Georgia who also use the EWYL curriculum were also interviewed in order to gain a more thorough understanding of the perception of the usefulness of the curriculum in general. Of the seven directors interviewed, five were able and willing to contribute clinic data for use in this study. From the data gathered in this process, it was determined that an average of 83% of their total clients were between the ages of 15 and 19 during the year 2010, giving an accurate idea of the age group primarily represented (Employee Interviews 2011). Of the 270 clinics across the nation who use eKyros, 54% were between the ages of 15 and 24; 66% of the 15 to 19 year olds in that year were unmarried (eKyros 2010). These numbers are consistent with literature on the high teen pregnancy rates in the U.S. (Kost, Henshaw, & Carlin 2010; United Nations 2011; Henshaw, Singh, & Haas 1999).

One director described EWYL as a “vital part of our ministry,” while another (who reported using the program for over 8 years) states that the program allows a medical pregnancy clinic to build structured, healthy relationships with their clients at the same time they “provide accurate and professional life skills” to them. A description of the program as well as a detailed description of each of the two formats of usage was obtained. Some clinics use the individual format, some use the class format, and still others reporting using a combination of the two formats. When interviewing staff from other, similar clinics, questions were utilized regarding which of the two formats they use as well as their perception of the curriculum as a whole. The purpose of this was to gain first-hand knowledge of the curriculum as well as compare the opinions of those outside the PSC to those within the clinic to ascertain if their opinions and perceptions may be

unique to that specific clinic or if they might be generalizable across other areas. The counselors who teach the curriculum were also interviewed in order to collect data related to the amount of time the counselor spends on each of the two format types, both before the class/individual appointment, during the appointment, and after the appointment. This information was instrumental in determining which format uses the most time and clinic resources.

In the process of interviewing the Executive Director it was revealed that she believes strongly in the effectiveness of the EWYL program. Having worked at the PSC for many years, she has personally witnessed clients who came in seeking services, carrying an unwanted pregnancy and afraid for their future. She has seen the clients gain confidence, time and again, in their own ability to parent successfully regardless of their circumstances, and she has seen those enrolled in the EWYL program proudly earn much-needed supplies, such as strollers, carseats, cribs, clothes, and even diapers while simultaneously learning how to take care of themselves and their new babies. The Executive Director also believes that the individual format is more conducive to client-counselor relationships and much more client-friendly than the class format. The increased flexibility of scheduling allows more clients to participate in the program than were able to before, a quality also highly praised by all three of the staff counselors interviewed. The staff marriage and family therapist conducted both the class format and the individual format during her time at the PSC, and prefers the individual format for several reasons. First of all, she reports, it takes up considerably less time on her part than the class format did. She has more time to perform her other work duties now because

less time is taken up in the preparation and participation in classes. Also, she believes that, although it may be difficult to see based on the archival data alone, the client retention rate has gone up dramatically since the change. She remembers in the class format that there was a high drop-out rate, meaning that though there may have been a full class each week, the same clients were not returning week after week. Instead, new clients were coming in and attending a class or two before dropping out, so that the class itself was always comprised of new people, preventing any real relationship or camaraderie from developing. Under the individual format, however, she testifies that the same clients are coming in regularly from first learning of their pregnancy until after the baby is born, allowing for the counselors to really get an understanding for each client's situation and circumstances, better enabling them to aid her as she most needs it. Another result of this is that the clients are learning more from the program since they are completing the entire series rather than just dropping in for bits and pieces, as they tended to do during the class format. The staff member who gathered the data also suggested that she had observed that more people participate in the EWYL program now than before, as a percentage. She pointed out that the client numbers were dropping in recent years, as a whole, and that would also contribute to the lower numbers of AM/AV and EWYL participants that might be observed. Because of this, it was important to also look at the proportion of participants in relation to the total client numbers, rather than just examining the relationships between the variables.

The interviews with the Executive Director, as well as the counselors, revealed that, without even considering the material costs, the class format of the EWYL program

entailed twice as much counselor time-expenditure as did the individual format. In addition to this, it was also revealed that the counselors themselves spent an average of $20.00 (sometimes reimbursed and sometimes not) on each class meeting (this was not figured into the cost for this study). This cost was for the snacks and drinks which they served the clients during the class time. The individual format does not include any form of snacks or drinks, so does not have any additional cost to the clinic beyond the materials themselves and the cost of salaried time expenditure by the counselors. In addition to this, the individual format allows for the use of volunteers, saving the clinic cost in the area of employee wages. The counselors stated that they spend an average of one and one-half hours on each individual EWYL client appointment, whereas they spent a minimum of three hours on each EWYL class meeting. There was a minimum of two counselors present for each class, as well, which meant that the cost expenditure of those three hours was doubled for the clinic. The researcher will include this factor, as well as the use of volunteers for the individual format, in the cost analysis. The difference between the formats when assuming that each class takes six hours of counselor time and each individual appointment takes one-and-one-half hours of counselor time is examined, understanding that this is an average and not an absolute. It can be safely assumed that any correlation shown is probably actually larger in reality, given that this study is disregarding several cost factors. The basic program costs submitted by the Executive Director included appear to be significantly higher for the class format than the individual format on first glance. Before even conducting any analysis, it appeared that the

individual format costs the clinic much less in terms of actual cost. Table 4:3 (below) shows a breakdown of the data used in this study:

Table 4:3: Variable Breakdown of Data for Individual vs. Class Formats 2007-2011:

Variable	2007 (C)	2008 (C)	2009/2010 (I)	2010/2011 (I)
EWYL Clients	**66**	**73**	**85**	**72**
EWYL Appointments	**162**	**143**	**240**	**202**
AM Clients	**56**	**59**	**72**	**61**
AV Clients	**207**	**398**	**358**	**321**
TIME/HOURS	**75**	**66**	**240**	**202**
Program Cost	**1036**	**1393**	**495**	**697**
Total Clients	**1364**	**1562**	**1187**	**1055**

Variable Breakdown Jan-Dec 2007-2011, *Pregnancy Support Clinic* (2013).

Subsequent to running statistical analyses on these figures, the findings and implications of such are discussed further. Pertinent values are displayed in tabular format in Table 4:4:

Table 4:4: Cross-tabulation of the variables:

Variable	*N*	*n* (Class/Indiv)	*M* (Class/Indiv)	*SD* (Class/Indiv)	*t*-value	*Pearson's r*
EWYL Client*	296	139/157	5.792/6.542	2.021/2.265	1.21	.2062
EWYL Appts*	747	305/442	12.71/18.42	2.545/3.787	6.13	.6087
AM Clients*	248	115/133	4.792/5.542	2.146/2.323	1.16	.3029
AV Clients*	1284	605/679	78.71/28.29	9.311/5.575	1.39	.0431
Time Expenditure *	583	141/442	70.5/221	6.36/26.87	------	.9713
Cost Expenditure *	3621	2429/1192	1214.5/596	252.44/142.84	------	-.9706

*Indicates an analysis between this variable and format type (Class vs. Individual)

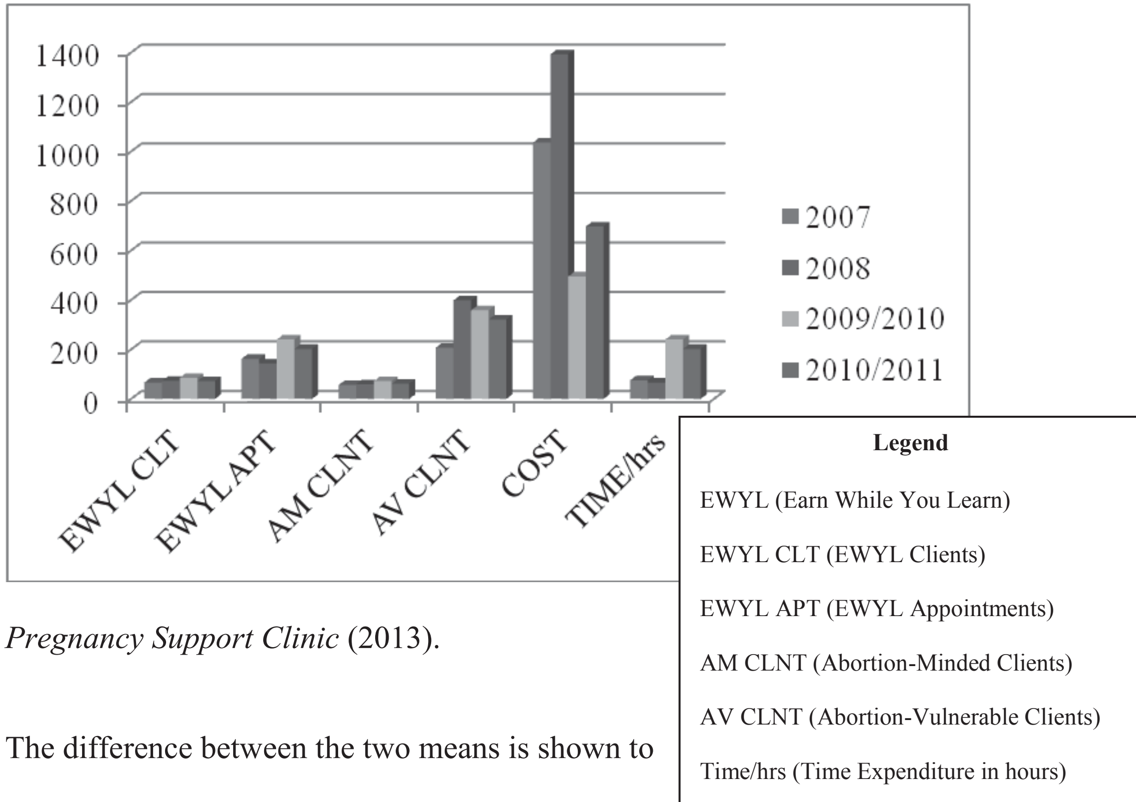
Pregnancy Support Clinic (2013).

Results of Research Question One

The first question this research sought to answer was, "Which of the two EWYL formats expends the least in terms of time?" Therefore, the first hypothesis was that the individual format of the EWYL program uses less time resources of the clinic than does the class format. Based on the employee interviews, it was expected that a decreased time expenditure correlated with the change in format would be found. The time expenditure for the individual format had a mean of 221 ($M = 221$), as opposed to the mean of the

class format of 70.5 (M = 70.5). Table 4.5 (below) shows a bar graph illustration of the variables examined across the four year span:

Table 4.5: Bar Graph of Variables 2007-2011



Pregnancy Support Clinic (2013).

The difference between the two means is shown to be statisically signficant at the .05 level ($r = 0.97$, $p < .05$). Analysis revealed a strong positive correlation between time expenditure and EWYL format.

Results of Research Question Two

The second question this research sought to answer was, “Which of the two EWYL formats expends the least in terms of cost?” Therefore, the second hypothesis was that the individual format of the EWYL program uses less money than does the class format. Based on the employee interviews, it was expected that a decreased cost

expenditure correlated with the change in format would be found. In regards to the program costs, the mean for the class format was (M = 1214.5), as opposed to the mean for the individual format (M = 596). The difference between the two means was shown to be statistically significant at the .05 level (r = 0.-97, p < .05). Analysis revealed a strong negative correlation between cost expenditure and EWYL format. Thus, the second hypothesis was supported.

Results of Research Question Three

The third question this research sought to answer was, "Does the format type of the EWYL program have an effect on the number of clients participating?" Therefore, the third hypothesis was that the individual format of the EWYL program results in an increase in the number of clients participating in the program. Based on the employee interviews, it was also expected that an increase in client participation is correlated with the change in format from class to individual.

Of the total clients who came into the clinic from 2007-2009, 4.75% (n = 139) participated in the EWYL program by attending classes. Of the total clients who came into the clinic from 2009-2011, 7% (n = 157) participated in the EWYL program by making individual EWYL appointments. Using the formula for a hypothesis about two proportions, with $p_1 = 0.475$ (class) and $p_2 = 0.7003$ (individual), p^ = 0.573. When running a test for comparison of proportions, the following results were obtained, pictured below in Table 4.6:

Table 4.6: Comparison of Proportions of Total Clients who Participate in EWYL:

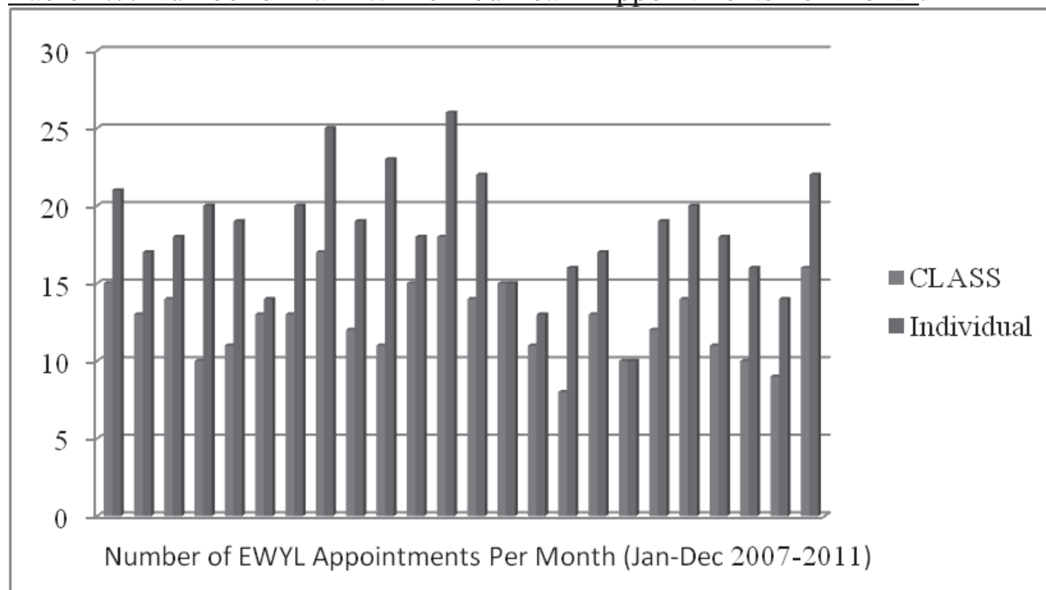
Difference	**2.25%**
95% Confidence Interval	**0.931% to 3.607%**
Chi-square	**11.491**
DF	**1**
Significance level (p < .05)	**P = 0.0007**

Pregnancy Support Clinic (2013).

As shown in the above table, at the significance level of .05, with a 95% confidence interval, the difference between the two percentages is significant. This test confirms the suspicion of clinic staff that the percentage of total clients who participate in the EWYL program has increased significantly since the change in format. This is indicative that the factors increased flexibility of scheduling attached to the individual format, the increased relationship-building that takes place, and the more personal style of the individual format have had a significant effect on the client's decision to attend EWYL sessions. These results are also consistent with literature demonstrating that clients prefer individual appointments to group or class sessions (Broussard & Broussard 2012). As demonstrated by a study, one-on-one contact was more desired by participants (Broussard & Broussard 2012). Previous research also shows that significantly higher ratings of self-understanding are found when participants experience one-on-one, or individual, contact (Aughinbaugh 1969). Research also demonstrates advantages for the individual format of

instruction (Dollahite & Scott-Pierce 2003). While this particular study does not examine effectiveness and does not show a significant difference in effectiveness between types, it does demonstrate that clients prefer the individual method. One can still conclude that the ultimate decision of format type should be made by each individual clinic based on pragmatic considerations, as suggested by previous literature (Panas, Caspi, Fournier, & McCarty 2003).

Table 4.7: Number of Earn While You Learn Appointments Per Month:



Pregnancy Support Clinic (2012).

Table 4.7 (above) visually demonstrates the increase in EWYL appointments using the individual method as opposed to the class method. When taking into account that the total client number decreased considerably during the time-span that the individual format was utilized, this difference takes on even more significance.

In the course of this process, analysis was also performed on the number of EWYL appointments during the two different formats. The individual format resulted in 442 EWYL appointments (M = 18.42, SD = 3.79), whereas the class format resulted in 305

EWYL appointments (*M* = 12.71, *SD* = 2.55). The difference between the two means was statistically significant at the .05 level ($t = 6.13$, $p < .05$, $r = .61$, $df = 23$). Analysis revealed a positive correlation between the individual format and the number of EWYL appointments.

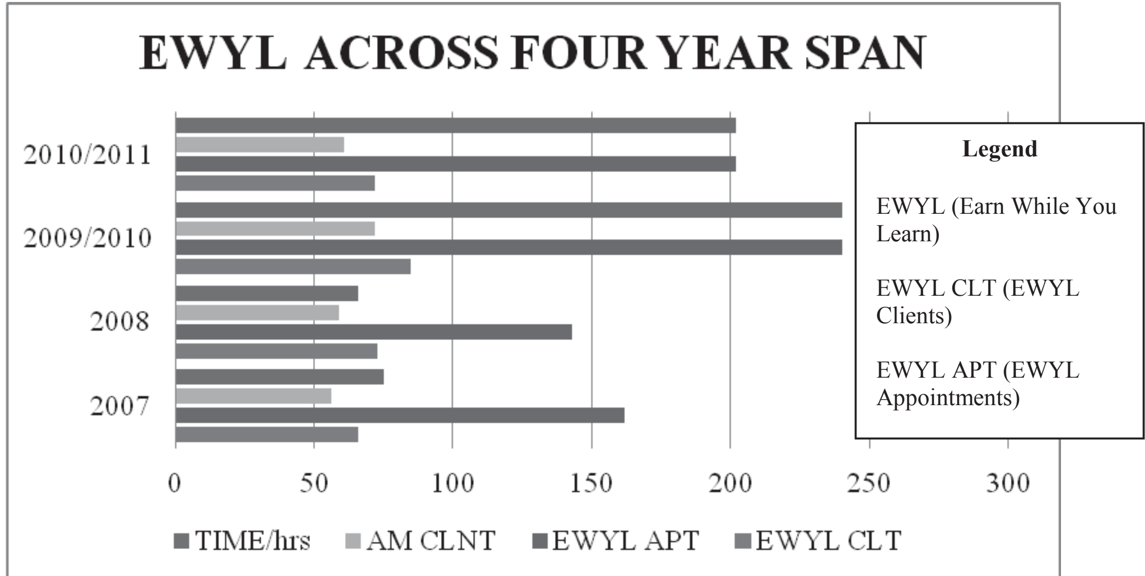
Results of Research Question Four

The fourth question this research sought to answer was, "Is there a correlation between the EWYL format type and the number of Abortion-Minded/Abortion Vulnerable clients coming into the clinic?" Based on the conversations with the clinic staff, it was expected that there would be an increase in the number of AM/AV clients that correlated with the implementation of the individual format. However, in order to answer this question accurately, the following hypothesis must be tested:

> H_2 = The individual format of the EWYL program results in an increased number of AM/AV clients coming into the clinic.

The number of AM ($n = 133$) clients during the use of the individual format had a mean of 5.54 and a SD of 2.32, as opposed to a mean of 4.79 and a SD of 2.15 for the class format. The number of AV ($n = 679$) clients during the use of the individual format had a mean of 28.29 and a SD of 5.58, as opposed to a mean of 78.71 and a SD of 9.31 for the class format. Statistical analyses of this data revealed no significant correlation between the EWYL format type and either the number of AM or AV clients ($t = 0.12$, $t = .08$, respectively). Therefore, the null hypothesis was not rejected and the fourth research hypothesis was not supported in this case. Table 4.8 demonstrates the numbers across the four year span for the categories of AM and AV within the EWYL program:

Table 4.8: EWYL and AV/AM Clients 2007-2011



Y represents Year of Data, X represents Number of Clients.

Pregnancy Support Clinic (2012).

Summary

During the four-year span from 2007-2011, a total of 5168 client appointments were conducted by the PSC. Of those, only 747 appointments were for the EWYL program. The time expenditure of the clinic staff for those EWYL appointments was approximately 583 hours. The cost expenditure of the clinic on the EWYL program for this time period was $3,621. The primary question being examined in this research was which format utilized the least number of clinic hours and clinic money. Statistical testing revealed a clear and very significant; i.e., the individual format used significantly less money, but significantly more time, than the class format did. This significant decrease in cost expenditure was directly correlated with the significant increase in the number of EWYL appointments. The time expenditure and the number of EWYL appointment

variables were directly correlated with the format type. These findings contradicted the first hypothesis being tested and confirmed the second hypothesis being tested.

In an effort to understand client participation, the third research question this project sought to answer was which format of the EWYL program enlists the most client participation. Of the total of 5168 appointments, 747 appointments were for the EWYL program. Therefore, only around 14% of client appointments were for participation in the EWYL program during this timeframe. Clearly, not all clients are participating. In an effort to understand client participation, one of the secondary research questions this project sought to answer is which format of the EWYL program enlists the most client participation. To answer this question, first the null hypothesis must be rejected. The null hypothesis is that there was no difference in client participation between the two EWYL formats ($H_0 = n_1 - n_2 = 0$). Based on testing that was conducted to compare the proportions, it was determined that there was a significance difference between the two proportions. This means that the format type of the EWYL program plays a strong role in client attendance, and client attendance was shown to statistically increase in correlation with the change to the individual format. These findings supported the third hypothesis being examined herein.

The fourth primary question this research sought to answer is whether there was an increase in either AM or AV clients which could be attributed to the change to individual format. Unfortunately, statistical testing did not show any significant relationship between format type and the number of AM/AV clients coming into the clinic. Therefore, the fourth hypothesis was not supported by the research data.

Although it was not part of the primary research questions being explored in this study, another important finding was discovered. When examining the number of red rose babies over the course of the last six years it was noted that the number has been steadily increasing, despite of the fact that the overall client numbers has decreased somewhat. Upon closer inspection, it was discovered that in 2007 the client to red-rose birth percentage was 6.23%. In comparison, in 2012 that number had risen to 13.97%, substantially higher (more than double) as a proportion. The total number of clients did not increase proportionate to the increase in red rose babies. The Pearson's r coefficient for the number of clients to number of red rose babies over that time span is shows a negative correlation (r = -.19).

Table 4.9: Red Rose Babies 2007-2012:

	2007	**2008**	**2009**	**2010**	2011	2012
PT	452	510	476	435	448	512
Red Rose	85	154	162	136	196	153
Total Clients	1364	1562	1336	1085	1175	1095

Pregnancy Support Clinic (2013).

The reason for this trend cannot be determined based on the data collected for this study. Further studies are needed to determine if this increase is related to the EWYL program, the EWYL program format, or other factors. The following chapter seeks to explore the findings and their implications.

Chapter V

DISCUSSION

The issue of abortion is no less controversial now than forty years ago when *Roe v Wade* changed the history of life versus choice forever (*Roe v. Wade*, 410 U.S. 113, 1973). Though each side of this heated debate has its own idea of what the "right" choice is for women in unplanned pregnancy situations, they both share the weight of the teen pregnancy crisis our nation is faced with. The extensive literature supporting the emotional sensitivity of women faced with a pregnancy decision and the emotional trauma following the decision to abort, in particular, is indicative of a vast need for counseling support for women who find themselves in the face of a crisis pregnancy. Attempting to fill this need are the thousands of CPCs across the U.S. Though most CPCs are staunchly positioned on the LIFE side of the life versus choice debate, that in no way negates the tremendous work they are doing to help alleviate the stress, anxiety, and fears of young women across our country faced with a decision that will inevitably change the course of their entire future.

Many of the thousands of CPCs in the U.S., and the Pregnancy Support Clinic of Valdosta, Georgia, specifically, use the EWYL program to aid them in the goal of assisting, educating, and reassuring young women in crisis pregnancies. In conjunction with free counseling services, free pregnancy tests, free ultrasounds, and free STI testing, they also offer educational programs such as the EWYL program as a mutually beneficial

means of preparing and equipping unprepared expectant mothers. This study sought to evaluate this program and the efficiency of the two different formats of its usage.

The primary problem investigated by this particular study was the comparable efficiency of the two different teaching formats of the EWYL program being utilized by the PSC. In order to ascertain which format is more efficient in terms of usage of the least amount of time and money, the cost and time factors of both formats was examined closely. The time and money expended on each presentation format of the EWYL program was compared to find out which is more efficient. Another problem explored by this study was whether the format type of the EWYL program has any effect on the number of Abortion-Minded (AM) and Abortion-Vulnerable (AV) clients coming into the clinic. This knowledge is very important because attracting and serving as many AM/AV clients as possible is a primary focus of the PSC. The other issue being examined is whether one format of the EWYL has an effect on client participation.

Due to the small sample size available, this is an exploratory and descriptive study only. The CPC studied is located in Valdosta, Georgia, and other clinic directors interviewed are all in the state of Georgia; therefore, the findings of this study may not be representative of CPCs on the national level. The results of this study are meant to provide useful insight and guidance for future research and study. The following chapter will discuss the findings of this study, make suggestions on the future use of the EWYL program, and also give recommendations for future studies in this area.

Who Benefits from the Services of the PSC?

As demonstrated in the literature review, the primary target population of the PSC and other clinics like it across the U.S. are women who find themselves in a crisis pregnancy situation. Research shows that the majority of women in crisis pregnancy are unmarried, school-aged urban minority youth with less than a high school education and from a low-income household (Basch 2011; Cote et al. 2009). The results of this research were consistent with those found in related literature. As discussed in the literature review, the highest percentage (80%) of unplanned or crisis pregnancies exists in the 15-24 age range, also the age range of the majority of the participants of this study (CDC 2000, 1; NHSR 2012, 7). The need for the work of the clinic is well established, given the high rate of teen pregnancies in the state of Georgia (95 per 1000) and, particularly, the prevalence of this among the clinic's target population, as supported by research stating that those living in impoverished, low-educated, urban areas are the most vulnerable to teen pregnancy (Guttemacher 2004; Kost, Finer, & Singh 2012; Miller 1991).

It follows then, that most of the clinic's clients are young women aged 15-24, primarily African American. Nationally, eKyros data demonstrated that 54% of their clients were between the ages of 15 and 24, with 66% of the 15-19 year olds being unmarried (eKyros 2010). Within the state of Georgia, among the clinics interviewed, 83% of their clients are aged 15-19 (Employee Interviews 2011). Among the PSC clients, it was found that that 74% of their affiliated CPC clients are aged 15-24 and 65% are African American (Employee Interviews 2013). All of these findings coincide with the literature review discussed earlier in this paper.

The age of the clients is an issue since many are too young to be knowledgeable about either proper medical care or options during pregnancy. The PSC is able to offer information to these young girls even before they have informed their parents or families in many cases. The majority of the clinic's clients are also very low-income and often unable to access standard health care. The PSC entails their first prenatal medical visit. While not a full medical clinic, the PSC can at least confirm or deny pregnancy, educate them on the proper health and care during pregnancy, assess for viability of pregnancy, provide them with prenatal vitamins, and encourage them to seek the care of an obstetrician. The PSC also refers them to the proper resources to gain access to government provided health care plans, giving them the best avenue for affordable health care for themselves and their pregnancy. Though not the majority, older married and unmarried women also seek services at the clinic when faced with an unexpected pregnancy. The free medical services are very beneficial to them, but they primarily seek the free counseling to help them deal with the emotional strain of the decision. There are hundreds of thousands of women who benefit each year from the services offered at CPCs across our nation, and thousands who benefit each year from the services offered at the PSC in Valdosta, Georgia.

Is Education During Pregnancy Important?

As demonstrated in the literature review, prenatal education does have an impact on maternal behavior and can change her decisions during and following the pregnancy (Caine, Beasley, & Brown 2012). In reference to behaviors such as smoking and breast-feeding, studies found a significant correlation in behaviors in relation to pre-natal

education (Cain, Beasley, & Brown 2012). It was also found that behaviors such as shaking a baby, ensuring the baby sleeps in a safe position, and the use of, style of, and degree of physical punishment were all significantly impacted by prenatal education (Ateah 2012). These studies demonstrate that education during pregnancy is more than just important, it is critical. Proper education during pregnancy can prevent serious birth defects and even death of the fetus, child neglect and abuse following birth, and the death of the baby due to poor or abusive parenting practices. If even one baby's life is impacted by the educational services his or her mother received, then that education has immeasurable value.

Does the Use of the Earn While You Learn Program have Merit?

Based on research on other earn while you learn programs, it has been clearly demonstrated that students are more motivated to participate and to learn and retain information when there is a reward offered. Regardless of whether this is an apprenticeship program, a clinic-designed earn while you learn curriculum, or the Heritage House EWYL curriculum studied herein, the motivation factor involved is apparent. Speaking specifically to the use of an EWYL program in a pregnancy support clinic setting, not only does it motivate the clients to learn the material and to attend the classes, it also provides them with material essentials that they need for themselves and for their coming baby. It perfectly suits the purposes of the CPC—to help any woman in an unplanned or crisis pregnancy. The help given through this curriculum is bi-fold; it helps prepare her for pregnancy, childbirth, delivery, and parenting, and it also helps by alleviating her financial strain in becoming physically prepared for the baby. In addition

to this, the research-supported increased motivation means that more of the material will be learned, retained, and applied than in any other method of teaching. This equates to more babies' lives being affected positively by the education received. In short, the earn while you learn method has great merit, particularly in the pregnancy resource center setting.

Which Format of Implementation is Best?

The primary focus of this study was to determine which format of implementation of the EWYL program is "best" (i.e., most efficient and most effective). Previous literature discussed in the literature review showed mixed findings in reference to the individual versus group format. In effect, it is quite difficult to definitively say one format is "better" than the other because there are so many extraneous factors involved in any situation. However, this study determined that the individual format is best in terms of client retention, client participation, and cost. Literature supports the finding that clients clearly prefer the individual format of teaching, as shown by the increase in client participation in the EWYL program under the individual format (Broussard & Broussard 2010).

This study did reveal that more time is involved in the individual format than the class format, however. The finding that more time is involved in the individual format is also supported by literature discussing the need for universities and schools to primarily teach in the group or class format due to budget and time constraints (Auginbaugh 1969). Because the majority of literature does not show a significant difference between effectiveness in format type, it can be concluded that there are advantages of both but that

it is ultimately left up to pragmatic considerations of the clinic or facility as to which format is best suited to their needs (Panas, Caspi, Fournier, & McCarty 2003). Given the previous literature in addition to the findings of this study, it should be taken into consideration the strong client preference for the individual format and that format should be at least an option for clients if not the primary method of teaching when at all possible.

Implications

The findings of this study are intended to provide guidance and direction to the Executive Director and Board of Directors of the PSC. The correlations between the format type and number of EWYL appointments and cost expended by the clinic essentially means that, with the change in EWYL format type, the number of appointments went up while the cost spent on the EWYL program simultaneously went down. This is an important discovery for the PSC because it means that the clinic is using less money with more clients participating in the educational program. Continuing to utilize the format that costs less (the individual format) will also result in the maximum client participation, which is ideal for the PSC. The findings also show that the class format does use less time per client, which is advantageous in being able to offer this opportunity to as many clients as possible. However, fewer participants suggests that the time saved may fail to be an advantage. An alternate suggestion would be to train volunteers to instruct the classes and offer 1-2 classes per month as an alternate choice to clients. This would allow more flexibility and offer the class option to the clients who do prefer that choice, as well as allow more clients to take advantage of the opportunity within the limited operating time of the clinic facility. By utilizing volunteers rather than

paid staff to teach the classes it would substantially decrease the cost difference associated with the format type. As previously conducted, the classes cost the clinic significantly more. By extracting staff wages out of the cost for classes it will make the expenditure of the two different formats more equitable.

Based on the findings of this research the Director, Board, and staff of the PSC now know that there is credibility to the EWYL program itself, in that literature demonstrates the effectiveness and attractiveness of a reward-based curriculum—literature specifically demonstrates that material rewards are appreciated by participants, are known to encourage client participation, and are also known to increase motivation of the participants to learn and apply the material covered (Broussard & Broussard 2012; Dickson 2001; Hoban 2007). This study also demonstrates that it is best to continue using the individual, one-on-one format, as it clearly increases client participation and retention, increases the number of EWYL appointments, and also uses less of the clinic's money. They also have the additional option of offering volunteer-taught classes to save clinic time as well as decrease the cost of the class format. Previously, there was no statistical data to help guide their decisions, so this research now provides that to them. This study can also be shared with the 10 other clinics in their district so that they can determine which format of the EWYL program to implement in their own clinic. It is also the hope of the researcher that this will generate more research of the services and programs within the thousands of CPCs in the U.S.

Study Limitations

This study faced several limitations. First of all, all data was archival, meaning that the researcher only had access to data that had been previously collected. The time-span of available data was also limited for the EWYL program, only spanning four years—certainly a repeated study in future years would be able to make a more complete analysis. Additionally, for the years 2007-2009 there were aspects of the data that were not entered into the database, so even though those characteristics were available for the years 2010-2011, no comparisons could be made because the earlier data was missing those characteristics. The available archival data was also insufficient in some respects to do a more specific study. Having access only to archival data was certainly a limitation.

In order to determine the effectiveness of the EWYL program itself, a survey should be given to the program participants. There is a real need to hear their voice in regards to how effective EWYL is as a teaching tool for them. In addition to that, there is no way to know how many clients chose to parent or adopt (as opposed to abortion) without being able to either interview them directly or given them an anonymous questionnaire. For this study, the researcher did not have access to any of the actual clients and was unable to use any interviewing or surveying tools for that purpose. Another benefit of being able to access the clients directly would be to follow them individually to see how much of the program they attend, as suggested by one of the counselors. The fact that the counselors stated that the clients tended to drop out under the class format, but attended more regularly during the individual format appears to be evidence for increased client retention due to the individual format. However, because of

the limitations of the archival data, the researcher was not able to test this theory during this study. Examining this more closely would be beneficial for future studies.

Recommendations for Future Research

The researcher recommends further studies be done in this area. There is a massive void in the research of CPCs which sorely needs filling. In regards to the EWYL program, specifically, further studies should be conducted to determine its effectiveness in teaching, its role in client retention, and its relationship (if any) to the decisions of AM and AV clients. Testing clients on their parenting and pregnancy knowledge prior to the EWYL program and then after completing the program to ascertain its effectiveness in teaching material is recommended. Further research on the two formats of the EWYL program, particularly studies on different variations of these formats, would also be useful to the many CPCs who use this program. The use of interviews and survey tools in conjunction with direct interaction with clients currently enrolled in the EWYL for more accurate results is also recommended. Survey instruments should include questions about demographic information of the client (age, race, ethnicity, religion, socioeconomic status, level of education, area of residence) in order to allow for statistical analyses testing to be conducted in reference to correlations between demographic characteristics and their perception of the EWYL program as well as format type. Questions should be included in the survey and/or personal interviews regarding their perception of the program and whether they prefer the individual or class format. It is strongly recommended that future studies utilize both anonymous survey instruments before and after enrolling in EWYL programs as well as personal interviews with clients who have

participated in the EWYL program. This will allow the clients to contribute their perspective of which format is preferred, how much material is retained, what is considered by the client to be most important, as well as the reasons behind their perceptions. Similar studies conducted at other CPCs which utilize the EWYL program, particularly when attempting to do away with the current limitations, would provide these results with more validity.

It is also recommended that future research take into account the existence of other community resources, such as government-funded resources, for the same population. Attention should be given to the existence of concurrent use of these services to help eliminate unnecessary spending on the part of one or both organizations. It is recommended that studies be done on existing intergovernmental relations between such organizations to determine if the lack of communication between NGOs and GOs is leading to budgeting issues that can be resolved through collaboration. Attention should also be given in this area to any gaps in service provision for this population in order to identify a need for additional community support. Ideally, there should be continuity of services so that young women who are pregnant and/or parenting are able to access support services as long as they are needed (beyond pregnancy and the infant's first year of life), particularly in the area of parenting support and education. The identification and resolution of gaps in such supportive services could be crucial in the prevention of child neglect and abuse. Further study is recommended to determine the existing need and the possible ramifications of this issue.

Conclusion

This chapter discussed the findings and analysis of the data collected for this project. Descriptive statistics were presented for all the variables along with statistical analysis for each research question. This research study sought to answer a few basic questions about the PSC's EWYL program. During the course of this research, archival data collected over the years 2007-2011 was analyzed. Data from the two different formats of the EWYL program (the *individual* versus the *class* formats) were statistically analyzed for possible correlations. Data for the variables of time expenditure, number of EWYL clients, number of EWYL appointments, total number of clients, EWYL format type, and number of AM/AV clients were analyzed for correlations in relationship to the format type. Analysis revealed a negative correlation between format type and time expenditure, as well as a positive correlation between format type and number of EWYL appointments, clearly demonstrating that the individual format directly results in an increased number of EWYL appointments as well as a corresponding decrease in time expenditure. A comparison of proportions test also revealed a significant difference between the EWYL client participant percentages, indicating further that the individual format of the EWYL program also increases client retention. The results demonstrate that the individual format of the EWYL program is much more efficient than the class format. Analysis did not reveal a statistically significant correlation between the number of AM/AV clients and the EWYL format type, which is also important information for the clinic. Overall, the results of this study make a valid contribution to the PSC in regards to the future utilization of the EWYL program.

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APPENDIX A:

Institutional Review Board Exemption Letter

APPENDIX A: Institutional Review Board Exemption Letter

Institutional Review Board (IRB)
for the Protection of Human Research Participants

PROTOCOL EXEMPTION REPORT

PROTOCOL NUMBER: IRB-02759-2011 **INVESTIGATOR:** Kristi Godwin

DETERMINATION:

☑ This research protocol is exempt from Institutional Review Board oversight under Exemption Category(ies) 2. You may begin your study immediately. If the nature of the research project changes such that exemption criteria may no longer apply, please consult with the IRB Administrator (irb@valdosta.edu) before continuing your research.

☐ Exemption of this research protocol from Institutional Review Board oversight is pending. You may **not** begin your research until you have addressed the following concerns/questions and the IRB has formally notified you of exemption. You may send your responses to irb@valdosta.edu.

ADDITIONAL COMMENTS/SUGGESTIONS:

Although not a requirement for exemption, the following suggestions are offered by the IRB Administrator to enhance the protection of participants and/or strengthen the research proposal. If you make any of these suggested changes to your protocol, please submit revisions so that IRB has a complete protocol on file.

Recommendations

Please remove the statement re: IRB approval above the IRB approval box as well as the box itself. The IRB does not affix an approval stamp with a time limitation to consent documents for exempt research. There is no expiration date for exemptions.

Please change “approved” to “exempted” in the second line of “Information Contacts” on the consent form.

Barbara H. Gray Date: 5/17/13 ***Thank you for submitting an IRB application.***

Barbara H. Gray, IRB Administrator ***Please direct questions to irb@valdosta.edu or 229-259-5045.***

APPENDIX B:

Interview Questions

APPENDIX B: Interview Questions

Interview Questions for the Staff of the Pregnancy Support Clinic/Options Now

1. What is (was) your official title at the Pregnancy Support Clinic?
2. When you taught EWYL classes (First Time Moms and Parenting Classes), can you estimate how much prep time went into each class?
3. What was the average time for an actual class (class time only)?
4. If there was time spent talking after class was over, please estimate that time also.
5. How much time is spent after the class cleaning up, writing case notes, entering information into the database, etc?
6. Do volunteer counselors teach EWYL classes? If so, what is the staff/volunteer ratio for classes?
7. What are the program costs for the class format of the EWYL program for the years 2007 and 2008?
8. How much money do you estimate was spent on snacks and refreshments for each class?
9. How much total counselor/staff time was spent on each class?
10. What was the average time spent on mall shopping appointments?
11. How many classes were taught each week? How many per month?
12. When you do individual EWYL appointments (First Time Moms and Parenting), can you estimate how much prep time goes into each appointment?
13. What is the average time for the actual appointment (client time only)?
14. How much time is spent after the appointment writing case notes, filing the note, entering the information into the database, etc?
15. How much total counselor/staff time is spent on each appointment?
16. How much money is spent on snacks/refreshments for individual appointments?
17. What are the program costs for the individual format of the EWYL program for the years 2009 and 2010?
18. How many individual appointments do you do each week? Each month (on average)?
19. Do volunteer counselors do individual appointments? If so, what is the staff/volunteer ratio for individual appointments?
20. Can you put into words your thoughts on the program overall, its effectiveness, how women responded to it, and how effective you think it is in helping the girls/women be prepared for childbirth and parenting?
21. What is your opinion on which program format is more effective and more efficient?

22. What is your opinion on which format clients prefer, or if clients are more likely to complete the program in one format versus another?
23. Do you have anything you would like to say about the clinic itself, what you think it does for our community and if you think it is effective in helping girls and women in our area?

Interview Questions for the Staff of Other CPCs within the State of Georgia

1. What is the name of the city where your clinic is located?
2. What is your position/job title within this organization?
3. What was the total number of pregnancy test clients seen at your clinic in 2010 and 2011?
4. Of those, what was the total number of AM clients seen in 2010 and 2011?
5. What was the number of AV clients seen in 2010 and 2011?
6. Does your clinic utilize an educational program with material incentives (such as the Earn While You Learn/Mommy Money system)? If so, please state which product you use.
7. Do you utilize this program in an individual (one on one, counselor to client) or in a group/class format?
8. How many clients completed the program in 2010 and in 2011?
9. How many individual and/or group appointments/classes are offered per year or per month (please specify which and give data for 2010 and 2011)?
10. What is the number of participants who are:

    Below 15:____
    15-19: ______
    20-24: ______
    25-29: ______
    35+-38: _____
11. What is the number of participants with each of the following marital status':

    Single: ______
    Married:_____
    Engaged:_____
    Co-Habitating:_____
    Never Married:_____
    Unknown:________
12. If you use the Earn While You Learn program, do you have any comments you would like to contribute about the program, its effectiveness, and the impact it has on your clinic?