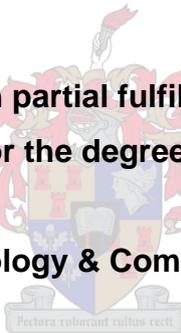


EXPLORING THE PSYCHOLOGICAL SEQUELAE OF WOMEN WHO HAVE UNDERGONE ABORTION: A MULTIPLE CASE-STUDY APPROACH

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DECLARATION

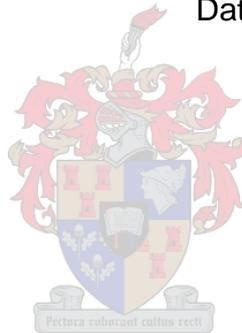
I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

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Signature

Date



ABSTRACT

The South African government has legalised abortion with the intention of reducing deaths from clandestine and illegally performed abortions. With this Act came the freedom of choice regarding termination of pregnancies for most women who found themselves in the midst of unintended pregnancies and could not carry them to term. The aims of this study were to examine the process of decision making, the role of perceived support and women's psychological outcomes to abortion taking into consideration the accessibility to psychological interventions and mental stability prior to the procedure. Personal, semi-structured interviews were conducted with five women aged between 22 and 24 years who had legal, induced abortions within the first trimester of their pregnancies. Interviews were conducted within at least two months after the abortion had been performed. A qualitative analysis of the findings revealed that responses to abortion are influenced by the decision-making process, perceived social support, and the dynamics of the relationships in which the child is conceived. These factors play a vital role in the ultimate psychological outcome and adjustment to the abortion process. The women's responses involved negative and positive emotions towards the resolution of the unintended pregnancy. Negative emotions included among others, feelings of shame, embarrassment, guilt and sadness. These were associated with the loss. The predominantly expressed positive emotion was relief. The conclusion yielded was that the relationship between the two consenting adults is significant and it is influential in the decision making, perceived support and therefore the response to abortion.

OPSOMMING

Die Suid-Afrikaanse regering het die uitvoer van aborties gewettig met die doel om sterfgevallen wat veroorsaak word deur ongeoorloofde en onwettige aborties te probeer verminder. Hierdie wetsontwerp besorg aan die meeste vroue wat hulle te midde van 'n onbedoelde swangerskap bevind, die vryheid van keuse om die swangerskap te beëindig. Die doel van hierdie studie was om die besluitnemingsproses, die rol wat waarneembare ondersteuning speel en die vrouens se sielkundige reaksies tot abortie te ondersoek, en ook faktore wat 'n impak het op die effek van abortie, inaggenome die beskikbaarheid van sielkundige hulp en geestesstabiliteit voor die abortie. Persoonlike, semi-gestruktureerde onderhouds is gevoer met vyf vroue tussen die ouderdomme 22 en 24 jaar wat wettige, induksie aborties binne die eerste trimester van hul swangerskap ondergaan het. Onderhoude is gevoer ten minste twee maande nadat die abortie plaasgevind het. 'n Kwalitatiewe analise van die bevindings het aan die lig gebring dat reaksies tot die abortie beïnvloed is deur: die besluitnemingsproses, die waarneembare sosiale ondersteuning, en die dinamiek van die verhouding waarbinne konsepie plaasvind het. Hierdie faktore speel 'n essensiële rol in die uiteindelijke sielkundige uitkoms en die instelling tot die abortieproses. Die vrouens se reaksies tot die probleemoplossing van die onbeplande swangerskap het negatiewe en positiewe emosies uitgewys. Negatiewe emosies het onder andere ingesluit gevoelens van skaamte, verbouereerdheid, skuldgevoel en hartseer. Hierdie gevoelens is met die verlies geassosieer. Verligting was die oorheersende positiewe gevoel. Die gevolgtrekking wat gemaak is, is dat die verhouding van die twee instemmende volwassenes belangrik is. Dit is ook fundamenteel tot die besluitneming, waarneembare ondersteuning en reaksie tot die abortie.

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CHAPTER 1

INTRODUCTION

Abortion in South Africa was legalised on December 11, 1996, granting women of any age or marital status access to abortion services upon request during the first trimester (12 weeks of gestation) (Guttmacher, Kapadia, Naude, & Pinho, 1998). The Choice on Termination Act (1996) allows abortion from 13 weeks through to 20 weeks gestation if a continuing pregnancy would pose a risk to the woman's mental or physical health; if it would end in the birth of an infant with a severe mental or physical abnormality; if the pregnancy resulted from rape or incest, or if carrying it to term would significantly affect the woman's social and economic situation. Additionally, for longer gestations, abortion is legitimate only if continuing the pregnancy would endanger the woman's life or result in a severe foetal malformation or a risk of foetal injury (Dickson-Tettech & Billings, 2002).

The Act (1996) makes provision for non-mandatory and non-directive counselling, which aims to assist women in making informed choices. During this consultation women are provided with information about alternative options, the medical procedure, the after-effects, and possible risks involved in the termination of pregnancy. Since the abortion experience is perceived as a stressful life event, it is therefore important to explore the role of support, decision making and psychological responses thereafter. Speckhard and Rue (1992) assert that abortion may relieve stress for some women by ending an unwanted pregnancy, but the event itself may simultaneously be experienced as a stressor causing anxiety, grief, despair, guilt and anger. Collectively, these factors could contribute towards predisposition to depression, as feelings of powerlessness, anger and self-condemnation are emotions that underlie depression.

The primary aim of the abortion Act (1996) is to provide women with the safe option of a legal abortion in the case of an unwanted pregnancy. Parliament passed this law with intentions of ensuring accessibility and

availability of abortion services for all women, particularly those who are poor or were previously disadvantaged, who are most likely to suffer complications or die from unsafe abortions (Dickson-Tettech & Billings, 2002). It is reported that women who most stood to benefit from this were those who could not afford safe alternatives outside the public sector to terminate their pregnancies (Clarke, <http://new.hst.org.za/news/index.php/20000605/>).

Data collected on abortion during the reformulation of the abortion act revealed that prior to the legalisation of abortion, an estimated number of clandestine abortions were dramatically larger ranging from 120,000 to 250,000 per year between 1975 and 1996 (Guttmacher et al., 1998). Moreover, data collected by the Medical Research Council (MRC) indicate that women under the age of 20 were three times more likely to present at a hospital with incomplete abortions than were older women (Guttmacher et al., 1998). Additionally, historical abortion statistics shows that there were 70,000 legal abortions performed in 2004; 54,500 in 2003; and 57,451 in 2002 in South Africa (Johnston, 2004).

Most women who undergo abortion have different and yet sound reasons for deciding to terminate their pregnancies. Such reasons differ from one woman to another and are impacted on by external factors and internal factors. Barglow and Weinstein (cited in Franz & Reardon, 1992) assert that there are two classes of decision making problems, i.e. intrapsychic and extrapsychic. Intrapsychic factors experienced during this process include poor reality-testing, inability to project the self into the future, massive denial, failure of the executive ego-function, and anxiety. Extrapsychic problems would include inexperience in decision making, unfamiliarity with pregnancy, and peer and parental pressures regarding the decision outcome. Another factor that plays an important role during the stage of decision making and the outcomes of abortion is social support.

Other theories provide alternative explanations to high levels of state-anxiety associated with abortion. On the one hand, psychodynamic theories attribute anxiety to intrapsychic conflicts and ego defence mechanisms, such as avoidance and denial (Bandura & Reardon, cited in Faure & Loxton, 2003). On the other hand, conditioning theories attribute anxiety to the fear-provoking

properties associated with the anticipation of a painful and stressful experience. However, neither of these theories can be discounted, as abortion is both the termination of a pregnancy, which may evoke feelings of guilt and self-condemnation, and a surgical procedure, which may cause pain and discomfort.

While there is intense controversy regarding how many women experience post-abortion psychological problems, researchers do admit that at least some women are negatively affected. Reardon (retrieved from <http://www.Abortionfacts.com>) states that risk factors predicting post-abortion sequelae include conflicted decision; which varies from difficulty making the decision; ambivalence and unresolved doubts, conflicting maternal desires, feeling pressured or coerced to abort. He adds that the second factor is the psychological or developmental limitations which focus on adolescent minors having an increased risk, prior emotional or psychiatric problems, lack of social support and prior abortion(s).

Moreover, there are many factors that contribute to post-abortion psychological responses. These factors range from the abortion procedure itself because the method of procuring abortion generally depends on who induces the process and where it is induced. Abortion procedures vary with the place, competence of the abortion provider, gestation period and availability of equipment of drugs. This suggests that treatment by abortion provider also plays a significant role. Adler (1979) established that unpleasant treatment from abortion providers, such as disapproval and hostility towards the woman, may contribute to poor post-abortion adjustment.

Reasons for termination of pregnancy range from unplanned pregnancy, women forced by families and partners to abort the baby, women who were victims of rape and women who abort their pregnancies due to genetical defect in the development of the foetus, to mention a few. Since people undergo the procedure for different reasons, presumably their emotional affect differs, and therefore subsequent responses would differ from one woman to another based on their emotional stability prior to the abortion, the decision making process and perceived social support.

A study by Bracken, Phil, Hachamovitch and Grossman (1974) reports that before abortion women present with ambivalent reactions to the pending procedure, while other women are faced with moral issues and therefore feel guilty about the decision they made, others cannot wait to be relieved of the problem. A study by Lawlor (<http://www.PostAbortion Syndrome-Effects of Abortion on women.htm>) affirms that the population of women who show some ambivalence and conflictual emotions about abortion are more likely to have long-term emotional affect after abortion itself.

It is comprehensible that individuality needs to be taken into consideration when dealing with this sensitive issue especially since the outcomes of this procedure differs from one individual to another. It is important that it be acknowledged that all women come from different backgrounds and therefore brings different dynamics into the process of abortion and that they all have unique life experiences. It is therefore important that each woman's experience be treated with caution and as unique as possible while it can still be generalised to a larger population.

Hence the purpose of this study is:

1. To investigate the psychological sequelae of women who have undergone abortion, particularly investigating women's psychological outcomes to abortion.
2. To explore how the process of decision making and how intricate is the role of perceived social support to the psychological outcome of women who underwent an abortion.
3. To assess whether psychological interventions for those women who as a result of abortion may have mental distress are as easily accessible as abortion services and how they contribute in alleviating resulting difficulties.
4. Mental stability of participants prior the abortion plays a crucial role in the outcomes of abortion and therefore needs cautious consideration to assess effects of abortion on the psychological outcomes for participants.

CHAPTER 2

LITERATURE REVIEW

Abortion is oftentimes construed and presented in negative ways in the literature. Deciding to have an abortion is presented as inevitably painful and traumatic for women. Women experience moral qualms about abortion itself. Some have maternal desires to protect their pregnancies. Therefore, for these women, abortion is not a glorious right by which they are able to reclaim control of their lives; instead it may be construed as an evil necessity to which they submit because they have no choice (Reardon, <http://www.Abortionfacts.com>). Rather than feeling proud of themselves for standing up against difficult situations, they tend to feel ashamed of themselves. This feeling of 'self-betrayal' is devastating for women and it creates an internally divided emotional conflict within and against herself. On the one side, are her original moral beliefs; whilst on the other side, is her abortion experience which represented a choice to act against those feelings.

Diversity in opinions and conflicting messages from groups espousing polarised views regarding the place of abortion in our culture has the unfortunate result of overwhelming women facing unintended pregnancies with many mixed messages. Despite the great controversy surrounding abortion, the psychological literature at the level of individual decision-making and adjustment has tended to suggest that the termination of an unplanned pregnancy is an emotionally benign experience for most women. The discrepancy between societal and individual experiences of abortion may represent an accurate view with personal experiences inherently less complicated than those at the broader level of analysis (Coleman, Reardon, Strahan, & Cogle, 2005).

Ciafone and Robin assert that multiple abortions are highly stigmatised, evoke less social support, and have more negative repercussions both medically and psychologically than single abortions. Going through the procedure repeatedly may thus contribute to differences in emotional and

social experiences, perceptions and views of abortion (cited in Mojapelo-Batka. & Schoeman, 2003).

Abortion is the umbrella term classifying various kinds of abortion ranging from induced to spontaneous abortions. It is therefore important that the definition of abortion pertaining to the focus of this study be clearly delineated. The type of abortion that is of concern in this paper is induced abortion referring to the intentional expulsion of the embryo or foetus from the uterus (Boyle, 1997).

However, this interpretation seems improbable given that women's lives are inextricably linked to the surrounding environment, as Armsworth (1991, p.378) noted "Abortion is an issue that cuts through multiple levels of individual, societal, cultural, and political spheres, all of which seem to have an impact on the individual response. A likely cause for the apparent inconsistency between societal and individual experiences is the theoretical and methodological deficiencies plaguing the area of study, with the available data often missing the complexity and depth of individuals' inner experiences."

2.1 THE PROCESS OF ABORTION

The aborting procedure is planned in a way that provides pre-abortion counselling and post-abortion counselling, also known as contraceptive counselling, to women undergoing the procedure. Before abortion, counselling is done by midwife nurses. This is more of an information giving process informing the client of the procedure and thereby preparing them for the procedure.

Post-abortion counselling is also an information process informing the client about the importance of using contraception and the importance of engaging in safe sexual encounters to avoid having another abortion. Mavroforou, Koumantakis and Michalodimitrakis (2004) assert that the high rates of abortion among young women are indicative of insufficient contraceptive use, lack of sex education and information about contraceptives, as well as inadequate or inaccurate family planning efforts.

Overall, while these two procedures are important for women undergoing such procedures, studies show that after abortion most women

feel relieved and never really engage in post abortion counselling and therefore still remain at risk of yet another abortion (Miller, 1992; Tietze, 1978). However, the study conducted by Dickson-Tettech and Billings (2002) show that post abortion counselling has some positive effects to some women who end up using contraceptives after a successful abortion.

Still, contraceptive counselling does not seem to be enough for some women who undergo abortion. Research shows that most women who have aborted their unwanted or unplanned pregnancies do not show long-term negative effects from the abortion itself (Bracken et al., 1974). However, in South Africa provision is made on a small scale for the minority who are faced with such long-term negative effects that have the potential to progress into a clinical psychological disorder after undergoing abortion. Some women require psychological interventions to assist them with effects of abortion; but in most cases such services are not as easily accessible as abortion services. Some women also cannot afford them because of socio-economic circumstances.

2.2 EMOTIONAL ASPECT OF ABORTION

Abortion is an emotional process and the most common emotions that are associated with it are guilt, fear, self-blame, grief, feelings of emptiness, unworthiness, depression, loss, anger, and even suicide (Speckhard & Rue, 1992). How well the person copes with this stress depends on the individual's resiliency and the conditions under which the stress occurs (Reardon, <http://www.Abortionfacts.com>). Clinical research has found that when women are in trusting, sharing relationships, they report deep seated feelings of exploitation over their abortion experience (Lawlor, 1996).

Some women, after abortion, suffer from Post-Abortion Syndrome (PAS) showing symptoms of stress, guilt, depression and anger (Vaughan cited in Speckhard & Rue, 1992). According to Speckhard and Rue (1992), PAS is a type of Post-traumatic Stress Disorder (PTSD) characterised by chronic or delayed development of symptoms resulting from affected emotional reactions to the physical and emotional trauma of abortion. They assert that it is composed of: (1) Exposure to or participation in an abortion

experience; (2) uncontrolled negative experiencing of the abortion death event; (3) unsuccessful attempts to avoid and deny abortion recollections and emotional pain, leading to emotional reduced responsiveness to others and one's environment; and (4) experiencing associated symptoms that were not pre-morbidly evident.

However, a study by Lawlor (1996) contends that the existence of Post-Abortion Syndrome is debatable because it often does not surface until many years after the abortion. Lawlor adds that it is very common for women to report feeling fine about the whole experience, but later in life they tend to find themselves engulfed in feelings of guilt, confusion, and exploitation. Gentles (1990) adds that the reason for the surfacing anxiety is partly mysterious, but is often associated with the birth of a wanted child later in life, or during unrelated counselling. Lawlor (1996), however, reports that symptoms of this disorder seem repressible for a time which implies that the causes for the disorder surfacing seem to be in many ways, time itself.

2.3 RESPONSES FOLLOWING ABORTION

There is evidence that legal abortion, a resolution of an unwanted pregnancy, particularly in the first trimester, does not create psychological hazards for most women undergoing the procedure. There is persuasive evidence that abortion is usually psychologically benign (Boyle, 1997).

Responses to abortion may differ by age within the adolescent group (Adler, 1992); nonetheless, adolescents are more likely than adults to experience negative responses following abortion, for several reasons. For example, adolescents may be more vulnerable than adults to pressure to abort, particularly from parents. Additionally, they may be inclined to keep their pregnancy from their parents and therefore be less likely to receive support from parents for the abortion, and lack of support is associated with more negative responses following abortion (Adler, David, Major, Roth, Russo, & Wyatt, 1990).

The vast majority of studies conducted on the topic of psychological responses to abortion have dealt with potential negative effects. However, abortion is sometimes conceptualised as a maturing experience for women

and as an efficient means of coping likely to be associated with an enhanced sense of control over their lives, a greater capacity of fulfilment, and high levels of self-esteem (Adler et al., 1990; Armsworth, 1991; Major, Cozzarelli, Sciacchitano, Cooper, Testa, & Mueller, 1990). Some women have expressed the potential for growth through the process of introspection frequently associated with abortion decision-making. The re-examination of one's needs, values, relationships with others and life goals that are part of the decision process are proposed to bring women to a state of greater self-understanding (Coleman et al., 2005). However, this positive growth has not been subject to empirical testing and needs more systematic analysis.

It has been found that healthy post-abortion adjustment is more likely to occur in women who hold strong views of the women's rights to choose, had positive beliefs about their own ability to cope, had higher levels of education, had supportive social structures, and were able to talk about their experiences (Varkey & Fonn, 2000). In contrast, Suffla (1997) reports that induced abortion is associated with negative emotions. Attachment to the foetus, high trait anxiety, coercion, lack of support from a partner, and negative social stigma contribute to negative feelings after abortion (Varkey & Fonn, 2000).

Adler (1975) distinguished between two kinds of negative emotions, namely those that are socially based and those that are internally based. The former set of emotions include shame, guilty and fear of disapproval, and evolve from the stigma attached to abortion by society and the violation of social norms. Internally based negative emotions include regret, anxiety, depression, anger and doubt. Internally based negative emotions are likely to derive from the personal meaning that the pregnancy and the abortion has for the woman, such as feelings of loss.

Minimising acknowledgement and discussion of post-abortion trauma may result in women feeling abandoned and isolated to the detriment that they may be discouraged from revealing their post abortion feelings and this may result in experiences of emotional difficulty. Steinberg (cited in Speckhard & Rue, 1992) has cautioned that we must examine the impact on

these women because their numbers are so great and because the political and social volatility of this issue locks so many of them into silence.

There are three obstacles to clinical identification of negative responses following abortion that have been identified by Harris (cited in Speckhard & Rue, 1992). These are: (1) masking of emotional responses may occur both at the time of the abortion or in later contacts with professionals; (2) if grief persists, it may surface in a disguised form and be expressed behaviourally or in psychosomatic complaints; and (3) if the caregiver has ambivalent or unresolved feelings about abortion, this may interfere with the accurate assessment of post abortion trauma and the establishment of trust and the ability to be patient and empathic.

Although studies show that most women do not experience negative psychological responses after abortion (Bracken et al., 1974), there is a minority subgroup that does experience negative psychological disturbances. The following are factors that play a role in whether women would experience difficulties coping with the abortion procedure, i.e. the decision process, perceived social support and coping process and expectancies (Adler, 1990). Bracken et al. (1974) assert that women who prepared themselves mentally for the possible consequences of abortion and had reliable support structures are more able to cope with post-abortion reactions and therefore experience fewer psychological sequelae as compared to women who are not prepared. Furthermore, they state that women who do not explore possible reactions prior to the abortion have post-decisional regrets that often manifest themselves as guilt, regret, depression or some adverse acute reactions. The study conducted by Bracken et al. (1974) also revealed that significantly more favourable reactions to abortion were found in women who were married and older. Furthermore, when perceived partner support in married women and parental support in younger age group was more supportive, the reaction to the abortion was more favourable.

Researchers tend to agree that, at some level, abortion is a stressful experience for all women who undergo it (APA, cited in Speckhard & Rue, 1992). As a psychological stressor, abortion may lead some women to experience reactions varying from mild distress to severe trauma; creating a

continuum conceptualised as progressing in severity from Post abortion distress (PAD), to Post Abortion Syndrome (PAS), to Post Abortion Psychosis (PAP) (cited in Speckhard & Rue, 1992).

A study by Miller (1992) outlines the decision making process around abortion. First, is the motivational; antecedents to conception. This assesses whether the pregnancy was intended or not. Second, once the conception has occurred, it becomes the status quo and therefore needs to be undone. The reasoning underlying this stage is the perceived adjustment to having a baby that was not intended to be conceived. Third, consideration of abortion or adoptive placements; here rare moral and religious issues that also play a role at this stage and therefore ruminative consideration and the pressure to make a good decision may result in distress for some women. The fourth consideration involves time and partner constraints, considering that one can abort a baby in the first trimester to avoid medical complications. The more people involved in making this decision, the more complex it becomes. The fifth and final consideration involves the availability of services especially if the decision is to abort the baby.

Although the degree of support plays a significant role in decision making and therefore the effects of abortion, there are other factors that also need to be considered, i.e. the interaction of personality, socio-cultural milieu, and intra-psychic factors. However, these factors are beyond the scope of this paper and therefore will not be discussed in great detail.

2.4 DECIDING ON ABORTION

The abortion decision is complex, involving a wide variety of influences. In general, women's abortion decisions are made within the diverse context of their relationships and life choices. In a South African context, women's decisions are further influenced by a socio-cultural environment that is intolerant to abortion as a reproductive choice (Suffla, 1997). Suffla adds that the *raison d'atre* for seeking abortions for some women were based on personal (internal) and situational (external) reasons of which both reasons are not distinct from one another and may present some degree of overlap.

The decision for abortion is private and does not require evidence of psychological impairment before abortion can take place. It is, however, paradoxical that the decision to opt for abortion can generate significant resulting psychological distress. Individuals opt to abort their pregnancies due to several and personal reasons that are informed by factors such as economic factors, future considerations for both the soon to be a mother and father, ongoing education and preparedness for fatherhood and motherhood (Holmberg & Wahlberg, 2000). In Holmberg and Wahlberg's (2000) study on the process of decision-making for abortion, the results suggested that younger males were less prepared for possibilities of being a father.

In a study by Mojapelo-Batka and Schoeman (2003), most women disclosed various reasons for the termination of pregnancy. These included the possible loss of educational and career opportunities; financial considerations were also raised of which these considerations were *inter alia* to parents who were unemployed or could not afford supporting another child in the home. Several researchers found that reasons for deciding on termination of pregnancy included women's financial position, career and future prospects, feelings of being emotionally unprepared to raise a child, and fear of disappointing their families (Mojapelo-Batka & Schoeman, 2003).

The consequences of abortion seem to differ depending on gestation. In a study by Osofsky, Osofsky and Rajan (cited in Boyle, 1997) a large majority of women said they did not find their decision to have an abortion in the first trimester difficult; 12% said the decision was difficult. However, 51% of women surveyed who had abortions after the first three months of pregnancy found the decision difficult. The fact that so many women have early abortions is consistent with reports that many of them seem to make the decision very soon after suspecting or confirming they are pregnant. Holmgren (1994) similarly found that 70% of the women in her sample had made the decision to abort before the pregnancy was confirmed.

Women of different age groups experience and react to abortion in different ways. For individuals, pregnancy begins a marked physical, emotional and socialisation shift. For most women pregnancy and parenthood have essential implications for families, whilst for adolescents pregnancy

implications magnify due to limitations in economic resources, life experiences, educational background, employment opportunities, and interpersonal skills. McCulloch (1996) alleges that the statement that adolescents are prone to experience more difficulties with unplanned pregnancies than do older women may be due to developmental factors - adolescents' high need for social approval and acceptance, their economic and emotional dependence on their parents and the stigmatisation of teenage pregnancies.

Furthermore, adolescents are still in the process of maturation, identity formation and learning more about who they are and what they need out of life; and therefore are more susceptible to struggle when confronted with major challenges during this stage of their lives. On the other hand, women who are matured have passed through this stage and are in a better position to reason and make invincible decisions about their unwanted pregnancies. Bracken et al.'s study (1974) confirms this statement by indicating that adolescents who were sampled in the study reported to be more affected by abortion than reported older women. However, it falls out of the scope of this paper to account for all the complexities of adolescence.

The other factor that plays an important role in this matter is the complexity of moral concerns. Morality may also play a role in deciding to abort. According to Mojapelo-Batka and Schoeman (2003), human morality recognises responsibilities to others, for instance such as providing a secure economic environment for the potential child and conforming to the ideals of good parenting. An individual's sense of morality may mitigate against the decision to abort or may justify and exonerate the decision to have the abortion.

2.5 ADOLESCENT PREGNANCY

Studies show that the percentage of pregnancies that end up in abortion is higher among adolescents than in older women (Henshaw & Van Vort, 1989; Ventura, Taffel, and Mosher, 1988 cited in Adler, 1992). Indications are that adolescents are more likely than adults to have unplanned or unintended pregnancies (Forrest & Singh, 1990). Adolescent pregnancy is associated

with the number of adverse consequences. Those who become mothers at an early age are more likely to drop out of school, of not completing high school and of experiencing economic disadvantages (Furtenberg, Brooks-Gunn, & Chase-Lansdale 1989; Mott & Marsiglio, 1985; Upchurch & McCarthy, 1989; Zabin, Hirsch, & Emerson, 1989 cited in Adler, 1992). However, some studies show that there are sometimes positive values associated with adolescent pregnancy. Some adolescents feel that being pregnant and therefore becoming a mother can enhance self-autonomy or adult status (Hatcher, 1976; Leifer, 1977 cited in Adler, 1992), or can demonstrate love for a partner (Freeman, Rickels, Huggins, Garcia, & Pollin, 1980; Scott, 1983 cited in Adler, 1992) or give them access to government child support grants.

Abortion is a conflictual decision to make for some women but easier for others. While women have different reasons to undergo this procedure, their mental state prior the procedure plays an imperative role towards their ultimate psychological well-being after the abortion. Moreover, perceived support before abortion also plays a vital role in the post-abortion adjustment process. Most women who feel supported are more inclined to show better adjustment compared to those without support.

The next chapter describes the methodology adopted in this study.

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CHAPTER 3

METHODOLOGY

In this section the methodology used to pursue the aims of the study will be described. Lincoln and Guba (2000) assert that qualitative research is based on a view that social phenomena, human dilemmas, and the nature of cases are situational, revealing experiential happenings of many kinds. In light of this statement a qualitative research methodology was utilised to understand subjective and unique experiences of women who participated in this study.

The experiences of five Black young women who underwent an abortion were presented as case studies to explore themes and variations emanating from their individual and subjective experiences. This investigation utilises the method of *multiple case study* format, which Stake (2005) describes as the instrumental study extended to several cases to explore the phenomenon, population, or general condition (in Denzin & Lincoln, 2005). Multiple case studies are chosen with the belief that understanding them will lead to a better understanding and possibly better theorising about a larger collection of cases. The 5 case studies are summarised at the beginning of chapter 4.

3.1 RESEARCH PARTICIPANTS

Age and marital status influence emotional reactions to abortion (Adler, 1972) and therefore were taken into consideration when selecting a sample since these variables could have impacted on the ultimate experiences and perceptions of women who have undergone the process of pregnancy termination. Participants of this study are unmarried and are between the ages of 22 and 24 years; all five women participants are Black South African women who grew up in urban environment and are currently tertiary students from the same institution.

Participants' pregnancies were terminated at different weeks, ranging from the 6th week to the 11th week. However, all participants were at least two months post-abortion when data were collected. This was the first pregnancy

and first termination for all participants. Participants' choice to abort was not influenced by the risk to physical or mental health to the mother or the baby, the risk of giving birth to a genetically defected child, or pregnancy resulting from rape or incest. The motivation to this exclusion was to ascertain that there were no other distressing factors connected to the pregnancy.

3.2 DATA COLLECTION

Participants were recruited at a tertiary institution through the technique of snowballing. Participants were asked to identify other women meeting the criteria who might be interested in participating (snowballing technique). As anticipated some participants that were contacted were reluctant to participate in the study. Some women were also reticent to express themselves freely; they seemed to be holding back on divulging some information. This could be due to personal meaning attached to abortion, controversies associated with it or fear of being judged.

A consent letter (Refer to Addendum I) was signed by all participants prior to commencement of interviews. This letter clearly explained confidentiality (that no personal detail will be revealed), risks of participation, the procedure of collecting data and that participants would not receive any incentives from this research. It was also clarified that if participants experienced any difficulties about past experiences evoked by their participation in this study, psychotherapy sessions would be provided to assist with them.

Participants were interviewed individually in a closed private office where no one outside could see into the office. Appointments were scheduled on different days to ensure that participants remained anonymous and that they do not meet each other outside the office. All interviews were audio-taped and notes were taken during interviews. The first interview was used to develop rapport with the participants, getting to know and understand them better and in discussing any difficulties they may anticipate regarding their participation in the study. The interview was also used to address any misconceptions that the participants had about the study and to reassure the participants that participation was entirely voluntary, that their personal

information would be protected and that their identity would be kept confidential.

A semi-structured interview format was used with each participant, conducted by the researcher, to ascertain relevant demographic information and obtain data on the following themes: the woman's perception of, and attitude towards abortion, whether she involved other people in the decision making process and the reaction of other people who were closely related to the matter (refer to Appendix II). Since data collection was to inform the case study of each participant, the women were also encouraged to express their thoughts and feelings freely on each theme and to discuss any other related themes that may arise.

3.3 DATA ANALYSIS

Data were analysed through the use of content analysis defined by Holsti as "any technique for making inferences by objectively and systematically identifying specified characteristics of messages" (cited in Wikipedia, 2006, p. 23). Audio-taped interviews were transcribed and integrated with notes taken during the sessions. The researcher familiarised herself with the interview protocols by reading them several times. Data were then examined for common themes and patterns and these were subsequently grouped into categories. Each category was then assigned a psychological meaning through theoretical interpretation. An inductive reasoning process was used to interpret and structure the meaning derived from data (Thorne, 2000). Each theme is discussed across all case studies to deduce any commonalities and subsequent variations. An integration of findings in a form of a summary and linked to previous research findings will be provided.

CHAPTER 4

FINDINGS AND DISCUSSION

Given the case study format of this study, a short biography of the 5 participants will first be presented:

Participant 1:

Katlego is a 24 year old woman originally from Bloemfontein currently in her honours year as a drama student. She is the last born of five children. Katlego became pregnant after consensual sex with her boyfriend of one year and 8 months. She reported constant conflict between her and her boyfriend, and as a result found it difficult to disclose the pregnancy to her boyfriend. However, she disclosed to her close friend who was supportive and eventually told her family. As a result she was temporarily thrown out of the house. In spite of this, she had decided to carry her baby to term with reason that being a mother would teach her some responsibility. Katlego planned to give birth and then continue with her studies. Her plans were unsuccessful because she was "coerced" by her family to terminate the pregnancy on the 11th week of gestation. Additionally, her boyfriend had already given a ultimatum of either keeping the baby and breaking up or aborting the baby and continuing with the relationship. She reports that her parents decided on her behalf and she had to abide to preserve her relationship with her family. Katlego was in therapy following her termination of pregnancy and reports that her boyfriend had been very supportive.

Participant 2:

Phina is a 23 year old woman from Kwa-Zulu Natal (KZN). She is currently studying her final year in Agriculture; she comes from a family of six. She fell pregnant after a sexual engagement with her boyfriend of four months. When she found out she was pregnant, she instantly decided she was terminating this pregnancy. Her reasons were: she had already repeated a year of her studies and therefore she could not afford to drop out for another year, this decision was also influenced by her not wanting to risk losing her

sponsorship. Moreover, she was dating a married man at the time who also made it clear that he could not have a child outside his marriage for he had plans of divorcing his wife. She disclosed her pregnancy to her boyfriend and they spoke more with her doctor. Her pregnancy was terminated on the 11th week after conception. She found her boyfriend to be very supportive of her decision and she could talk to him about her difficulties resulting from the abortion. Phina never disclosed this to her family - she preferred to keep it a secret between herself, the doctor and her boyfriend. She was very adamant about issues of confidentiality and anonymity because she did not want anyone to know about this.

Participant 3:

Mathabo is a 22 year old woman currently busy with the final year of her studies in Food Science. She was brought up by her a single parent-mother and has a twin brother. She fell pregnant after consensual sexual behaviour with a boyfriend a week after they started dating. She reports that her boyfriend was in a relationship with another woman and was expecting a baby already from that relationship. Her boyfriend disappeared after she disclosed her pregnancy to him. She had difficulties coping with his reaction and spoke to her friends about her problems. She was supported by her friends but never by her boyfriend. This also affected their level of communication that mainly conducted telephonically and never physically. Her boyfriend reminded her that he was already expecting a child and could not afford both children at the same time and therefore left her with no option but to abort the baby. Even though she was studying at the time, he indicated that was unwilling to be part of their child's life should she carry the baby to term. Mathabo never disclosed her pregnancy to her family. She was worried of her mother's reaction because she is considered to be the most responsible one compared to her brother. She was worried that her mother would not be able to cope and understand her "irresponsibility" in this regard. She then went for an abortion (at 9 weeks) after which her boyfriend blamed her for deciding on his behalf. This upset her because he was clear he did not want the baby and after she had aborted the baby he acted as if he wanted this baby.

Participant 4:

Keketso is a 23 year old pursuing a master's degree in Political Science. She is the second born of seven children. She has currently undergone an abortion in the first trimester mainly because she was not ready to have a baby and she was not sure who the father of her child was. She had engaged sexually with two men within two weeks and had difficulty knowing the paternity of baby. It was difficult for her to carry the baby to term because she would have had to tell her boyfriend she did not know if he was the father of the baby and face the prospect of losing her relationship with her boyfriend whom she reports she loves. She spoke to her friends and sister at the clinic about this dilemma but made a decision not to tell anyone about this pregnancy and go ahead with the abortion. She believed there was no other option but to terminate her pregnancy (which was at 10 weeks of gestation) and also to terminate the other relationship. However, she feels if it were not for the paternity uncertainty, she would have been able to carry on with the pregnancy and continue her studies after giving birth. She feels that having a baby would have been a motivation to complete her studies sooner and start work to support the child and the father financially. She never disclosed any of this to her family because she anticipated a negative reaction from them. Keketso experienced severe psychological distress following the abortion and has been in therapy since.

Participant 5:

Tshidi is a 23 years old female studying B.Com. She is the eldest of three children and has always been thought of as the role model to her siblings. Tshidi fell pregnant after consensual sex with her boyfriend of two years. She felt that the dynamics of her relationship were rather complicated for her boyfriend is 20 years older than her and is married with two children from his marriage. She said she knew her relationship with her boyfriend would never be accepted at home and therefore they would never accept her child. Moreover, her boyfriend could not have a child outside his marriage. Therefore they both agreed to terminate the pregnancy. Tshidi also considered her studies while making this decision for she is in the final year of her studies. She terminated her pregnancy at 9 weeks. Her boyfriend was the

only person she disclosed her pregnancy to and he was very supportive and availed himself to her.

4.1 DATA INTERPRETATION

The data from the individual interviews suggest a considerable degree of overlap in the experience of the individual participants. The accounts of their experiences are presented within an analytic, interpretive framework. Here, inquiry is directed into the processes by which the women had come to describe their experiences, in an attempt to illuminate the factors shaping their experiences. Furthermore, results will be reported and discussed by exploring perceived social support and women's coping mechanisms in dealing with the pain.

4.2 THE DECISION-MAKING PROCESS

The abortion decision is complex, involving a wide variety of influences. Typically, women's abortion decisions are made within the multifarious contexts of their relationships and life choices. The association between decision difficulty and poorer post-abortion adjustment is that women who experience a difficult decision are those who intended their pregnancy or attach more meaning to their pregnancy (Major & Cozzarelli, 1992). Suffla (1997) states that in South Africa women's decisions are further influenced by a socio-cultural environment that is hostile to abortion as a reproductive choice. She adds that within this psycho-social climate, it is important to understand the realities of the lives of women who are in varying life stages, who have differing roles and responsibilities, and who come from different economic backgrounds. This is crucial in order to illuminate the impact of these factors on the decision making process and its influence on post-abortion adjustment.

When evaluating the data presented, the most common factors that played a significant role in the whole process (from conception to abortion) were the dynamics of the relationship with the partner in terms of the relational patterns and the duration of the relationship. The period and complexity of the relationships impacted on the decision making process. Bracken and Osofsky (cited in Adler et al., 1992) report that most women do

not have difficulties with the abortion decision, while Adler et al. (1992) indicate that young unmarried women are relatively more likely than those who are older and married to have difficulties around the decision making process as much as they are prone to experience negative responses to abortion. However, participants in this study never related that they experienced much difficulty with decision making, abortion may not have been an option under different circumstances but based on an overview of their lives at the particular stage it seemed to be the only option for most of them.

In this study as in Suffla's study, participants' motivations for seeking abortion were based on both personal and situational reasons. Personal (internal) and situational (external) reasons are not essentially different from each other for some women and may present some degree of overlap across categories. McCulloch (1996) found that the reasons for deciding to undergo an abortion included the women's financial position, career and future prospects, feelings of being emotionally unprepared to raise the child, and fears about disappointing the family. These reasons for deciding to end the pregnancy reflect the women's desire to optimise their own quality of life and well-being, and to take charge of their own lives and future (Suffla, 1997).

4.3 PERSONAL REASONS

The reason for choosing abortion for some of the participants in the study was based on unpreparedness for childbearing and rearing that was mainly future oriented. Some participants were unsettled by the thought of leaving their children at home while completing their studies. A concern with the latter statement was burdening their families with their "carelessness". Unpreparedness for child rearing was shared by both participants and their partners. Mathabo, Phina and Tshidi expressed their unpreparedness for motherhood among other influential factors whereas Keketso would have opted to keep her baby provided she was confident who had fathered her unborn child.

Since all participants were tertiary students, they raised concerns about their studies. Having a child was seen as a possible hindrance to future plans and therefore holding them back from completing their studies on time with

added possibilities of losing financial assistance. Phina particularly voiced this problem since she almost forfeited her sponsorship when she had to repeat a year of her studies due to underperformance.

I had already repeated a year and almost lost my sponsorship so I could not keep my baby because it would have meant dropping out to give birth and I could not afford to waste anymore time. Besides, he is married and I was not going to raise our child alone. (Phina)

4.4 SITUATIONAL REASONS

Within socio-economic context, insecure and unstable financial circumstances characterised the economic position of all participants. Moreover, participants emphasised the value of educational and vocational pursuits in their personal lives. They expressed the desire for optimal performance in their education and career setting and therefore carrying an unplanned pregnancy to term was seen as an obstacle to their immediate term educational and career objectives. However, even though this was more of a concern for all women, one was willing to take a gap year to give birth and then continue with her studies. She had wanted to carry her pregnancy to term with the hope that she would learn some responsibility from being a mother. Although the participant felt she was not ready for motherhood, she came to believe that a child would bring meaning to her life.

I could drop out of school and then continue with my studies the following year because to tell you the truth I really wanted to have a baby. I just adore them. I know you cannot have a baby and then take it back. I was willing to suffer for my child, somehow I would have made it; it wasn't going to be easy but it is doable. (Katlego)

However, Katlego felt coerced into terminating her pregnancy for her parents decided she should go for an aborting. Upon inquiry about how she arrived at the decision to abort she said:

I didn't, they (her parents) did. I had finally decided I'm keeping my baby because I thought having a baby will teach me some responsibility since they always say I am irresponsible. I felt I can grow a lot faster if I had a child and the thought of being a mother was really fulfilling to me. The next

thing I heard was my mother ... telling me that my dad has decided that I abort the baby. I had a hard time with that decision that was made on my behalf. (Katlego)

As mentioned above the relationship with the partner played a crucial role in the decision-making process for all participants given that pregnancy is an occurrence between two people and the decision to abort often involves both a woman and her partner. For all women in this study, the duration and nature of, as well as the level of commitment lacking in their relationships, were also related to the abortion decision. The common theme of their dynamics was that all their relationships were still in the early phases and there seemed to be lack of allegiance to one partner. For Phina, Mathabo and Tshidi the relationships had been going on for less than six months and their partners were either married or having other relationships. Katlego was the only participant whose partner did not have a coexisting relationship whilst Keketso had two concurrent relationships. It had seemed from the data that another theme carrying almost the same value as their career establishment was their understanding/realisation and concerns for partners who had other commitments and therefore would not be able to father their child.

The following extracts illustrate this:

My boyfriend told me he is still young and is starting his career and therefore does not want a child. He said if I decide to keep it, I should know I am in this alone. He then gave me a choice, if I keep the baby it's over between us - we are breaking up and if I abort the baby we can continue being together. (Katlego)

There was no other option for me. I had to terminate the pregnancy. I mean even if I wanted to keep the baby, he didn't and he had a good reason why I knew he was going back to his wife, and therefore I really could not do that to him. (Phina)

He was involved in another relationship and was expecting a child from that relationship, as his girlfriend was pregnant, so the message I got from him was that he could not afford another child. (Mathabo)

My boyfriend has a wife and two children so he was adamant that our baby could not be brought into the world and I understood his reasons. I knew he is married when we started having a relationship and therefore I could not carry my baby to term. He would have been furious and the relationship would have ended. (Tshidi)

This suggests that the nature of the relationship with the partner plays a significant role in the decision making process. A non-supportive relationship with the partner is more likely to result in a decision to abort. This suggests that the converse may hold true! It can be hypothesised that when a relationship has relatively few complexities and external difficulties, partners may not opt for abortion but may be more willing to give the pregnancy a chance. Research on this view may prove to be useful because it may give light to factors that may minimise the rate at which abortions take place and therefore inform interventions that may teach women how to make better choices about their lives and therefore their relationships.

4.5 THE ROLE OF PERCEIVED SOCIAL SUPPORT

Studies emphasise the important role of support in this process, showing that when there is support, the abortee is unlikely to show poor post-abortion adjustment (Boyle, 1997; Corbet-Owen, 2003). Social support is a form of interpersonal interaction in which one individual offers or renders assistance to another; this is experience as enabling and is associated with better psychological health (Cohen, 1992). It enables a stressed person to change his or her emotional reaction to stressful events. Corbet-Owen (2003) adds that women experiencing pregnancy loss(es) are often not able to find the kind of support they feel would be helpful within their familial and social networks. For example, a study by Beutel, Willner, Deckard, Von-Rad and Weiner (cited in Corbet-Owen, 2003) documents that 41% of women were disappointed by the reactions of their friends and family members and complained of lack of understanding and interest in their experience. Participants in Corbet-Owen's study also shared similar experiences.

In light of feared disapproval and expressed disappointment from family members, some participants did not disclose to their families and

consequently did not receive support from them. Although the findings of this particular study do not provide a conclusive indication of how family members would react to the information since most participants never disclosed to their families, they do suggest that family responses to the pregnancy and abortion may be an influential determinant of women's adjustment to the abortion experience. The results of this study correlate with the findings in the study on perceived social support and adjustment to abortion by Major, Cozarelli, Sciacchitano, Cooper, Testa, and Mueller (1990) that found women who disclosed to their families to be less likely, on average, to perceive their families as completely supportive than those who told either their partner or their friends.

I never disclosed any of this to my family because I anticipated a negative reaction from them. My family would have been against my decision to abort the baby because they are very religious and do not believe in abortion ... I spoke to friends and the sister at the clinic about my decision and difficulties. (Keketso)

The strongest negative reaction was reported by Katlego who experienced difficulties with her family after disclosing to them and was therefore coerced to terminating her pregnancy. Katlego expressed unsupportive reaction and behaviour from her parents who ultimately assumed control of the 'situation' and pressurised her into aborting the baby.

My dad kicked me out of the house when I told them I was pregnant and my mother could not do anything about that. My dad told me never to go home again. I remember I was at home that time for holidays and he said he does not want me in his house with that bastard in my tummy. I went to sleep at my aunt's house. That night I could not even tell my aunt what was happening; it was terrible ... I mean if my family chases me away, where am I supposed to go? (Katlego)

Interestingly in this study, all participants reported having "good" family ties and relationships with their families but only one respondent disclosed her pregnancy to her family whereas other participants feared their family's reaction. Although this possibly helped them to avoid social rejection, it also

precludes social support. When emotional support from family and friends is lacking, it seems logical and necessary for a woman to be able to get support from the person who has shared her losses - her partner. Dyregov and Matthiesen (cited in Corbet-Owen, 2003) assert that while some women are able to get support from their partners, some women may find that the type of support they need is not forthcoming in the way or for the duration, they need. Participants who never disclosed their pregnancy to their families managed to obtain support from a network of friends and some their partners. In this study, Katlego, Phina and Tshidi were supported by their partners while Mathabo and Keketso were mainly supported by friends.

This affected our relationship but in spite it all he stuck by me and suggested that we both go for counselling because he was struggling to see me like this and started blaming himself because he gave me no choice. (Katlego)

Well I have two friends and spoke to both of them. I could relate to the other one more because she had just went through the same process a month before I fell pregnant. We spoke more about it and we could relate and share experiences. The other friend was also supportive even though she hasn't been through this. I knew I could talk to her about it whenever I felt like talking. (Mathabo)

As feelings attached to their loss(es) are determined by the meaning attached to their pregnancies, not all women would feel distraught at their loss. Corbert-Owen and Kruger (2001) assert that when pregnancy is unwanted, the resultant emotions when loss(es) occur are filled with ambivalence. For some women who desire pregnancy loss, attaining support might be difficult since they have difficulty turning to their partners for support as their reasons for opting for termination of pregnancy are often rooted in difficulties in the relationship. On the hand, if both partners reached a consensus regarding the decision to terminate then turning to one's partner may actually be easier provided the feeling of loss is mutual between both partners.

We both knew we could not keep the baby and therefore this was a mutual decision that never caused problems between and it actually brought us closer together. (Phina)

In spite the difficulties of abortion, my boyfriend and I decided this was both our problem and therefore we stuck by each other's side. He was so supportive it was unbelievable; I would not have made it without him. We made it an open discussion and we really engaged with it, this made it easier for us to move on afterwards. I guess another reason was that we both understood we could not keep the baby. (Tshidi)

I never saw him during the time I was pregnant, he preferred to communicate with me telephonically. I never got any support from him we could never talk openly about our situation. All that he wanted to know was whether I had done something about the abortion. He never even gave me money for the procedure. (Mathabo)

I was involved in two relationships at that time ... happened to engage sexually with both within the same week ... I fell pregnant and could not tell who was the father between the two boyfriend ... I therefore decided to abort the pregnancy to make things easier for me and I could not disclose this to my boyfriend. (Keketso)

Keye (1994) reports that gender differences in the meanings and feelings attached to pregnancy and its subsequent loss, suggest that differences in the intensity, quality, and quantity of feelings, as well as coping methods are to be expected at the time of the loss. Conflict in relationships is bound to occur with different coping mechanisms between partners with possibilities of one partner struggling to acknowledge the other partner's way of grieving or coping because their styles may differ.

4.6 POST-ABORTION PSYCHOLOGICAL RESPONSES

Termination of pregnancy feels to some women as a relief that the "problem" is sorted out. However, the outcome and resolution of the abortion also has to do with the procedure itself. It was apparent during the interviews that the procedure and treatment by professional health care workers differed with the place where the abortion took place. Some of the participants utilised state

facilities, whilst others went to private clinics for the abortions. One out of five women reported an unsatisfactory treatment by the staff; she reported being ridiculed and being "victimised" by the members of staff.

The procedure itself was not impressively done. I felt like I was victimised for opting for an abortion. The people who performed the procedure were not warm they were just doing it without care and they said a lot of hurtful things to me. (Keketso)

This added to her distress about the decision she made and felt ashamed that she went through the whole procedure and she was screamed at in front of other patients. Additionally to this she had physical symptoms resulting from the procedure that needed a doctor's attention.

I happened to develop complications afterwards, I started bleeding and the doctor I saw told me they had blemished some tissue inside me, which is often a case of negligent people not taking care because this is a sensitive area ... I had a traumatic experience, I felt judged by the staff and that made me feel bad and I hated myself for going through with this in spite the fact that I had my reasons I really felt like a murderer after I had done it, it was a terrible experience. (Keketso)

Only two of the participants (Tshidi and Mathabo) received post-abortion counselling.

I felt that the nurse that worked with us really knew her job and she has the patience and is good at what she does. She was supportive and non-judgemental. (Tshidi)

Tshidi had a productive session and her boyfriend joined her for the session whereas Mathabo felt forced to take contraceptives and when she refused, she was mocked by the staff.

During post-abortion counselling they wanted to force me to take contraceptives without even asking me and explaining why is it important to take them. They then started cursing and telling me they thought people who have studied further would know better not to get themselves in such stupid situations ... This felt like my choice to abort was taken away from

*me. Why should it be legalise when it gets thrown back in your face.
(Mathabo)*

Termination of an unwanted pregnancy may reduce the stress engendered by the occurrence of pregnancy and the associated events. At the same time, the abortion itself may be experienced as stressful. As with pregnancy, the circumstances surrounding abortion (e.g. the woman's feelings about moral issues, support from significant others, and the actual experience she has in obtaining the abortion) are likely to influence later response. Earlier studies (cited in Cozzarelli, 1993) suggested that characterological self-blame, low levels of support, difficult abortion decision, and having a partner who does not expect to cope well with the abortion increases the likelihood that a woman will experience some post-abortion distress. Although it is beyond the scope of this study, personality characteristics also play vital role in the outcomes of abortion, as Cozzarelli's study has revealed that feelings of self-efficacy for coping are an important determinant of coping behaviour and of adjustment to negative emotions post abortion.

A study by Faure and Loxton (2003) yielded results suggesting that termination of a first trimester is perceived as a stressful experience. However, they found that the levels of anxiety and depression of the majority of participants declined after the termination. They found that approximately two to three weeks after the abortion, only 7% of their sample reported high levels of depression, 2% reported high levels of trait-anxiety, and no participants reported high levels of state-anxiety. Before the abortion, 55% of the participants expected to cope well with the experience and only 15% thought that they might experience difficulties.

Suffla's study yielded results suggesting that the presence of non-supportive or conflictual communication is related to poor post-abortion adjustment (Suffla, 1997). In this study Katlego was the only women who showed some ambivalence to terminating her pregnancy even though she considered her studies she also considered the effect having a child would have in her life, help her better her life. Since she was forced into the abortion, she reported struggling to cope with it.

Adler (cited in Suffla 1997) found that the positive emotions identified by women after an induced abortion were happiness and relief. Additionally, negative emotions identified consisted of shame, guilt, and fear of disapproval, regret, anxiety, depression, doubt and anger. Faure and Loxton's (2003) study found confirmed that only a small percentage of women who undergo a first trimester abortion, experience adverse reactions. However, they acknowledge that there is far more to termination of pregnancy than their statistics show. This is because the complexity of the abortion itself should not be underestimated as every woman brings to the process her own unique life experiences that influence the meaning they attached to abortion.

I felt so relieved but yet guilty. I could not believe I had just gone through that but it felt like the weight had been taken off my shoulders. (Phina)

Katlego and Keketso were the only ones among the participants who reported experiencing clinical post abortion symptoms. Faure and Loxton's study (2003) revealed that depression, rather than anxiety, was the dominant psychological factor in post-abortion distress. It has been suggested that abortion experience potentially presents situations where women may be more likely to present with depressive symptoms in certain anxiety-provoking situations. It would appear; however, that gestation and level of education are biographical variables that are strongly related to the levels of depression. However, Katlego was diagnosed with Post Traumatic Stress Disorder (PTSD) as her response to the whole procedure her symptoms were exacerbated by the ambivalence and coercion to abort her pregnancy. Keketso was diagnosed with Acute Stress Reaction. However, all participants except Katlego reported feeling relieved soon after the abortion but experienced negative symptoms after a few months. Negative emotions identified were shame, guilt, embarrassment and sadness. The experience of sadness could be interpreted in terms of grief following the loss of an unborn child, as both women needed therapy. Keketso is still continuing with therapy whereas Katlego felt she has dealt with her pain and has terminated therapy.

Post-abortion distress seemed to be highly associated with the nature of the relationship post abortion. For those women whose relationships

continued and there were no other complexities like in the case of Katlego, the adjustment phase was reached quicker with less difficulties.

I think the fact that my relationship with my boyfriend continued like nothing ever happened helped me cope with the situation ... I chose to put the abortion at the back of my mind and I never spoke about it anyone else until today. (Phina)

This therefore points out another factor that probably contributes to psychological response of women to abortion; whether the result of the relationship in which the child was conceived plays a role in the ultimate response to abortion. Literature on perceived social support illustrates that, the male partner is a potentially crucial factor in women's adjustment to abortion (Major & Cozzarelli, 1992). The dynamics between couples seeking abortion may have important implications for women's adjustment to abortion. This factor guides future research to examine the relationship between adjustment to abortion and how it is impacted on by outcomes of the relationship in which the child was conceived.

Furthermore, Katlego also experienced difficulties with her partner while pregnant but re-established her relationship with him afterwards in spite of her psychologically linked difficulties. These findings suggest the importance of partner's support post-abortion plays a vital role in women's adjustment to the loss they have suffered.

This affected our relationship but in spite it al,l he stuck by me and suggested that we both go for counselling/therapy because he was struggling to see me like this and started blaming himself because he gave me no choice. (Katlego)

The ambivalence felt by most women prior the abortion can be attributed to feelings of negative and positive emotions found amongst women who voluntarily terminated their pregnancies (Geldenhys & De Lange, 2001; Thobejane, 2001 cited in Mojapelo-Batka & Schoeman, 2003). For example, Mathabo felt a sense of relief after the abortion considering she had a complicated relationship with her partner but had also experienced flashbacks and feelings of guilt especially when she saw

her partner. She felt distressed when he blamed her of not consulting with him before terminating the pregnancy. She added that her guilty or negative emotions were normally triggered by the sight of her partner; she reported feeling angry towards him and expressed other strong negative emotions towards him.

All participants reported never having an aversion towards abortion. They felt it will help women who feel they could not continue with their pregnancies and therefore reduce illegal abortions that cost some women their lives. While they all never thought they would have to undergo this process, this did not change their opinions about abortion even though they would not recommend it to anyone. Phina, Keketso and Kathlego believe people have reasons for considering it and should have the freedom to make their own choices.

I always felt that one should do it (abortion) if they really see no other options ... I never anticipated going through it, but I have, and but it is a good thing I never had anything against it otherwise I would be stressing about it. (Phina)

I personally would not recommend abortion to anyone based on my experience but people have their reasons for doing it and as much as they may not sound like good reasons to some people they are for those who make them and they need to be respected. I had nothing really against abortion and I still do not have anything against it but if it can be prevented I think people should do just that, avoid it at all costs because it can affect one's inner peace. (Keketso)

To tell you the truth I never thought I would do it, I thought it's good for other people but never for me; it was not an option. I just never entertained the thought of doing it myself but I could understand if it was someone else doing it. (Katlego)

4.7 INTEGRATION

The most common and fundamental finding of this study is that the young women participants who were all tertiary level students, found themselves in non-monogamous relationships that placed further strain on the relationship

once the pregnancy was confirmed and disclosed. The nature and emotional quality of the relationship appeared crucial in the decision-making process for the women concerned. Richards (1997) declares that while social relationships have the potential to be nurturing and caring, they can also be sources of rejection, criticism and conflict. Non-supportive actions fail to provide positive input, whereas negative interactions contribute negative input and both can be problematic. Lakey, Tardiff and Drew (1994) declare that negativity in social relations is related to poorer mental health. This was apparent in this study with the complexities of the participants' relationships with their partners and the family reaction to one participant. The most important social support can come from a relationship that is characterised by feelings of responsibility for the other's well-being (Clarck & Mills, cited in Corbet-Owen, 2003).

Mathabo was blamed by her partner for aborting their unborn child after he indirectly suggested abortion because of his complicated life. Mathabo related that being blamed for terminating her pregnancy was rather devastating especially since her partner disappeared and never even offered financial assistance for it to be done.

After my pregnancy was confirmed ... he disappeared and communicated with me by phone ... he said he is expecting a child with his girlfriend and could not afford to have another child. (Mathabo)

Keye (1994) interpolates that a man may blame a woman for causing the pregnancy loss in an attempt to reduce his feelings of inadequacy and helplessness and to ease their conscience for they pass on the ownership of their guilt and fault.

While there are compelling reasons for women wanting to terminate their pregnancies, at the same time there may be conscious and unconscious reasons for wanting to continue with the pregnancy. Although this study did not investigate the intrapsychic meaning of abortion directly, it is clear that some participants were somewhat ambivalent about terminating their pregnancies. It is also perceptible that the experience of loss held by the participants differed from one woman to another. The abortion seems to be

perceived as the final closing off of whatever positive potential the pregnancy may have held for the women. The emotional reaction of the participants showed more negative emotions of sadness, guilt and embarrassment regarding decision making which corresponds to the finding of Suffla (1997) that there is no painless way of dealing with an unwanted pregnancy.

The decision to abort for all women had to do with their education first and foremost. Faure and Loxton's (2003) findings suggest that women with higher level of education may be more certain of what they want to do with their lives. They add that the decision to terminate is made faster with less confusion and ambivalence. This seems to imply that these women may have had a wider repertoire of coping resources at their disposal, which they were able to apply to the situation. Even though the women's careers influenced the decision to terminate their pregnancies the nature of their relationships seemed to have played a tremendous role in the resolution of their unwanted pregnancies.

In this study, four out of five of participants reported having difficulties with unwanted pregnancies but having the abortion was an addition to the distress. Although it was difficult for some women to admit to the distress caused by abortion, it was very apparent from their statements that, even though it was a means to an end, it had affected them in many ways. One could therefore attribute the perceived and reported inadequate support from partners to the notion that some women do not allow themselves to acknowledge their pain and underplay it, pretending that all is well. Their silence may result in them not receiving the desired reaction (and support) from their partners and families. One of the women was more worried and concerned about having children in the future. Two of the participants had vowed that if they ever fall pregnant again they were not going through this process again; and would rather keep their babies and endure the consequences. Two participants were unconcerned about any intricacies and possible consequences of abortion but felt relieved that they had resolved their 'problem'.

One of the reasons expressed when women were asked how come they did not disclose to their families, they reported not wanting to disappoint their families and the fear of disapproval and being judged. Russo and Dabul

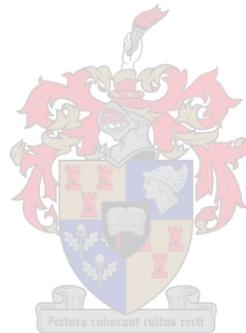
(1997) looked into factors that are most influential to the well-being of women who have undergone abortion and suggested that it is important to avoid stereotyping and to appreciate the valour of women having abortions. They added that the major predictor of women's well-being after an abortion is the level of well-being before becoming pregnant.

Studies examining the relationship between aspects of satisfaction with the abortion decision and post-abortion emotional response consistently find that women who are satisfied with their choice or who report little difficulty in making the decision to abort show more positive post-abortion responses (Tietze, Rowland-Hogue, & Cates, cited in Coleman et al., 2005). Greater indecisiveness in making the decision has been associated with higher negative post-abortion reactions (Shusterman cited in Adler et al., 1992). Furthermore, a study by Major and Cozzarelli (1992) also identified several categories of psychological factors that maybe predictive of adjustment to abortion including personal conflict, attributions for the pregnancy, coping expectations, perceived social support, perceived social conflict, the relationship with the male partner, specific coping styles, the woman's general level of psychological functioning prior to the discovery of pregnancy, and specific life events that occur subsequent to the abortion.

As that some women have difficulty with the decision to terminate their pregnancy, it would be helpful if they are treated with compassion by health care professionals. Feeling victimised while exercising one's right to choice has a potential to cause harm to the women requiring the service. Some women felt judged and mishandled by members of staff at the facilities they attained their abortion and had subsequently expressed psychological distress. This suggests that the procedure itself and the care invested into it by the personnel plays a vital role towards the recovering process of the woman undergoing this procedure. At least one participant's trauma and pain dealing with the abortion was mainly emanating from the procedure and treatment by health care professional that landed up with her developing complications that led to her seeking therapy.

The findings of this study indicated that most of the women who were relatively certain about their decision to undergo the abortion had adjusted

satisfactorily to the process. One woman who felt forced to terminate her pregnancy, took longer to process the abortion experience. The degree of coping with the post abortion period was found to be linked to the level of perceived support received from the partner or family and friends, and in some cases, by the health staff involved in the process. Women report being supported had an important role in their recovery process and they believe that withholding the information from their families minimised their intricacy of dealing with abortion. In spite of an extended invitation to contract sessions with participants who might experience difficulties stemming from the study, none of the women needed any sessions after the data collection and follow-up sessions. The researcher followed-up with all participants after the study to ensure that no woman was left traumatised by re-telling their experiences. Those who were still in therapy preferred to address such difficulties with their therapists if they were to surface subsequently.



CHAPTER 5

CONCLUSION

This study gave attention to the personal, interpersonal, and contextual complexity of women's choice to abort, which carries the potential to produce both negative and positive outcomes. The aims of the study were to determine the process of decision making (whether to terminate an unintended pregnancy), to examine the role of perceived social support, subsequent adjustment to abortion, and accessibility to psychological interventions and mental state prior to the procedure.

Regarding decision-making process the findings of this study revealed that most of the women indicated that they intuitively knew that they needed to terminate their pregnancies. Their decisions were influenced by reasons such as future goals and career establishment, complicated relationships, perceived apprehensive reactions from their families and unpreparedness for parenthood. A crucial factor impacting on the process, as deduced from the women's responses, was the quality of the relationship in which the pregnancy occurred; four of women in this study were involved in a precarious relationship that did not afford a sense of psychological security for the pregnancy to be sustained.

Although women instantly knew they had to terminate their pregnancies, they all expressed difficulties coping with the decision. Studies show that some women who have an abortion become pregnant again within the one year and elect to carry the subsequent pregnancy to term (Tietze, Rowland-Hogue, & Cates, cited in Coleman et al., 2005). In this case the second pregnancy may be a result of women feeling as though the previous abortion was a mistake. It is important that research be conducted in understanding the sentiment attached to the second pregnancy whether it is a replacement of the previous pregnancy or it is used to ease the residual feelings after the abortion. The result of such research may guide post-abortion counselling and inform the naissance of support groups to help women who experience difficulties coping with the abortion.

Furthermore, future research utilising data gathered from significant individuals (partner and family members) in the women's lives may prove to be a useful source of information enhancing efforts to assess the complexity of women's positive and negative experiences before, during and after the decision to abort. Studies by Pattersen, Hansen, Lyngberg and Noddebo suggest that women may have doubts after the decision has been made and some may want to reconsider their decisions (cited Coleman et al., 2005). Research should focus on relational dynamic between couples; studying partner relationship during the decision making process and after the abortion itself can help to elucidate to the interpersonal factors impacting on the abortion experience.

Psychological responses of women participating in this study were impacted on by the process of decision-making, perceived social support, the relationship with their partner after the abortion, the abortion procedure and treatment by health care professionals. Women who were certain about their decision and felt supported reported having less difficulty in adjusting to the abortion as compared to those whose decision was imposed upon by significant others. The results showed that women who felt supported coped better with abortion than those who felt unsupported. Moreover, women who felt ill-treated by the health care personnel also reported feeling victimised and judged by the staff. Varkey's (2000) study examining women's experiences when obtaining an abortion found that staff at referral centers sometimes put obstacles in the way of women seeking services. Some women have had to go from one clinic to another to find a sympathetic health worker who would give a referral letter, while others have had to listen to the provider's personal opinion about abortion. This behaviour subsequently exacerbated negative emotions experienced by women and aggravated their distress.

Literature on abortion has not yet conducted well-controlled studies investigating the influence of relationships on the decision making and outcomes of abortion. The salient finding of this study was that partner relationship is the fundamental foundation which mediates other variables related to the abortion decision. The nature and quality of the relationship between the two involved adults was the determining factor in how the

unintended pregnancy was resolved. Relationships had two primary influences in the whole abortion process. The prospect and/or security of the relationship surviving after the abortion appeared to be instrumental not only in terms of shaping the decision but also in enhancing the recovery from the abortion. Women whose relationship remained relatively unaffected by this turbulence showed a speedy recovery than those whose relationships were affected by the abortion. The basis of the relationships determined the decision about the unintended pregnancy for most women in the study. Three women terminated their pregnancies because their partners were not free (and willing) to father their children because of other concurrent relationships. One woman terminated her pregnancy because she was uncertain who fathered her child.

Most participants in the study were involved in non-monogamous relationships. There is therefore a need for future research devoted to understand and investigate the dynamics in which women involved themselves in precarious relationships that undermine their sense of being truly supported in their time of crisis. More research investigating the dynamics regarding the processes underpinning the use or not of contraceptives is needed to understand the reasons women participants expose themselves to increasing danger from partners who are evidently non-monogamous, and to understand the male-female discourses in this regard. Although it is beyond the scope of this paper, understanding this behaviour is important to investigate given the escalating HIV/AIDS pandemic and the disempowered position that women find themselves regarding their sexuality, bodies and their health.

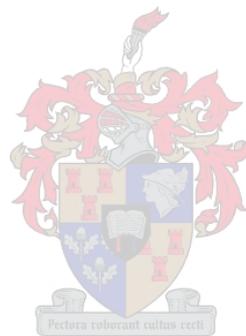
Not one of the women reported feeling unduly anguished about their pregnancy and the subsequent abortion. Participants were students in an institution that has a counselling centre and therefore had easy access to counselling services. Two of the participants utilised the universities counselling centre after the abortion and were complimentary about the interventions they received. However, this does not reflect the accessibility of psychological interventions in the general public.

The experiences related in the case studies confirm that the primary factor affecting the psychological sequelae of women undergoing abortion upon which other factors such as decision making and perceived social support untangle is the nature of the relationship in which the pregnancy occurs. The decisions emanated from the complexities of the relationship and for some women such relationships predetermined the support from the partner. While other relationships remained unaffected by the abortion, some were destroyed by it. While some studies suggested that most women do not require psychological interventions post abortion (APA, cited in Fergusson, Horwood & Ridder, 2006), it is evident that some women do need such services; those who seem not to utilise them have adequate support systems.

The study focused on the experiences of five women participants who were tertiary level students at the same institution. Yow (1994) relates that qualitative research design allows researchers to interject themselves into the process, the researchers' subjectivity impacts on the process. With the researcher of this particular study being a black female and a student at the same institution, this may have impacted on the narrative of the women. These factors together with the multilingualism of the researcher and therefore creating flexibility in terms of language used during data collection may have shaped the participants' close identification with the researcher. Hence the women could easily express themselves which anchored the relationship of the researcher with the participants.

While Yow (1994) asserts that small sample size and restricted sampling are not justifiable as limitations in a qualitative research design, there were limitations that affect the generalisability of the findings: the findings pertain to a very circumscribed sample that of tertiary level black women; all were involved in complicated relationships which had a direct impact on their abortion experience; given the personal nature of the study there was less opportunity to engage other methods to consolidate the reliability and validity of the data generated. Due to the stigma associated with abortion and the need to keep abortion as private for women, it was difficult to obtain a sample particularly of women who are at least two months post abortion. Records of women who underwent abortion are strictly confidential

and their personal details cannot be divulged without their permission. Notwithstanding, replication of this study with women with different demographic backgrounds is recommended to further understand the complexities, at the personal, relational and societal levels associated with the abortion experience.



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ADDENDA

ADDENDUM I

STELLENBOCH UNIVERSITY

Department of Psychology

Day telephone Number: 021-799 6182

Consent Form

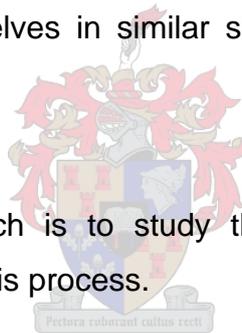
Examining the psychological sequelae of women post-abortion

INVITATION TO PARTICIPATE

You are being asked to participate in this research study because you have been identified as someone needing counselling after the process of abortion. Participants who find themselves in similar situations are the focus of this study.

PURPOSE

The purpose of this research is to study the psychological sequelae of women's who went through this process.



PROCEDURES

As a participant, you will receive brief counselling from the researcher. You will be contracted for a maximum of three fifty minute (50 minutes) sessions with the researcher during which you will be helped with your difficulties.

RISKS

Dealing with your experiences may not be difficult and overbearing; it may evoke feelings and emotions in you that you probably have not managed to deal with thus far. However, every effort will be made by the researchers to minimize your discomfort. You are encouraged to discuss with the researcher any negative or difficult feelings or experiences you have as a result of participating in this research project. If at anytime you feel you would like to stop your participation in the research study you will be free to do so. However, I is highly recommended that you remain in the study for the

duration of the contacted sessions to ensure that your discomfort or struggles that may be evoked/transpired due to the study may be dealt with accordingly.

COSTS AND FINANCIAL RISKS

There are no financial costs directly associated with participation in this project. Services from researcher are provided at no cost to you.

BENEFITS

There is no guarantee that you will benefit directly from the study. However, the researcher believes that it is important that one works through any emotional instability that they may be experiencing.

COMPENSATION

You will not receive any compensation for participating in this study.

ALTERNATIVES

Participation in this research project is entirely voluntary and you may choose not to participate.

CONFIDENTIALITY

Every attempt will be made by the researcher to keep all information collected in this study strictly confidential, except as may be required by court order or by law. If any publication results from this research, you will not be identified by name.

ADDITIONAL INFORMATION

Your participation in this study is entirely voluntary, and you are free to refuse participation. You may discontinue your participation at any time without prejudice or without jeopardizing the future care either of yourself or your family members. If you discontinue participation in the project, you may request that we not use the information already given us. You are encouraged to ask questions concerning the study at any time as they occur to you during the program. Any significant new findings developed during the course of the study that may relate to your willingness to continue participation will be provided to you.

DISCLAIMER/WITHDRAWAL

You agree that your participation in this study is completely voluntary and that you may withdraw at any time without prejudicing any further consultation you may request in this clinic.

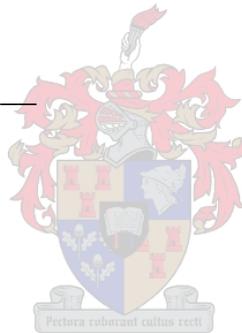
CONCLUSION

By signing below you are indicating that you have read and understood the consent form and that you agree to participate in this research study.

Subject's signature

Date

Interviewer's signature



Date

ADDENDUM II

Research Questions

- A. Biographical details
- B. Family History
- C. Personal history
- D. Current functioning
 1. When did you fall pregnant?
 2. How did you cope with the pregnancy?
 3. Who did she disclose to/ talk to about her pregnancy?
 4. What other options were explored or available besides abortion and consequences thereof?
 5. How did being pregnant affect her future plans/career?
 6. Was her family supportive? What was their reaction to the pregnancy?
 7. If she did not disclose to them what was her confidante's reaction towards her being pregnant?
 8. Nature of her relationship with her:
 - a. Family
 - b. Child's father
 9. How did she arrive at the decision to abort the pregnancy?
 10. Who did she consult?
 11. When did the abortion take place?
 12. Who was her source of support after abortion?
 13. How did she cope with the abortion?
 14. Did she develop any physical symptoms related to the abortion?
 15. Did you receive of need psychological or medical assistance after abortion?
 16. Were there any long-term consequences of abortion?
 17. How was your attitude towards abortion and how has that changed, if ever?
 18. Would you do it again?
 19. Looking back now how do you feel about it?