

**ADOLESCENT PREGNANCY RESOLUTION WITH  
SPECIAL REFERENCE TO PRE-ABORTION  
COUNSELLING**

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## **DECLARATION**

I, the undersigned, hereby declare that the research comprising this thesis is my own original work. This work has not been submitted either in part or completely to any other University to obtain this degree.

## SUMMARY

An exploratory study of the extent and nature of adolescent pregnancy resolution and pre-abortion counselling was undertaken. Little research has been done on pre-abortion counselling in South Africa since the Choice of Termination of Pregnancy Act (92 of 1996) was passed in February 1997. This study emphasised pre-abortion counselling since this is a new field for most counsellors.

A literature study was conducted on adolescent pregnancy, focussing on the factors and possible consequences of the choice to carry the pregnancy to term or to terminate it. Adolescents, more than adults, need assistance to make this decision. Crisis intervention was explored as a possible counselling model for pregnancy resolution and pre-abortion counselling.

The preliminary investigation included interviews with social workers and nursing professionals in Mossel Bay. Nursing professionals were included in the study since they administer the pregnancy tests and are therefore the first professionals with whom the pregnant adolescent comes into contact. This investigation revealed that nurses, not social workers, do most of the pre-abortion counselling in Mossel Bay. The Choice on Termination of Pregnancy Act emphasises the importance of supplying pre and post-abortion counselling at the facility providing the termination of pregnancy. The Act also envisages this as primarily a medical concern, with the implication that nursing professionals should do the counselling. The role of professional counsellors such as social workers is not mentioned in the Act. The Act lays down that training will be provided to equip nursing professionals with necessary skills to render this service.

The empirical study examined the training and skills of nursing professionals and social workers to determine whether they were adequately qualified to render these services. The respondents' attitude towards pregnant adolescents

who choose abortion was also investigated, since this would influence their counselling skills.

The investigation revealed that many of the nurses did not seem confident in their counselling although they felt that they were adequately qualified to counsel pregnant adolescents. The nurses explained that they did not feel that they had enough knowledge of the different options, especially foster care and adoption and therefore referred patients to a social worker or Options Pregnancy Centre (a volunteer based counselling centre).

The social workers felt confident in counselling adolescents who decided to carry pregnancy to term. The counselling model used was crisis intervention, which is most appropriate for pre-abortion counselling as well. However they felt that they did not have enough information of abortion procedures and emotional consequences of abortion to counsel a pregnant adolescent requesting an abortion effectively.

The study showed that respondents felt empathy and understanding for the adolescents' situation and the seriousness of the decision needing to be made. The study also found that social workers and nurses were willing to attend further training in order to improve their knowledge and their counselling skills. The training should therefore not focus on attitudes but simply on improving counselling skills. Training should focus on the nature of a crisis and the steps of crisis intervention.

## OPSOMMING

'n Studie is gedoen om die aard en omvang insake die besluitneming ten opsigte van tienerswangerskappe en berading voor 'n aborsie te ondersoek. Sedert die Wet op Beëindiging van Swangerskap (92 van 1996) in Februarie, is weinig navorsing in Suid-Afrika gedoen oor berading voor 'n aborsie. Hierdie studie beklemtoon voorafgaande berading aangaande aborsie, aangesien dit 'n onbekende terrein vir baie beraders is.

'n Literatuurstudie oor tienerswangerskap is geloods met die fokus op faktore en moontlike gevolge van die keuse om die volle termyn van die swangerskap te voltooi of die beëindiging daarvan. Adolessente het meer ondersteuning nodig as volwassenes om so 'n keuse uit te oefen. Krisis-ingryping is ondersoek as 'n moontlike model vir die beslissing van 'n swangerskap en berading wat 'n aborsie voorafgaan.

Met die voor-ondersoek is onderhoude met maatskaplike werkers en verpleegkundiges in Mosselbaai gevoer. Verpleegkundiges was deel van die studie aangesien hulle die eerste kundiges is met wie die swanger tiener in aanraking kom, omdat hulle die swangerskaptoetse uitvoer. Dié navorsing toon dat verpleegsters in Mosselbaai (nie maatskaplike werkers nie) grotendeels die berading voor 'n aborsie hanteer. Die Wet benadruk hoe belangrik dit is om beradingsdienste vir voor- en na-aborsie te voorsien by die plek waar die aborsie toegepas word. Dié Wet beskou dit ook primêr as 'n mediese aangeleentheid, gevolglik behoort verpleegkundiges die berading te doen. Daar word egter nie melding gemaak van die rol van professionele beraders soos maatskaplike werkers, in dié verband nie. Die Wet bepaal ook dat verpleegkundiges opleiding sal ontvang om hulle met vaardighede toe te rus om so 'n diens te lewer.

Die opleiding en vaardighede van verpleegkundiges en maatskaplike werkers is dus getoets aan die hand van studies, gegrond op praktiese ervaring, om te bepaal of hulle bevoegd is om die dienste te lewer.

Daar is ook ondersoek ingestel na die respondente se houding teenoor die swanger adolessent wat 'n aborsie verkies, aangesien hul vermoë om die berading te hanteer, beïnvloed kan word.

Die ondersoek toon dat baie verpleegsters onseker voorgekom het tydens berading, hoewel hulle gevoel het dat hulle bekwaam is om swanger adolessente te adviseer. Hulle verklaar dat hulle nie genoeg kennis oor die verskillende opsies, veral pleegsorg en aanneming, gehad het nie, en dus pasiënte na 'n maatskaplike werker of Options Pregnancy Centre verwys het.

Maatskaplike werkers het berading aan swanger adolessente wat die termyn van die swangerskap wou voltooi, met sekerheid hanteer. In die proses is krisis-ingryping uitgeoefen wat dan ook gepas is vir berading voor 'n aborsie. Die maatskaplike werkers het egter gevoel dat hulle nie genoeg inligting oor die aborsieproses en die emosionele gevolge daarvan gehad het om die swanger adolessent wat 'n aborsie verlang, effektief voor te lig nie.

Die studie het getoon dat respondente die adolessent se situasie en die erns van die besluit wat gemaak moes word, met empatie en begrip hanteer het. Met die studie is ook bevind dat maatskaplike werkers en verpleegsters bereid was om verdere opleiding te ontvang en sodoende hul kennis en vaardighede te verbeter. Die opleiding moet dus nie op houdings fokus nie, maar eerder die ontwikkeling van vaardighede. Dit behoort te fokus op die aard van die krisis en die stappe van krisis-intervensie.

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## TABLE OF CONTENTS

### CHAPTER 1: INTRODUCTION

1.1	MOTIVATION FOR THE STUDY .....	1
1.2	GOAL AND OBJECTIVES OF THE RESEARCH.....	7
1.3	AREA OF RESEARCH.....	7
1.4	RESEARCH DESIGN.....	8
1.5	DURATION OF THE STUDY .....	9
1.6	LIMITATIONS OF THE STUDY.....	9
1.7	PRESENTATION.....	10

### CHAPTER 2: ADOLESCENT PREGNANCY

2.1	INTRODUCTION.....	11
2.2	ADOLESCENT SEXUALITY .....	12
2.2.1	Adolescents at risk of becoming pregnant.....	14
2.2.2	Adolescent use of contraceptives.....	15
2.2.3	Adolescent pregnancy: emotional effects .....	17
2.3	ADOLESCENT PREGNANCY RESOLUTION .....	19
2.3.1	Factors which may influence adolescent pregnancy resolution.....	21
2.3.1.1	Parental influence.....	22
2.3.1.2	The influence of the biological father .....	24
2.3.1.3	Peer influence .....	25
2.3.2	Carrying the pregnancy to term .....	26
2.3.2.1	Influencing factors .....	26
(a)	Education .....	26
(b)	Ethical issues .....	28
2.3.2.2	Possible consequences.....	28
(a)	Medical consequences.....	28
(b)	Consequences of placing the child for adoption.....	29
2.3.3	Terminating the pregnancy .....	30
2.3.3.1	Influencing factors .....	31
2.3.3.2	Possible consequences .....	32



(a)	Medical risks.....	33
(b)	Emotional consequences .....	33
2.4	CONCLUSION .....	35

**CHAPTER 3: CRISIS INTERVENTION: A MODEL FOR UTILISATION DURING PREGNANCY RESOLUTION COUNSELLING**

3.1	INTRODUCTION.....	37
3.2	UNPLANNED PREGNANCY AS A CRISIS SITUATION FOR THE ADOLESCENT .....	38
3.2.1	Hazardous event .....	39
3.2.2	Vulnerable state .....	39
3.2.3	Precipitating event.....	40
3.2.4	Active crisis .....	40
3.2.5	Reintegration .....	41
3.3	CRISIS INTERVENTION AS A COUNSELLING FRAMEWORK FOR UTILISATION DURING PREGNANCY RESOLUTION COUNSELLING.....	44
3.3.1	Characteristics of an effective counsellor .....	46
3.3.2	Steps for pregnancy resolution counselling .....	48
3.3.2.1	Step 1: Making contact.....	49
3.3.2.2	Step 2: Reducing anxiety.....	49
3.3.2.3	Step 3: Focussing on the unplanned pregnancy .....	50
3.3.2.4	Step 4: Evaluating resources.....	51
3.3.2.5	Step 5: Encouraging action .....	52
3.3.2.6	Step 6: Following up.....	53
3.4	COUNSELLING A PREGNANT ADOLESCENT ABOUT PREGNANCY RESOLUTION OPTIONS .....	55
3.4.1	Marriage .....	55
3.4.2	Single parenting.....	56
3.4.3	Adoption .....	56
3.4.4	Foster care .....	57
3.4.5	Abortion .....	58

3.5	CONCLUSION .....	59
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**CHAPTER 4: PREGNANCY RESOLUTION AND PRE-ABORTION  
COUNSELLING WITH ADOLESCENTS BY NURSING PROFESSIONALS  
AND SOCIAL WORKERS**

4.1	INTRODUCTION .....	60
4.2	METHOD OF STUDY .....	60
4.3	THE INTERVIEW SCHEDULE .....	61
4.4	IDENTIFYING DETAILS .....	61
4.4.1	Occupation .....	63
4.4.2	Tertiary training .....	63
4.4.3	Organisation to which affiliated .....	64
4.4.4	Years of experience at present organisation .....	64
4.4.5	Nature of tertiary training .....	65
4.5	RESPONDENTS ROLE AND VIEWS ABOUT ADOLESCENT PREGNANCY .....	66
4.5.1	Pregnancy tests administered to adolescents .....	67
4.5.2	Number of pregnancy tests administered monthly .....	67
4.5.3	Number of pregnancy tests with a positive result .....	68
4.5.4	Response to the pregnant adolescent .....	68
4.6	RESPONDENTS ROLE AND VIEWS WITH REGARD TO ABORTION .....	70
4.6.1	Knowledge of the Choice of Termination of Pregnancy Act (92 of 1996) .....	70
4.6.2	Respondents role according to the Act 92/1996 .....	72
4.6.3	Personal views about termination of pregnancy .....	73
4.6.4	Response to clients who choose termination of pregnancy .....	74
4.6.5	Parental consent with regard to abortion .....	77
4.6.6	Referrals for termination of pregnancy .....	79
4.7	TRAINING IN PREGNANCY RESOLUTION AND PRE-ABORTION COUNSELLING .....	80
4.7.1	Adequate training for pre-abortion counselling .....	87

4.7.2	Training in rendering pre-abortion counselling services .....	82
4.7.3	Additional pre-abortion counselling training.....	82
4.8	COUNSELLING.....	84
4.8.1	Involvement of respondents in pre-abortion counselling.....	84
4.8.2	Type of counselling done.....	84
4.8.3	Counselling facilities .....	88
4.8.4	Duration of counselling session.....	89
4.9	CONCLUSION .....	90

## **CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS**

5.1	INTRODUCTION.....	92
5.2	CONCLUSIONS .....	92
5.2.1	Demographic profile of the respondents.....	92
5.2.2	Nature of the respondents tertiary training .....	93
5.2.3	Adolescent pregnancy tests .....	93
5.2.4	Attitude to adolescent pregnancy .....	94
5.2.5	Choice on Termination of Pregnancy Act (92 of 1996) .....	94
5.2.6	Responses to termination of pregnancy and adolescents requesting abortions.....	95
5.2.7	Responses to parental consent for abortion .....	96
5.2.8	Training .....	96
5.2.9	Counselling.....	97
5.2.10	Referrals.....	98
5.2.11	Prevention .....	98
5.3	RECOMMENDATIONS .....	98
5.3.1	Training .....	99
5.3.2	Counselling.....	100
5.3.3	Referrals.....	100
5.3.4	Prevention .....	101
5.3.5	Further research.....	101
	<b>BIBLIOGRAPHY .....</b>	<b>102</b>
	APPENDIX 1 : INTERVIEW SCHEDULE .....	110

## LIST OF FIGURES

### Figure

3.1	Effects of a crisis situation .....	42
3.2	Framework for counselling pregnant adolescents .....	54
4.1	Responses of nursing professionals to adolescents requesting abortion.....	74
4.2	Responses of social workers to adolescents requesting abortion .....	76

## LIST OF TABLES

### Table

1.1	List of organisations and the number of nurses who do counselling with pregnant adolescents.....	8
1.2	List of organisations and the number of social workers who do counselling with pregnant adolescents .....	8
4.1	Demographic profile of respondents.....	62
4.2	Number of pregnancy tests administered monthly by nursing professionals .....	67
4.3	Knowledge of the Choice of Termination of Pregnancy Act (92 of 1996).....	71
4.4	Respondents personal views with regards to parental consent .....	77
4.5	Duration of counselling sessions .....	89

## CHAPTER 1

### INTRODUCTION

#### 1.1 MOTIVATION FOR THE STUDY

Abortion was controlled in South Africa in terms of the Abortion and Sterilisation Act (2 of 1975) until new legislation was passed on 1 February 1997. Women in South Africa have tried to regulate their fertility by resorting to abortion, for more than 150 years (Bradford 1991:1). Estimates with regards to abortions performed illegally in South Africa vary greatly. Some believe that over 200 000 illegal abortions were performed annually, of which 42% were performed on adolescents (Van Rooyen 1998:296). It is estimated that illegal abortions were carried out every two minutes in South Africa, causing high maternal mortality rates. Nearly 36 000 women report annually to doctors and hospitals with complications due to incomplete or septic abortions (Walker 1996:44). According to the Medical Research Council the number of deaths due to illegal abortions is close to 400 women yearly (Mayibuye 1996).

On 1 February 1997, new legislation governing abortion, namely The Choice on Termination of Pregnancy Act (92 of 1996), became effective in South Africa. According to Salie (1997) abortion was legalised, not only with the goal of empowering women, but also to prevent the large number of backstreet abortions which took place throughout the country. Even though abortion has been legalised, the battle between the pro-life movement and the pro-choice movement in South Africa continues. The debate concerns the argument of the rights of the unborn child against the rights of the woman. The pro-life movement believes that life begins with conception, and that the unborn child has a soul and therefore a right to life, and that abortion is therefore to be regarded as murder. The pro-choice movement advocates abortion on request, and believes in the woman's right to choose, arguing that if women are to play

a full, active part in society, they must be able to choose when, and whether they want to have children (Walker 1996:66). The prevention of abortion is viewed as not only violating the woman's rights, but also encouraging dangerous and life-threatening backstreet abortions, as well as the fact that it forces women in poverty stricken communities to raise children (Mayibuye 1996). The 1996 Act protects the right of women to make decisions concerning reproduction, security of and control over their bodies (Choice on Termination of Pregnancy Act, 92 of 1996). The National Association of Social Workers' policy on abortion states that a woman's right to choose is consistent with basic principles of social work, namely; self-determination, empowerment and dignity (Lieberman & Davis 1992:365 and Gameau 1993:184).

Ignoring this debate, the Choice on Termination of Pregnancy Act (92 of 1996) clearly states that all women are entitled to an abortion on request during the first 12 weeks of pregnancy. After this period, a medical practitioner must give consent for the abortion procedure to be performed. The 1996 Act also states that women are entitled to counselling services both before and after the decision to terminate their pregnancy, and that these counselling services are to be provided by the facilities performing the abortions (Mhlanga 1996). This statement implies that counselling services must be done by medical personnel and does not indicate the need for professional counsellors, such as social workers. The South African National Council for Child and Family Welfare agrees that counselling for the termination of a pregnancy is primarily a health responsibility (Wessels 1997:1). Initially, during the debates on the legislation, it was suggested that social workers would have a direct and legally determined role to play in the process of legal abortion. However social workers were not referred to in the final legislation that came into effect in February 1997 (Van Rooyen 1998:305).

The researcher has been involved at a volunteer based crisis pregnancy centre in Mossel Bay since September 1998. Through interviews with women experiencing unplanned pregnancies, the researcher realised that an unplanned or unwanted pregnancy creates a crisis in any woman's life, more so for adolescents. The volunteers at the centre do pregnancy resolution counselling, where the different options are discussed with the women, namely, adoption, single parenting and abortion. The researcher began to contemplate the role of social workers in pregnancy resolution counselling, since social workers have four years' training with regard to counselling and especially crisis intervention, whereas the volunteers and other personnel working with pregnant women have only minimal training with regard to counselling. It is the researcher's understanding that most of the pregnancy resolution counselling in Mossel Bay is done by the nursing staff at the provincial hospital, as well as at the local clinics. Pregnancy resolution counselling and pre-abortion counselling is very similar, the difference being that pregnancy resolution counselling is done with a woman who has not yet decided what she wants to do about the pregnancy, and needs assistance to make this decision. Counselling is intended to assist a woman to make an informed choice regarding abortion, adoption, or single parenting, and to provide her with the information on family planning that may help her avoid a future unplanned pregnancy (Halkett 1997:7). Pregnancy resolution counselling is done at the local clinics as well as at the welfare organisations. Pre-abortion counselling however is done once the woman has decided to have an abortion. In Mossel Bay pre-abortion counselling is mostly done at the Provincial Hospital.

The Department of Health recommends pre- and post-abortion counselling in order to identify the women at risk of depression, and to assist any woman with post abortion syndrome. According to Halkett (1997:2), pre-abortion counselling will help the woman to adjust as well as possible to what could be a potentially negative life experience. Following research done at an abortion facility in

South Australia, Gameau (1993:182) stated that women must have a consultative visit prior to surgery. This must include an initial interview with a registered nurse, who explains the procedure, discusses the clinic and introduces the patient to the day surgery unit and its staff. The visit must also incorporate consultation with the medical specialist, routine blood and urine screening, contraceptive counselling, and social work intervention for those at high risk of psychosocial problems. The social worker should play a key role in conjunction with other health professionals.

An unplanned pregnancy is a crisis in most women's lives. It, however, tends to be more of a crisis for the adolescent (Adler, David, Major, Roth, Russo & Wyatt 1992:1200). Due to adolescents' lack of experience in making major life decisions, many need help in order to make an informed decision. The decision-making process is frequently confusing and painful, and it may involve complex and conflicting feelings, values and goals (Gameau 1993:183). Trad (1993:397) states that an abortion, particularly in adolescence could evoke strong emotions, and it is therefore important that patients receive counselling to work through these feelings. Pregnancy resolution should be facilitated by truly non-judgmental and easily accessible pregnancy counselling, which will help the adolescent to identify the values and priorities that are important to her (Faber 1991:714).

According to Compton and Galaway (1989:150), an understanding of a crisis such as adolescent pregnancy is an important part of the knowledge base of social work. Social work practice often involves work with clients at a time when the individuals realise that their coping devices have been exhausted, and that the situation remains threatening. Gameau (1993:180,184) states that pregnant women often present with social, psychological, and family stresses associated with an unplanned pregnancy, and social workers are well equipped to address such problems. The goal of social work intervention is healthy resolution in



which a woman understands the meaning and consequences of a decision to abort, to place the child in adoptive care or single parenting. She must make a choice for which she feels responsible. Social work intervention will help her to find ways in which to cope with her decision. The fact that the role of social workers is not referred to in the Act 92 of 1996 concerns the researcher, since it is clear that social workers could play a very important role in the counselling process.

Many women find the actual decision to have an abortion very difficult and confusing, even if they have decided that abortion is their only alternative (Mueller & Major 1989:1059; Zakus & Wilday 1987:83; Handy 1982:36; Schloessinger-Chesler & Davis 1980:173). The counselling model preferred by these authors is crisis intervention, because it is short-term, readily available, emphasises coping skills, and focuses on the client's current life situation. Crisis intervention implies that current levels of functioning are often disrupted during a crisis, and that internal psychological difficulties are evoked. Crisis intervention postulates that a person is most vulnerable to change at the point of crisis, and therefore counselling is needed the most at this point, and will probably have the most positive effect. These services are rendered primarily during the period when the client is emotionally disrupted and in desperate need of counselling. For example, a pregnant adolescent who needs to make a decision quickly due to time limits for having an abortion (Zastrow 1992:507).

Adolescents are especially vulnerable, since many feel they are not able to discuss the pregnancy with their parents or any other adult. A successful resolution of the crisis involves the adolescent's taking control of her behaviour, and making an informed rational decision. If abortion is chosen as an option, the counsellor must help the client to work through the loss of the potential child, and help her to face the medical procedure. The counsellor offers guidance and support. The adolescent who opts to carry the pregnancy to term

will require just as much support from a counsellor. The support is long-term and may have to continue for a period after the child is born, depending on whether the adolescent chooses adoption or single parenting. This support is especially necessary when the client's informal networks have broken down (Faria, Barrett, Goodman 1985:97).

Due to the fact that abortion has been legal in America and Australia for many years it is meaningful to look at the statistics from these countries in comparison to the statistics available for South Africa. In the United States of America one out of 10 adolescents became pregnant, this averages approximately 1 million per year (Coley & Chase-Lansdale 1998:152; Pistella & Bonati 1998:206; Trad 1993:397), with abortion being the option chosen most often by pregnant American adolescents. Approximately 40 - 45% of all adolescent pregnancies in the USA are aborted (Hoffman 1998; Murry 1995:326; Griffin-Carlson & Mackin 1993:2). In Australia approximately 65 000 – 80 000 abortions are performed annually, of which 23,7% are performed on adolescents between the ages of 15 and 19 (Gameau 1993:179).

The trend in South Africa is very similar to that in America and Australia. The statistics for adolescent pregnancies in South Africa is also alarmingly high, which creates a large number of adolescents who need assistance in making a decision with regards to the unplanned pregnancy. According to Price (1999:4) 45% of pregnant women in South Africa are under the age of 19 years. From February 1997 until July 1998, 3884 adolescents under the age of 18 years had abortions. Adolescent abortions total 6,3% of all abortions performed. The number of adolescent abortions in South Africa is high and clearly indicates the need for pre-abortion counselling for especially adolescents.

The Provincial Administration of the Western Cape have only started calculating adolescent live births separately from adult live births in Mossel Bay

since July 1998. From July 1998 to June 1999 there were 117 adolescents who gave birth. The number of abortions performed in Mossel Bay with regard to adolescents was 50 for the same period of time. It is clear that approximately 170 adolescents fell pregnant during this period.

## 1.2 GOAL AND OBJECTIVES OF THE RESEARCH

The goal of this study is to present a theoretical framework for adolescent pregnancy resolution with special reference to pre-abortion counselling.

The objectives of the study were:

- To provide a theoretical foundation for pregnancy resolution counselling.
- To investigate pregnancy resolution counselling with the focus on pre-abortion counselling services rendered to pregnant adolescents in Mossel Bay.
- To provide guidelines for the counselling of pregnant adolescents.

## 1.3 AREA OF RESEARCH

The investigation took place in Mossel Bay, in the Western Cape Province. The town has a provincial hospital at which abortions are being performed. The researcher investigated the counselling services rendered at this facility. Clinics and other health organisations were approached in order to obtain statistics with regards to adolescent pregnancy and abortion statistics as well as to determine the extent of pregnancy resolution counselling done at these facilities. Welfare organisations were also included in the investigation in order to determine the number of adolescent pregnancies which they deal with, the attitudes of the social workers with regard to abortion, and the type of intervention model or models utilised during counselling.

A list of organisations with the number of nursing staff employed at each organisation that administers pregnancy tests and thereby being among the first people to come into contact with a pregnant adolescent is presented. Table 1.1 is a list of social workers in Mossel Bay who counsel pregnant adolescents.

Table 1.1 List of organisations and the numbers of nurses who do counselling with pregnant adolescents

ORGANISATION	NUMBER OF NURSES WHO ADMINISTER PREGNANCY TESTS
Alma Clinic	3
D'Almeida Clinic	2
Mossel Bay Clinic	3
Mossel Bay Provincial Hospital	3
TOTAL	11

Table 1.2 List of organisations and the numbers of social workers who do counselling with pregnant adolescents

ORGANISATION	NUMBER OF SOCIAL WORKERS
ACVV Mossel Bay	2
Child and Family Welfare Mossel Bay	2
FAMSA	1
TOTAL	5

#### 1.4 RESEARCH DESIGN

An exploratory design was used for the purpose of this research. According to Grinnell (1993:119) an exploratory design is used to explore the research question or problem area, and not to produce statistically sound data or conclusive results. The purpose is to build a foundation of general ideas, which can be explored at a later stage with more complex research designs. This

research design is often referred to as pre-experimental or non-experimental. This design is used for data gathering in an area of enquiry where very little is already known (Grinnell 1993:442).

Due to the nature of the study, all personnel who work with pregnant adolescents, those who administer pregnancy tests as well as those who do only pregnancy resolution counselling or pre-abortion counselling, were interviewed. An interview schedule was used, since the researcher could pose questions directly to each respondent and could immediately record the response on the interview schedule. Self-administered questionnaires result in higher response rates and more complete responses (Grinnell 1993:268). Ruben & Babbie (1993:342) state that although it is desirable to have more than one interviewer, in the case of small samples it is satisfactory to have a single interviewer. The interviewer can also guard against confusing questionnaire items, which is appropriate when one is dealing with sensitive issues such as abortion (Babbie 1989:244). More open-ended questions can also be incorporated in an interview schedule, supplying qualitative data.

## 1.5 DURATION OF THE STUDY

The research was undertaken between 1 February 1998 and 1 December 1999. The literature study and empirical study was completed by December 1999.

## 1.6 LIMITATIONS OF THE STUDY

Due to the lack of South African literature with regard to abortion statistics and the unique South African situation with regard to the different cultures, much of the literature study is based on European, Australian and American literature.

## 1.7 PRESENTATION

Chapter 1 consists of the motivation, and method of the study. Chapter 2 focuses on adolescent pregnancy, with regard to the emotional and psychological response to an unplanned pregnancy.

In chapter 3 the nature of a crisis, the nature of a crisis pregnancy, and crisis intervention as a counselling model to be utilised when counselling pregnant adolescents are discussed. Chapter 4 consists of an analysis of the findings from the interview schedules with regard to the pre-abortion counselling services that are available at medical facilities and welfare organisations in Mossel Bay. In chapter 5 conclusions and recommendations are presented.

## CHAPTER 2

### ADOLESCENT PREGNANCY

#### 2.1 INTRODUCTION

Adolescence begins during puberty, roughly at the age of thirteen, and ends with graduation from high school, at approximately eighteen years of age (Newman & Newman 1999:304). The teenage years are a time of great change; the adolescent is in a period of transition between childhood and adulthood (Trad 1993:398). This stage is characterised by rapid physical changes, significant cognitive and emotional maturation, sexual awakening, and a heightened sensitivity to peer relations.

Due to the impact of all the changes and circumstances converging on adolescents, they may be described as being in a state of crisis, a state where they are in search of self-definition and when they attempt to find a place in society. They also develop psychologically and intellectually and begin to assert an autonomous identity (Louw 1991:379). Adolescence is characterised as a period during which the teenager faces numerous conflicting pressures from parents and peers (Jaccard & Dittus 1993:329) and is faced with many changes in roles, values and behaviour, which they need to adapt to their new phase in life (Louw 1991:379). As a result of these changes, an adolescent who becomes pregnant, experiences more problems than an adult who has an unplanned pregnancy does. Adolescent sexual behaviour, pregnancy, and factors which influence pregnancy resolution will be discussed in the following chapter, with the emphasis on the level of maturity of the adolescent and how she copes with an unplanned pregnancy.

## 2.2 ADOLESCENT SEXUALITY

Archer (1994:145) found that gender identity incorporates a sense of ones maleness or femaleness. Acceptance of ones gender as a social, psychological construction shows acceptance of one's biological sex. The basic sense of female identity and development is based on self in the world and self in relationships. Males push for independence and separation, defining themselves in terms of what they do, while females define themselves by what they are and in their relationship to others. Females are therefore more influenced by relationships, support, and approval than men are.

During adolescence peer relationships are influenced by the introduction of sexual interests and behaviour (Newman & Newman 1999:326). Adolescents need to learn how to satisfy their sexual needs in a socially acceptable way so as to contribute positively to the development of their identity. The heterosexual relationships that begin during adolescence, offer the adolescent an opportunity to achieve a certain amount of sexual satisfaction, and also the opportunity to develop their identity as sexual beings. Once adolescents begin to date and develop steady relationships, their sexual identity, as well as their self-esteem, is boosted (Louw 1991:398). Adolescents tend to romanticise their love relationships, sometimes displaying a need to have someone depend upon them or to have someone to love and protect. These needs, involving love, sharing and continued close relationships, are strongly linked to sex, pregnancy and childbirth (Davis 1989:23).

According to an American study, eight in ten males and seven in ten females will have had sexual intercourse by the time they reach the age of 19 years (Suri 1994:38). Sexual intercourse is associated with being grown up and traditionally, with being married. Sexual behaviour is also linked to other factors such as wanting to conform to the behaviour of peers, especially the



expectations of the girl's boyfriend. This is also a time when adolescents tend to rebel, wanting to reinforce their independence and emphasise how different they are from their parents (Louw 1991:394; Cervera 1993:323; Jaccard & Dittus 1993:331; Newman & Newman 1999:326).

Although adolescence may be a time of rebellion and experimentation, it is also a time when cognitive abilities are not yet fully developed. As a result, the adolescent is at risk of acting impulsively. Urges and desires may be pursued without consideration of the consequences. Research shows that many girls who engage in sexual intercourse, are either unaware of the likely outcome of this behaviour, or choose to ignore the consequences of their behaviour (Trad 1993:398). Van Hasselt & Hersen (1987:433) stated that the transition between concrete, childhood cognitions and abstract adult reasoning occurs throughout the teen years. One outcome of abstract reasoning is a future-time perspective. This perspective enables the person to anticipate and plan for events that have not yet happened. Decisions surrounding intimacy, sexual behaviour, contraception, and marriage, require a future time perspective. The adolescent's cognitive awareness may be such that, unless an outcome is certain, they will accept the risk (Trad 1993:405). The question which remains is whether teenagers accidentally become pregnant, or whether some form of conscious or subconscious intent is at work in their willingness to risk pregnancy through unprotected intercourse (Griffin-Carlson & Mackin 1993:4; Suri 1994:40).

Around 80% of teenagers who become pregnant, do not anticipate this outcome at the time of sexual activity. This suggests that most teenagers do not have the requisite cognitive development to understand the concept of pregnancy (Black & DeBlassie 1985:281; Suri 1994:40). For most adults the cause-effect connection between sexual intercourse and pregnancy is evident, however this connection is not necessarily a reality for all teenagers (Trad 1993:405). Teenagers also tend to

deny the risks involved, making comments such as “it won’t happen to me”, and “I know what I’m doing” (Devenish, Funnell & Greathead 1992:80).

Adolescents are developmentally immature in various respects, as they are still in the process of acquiring formal operational thought and this immaturity affects their sexual decision-making. They are at times developmentally unable to predict long-term consequences of their behaviour (Franz & Reardon 1992:162). They are therefore at greater risk of experiencing an unplanned pregnancy than adults are. There are certain adolescent characteristics, which increase their risk of becoming pregnant. These will be discussed in the following section.

### 2.2.1 Adolescents at risk of becoming pregnant

All sexually active teenagers are at risk of becoming pregnant. Research, however, shows certain characteristics in girls who are more likely to fall pregnant during their teenage years. Adolescents, who are vulnerable and emotional are the most prone to engage in irresponsible sexual behaviour. Because they feel inadequate and inferior, they often feel compelled to prove something to themselves or their peers through sex. Sexually active teenagers have often also been physically, sexually and/or emotionally abused and are therefore at greater risk (Van Hasselt & Hersen 1987:147). When proper physical affection is absent in the home, it creates insecurity, and a girl in this situation will often be more vulnerable to sexual advances in an attempt to have her need for affection and security met (Van der Berg 1996:81).

Adolescents who also fall into the high-risk category are those with lower socio-economic status, those who see themselves as having no meaningful educational or work opportunities, those from single-mother families and those who begin sexual activity early (Coley & Chase-Lansdale 1998:153; Suri 1994:38,41; Farber 1991:698). Teenagers whose parents have not completed high school are

substantially more likely to become pregnant and to bear a child out of wedlock than are their peers whose parents have at least a secondary school education. This may be due to parents who do not encourage further education for their children since they themselves have not completed secondary education, and may not see the need for completing an education especially if they are more practically orientated (Suri 1994:36,41). Teenage pregnancy is also linked to other problematic adolescent behaviour such as alcohol and drug use (Coley & Chase-Lansdale 1998:153). All of these factors negatively influence the adolescent's ability to behave responsibly especially with regard to sexual behaviour and the use of contraceptives.

### 2.2.2 Adolescent use of contraceptives

There are many factors that may influence an adolescent's use of contraceptives, some of which may seem like excuses instead of logical reasons. Investigators like Handy (1982:35), Devenish *et al.* (1992:256) and Lachance (1997) have reported that the majority of sexually active adolescents do not regularly use contraceptives, with non-use being prevalent in younger adolescents. Despite the fact that they are not using contraceptives, adolescents believe they will not become pregnant (Trad 1993:397) or say that they did not expect to become sexually active (Lachance 1997).

Many adolescents do not even admit to themselves that they are sexually active. They also tend to believe that discussing contraception with their partner takes away the romance and spontaneity of the moment. They may also feel guilty about anticipating sexual intercourse (Devenish *et al.* 1992:56). Some refrain from using contraceptives because they fear their parents finding out that they are sexually active more than they fear the risk of pregnancy (Plotnick 1993:324). Murry (1995:331) on the other hand found that some of the reasons why adolescents don't use contraceptives could be transportation problems to

and from the clinics, inconvenient clinic hours, the perception that clinic staff do not respect their right to confidentiality, or that the services are not geared toward their age group.

In America, 62% of sexually active teenagers who have never used contraceptives experience a premarital pregnancy, 30% of those who use contraceptives inconsistently become pregnant and only 7% of those who always use contraceptives become pregnant (Lachance 1997). In a study completed by Davis (1989:23) it was found that only a third of sexually active teenagers used any form of contraceptive. Rates of adolescent pregnancy are lower today than in 1970, not because of lower rates of sexual activity but because of more effective contraceptive use. Many adolescents who do not use contraceptives, become pregnant within the first year of initiating sexual intercourse (Murry 1995:326,344). In Mossel Bay alone there are currently 1 981 adolescents using some form of contraceptive. For the South Cape/Karoo Region the total is 11 958. These statistics only include girls who obtain their contraceptives from the local clinics (Provincial Administration of the Western Cape: Department of Health). Although so many adolescents are using contraceptives this does not guarantee that they will not fall pregnant and there has been no research to show that the number of adolescent pregnancies have decreased due to contraceptive use amongst adolescents.

Teenagers rely more on peers and printed material for information on sex and birth control than on any other source (Jaccard & Dittus 1993:341). If there is no open and honest communication in the home, school or in the community, adolescents have only their peers and the media to turn to for information (Cervera 1993:232). Most teenagers state that they have never been given advice about sex by either parent (Lachance 1997). About 40% of adolescent girls believe contraception is the responsibility of the male, but most males are ineffective or inconsistent in their use of contraceptives (Newman & Newman

1999:332). The risk of pregnancy therefore increases, and the adolescent is faced with having to make a decision with regard to her pregnancy.

### 2.2.3 Adolescent pregnancy: emotional effects

Once the adolescent finds out that she is pregnant, she is faced with many conflicting emotions. Not every pregnant adolescent experiences all of the following emotions listed by Phikill & Walsh (1997) and Van der Berg (1996), as given below, but the majority of them do at some point after finding out they are pregnant. Other authors' opinions will also be incorporated.

**Fear** is one of the first emotions experienced. However, the adolescent often does not realise her fear, and may not admit to experiencing fear. Stevens & Ellerbrock (1997) felt that fear might be related to a variety of factors, such as how to tell her parents, how she will support the child, how her boyfriend will react, and how the baby will change her life.

**Anxiety**, coupled with fear, forms a triangle with the sudden feeling of aloneness that erupts with the onset of a crisis. The adolescent in a crisis pregnancy is often unable to draw on the support of those around her. Kfir (1989:21) stated that she may realise that there are people around, whom are willing to help, and she may even appreciate their efforts, but she is experiencing a crisis and can therefore often not be reached emotionally.

**Denial** often follows fear and anxiety because the adolescent is unable to believe that she could be pregnant. She might try to deny that she heard the result of the test correctly, and try to pretend that everything is all right (Schonberg, Sanders, Beach & Brookman 1989). Even though everything within her wants to deny the pregnancy, it is better to get the crisis out in the open.

**Guilt** is another emotion that an adolescent who is experiencing an unplanned pregnancy may experience. It is often related to the fact that the truth of her sexual activity has been revealed. The guilt could also be due to the fact that she knows that her parents may have to assist her financially in order to be able to support the child. When plagued by guilt and fear, a reaction may be to terminate the pregnancy and thereby any evidence of sexual activity.

**Anger** may be experienced by the adolescent either at herself, her boyfriend, or her parents. She will use anger to justify and legitimise an abortion decision. The adolescent also feels totally helpless. She will feel that she does not have the inner strength to cope with this pregnancy and the daily responsibilities and pressures may begin to overwhelm her. She is often unable to think rationally about the choice that she has to make.

**Worthlessness** is often strongly sensed amongst teenagers. She may feel like a failure, and completely worthless, as a result of the pregnancy. This is related to her failed expectations of herself as well as of her parents and of her boyfriend. Due to these feelings, the woman begins to bargain, most often with God. She might pray or wish for a natural miscarriage.

**Depression** is one of the most concerning of all the emotional reactions. The overwhelming sense of hopelessness, despair, and a strong feeling that there is no solution, could lead to depression. The adolescent is confused, is unable to concentrate, and the feelings of futility become so extreme that she can no longer think rationally.

**Detachment** from the situation, may lead to a lack of emotional and intellectual involvement. The adolescent facing a crisis pregnancy may perceive her situation to be so threatening that she shuts off her feelings, and refuses to

think about it. In this state of detachment, the adolescent, could make a hasty uninformed decision concerning her pregnancy.

**Dependence** is one of the adolescent's feelings that a counsellor needs to be aware of. Ambivalence about the decision may also cause the adolescent to be indecisive, where people who are important in her life could easily influence her choice. By shifting the focus off herself, the adolescent may feel less responsible for her decision. It would be easier if someone else made the decision for her.

People in crisis often see the future as non-existent. They focus only on the next hour or the next day. They often believe that the future can only hold more pain and suffering. For this reason very little planning takes place. The adolescent struggles to comprehend the future. She could feel boxed in. The pain of the present cannot be avoided, the idealised past becomes unattainable, and the future provokes great anxiety. The adolescent may feel she is going through a nightmare that cannot be stopped and that will go on forever. From that frame of mind, a feeling that she has no choice or option is generated (Kfir 1989:23). However, no matter how she may feel, a decision needs to be made.

### 2.3 ADOLESCENT PREGNANCY RESOLUTION

Pregnancy resolution begins the moment a young woman realises that she is pregnant. The realisation itself takes many forms, from an immediate acknowledgement, to a long period of denial lasting until someone or something compels her to investigate the physical symptoms (Faber 1991:701). In spite of being willing to risk pregnancy, teenagers are often unprepared socially and physically to start families. Apart from the increase in psychological and social problems, pregnancy may at times also jeopardise the health of the young girl

(Louw 1991:397; Davis 1989:23). Undesired early pregnancy creates severe stress, threatens the adolescent's need for privacy and inhibits identity formations. The adolescent may experience anxiety due to her conflicting need for independence and her forced dependence on the adult world (Black & DeBlassie 1985:286).

The different age groups react differently to being pregnant. Young adolescents are caught up in the fantasy aspect of being pregnant and are less likely to consider the financial and emotional commitments of motherhood. They appear to be externally motivated and are more concerned about the effects of their decision on their parents and other family members. Older adolescents are more likely to consult an outside professional for advice. They tend to be more concerned about the economics of their pregnancy, and its effect on their own lives, than of the effect on their parents and other family members (Griffin-Carlson & Mackin 1993:3).

A pregnant teenager faces a number of choices, firstly whether to carry her pregnancy to term or to terminate the pregnancy. If she carries the child to term she must decide whether she will raise the child as a single parent, or place the child for adoption (Plotnick 1993:324). As stated in chapter 1, the researcher has been a counsellor at Options Pregnancy Centre since 1998, and it has been her personal observation that adolescents struggle greatly with the decisions that needs to be made. Of the adolescents counselled at Options Pregnancy Centre more chose single parenting than abortion, with a very small percentage choosing adoption. None have chosen marriage up to this point. The findings of Danziger & Faber (1990) and Davis (1989:23) and support this, although the statistics are of an American origin. They found that 45% of pregnant adolescents opt for an abortion, whereas adoption has become almost obsolete, with roughly 5% of pregnancies ending this way, leaving the rest having chosen single parenting or marriage.



The factors affecting and consequences of the different choices that will be discussed in the following section have proved to be very similar for the clients consulted at Options Pregnancy Centre. The organisation has counselled approximately 70 pregnant women since opening in October 1998 but has counselled only four women who have had abortions. Two had their abortions in their twenties and two when they were teenagers. All four women suffered negative consequences from the abortion. They stated that if they had counselling, and had been told of the possible after-effects of abortion before they made their choice, they would probably have made a different choice. It is therefore very important to look at all the pressures and factors which play a role in the decision that the pregnant adolescent has to make. These aspects are discussed in the rest of the chapter in order to help potential counsellors to be more aware of relevant influencing factors and also to identify adolescents at risk of becoming pregnant or suffering from post-abortion syndrome.

Some factors that influence adolescent pregnancy resolution, particularly people who may play a role in the adolescent's choice of whether to carry the pregnancy to term or to terminate the pregnancy will be discussed in the following section.

### 2.3.1 Factors which may influence adolescent pregnancy resolution

The pregnant teenager must be viewed in the environment of her particular family, and her wider social environment. The role significant adults and peers play in influencing the adolescents decision must also be considered. This socio-familial environment provides the context for considering the adolescent's psychosocial development, especially her values, beliefs, and attitudes about pregnancy, abortion, adoption and motherhood. The teenager's class and/or culture may be associated with differences in the particular values stressed in the decision-making process, including the specific value placed on each pregnancy resolution

alternative (Faber 1991:714). Parents play an important role in the adolescent's decision making process. Their role in this process will be discussed, as well as how parental consent with regard to abortion influences the parents' role. The influence of peers and the biological father of the baby on this decision making process will also be mentioned briefly.

#### 2.3.1.1 Parental influence

Family members and other important individuals, often exert direct influence on the adolescent's decision regarding pregnancy. These people actively participate in and shape the decision-making process, according to their preferences for adoption, single parenting or abortion. In particular family members exert indirect influence on the process of the socialising of their children, including the development of the teenager's values, beliefs, and attitudes which help guide pregnancy resolution. Although most teenagers expressed fear of their parents' reactions to their pregnancy, they still relied heavily on them for advice and guidance. Faber (1991:715) stresses that teenagers should be encouraged to openly involve their families in the decision-making process whenever it is feasible, especially since families also bear the consequences of the adolescent's decision. It can never be easy for a teenager to face her family with the news of an out of wedlock pregnancy.

Only a third of adolescents include their parents in their decision, with younger teenagers being more likely to confide in their parents than older teenagers, who consider themselves more mature, and more financially and emotionally independent. Those who confide in their parents, generally describe family communication as being more open. Many who chose to confide in their parents did so because they needed money, needed emotional support, or because they felt their parents had a right to know (Griffin-Carlson & Mackin 1993:7). Reasons why adolescents chose not to confide in their parents were fear of rejection; fear

of disappointing their parents; wanting to spare their parents the problem or wanting to handle the problem themselves (Griffin-Carlson & Mackin 1993:8).

Parental consent in connection with laws relating to abortion has become a heated topic of debate and concern in South Africa. The Choice on Termination of Pregnancy Act (92 of 1996) directly influences the parent's role with regards to pregnancy resolution. According to the Act (92 of 1996 sections 5[2] and [3]) "no consent other than that of the pregnant woman shall be required for the termination of the pregnancy" and "in the case of a pregnant minor, a medical practitioner or a registered midwife ... shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated ... the termination of the pregnancy shall not be denied because such minor chooses not to consult them". The consequences of this law have not as yet been researched in South Africa. However, in the United States of America extensive research has been done on this topic, and it is the researchers' belief that there may be many similarities.

In the United States of America the parental notification and consent requirement are laws relating to abortion and are in force in 31 states, where they require that a minor (a woman under the age of 18) must notify or obtain the consent of one or both parents or a legal guardian before having an abortion (Kaufmann 1997:38). Forty four percent of all abortion facilities require parental consent or notification for patients aged 15 years or under, while 30% have such requirements up to age 18 years. The legal debate centres on such issues as a minor's maturity level in making adequate judgements, violation of parental responsibilities, and the preservation of the family as a social unit (Griffin-Carlson & Mackin 1993:2).

Parental consent needed for an abortion was intended to improve communication between parents and their daughters. Kaufmann (1997:38) maintains that parental consent causes fear and confusion amongst young women. They also

cause unnecessary embarrassment and anxiety among teenagers, and increases family conflicts (Griffin-Carlson & Mackin 1993:3). Regardless of whether the State requires them to do so, 55% of American teenagers choose to confide in their parents, with the majority choosing to tell only their mother (Trad 1993:401; Lieberman & Davis 1992:367). It is clear that this issue will remain a heated topic of debate, since there are such conflicting views.

However, it is always important to keep the interest of the adolescent in mind. None of the above mentioned authors mentioned the consequences of a failed abortion that might lead to a radical hysterectomy or death of the minor. One needs also to look at the responsibility that this imposes on the hospital staff to inform the parents that their child is in critical condition or has died due to a medical procedure that they were not aware of. Nevertheless there are adolescents who still opt not to share the news of their pregnancy with their parents. They feel more comfortable speaking to a friend, their partner or a professional counsellor.

#### 2.3.1.2 The influence of the biological father

There is very little literature available on the role that the adolescent biological father plays in the decision making process. Many adolescent girls never tell their boyfriend about the pregnancy, especially if they choose abortion. Often parents feel that the boyfriend has little or no say in the choice that their daughter makes, since they feel that it does not influence his life as dramatically as it influences that of the girl. Teenage pregnancy has been viewed solely as a woman's issue, with the adolescent father regarded as an irrelevant figure, more a culprit than a potential contributor to either the mother or the child, only interested in his own pleasure. However, research has shown that he is just as confused, afraid, and anxious as is the girl (Huey 1991). Very little research has been done with regard to the influence which the adolescent father has on the decision with regard to the

pregnancy. Major & Cozzarelli (1992:131) state that social support, especially from the male partner, helps the girl to overcome the stress involved in making the decision. They state also that those accompanied by their male partner when having an abortion suffer less pre- and post-abortion depression. Although it would be expected of pregnant adolescents to ask for assistance from their partner they seldom do. In a study completed by Faria *et al.* (1985:96) it was shown that less than half of the women in the study requested assistance from the alleged biological father.

### 2.3.1.3 Peer influence

Trad (1993:401) found that teenagers do not appear to be significantly influenced by their peers when deciding about abortion. Although Jaccard & Dittus (1993:341) found that adolescents rely mostly on peers for information about sex and birth control, there was no evidence to show that they relied as heavily on them for advice with regard to pregnancy resolution. Murry (1995:329) and Griffin-Carlson & Mackin (1993:3) believe that adolescents who know of others who have had an abortion, are more likely to choose abortion themselves, especially if they have a relationship with this person. The same is true for any of the other options. If a friend is coping with a decision which they made with regard to an unplanned pregnancy, the adolescent is likely to believe that decision would be best for her.

The following section will look at the adolescents' choice whether to carry the pregnancy to term or to terminate the pregnancy. Little attention will be given to adoption since such a small percentage (roughly 5% of pregnant teenagers) chooses adoption. The focus will be placed more on the consequences of carrying the pregnancy to term than on the consequences of the decision that follows the birth.

## 2.3.2 Carrying the pregnancy to term

Many factors influence the adolescent's choice to carry the pregnancy to term. Factors that cause the adolescent to choose this option have been extensively researched, and two predominant factors have been found to have the greatest influence, namely her educational level, and future aspirations. These aspects as well as consequences of carrying the pregnancy to term will be discussed in the following section.

### 2.3.2.1 Influencing factors

#### (a) Education

It was found that adolescents who carry the pregnancy to term were more likely to be high school dropouts, to have lower grades in school, and to be less career oriented (Murry 1995:344). Having a baby as an adolescent leads to a 50% reduction in the likelihood of high school completion (Ahn 1994). According to Coley & Chase-Lansdale (1998:156) only 30% of adolescents who decide to carry their pregnancy to term and to raise the child themselves return to school and eventually graduate.

Adolescent pregnancy is given as the major cause for girls leaving school (Black & DeBlassie 1985:285). The National Educational Longitudinal Survey conducted by the National Centre for Education Statistics in America tracked the number of school dropouts from eighth grade in 1988 throughout a 4-year period. The survey showed that 12% of pregnant adolescents dropped out of school by the time they should have been in the twelfth grade. The young women who dropped out left for parenting reasons. Twenty seven percent were pregnant and 21% were already parents (Garber 1996:293). It seems that the younger the girl is at the time she

becomes pregnant, the less likely she is to return to school after delivering her baby. Because of lower educational attainment, adolescent mothers usually have lower incomes than those who delay pregnancy do. Pregnancy also minimises the acquisition of vocational skills (Simkins 1984:431; Rubenstein *et al.* 1990). Adolescent mothers frequently find their education interrupted, their occupational aspirations stunted, and their income diminished (Interdivisional Committee on Adolescent Abortion 1987:74). It would thus appear that educational and future occupational expectations are motivational variables in adolescent choices concerning unprotected intercourse and non-marital parenthood (Suri 1994:45).

Female adolescents who are poor students with low educational aspirations are more likely to become teenage mothers, with one third of teenage mothers dropping out of school before becoming pregnant (Coley & Chase-Lansdale 1998:153 and Murry 1995:328). Only 53% of women who became pregnant during adolescence and did not get married have a high school diploma. Poor performance in school is a strong predictor of early childbearing. For many unwed teenagers, it appears that both dislike of school and poor occupational prospects, stemming from below average academic performance in school, is a factor in the decision to carry the pregnancy to term. An adolescent girl who is not doing well in school, and who is aware that her poor academic record is likely to restrict her occupational choices, may consciously elect to become pregnant out of wedlock (Suri 1994:43). It is not only the teenager's school performance that seems to be a factor. Those who were raised in mother-only families, and those whose mothers had low educational attainments were more likely to carry their first pregnancy to full term (Murry 1995:345).

One of the most researched negative consequences of carrying the pregnancy to term and deciding to keep the child, is that of educational achievement. Another negative consequence is related to the adolescent's future economic situation. The majority of single teenage mothers will have lower incomes as adults and are

more likely to be dependent on government grants than their peers who delay childbirth. These adolescents also have poorer occupational achievements than their peers who do choose not to carry a pregnancy to term and keep the baby. Teenage mothers also tend to spend more of their parenting years as single mothers than do women who delay childbearing, and also have a higher divorce rate (Coley & Chase-Lansdale 1998:156, Hoffman 1998; Rubenstein *et al.* 1990:136).

(b) Ethical issues

Often teenagers who choose to keep their baby did not do so out of desire or intention to have a baby, or to be a mother, but rather considered it to be the most ethical, responsible decision. The decision must be congruent with personal or familial values, and beliefs about abortion and adoption, the sanctity of life and their family (Faber 1991:706). Many adolescents prefer to keep the baby. This may be due to “adolescent idealism” in which they hold highly idealistic notions about what parenting is like (Franz & Reardon 1992:169).

2.3.2.2 Possible consequences

The possible consequences of carrying the pregnancy to term will be discussed in the following section. Due to the adolescents cognitive immaturity they are at greater risk of negative consequences.

(a) Medical consequences

The decision to carry the pregnancy to term has many possible consequences for the adolescent, of which the medical consequences are among the most concerning. There are significant medical risks accompanying births to adolescent women, especially younger teens. There are higher risks of difficult labour,



premature birth and birth complications and a greater incidence of infant mortality, mental retardation and birth defects (Devenish *et al.* 1992:183; Rubenstein *et al.* 1990:136). Infant deaths in the first year occur two to three times more often for teenage mothers than women older than 20 years. Babies of teenage mothers also have a lower birth weight than babies of women older than 20 years (Louw 1991:397). Most often these outcomes are more related to poor antenatal care than to the actual age of the mother (Coley & Chase-Lansdale 1998:156).

(b) Consequences of placing the child for adoption

Adoption is a very difficult decision for anyone to make. In America only 5% of teenage pregnancies end in adoption (Davis 1989:22). In the 1970s there were more babies available than couples wanting to adopt babies. Today the opposite is true. In America there are over 2 million couples on the waiting list for adoption. The situation in South Africa is very similar, however for different reasons. Within the African and Coloured communities in South Africa there are strong family support systems, that step in to help with an unplanned pregnancy. For the African communities adoption is not acceptable for cultural reasons. However there are many European couples waiting to adopt babies. In Mossel Bay alone the waiting list has been closed for five years. There simply are no babies being placed for adoption.

Due to the fact that adoption is chosen so infrequently by adolescents the consequences of this choice will be mentioned only very briefly. Research shows that adolescent girls who choose adoption for their baby advance further in their education. Seventy seven percent finish school in comparison to 60% school completion among girls who choose single parenting. The adolescent who places her child for adoption is less likely to have repeated unplanned pregnancies. Only 18% of adolescents who opt for adoption, will live in poverty in comparison to 40%

of adolescents who choose to parent their child (Bachrach 1998; Maire 1998; Wilke 1998).

Although single parenting is prevalent amongst adolescents, and adoption is only chosen by a small number of adolescents, especially in America the majority of pregnant adolescents opt for abortion. Statistics for South Africa are not readily available to make comparisons, but as stated in chapter 1, over 3 000 abortions have been performed on adolescents since February 1997. The following section will discuss the factors, which influence an adolescent's choice to terminate her pregnancy as well as the possible consequences of this decision.

### 2.3.3 Terminating the pregnancy

Discovering an unintended pregnancy, and making the decision to abort constitutes a complex coping process involving several stages. These stages include primary appraisal of the significance of the event for one's well being, as well as a secondary appraisal process involving evaluation of available coping resources and efforts to cope actively and emotionally with the event itself. The abortion itself, as well as the implications of having an abortion on the emotional well being of the teenager, is the focus of coping efforts. Many women have moral concerns and value conflicts about their decision to have an abortion, and some describe the decision process as stressful and difficult (Major & Cozzarelli 1992:124). Arriving at the decision to abort is especially difficult for teenagers. They may be under great pressure from both family and friends (Trad 1993:406). Murry (1995:329) and Griffin-Carlson & Mackin (1993:3) agree that young women who know of others who have aborted are more likely to choose abortion for themselves, especially if they have personal relationships with people who support their decision to terminate the pregnancy.

According to Franz & Reardon (1992:163) girls differ in their response to the abortion decision depending on the stage of their development. Early adolescents (13–14 years) show a lack of knowledge regarding the nature of the decision, deny responsibility for actions taken, and often use the pregnancy to become closer to their mothers. The choice of abortion is made because the baby has no reality for the adolescent, and because she perceives that she has no other choice. Middle adolescents (15–16 years) are more self-involved, and are in the act of seeking autonomy from the family. They show a limited understanding of their own responsibility for the decision. They use the pregnancy as a means of obtaining autonomy from the mother and as a source of power over others. The father of the child is used as a means to personal ends. They show ambivalence toward the abortion. The late adolescents (17–18 years) are more in touch with their desires and emotions, take responsibility for their choices, are more apt to value the relationship with the father of the child, and find that they are the ones who find it most difficult to make the decision.

#### 2.3.3.1 Influencing factors

Due to the fact that abortion has only been legal in South Africa since 1997, there are no studies available to indicate the typical characteristics of an adolescent who chooses to have an abortion. Therefore the characteristics of a girl who chooses to have an abortion is based on American literature. However it is the researcher's belief that there will be similarities between the two countries.

Adolescents who choose abortion have higher educational and career aspirations than girls do who choose to carry the pregnancy to term do (Murry 1995:329). They are more likely to have completed more years of schooling, are older when the pregnancy occurs, live with both biological parents, and attend church at least once a week. Adolescents with incomes at or above the poverty level are more likely to terminate pregnancies. They tend to be younger at sexual onset, have

relatively well educated mothers, are more likely to live in urban areas, and tend to be members of the Catholic faith (Murry 1995:334 and Faber 1991:698). Due to their religious beliefs many girls opt to terminate their pregnancy because they are afraid of the church's reaction to pre-marital sex. When choosing an abortion the church will not know that they have been sexually active. One of the major differences that would be found in South Africa is that many of the girls choosing abortion may be doing so due to the financial inability to support the child, since their parents may be unemployed and unable to help them. South Africa has a much higher rate of unemployment than America (Van der Berg 1996:10).

Adolescents are more likely to have an abortion if they are sufficiently informed about reproduction to recognise or acknowledge pregnancy within the period in which to have a safe abortion (Murry 1995:329). If they are unaware of the safe period in which to have an abortion, teenagers are more prone to seek illegal abortions than older women are. They tend to disguise or deny their pregnancy until well into the second or third tri-mester. It has been suggested that developmental immaturity contributes to ambivalence toward the abortion decision, and increases the probability of medical complications (Simkins 1984:41).

#### 2.3.3.2 Possible consequences

The consequences of terminating a pregnancy will be discussed in the following section. Little research has been done on the long-term consequences of abortion and authors seem divided in opinion. Although most of the research done present findings that state that the consequences are greater for adolescents than for adults.

(a) Medical risks

The medical risk associated with adolescent abortion is, that in comparison with other women, they are twice as likely to obtain an abortion during the second trimester rather than the first. The risk of death from second trimester abortions increases by 15–30% each week after the eighth week of pregnancy. Faced with diminishing alternatives, some teenagers will attempt to perform the abortion themselves or seek an abortion outside a medical facility, which also increases the risk of death or serious medical complications (Lieberman & Davis 1992:367). Medical experts agree that second and third trimester abortions are more traumatic because the procedures are more complicated, and are associated with higher morbidity (Griffin-Carlson & Mackin 1993:2).

(b) Emotional consequences

Research seems to be divided with regard to the consequences of adolescent abortion (Franz & Reardon 1992:163). Former Surgeon General C. Everett Koop, who described himself as holding a “pro-life” perspective, testified in 1992 at a congressional hearing that there was not enough evidence to assess the psychological effect of abortion (Lieberman & Davis 1992:367). Due to limited research on the long-term consequences of abortion, it is important to pay attention to authors who believe that some women do experience negative consequences after an abortion in order to ensure that proper counselling is provided both pre- and post-abortion. However it is important to look at both opinions on the issue, namely that an adolescent will benefit from the procedure or that the adolescent is at greater risk for psychological problems after the abortion.

Research shows that women may feel a mixture of positive and negative feelings following an abortion, namely relief and happiness, but at the same time guilt, regret, doubt, or anger (Trad 1993:407; Adler *et al.* 1992:1197). Adler *et al.* (1992:1197) found that the weight of evidence proves that for most women undergoing the procedure of a legal abortion as a resolution to an unwanted pregnancy in the first trimester does not create psychological hazards. Unwanted pregnancy and abortion are seen as potentially stressful life events; events that pose challenges and difficulties to the individual, but which does not necessarily lead to psychopathological outcomes. Termination of an unplanned pregnancy may reduce the stress engendered by the occurrence of the pregnancy and the associated events. At the same time however, the abortion itself may be experienced as stressful.

According to Trad (1993:400) in the short-term, the mood of women who have abortions continues to improve. The most prevalent post-abortion emotional response is known to be that of relief. Better psychological health, less anxiety, and more internal locus of control were also more prevalent in women who chose abortion, relative to control groups of women who carried the pregnancy to term (Lieberman & Davis 1992:368). Franz & Reardon (1992:161) have found that some adolescents may benefit from an abortion.

According to Trad (1993:400) only a small percentage of adolescents have negative psychological outcomes as a result of an abortion. Women who are at greater risk of experiencing negative consequences after an abortion exhibit some common characteristics. They are younger and unmarried without children, their culture or religion prohibits abortions, and they attend church more frequently; they have a pre-existing psychiatric disorder, weak family support and ineffective coping skills (Trad 1993:407; Adler *et al.* 1992:1201). Greater opposition from parents with regard to the abortion correlated with increased post-abortion

hostility towards her parents and greater perceived distance from parents (Griffin-Carlson & Mackin 1993:4).

In a study by Franz & Reardon (1992), they found that adolescents were more likely to have greater psychological stress following an abortion than might be the case with adult women. The psychological stress could be due to the adolescent's cognitive and psychological immaturity, and these problems may affect the development of a healthy self-image. Women, who had an abortion prior to 20 years of age, made more suicide attempts after the abortion and experienced more nightmares than did the adult aborters. Anti-social and paranoid personality disorders, psychotic delusions, and drug abuse, were also found to be significantly more prevalent in the adolescent group (Franz & Reardon 1992:163). However the emotions experienced by the adolescent after the abortion are difficult to separate from the general stress associated with the unplanned pregnancy (Trad 1993:407).

The question that still remains is whether adolescents are mature enough to make a decision regarding the pregnancy on their own. The decision making process is multifaceted and varies among young women, and is often characterised by conflict, doubt and ambivalence (Faber 1991:699).

## 2.4 CONCLUSION

It is clear from the literature research referred to in this chapter, that adolescents are unable to foresee the consequences of their behaviour, and find themselves in situations where it is difficult for them to make a mature decision. Even though part of their development involves risk taking, this behaviour could have serious consequences of which one might be pregnancy.

The decision which the adolescent has to make with regards to pregnancy resolution is a very difficult one, since they are not developmentally ready to make such an important decision. The consequences of their decision stays with them for life, as mentioned in the sections on the consequences of carrying the pregnancy to term, and the consequences of abortion. In this chapter the consensus of researchers that the adolescent needs assistance to make the correct decision was clearly stated. The Choice on Termination of Pregnancy Act (92 of 1996) section [4]) confirms this in stating that the government would promote non-mandatory and non-directive counselling to all women both before and after abortion. The model recommended for counselling adolescents experiencing an unplanned pregnancy is that of crisis intervention. The nature of a crisis, as well as crisis intervention, will be discussed in the next chapter.



## CHAPTER 3

### CRISIS INTERVENTION: A MODEL FOR UTILISATION DURING PREGNANCY RESOLUTION COUNSELLING

#### 3.1 INTRODUCTION

An unwanted pregnancy, especially during adolescence, can be challenging or stressful. Stress has been defined as an emotional condition emerging from an interaction between individuals and the environment in situations which they appraise as taxing or exceeding their resources and endangering their well-being (Adler *et al.* 1992:1197). A stressful event does not by itself constitute a crisis, but it is rather the individual's view of the event and response to it. If the individual sees the event as threatening, and feels that all the usual coping strategies have been exhausted, then the event may push that individual toward psychological disequilibrium or a state of crisis (Stevens & Ellerbrock 1997).

"A crisis can be defined as an upset in a steady state, a turning point leading to better or worse, a disruption or breakdown in a person or family's normal pattern of functioning" (Parad & Parad 1990:3). Van der Berg (1996:71) furthermore describes a crisis as a highly emotional state of psychological turmoil, in which the person concerned feels totally unable to cope. Personal resources that would normally be relied upon during a stressful period are exhausted and the accompanying feelings of helplessness lead to bewilderment, distress, despair and even panic. Crisis situations are experiences that are totally new, unpredictable, psychologically paralysing, and that pose a shock to the emotional system. The person is caught unprepared and lacking a ready response (Kfir 1989:4).

The following chapter will focus on the nature of the specific crisis situation, specifically concerning unplanned pregnancy during adolescence. As this study deals with pregnancies, the person experiencing the crisis will be referred to as "her". The researcher will also examine the role of crisis intervention as a counselling model to be utilised during pregnancy resolution counselling with specific emphasis placed on pre-abortion counselling. The legalising of abortion presents a new area of counselling for most counsellors involved in pregnancy resolution counselling. The necessary characteristics of an effective counsellor will also be discussed.

### 3.2 UNPLANNED PREGNANCY AS A CRISIS SITUATION FOR THE ADOLESCENT

A pregnancy develops into a crisis situation when the woman perceives her pregnancy to be a threat to her emotional and physical well being. The threat might be caused by the attitude or behaviour of the people in her life, as well as by the circumstances and pressures bearing down upon her (Van der Berg 1997:71). An unplanned pregnancy is generally a crisis for most unmarried teenage girls, the father of the baby, her parents, and his parents if he is also an adolescent. Professionals should therefore treat it as a crisis for all those concerned (Danziger & Faber 1990).

Golan (1978:60) refers to a crisis situation as the sequence of events from equilibrium to disequilibrium and back again. This also applies to an unplanned pregnancy. Golan (1978) defined five components or stages during this crisis situation that leads back to equilibrium. In the following section, Golan's five stages have been used as a basis to describe the sequence of a crisis situation. The opinions of Steven & Ellerbrock (1997); Van der Berg (1996); Polio (1995); Parad & Parad (1991) Kfir (1989) will be incorporated into the discussion of these five stages.

### 3.2.1 Hazardous event

The first stage is the hazardous event which is a specific event that may be either external or internal, anticipated or not anticipated. An anticipated event may occur during a developmental stage such as adolescence, when a person may be particularly vulnerable to stress. An unanticipated event refers to non-predictable events that occur to a person with little warning (Golan 1978:64). During this stage of a hazardous event the individual is essentially living a normal life where obstacles may present themselves but the individual has the skills to overcome these. However, these skills can no longer be utilised once the situation becomes a crisis. As mentioned in chapter 2, an unplanned pregnancy is an unanticipated event in the life of most pregnant adolescents, since few adolescents believe that they could fall pregnant. Once the adolescent has had a positive pregnancy test, she may be thrown into a state of crisis, brought on by the shock of the news (Van der Berg 1996:72).

### 3.2.2 Vulnerable state

The next stage is the vulnerable state which is the subjective reaction of an individual to the initial blow of the crisis situation. Each person responds differently to this initial blow. A person may experience the crisis as a threat to her needs or her sense of integrity or autonomy (Golan 1978:64). The crisis for an adolescent may be characterised by a significant turning point, where she is required to use new coping mechanisms. During this stage, the adolescent may begin to experience a rise in tension and may try to respond by utilising one or more of her usual problem-solving measures. However she might find herself unable to cope by using her normal problem-solving methods. The tension, anxiety and struggle increases, and she begins to experience a sense of ineffectiveness and diminished control over her situation (Polio 1995:378; Parad & Parad 1990:7; Golan 1978:65). The nature of the crisis, namely the

unplanned pregnancy, especially concerning the time element with regard to safe abortions, is such that the situation cannot be ignored, and the adolescent is forced to make a decision (Van der Berg 1996:71).

### 3.2.3 Precipitating event

The third stage is the precipitating factor or event which is the link in the chain of stress, provoking events that convert the vulnerable state into a state of disequilibrium (Golan 1978:64). Usually the first reaction to the crisis is shock. The adolescent cannot believe that she could be pregnant. Shock serves as a psychological cushion, giving her time to absorb the fact of the pregnancy. However, shock disappears rapidly (Van der Berg 1996:75) and the adolescent tends to look for the quick solution, which might be abortion.

### 3.2.4 Active crisis

The next stage is the active crisis phase which, usually lasts from 4 to 6 weeks. During this period the person presents many predictable reactions namely, psychological and physical turmoil, aimless activity or immobilisation, disturbances in mood, mental content and intellectual functioning. This is accompanied and followed by painful preoccupation with events leading up to the state of crisis, after which comes a period of gradual readjustment as the individual becomes more aware of the altered situation (Golan 1978:65).

This stage is short-lived but overwhelming, and disrupts the adolescent's normal functioning. When the crisis situation is at its peak, her coping level plummets. Action on the part of the client and the counsellor needs to be taken in order to alleviate the disruption and to stabilise the situation. Due to the adolescent's cognitive and emotional limitations, special care needs to be taken to ensure supportive but factual counselling. There is a natural reaction to a

traumatic event or crisis in both behaviour and emotion, physiologically and psychologically (Harris 1991:196). Some physical symptoms that are natural reactions to a crisis are changes in overall health, energy, or activity level and in eating or sleeping patterns. Emotional reactions may include increased tension or fatigue and changes in temperament, such as angry outbursts or depression. Behavioural symptoms such as the inability to concentrate, being preoccupied with certain ideas, or social withdrawal are also natural reactions to a crisis (Stevens & Ellerbrock 1997). The emotions expressed by an adolescent during a crisis pregnancy were discussed in detail in chapter 2.

### 3.2.5 Reintegration

The final stage is reintegration, anxiety begins to subside, and some form of reorganisation of the adolescent's ability to function takes place (Golan 1978:70). Depending on the choices made during the crisis, the adolescent will emerge either at a higher, a lower or the same level of coping. At this stage there is potential for growth. Growth will come when the teenager learns how to cope with her stress and her feelings during this difficult time (Van der Berg 1996:73, 77). At this point the individual may be most receptive to outside assistance that will help her to cope with the choice which she has made. The extent and duration of the outside assistance provided to the adolescent will depend on the choice she has made, whether adoption, marriage, single parenting or abortion (Stevens & Ellerbrock 1997). Reintegration, and the time it takes, will depend on the choice which the adolescent makes. Carrying the pregnancy to term and keeping the baby as well as adoption each has its own consequences, and reintegration may depend on the support which the adolescent receives from family and friends. Reintegration after an abortion is very difficult to achieve. As the researcher has found from personal interviews, some women recognise problems due to their abortion only ten to fifteen years after the abortion. Once the decision has been made the adolescent may begin

to feel that the crisis has been resolved, she has made her choice and taken action. She can only experience acceptance when she receives some form of help to work through possible feelings of denial, anger, bargaining, guilt, fear and depression. Adjustment can then follow and the level of emotional and inner strength will rise. Positive attitudes reappear and there is a resurgence of hope. The teenager may appear to be in control of her emotions, but may still experience some of the negative emotions associated with the decision which she has made.

A crisis situation follows a certain pattern or sequence, with certain effects, which are very similar regardless of the nature of the crisis. Zastrow (1992:507) illustrates these effects in the following diagram. The most important aspect of this diagram is the path that is followed once the crisis is over, namely a constructive or destructive path. This path will depend on the adolescent's decision, as well as the counselling she received during and after the crisis period.

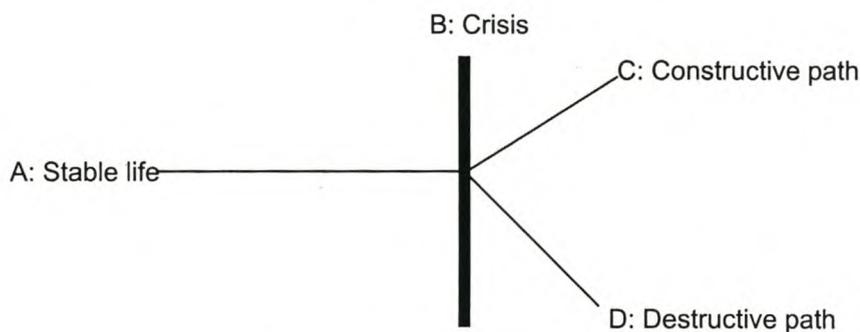


Figure 3.1: Effects of a crisis situation

A: Before the crisis the person had a relatively normal life, with only minor changes.

B: A crisis arises placing a person in an unfreezing position. This position is emotionally charged, and the person's lifestyle is highly vulnerable to change.

In such a crisis, a person may take either the constructive path (C) or the destructive path (D).

C: This constructive path has the person gaining an awareness of why the crisis arose. The person develops adaptive ways of handling the crisis and thereby grows through acquiring problem-solving skills that will enable her to solve future crisis situations.

D: If the destructive path is followed, the person does not resolve the crisis satisfactorily. Unsolved aspects of the crisis remain, and the person is apt to develop maladaptive coping patterns. The person remains in an emotionally charged situation, and is less able to face future crises that arise. Problems may well begin to snowball.

The situation as described in D is often the case after a decision to have an abortion. As has been stated, women often only begin to realise 10-20 years after the abortion that they have unresolved psychological issues with regards to the abortion that they had as teenager's. This could be due to denial of the loss that was experienced, namely the loss of a child. These feelings are often repressed and denied, and never spoken about. Most counsellors do not even deal with this issue. It is not only an abortion that could cause an adolescent to follow the destructive path. The decision to single parent, or place the child in adoptive care can also have a negative outcome. If they are not counselled after the decision, and if they do not have support from those around them, they could follow the destructive path.

Without a strong support base, very few adolescents cope well with single parenting. The need for counselling both before and after pregnancy resolution cannot be over-emphasised. For the purpose of this report however, the focus of the counselling will remain on pregnancy resolution counselling and pre-abortion counselling. The most appropriate counselling model to be utilised

during pregnancy resolution counselling as well as pre-abortion counselling is that of crisis intervention, which will be discussed in the following section.

### 3.3 CRISIS INTERVENTION AS A COUNSELLING FRAMEWORK FOR UTILISATION DURING PREGNANCY RESOLUTION COUNSELLING

As stated in chapter 2, the adolescent is likely to experience a variety of emotions, even though she is not always aware of these emotions herself. However it is essential for the counsellor to understand the emotions that the adolescent is facing, and help her to identify them and to work through the emotions in order to help her to make an informed decision. Crisis intervention as a framework for counselling pregnant adolescents, is the most effective way of helping the adolescent to express these emotions and to make an informed decision.

Crisis intervention provides the opportunity and mechanisms for change to those who are experiencing psychological disequilibrium, who are feeling overwhelmed by their current situation, who have exhausted their skills for coping, and are experiencing personal discomfort. Crisis intervention is a process by which the counsellor assesses with the individual in crisis and intervenes so as to restore balance and reduce the effects of the crisis in her life (Stevens & Ellerbrock 1997). Parad & Parad (1990:4) stated that "the aim of crisis intervention is to cushion the stressful event by immediate or emergency emotional and environmental first aid and to strengthen the person in her coping and integrative struggles through immediate therapeutic clarification and guidance during the crisis period." Crisis intervention services are generally brief and short-term in nature, and are provided primarily during the period when the client is in desperate need emotionally (Zastrow 1992:509; Parad & Parad 1990:8). Ideally, crisis intervention helps to reduce suffering and pain.



Crisis intervention therefore serves as preventative as well as remedial, as it may strengthen the person's ability to learn from the crisis experience, and may offer the individual opportunities for growth (Parad & Parad 1990:4).

Crisis intervention as a counselling model, is based on the fact that in a crisis situation, current levels of functioning may be disrupted, and previously manageable internal psychological difficulties stirred up. These emotional disturbances are often a result of the stressful situation which the person faces, or of the underlying emotional disposition that comes to the surface in crisis situations (Zastrow 1992:507). It is therefore important that the pregnant adolescent should have a feeling that she is being fully informed, and that she has time to make an appropriate decision. She must not be pressured to make a decision with which she does not agree, or does not believe is appropriate for her (Franz & Reardon 1992:169).

Most decisions regarding an unplanned pregnancy are made during the first 72 hours following the confirmation of the pregnancy. Access to help should be available early in the pregnancy, and is best timed at the onset of a crisis experience. Clients cannot be put on a waiting list (Van der Berg 1996:75; Parad & Parad 1990:11). Counselling (which should be crisis intervention) done with the girl before she makes a decision, is intended to assist her to make an informed choice regarding her pregnancy (Halkett 1997:6b).

According to Halkett (1997:1) and Marecek (1987:90) counselling in general, and specifically in pregnancy resolution, is a process of discussion which is directed at helping the client to achieve the following:

- to decide what is her best course of action, and what her real wishes are
- to mobilise her coping skills

- to help her to take responsibility for her decision in order to avoid later serious regrets
- to understand how she came to be in her present situation, so as to avoid finding herself in the same situation again.

The counsellor needs to have certain characteristics in order to achieve the above-mentioned goals, therefore these characteristics will be discussed in the following section.

### 3.3.1 Characteristics of an effective counsellor

The counsellor plays a vital role in the pregnant adolescent's decision process and it is therefore very important that the counsellor possesses certain characteristics that will enable her or him to have a beneficial influence on the client and will help the client to make an informed decision. Once again the focus will be on the issue of abortion. Because abortion is a moral issue, it may be difficult for counsellors to separate their personal feelings from their professional responsibility. Crisis intervention as an intervention model has no value if the counsellor is unable to remain objective and unbiased towards the pregnant teenager. The counsellors' attitude will also influence the adolescents' adjustment after the decision has been made. With regard to abortion, if the adolescent has not felt that the counsellor has been empathetic and understanding, she will not feel comfortable in coming back to the counsellor should she in future begin to experience problems.

Counsellors should examine their own beliefs and attitudes with regard to adolescent sexuality and adolescent pregnancy. Feelings about pre-marital sex, pregnancy and abortion are personal and deeply rooted. Counsellors must not allow their own sexual and moral standards to interfere with their counselling. Ideally, pregnancy resolution should be facilitated both emotionally

and practically by truly non-judgmental, non-directive and easily accessible pregnancy counselling (Kaufmann 1997:2; Faber 1991:715; Schonberg *et al.* 1989). Counsellors should be able to function effectively and efficiently in an emotionally tense atmosphere, and to give support and direction while helping the client to develop new coping skills (Zastrow 1992:510). It is important that the counsellor assumes the stance of an ally, and supports the woman's right to arrive at her own decision. During the counselling session, an atmosphere of acceptance, support and calm confidence about the future should be conveyed by the counsellor (Stevens & Ellerbrock 1997; Marecek 1987:91).

In a study completed by Walker (1996) on the responses of a group of African Primary Health Care Nurses (PHCN) she found that 70% of the sample of 27 nurses rejected abortion. They were angry, hostile and judgmental to women with unwanted pregnancies. They accused these women of being irresponsible, careless, unthinking and even promiscuous. Although this is a very small sample, it is disquieting to realise that there may be many PHCNs who feel the same way towards women who find themselves in crisis due to an unplanned pregnancy. As counsellors, it is their responsibility to provide unbiased counselling.

The view of the Movement on Abortion which was polled in 1996 was that abortion is an individual choice that should be based on an informed opinion. This means that, particularly when the counsellor has strong views for or against abortion, she or he will need skill and objectivity in discussing the various options with the pregnant woman. The counsellor may not make the choice for the woman, she or he must assist the client while she makes up her own mind, (Halkett 1997:2). Imposition of the counsellor's personal beliefs on the client is inconsistent with the client's right to self-determination. The client must feel free to be able to discuss any aspect relating to the pregnancy as well as her decision concerning the pregnancy, without the fear of being

condemned (Gameau 1993:188; Marecek 1987:92). Counselling is only possible where counsellors are neutral in respect to various courses of action. They must not presume to know the answers. Their only concern should be for the well-being of the client. If the counsellor is not able to remain neutral she or he must refer the client to someone who can be (Halkett 1997:2). The client must take responsibility for her decision, as well as its outcome, whether it is to terminate the pregnancy or to carry the pregnancy to term (Van der Berg 1996:77; Gameau 1993:188).

There are certain steps to crisis intervention that would benefit the counsellor, make the counselling more effective, and the counsellor's role easier. These steps will be discussed in the following section.

### 3.3.2 Steps for pregnancy resolution counselling

According to Phikill & Walsh (1997:55) and Van der Berg (1996:78) there are six essential steps to crisis intervention counselling during pregnancy resolution namely: making contact; reducing anxiety; focussing on the issues; evaluating resources; encouraging action and follow up. Other authors views will also be included in the following discussion although they may not have set them out in the form of these six steps. These steps will be discussed in the context of the pregnant adolescent who is considering an abortion. Since abortion is a decision that is sometimes made very hastily because the adolescent does not want to reveal her pregnancy, or because the safest time in which to have an abortion is within the first trimester (Howes & Green 1997:18 and Trad 1993:401), it is important that crisis intervention be implemented correctly, without the adolescent feeling rushed into a decision.

Major & Cozzarelli (1992:138) suggest that it may be possible to identify adolescents, prior to their abortions, who may be at risk for affective problems

shortly after the abortion. However, this would only be possible if effective pregnancy resolution and pre-abortion counselling was done, with proper assessment of the client and the total situation.

### 3.3.2.1 Step 1: Making contact

It is important to communicate compassion, empathy and concern in the early stages of the interview, as this will set the pattern for the intervention steps to follow. Empathy is necessary, since it is a principle without which a relationship cannot be formed. In a helping situation, a relationship will grow wherever counsellors demonstrate to clients by their actions and words that they respect the client, that they have concern for the client, that they care what happens to her and that they are willing to listen as well as to act helpfully (Compton & Galaway 1989:294). Empathy is very necessary, especially in the case of an adolescent who may want to choose abortion, since many girls may feel that they will be morally judged. A pregnant adolescent needs to know that someone cares, that she is not being judged and that her opinion will be respected regardless of her age.

### 3.3.2.2 Step 2: Reducing anxiety

The counsellor should let the client know what she can expect from her, and about the way in which the time together will be spent. Finding out what the client hopes will happen, will help the counsellor to gain a better understanding of what it is the client wants (Compton & Galaway 1989:424). The counsellor should attempt to alleviate the tension, and to create an atmosphere of trust and hope (Van der Berg 1996:75; Zastrow 1992:510). As during making contact (Step 1), listening is a very important skill, as the counsellor should become aware of the client's needs. The expression of emotions is strongly encouraged. The counsellor once again needs to show genuine empathy,

attempting to see the situation through the client's eyes (Phikill & Walsh 1997:54; Van der Berg 1996:75). It is usually at this stage that, if the girl does not know she is pregnant, the counsellor will have to inform her of the results of the pregnancy test. It is important that this information be shared in a personal and private setting (Schonberg *et al.* 1989). This will help to reduce the anxiety experienced by the adolescent. The initial anxiety could be due to not knowing whether she is pregnant or not. However, once she is told that she is pregnant her anxiety is shifted to a possible solution, who she will tell and how she will tell them. The counsellor needs to be very sensitive to this, and work through this anxiety before moving to the next step. The thought of having an abortion, and the moral implications thereof, may also create anxiety for many adolescents.

### 3.3.2.3 Step 3: Focussing on the unplanned pregnancy

It is easy to get side-tracked by all the problems in a client's life. The counsellor should stay focussed on the crisis pregnancy (Phikill & Walsh 1997:55; Van der Berg 1996:78). However, the counsellor should guard against being so focused on his or her definition of the problem that he or she does not hear what the client is saying (Compton & Galaway 1989:425). Defining the feelings and issues associated with the crisis, and the impact that the crisis has on her life, is very important at this stage (Stevens & Ellerbrock 1997; Polio 1995:378). If the adolescent expresses strong reservations about any one of the options available, she is at risk of experiencing problems at a later stage. Given the developmental needs of the adolescent, the counsellor should seriously consider the adolescent's desire to find a solution to her problem pregnancy, especially if the client is feeling that she is being pressurised in a certain direction by others. In addition, counsellors must recognise that adolescents may not adequately process the information given to them about their options, because they might be in denial or in shock, and unable to process the

information. They may be confused, and feel that they have not received sufficient information to make a decision. For this reason, they should be provided with very concrete information, and be helped to think through all the implications of their decision (Franz & Reardon 1992:170).

Clients should be encouraged to avoid rushing into a decision without careful analysis of all possible options. It is very important not to make the choice for the client, but to give her comfort and support, helping her to see the reality of her situation (Van der Berg 1996:76; Franz & Reardon 1992:170).

#### 3.3.2.4 Step 4: Evaluating resources

The counsellor should help the client to take stock of the resources available to her, such as family, friends, her own inter-personal skills and strengths, and community resources. An assessment should be made of internal as well as external resources that could be utilised (Phikill & Walsh 1997:55; Van der Berg 1996:78; Polio 1995:378). Clients should be given accurate information and help to explore alternative ways of seeing their situation. The counsellor should also be prepared to explain in detail each of the options, including the legal issues, and the kinds of help available from public and private agencies (Van der Berg 1996:76, Marecek 1987:91). Each option available should be discussed separately. All the pros and cons of each alternative should be discussed, and how each alternative would affect the adolescents future. The counsellor should ensure that she has correct, updated information to give to the client. Some essential points that need to be mentioned for each option will be discussed briefly in Section 3.4.

If possible, the counsellor should try to persuade the client to involve either the baby's father or her parents in the decision making process, since they can

especially be utilised as resources for emotional support as well as for financial support (Gameau 1993:188; Schonberg *et al.* 1989).

Regardless of the decision which the adolescent makes, it is the counsellor's responsibility to discuss future contraceptive use with the client. The client should be forced to think about future sexual intercourse, and how she will prevent falling pregnant again, especially in the case where the adolescent has chosen abortion. She may be sexually active again soon after the abortion. Although many adolescents may say that they will not be sexually active again, the counsellor should discuss the different contraceptives available to her and encourage her to use them. An aspect which is very difficult to discuss with the pregnant adolescent at this time is that of sexually transmitted diseases (STD) and Human immuno-deficiency virus (HIV). However, if the girl is pregnant, there is a possibility that she may have contracted a STD or HIV. It is estimated that two out of every five sexually active teenagers have an STD. The counsellor should encourage the client to be tested (Van der Berg 1996:55). This is not just for the sake of her health, but for that of her baby as well, especially if she decides to carry the pregnancy to term.

#### 3.3.2.5 Step 5: Encouraging action

Clients often come to the counsellor presenting a solution rather than the problem. The client comes to request help in implementing a solution already decided on, rather than examining alternative actions (Compton & Galaway 1989:430). Assistance will be needed to define problems and agree on the goals of intervention. Specific measures that will restore equilibrium, and new methods of coping, may be introduced (Gameau 1993:188; Trad 1993:401; Zastrow 1992:510). Once the problem has been defined, and goals have been set the counsellor should encourage the client to take action (Phikill & Walsh 1997:55; Van der Berg 1996:78). Each option available to the adolescent is discussed in Section 3.4.



In the case of abortion, the client will have to act quickly in order to ensure that she has an abortion in the safest time possible, which is the first trimester. The counsellor should help the client to make an appointment, and refer her to the abortion clinic or hospital where abortions are done. If the counsellor is not qualified to help with any of the options, she should refer the client to someone who is. If possible the counsellor should go with the client to those she has referred her to.

#### 3.3.2.6 Step 6: Following up

The sixth step is to follow up the situation of the client, to follow up on the decision she has made, and find out whether she implemented her decision. Adolescents often deny the counsellor permission to phone them at home or to visit them, which makes follow up very difficult. However it is essential that the counsellor builds a relationship with the client so that she will feel that she can return to tell the counsellor what her decision was, without the fear of being judged. The necessity of follow up also lies in the fact that the client may often leave the counsellor, having decided what she will do, but is then placed under pressure from family members, friends and her boyfriend to change her decision. At this point she will once again need the reassurance from the counsellor that her initial decision was the right one, regardless of the counsellors personal view, and the counsellor should offer support (Phikill & Walsh 1997:55). Follow up is essential for any option chosen by the client. She will need emotional support and perhaps financial support later and she should know that there is someone who cares and is willing to help her.

A framework summarising the steps and goals, and integrating the feelings of the client (see 2.2.3) as well as the counsellors skills will follow, this framework could be utilised as a guideline during counselling.

<b>STEP</b>	<b>GOAL</b>	<b>FEELINGS EXPERIENCED BY THE PREGNANT ADOLESCENT</b>	<b>COUNSELLORS SKILLS</b>
1. Make contact	Build relationship Establish trust	Fear Shock Numbness	Listening Empathy Understanding Non-judgmental attitude
2. Reduce anxiety	Alleviate tension Discuss counselling expectations Express emotions	Anxiety Denial	Interpretative listening
3. Focus on the unplanned pregnancy	Define feelings Look at impact of the crisis on her life	Guilt Anger Worthlessness Resentful	Questioning
4. Evaluate resources	Focus on internal and external resources Discuss options Discuss future goals	Detachment Depression	Feedback Information giving
5. Encourage action	Make decision Implement goals and objectives Referrals	Anger Dependence Depression Worthlessness	Subtle confrontation
6. Following up	Open door policy Continued support	Loneliness Isolation	Support

Figure 3.2 Framework for counselling pregnant adolescents

### 3.4 COUNSELLING A PREGNANT ADOLESCENT ABOUT PREGNANCY RESOLUTION OPTIONS

As stated before, there are five options available to a pregnant adolescent, namely, marriage, single parenting, adoption, foster care and abortion. These five options will be discussed briefly, highlighting important information that needs to be given to the adolescent. It is always important to find out what the adolescent knows about each option available, and to clarify any misconceptions. In choosing one of the first four options mentioned above, the adolescent has chosen to carry the pregnancy to term. The counsellor will need to discuss amongst other areas foetal development and prenatal care with the client, and refer her to facilities that will render prenatal care.

#### 3.4.1 Marriage

A very important aspect to mention to the adolescent is that statistics show that couples who felt that they had to get married, do not always live happily ever after. Currently, almost 75% of teenage marriages end in divorce. When pregnancy is the major reason for getting married, the failure rate goes up to 90% (Van der Berg 1996:40). The question to ask the adolescent is whether she and the father of the baby are ready to get married. It is the counsellor's responsibility to assess the nature of their relationship carefully. The legal aspects of a teenage marriage also needs to be considered. Questions to be considered are whether the parents will give permission for them to get married? If not, it has to be determined whether they are willing to proceed with the marriage without parental permission, and apply to the Court for permission? The Marriage Act (25/1961) section 24(1) states that "...no marriage shall be solemnised between parties of whom one or both are minors unless consent has been granted in writing". A minor is a person under the age of twenty one. Section 26(1) of the Marriage Act (25/1961) states that "...no boy

under the age of eighteen and no girl under the age of sixteen shall be capable of contracting a valid marriage except with the written permission of the Minister". If the adolescent's parents, guardian or Commissioner of Child Welfare refuse to consent to the marriage an application for consent may be granted by the Supreme Court of South Africa [section 25(4)].

If the adolescent is certain that this is the option which she wants, the counsellor needs to encourage her and her partner to attend some kind of marriage counselling in order to help them to cope with the added stress that a baby might cause in their marriage (Van der Berg 1996:40).

### 3.4.2 Single parenting

A very important aspect to examine with regard to single parenting is the adolescents' support base. The most natural response for a girl who has chosen to carry the pregnancy to term would be the further decision to raise the child. Due to adolescents' developing cognitive development, and the fact that they may not easily understand the responsibilities involved in raising a child, the support of her parents will be important. The single mother usually faces a very difficult financial situation. Due to her level of education, it will be difficult to find employment, especially in South Africa. If she is able to find employment, a large portion of her salary will have to be spent on child care during the day while she works. It is therefore very important to discuss all of these aspects with the adolescent, and also to determine how involved her parents are willing to be in raising their grandchild (Van der Berg 1996:39). The adolescent needs to look at the situation realistically.

### 3.4.3 Adoption

Adoption is also a very difficult choice to make, since there are many myths surrounding adoption. As stated in chapter 2, in America only 5% of adolescent

pregnancies end in adoption. There are either open or closed adoptions available, and it is very important that the counsellor has updated information with regard to their options. The counsellor should have knowledge of the Child Care Act (74 of 1983) and the Child Care Amendment Act (96 of 1996). Adoption is not an option to take lightly, since it affects not only the mother and father of the baby, but also the couple who wishes to adopt the child.

The counsellor should discuss the differences between open and closed adoptions. With open adoptions the client will be able to choose and meet the adoptive parents, and remain in contact for the first year. Then, if the child and mother agree, they may meet again when the child is eighteen. In a closed adoption, the identity of the adoptive parents is never known. It is very important to mention that according to the Child Care Amendment Act [(96/1996) section 18(7)] the consent of both parents is required, or in the case of a child born out of wedlock the consent of the mother is needed. A great deal of emphasis has been placed on obtaining permission from the biological father and the adolescent should be encouraged to include him in her decision.

The grief felt by the biological mother is usually great, and she will need a great deal of support to help her to work through her feelings, and eventually accept the loss. It is important for the counsellor to focus on the positive aspects of adoption as well. If the mother is unable to support the child, she is placing his or her needs and future opportunities before her own by placing the child in adoptive care. However, the counsellor should never minimise the effect which the adoption will have on the client (Van der Berg 1996:41).

#### 3.4.4 Foster Care

Foster care is substitute care within a family circle for children who cannot be cared for by their parents in the short, medium or long term. As foster care is a

legal procedure, it cannot be considered as a pregnancy resolution option, unless a social workers' investigation finds that the child, once it is born is in need of care (Child Care Act 74 of 1983 & Amendment Act 96 of 1996). In the case of the adolescent mother social work services will continue in order to return the child to her care. For the mother the consequences of returning the child to her care are the same as those of a single parent.

#### 3.4.4 Abortion

The counsellor should determine whether the adolescent is making this decision for herself, or whether she is being pressurised into choosing an abortion. Once it has been established that she has decided to have an abortion, the counsellor should explain the procedure to her. It is each counsellor's responsibility to know the provisions of the Choice of Termination of Pregnancy Act (92 of 1996) and know the facts with regard to the abortion procedures used in his or her area. The procedures used in South Africa differ from town to town. The most common procedures used are Manual Vacuum Aspiration (MVA) and Cytotec. MVA entails a manual vacuum apparatus that is used to remove the contents of the uterus. The cervix is dilated and the apparatus is inserted. This method is only used up to the end of the twelfth week of pregnancy. Artificial dilation of the cervix may weaken it, and place future pregnancies in jeopardy through miscarriage or premature delivery.

Cytotec is a pill that is inserted into the vagina as well as taken orally, this pill causes a spontaneous abortion. The girl is usually admitted to hospital for 24 hours, where she goes into labour and delivers the foetus. With both methods no anaesthetic is used. Often if the abortion is incomplete, dilation and evacuation (D&E) is used. This method is also used most often in second trimester abortions. This involves the stretching of the cervix and the use of small forceps to remove the foetus. Due to the size of the foetus, parts are removed individually. One of the dangers of this method is that, due to the fact

that the skull may already have hardened it will have to be compressed and then removed. If this is not done very carefully, the sharp edges may cause cervical lacerations. If all the contents of the uterus are not removed, the patient may suffer from infection, which can result in damage to the fallopian tubes and ovaries, a major cause of infertility (Gold, Luks, Anderson 1997; Van der Berg 1996:20).

### 3.5 CONCLUSION

Effective pregnancy resolution and pre-abortion counselling are important since they can diminish negative reactions to the decision made by the adolescent. Although all of the options have their pros and cons, abortion may have the most negative consequences of the five possible options since it could take years before the adolescent realises that she has suffered any negative reactions to the abortion. The possible medical consequences are also more serious since the adolescent may become sterile as a result of infection. It is evident that pregnancy resolution counselling is essential, not only to help the woman to make an informed decision, but also to prevent possible future problems. Because of the cognitive immaturity of adolescents', pregnancy resolution counselling helps them to predict the consequences of their behaviour, and also reduces impassivity, helping them to make a decision.

For adolescents who consider abortion, the importance of effective pregnancy resolution and pre-abortion counselling cannot be overemphasised. It is evident that adolescents, more so than any other group, cannot make this decision without counselling. The following chapter will discuss the results obtained from interviews done with nurses and social workers who are doing pregnancy resolution and pre-abortion counselling. Counsellors' skills, and the effectiveness of the counselling services rendered will be discussed.

## CHAPTER 4

### **PREGNANCY RESOLUTION AND PRE-ABORTION COUNSELLING WITH ADOLESCENTS BY NURSING PROFESSIONALS AND SOCIAL WORKERS**

#### 4.1 INTRODUCTION

In the previous chapters, adolescent pregnancy and crisis intervention as a counselling model were discussed. The literature study formed the basis for the empirical study. The motivation for this study began as a result of the researcher's involvement with Options Pregnancy Centre, a volunteer-based crisis pregnancy counselling centre. As the empirical study will show, most of the pregnancy resolution and pre-abortion counselling done in Mossel Bay is done by medical professionals and by a few social workers. The researcher was interested in determining the extent of the counsellors' training and knowledge especially with regard to pre-abortion counselling, since this is a new field of counselling for many of the counsellors. The nursing professionals were interviewed, because they counsel the majority of pregnant adolescents. The social workers were interviewed in order to determine whether they play a role in pregnancy resolution and pre-abortion counselling, since they have the counselling training needed to render these services successfully. The method, results and analysis of the empirical study will be discussed in this chapter.

#### 4.2 METHOD OF STUDY

As discussed in chapter 1, a structured interview schedule was used to gather the data. The researcher conducted the interviews. Although it would be advisable to use two interviewers when completing interview schedules, Rubin & Babbie (1993:342) state that it is acceptable to use one interviewer when the sample is very small. Sixteen interview schedules were completed. Of the



sixteen interview schedules, 11 were conducted with nursing professionals at the provincial hospital and clinics in Mossel Bay, and 5 with social workers. Once the head of the Health Department in Mossel Bay agreed that the nursing professionals might participate in the study, interviews were arranged. Each social worker was approached individually.

#### 4.3 THE INTERVIEW SCHEDULE

The interview schedule (Appendix 1) was designed to achieve the aims of the study, that is, to investigate the nature of pregnancy resolution counselling and specifically pre-abortion counselling, done with pregnant adolescents in Mossel Bay. The data that was collected with the aid of the interview schedule was based on the principles of an exploratory study. The interview schedule was adapted the social workers did not complete section B 9-11 since they do not perform pregnancy tests. The adolescents whom they counsel already know that they are pregnant, and the social worker therefore does not need to communicate this information. The data will be discussed in five sections, namely, identifying details, teenage pregnancy, abortion, counselling and training.

#### 4.4 IDENTIFYING DETAILS

The respondents were asked to detail their occupation, gender, the institution from which they obtained their degree or diploma, the year in which they obtained this degree or diploma, the organisation to which they are affiliated, and the number of years during which were affiliated to this organisation. The findings are presented in Table 4.1. Each aspect will be discussed separately. The respondents were also asked to indicate whether their tertiary education had included information regarding the emotional responses of adolescents to an abortion decision, and adolescent responses to an unplanned pregnancy.

Table 4.1 Demographic profile of respondents

Respondent	Occupation	Gender	Tertiary Training	Year Graduated	Organisation to which affiliated	Years affiliated to Organisation			
						<5	5-10	10-20	20+
1	Nursing Sister	Female	Hospital	1981	Municipal clinic	1			
2	Nursing Sister	Female	Hospital	1974	Municipal clinic			1	
3	Nursing Sister	Female	Hospital	1985	Municipal clinic			1	
4	Nursing Sister	Female	College	1982	Municipal clinic		1		
5	Nursing Sister	Female	Hospital	1986	Municipal clinic	1			
6	Health Official	Female	Hospital	1983	Provincial Hospital			1	
7	Matron	Female	Hospital	1969	Provincial Hospital				1
8	Matron	Female	Hospital	1976	Department of Health	1			
9	Nursing Sister	Female	College	1980	Provincial Hospital		1		
10	Nursing Sister	Female	Hospital	1986	Municipal clinic		1		
11	Nursing Sister	Female	Hospital	1989	Municipal clinic		1		
12	Social Worker	Female	College	1998	Welfare organisation.	1			
13	Social Worker	Female	University	1996	Welfare organisation	1			
14	Social Worker	Female	College	1976	Welfare organisation			1	
15	Social Worker	Female	University	1984	Welfare organisation	1			
16	Social Worker	Female	University	1996	Welfare organisation	1			

#### 4.4.1 Occupation

Of the sixteen respondents, eight were registered nursing sisters, two were matrons, one was a health official, and five were social workers. The majority of the respondents namely 11 (68%) were nursing professionals.

#### 4.4.2 Tertiary training

Two (18%) of the nursing professionals (n=11) completed their training at colleges. The other nine (82%) were trained at hospitals, namely, Grootte Schuur, Somerset, Victoria, Westlake, Tygerberg, Military Hospital and Livingston Hospital. Three (27%) nurses obtained their diploma in the sixties and seventies and eight (73%) in the eighties. All the nurses have therefore more than 10 years experience in their field, including experience of handling adolescent pregnancies. Five (45%) of the nursing professionals completed further studies in a specialised field, namely Community Health Care. Three (60%) of these respondents completed their studies at UNISA and the other two at the University of Port Elizabeth. Due to the nature of their studies, namely Community Health they obtained further theoretical training with regard to adolescent pregnancy.

Three (60%) social workers (n=5) completed their training at University, namely at Stellenbosch University and two (40%) completed their studies at Huguenot College. One (20%) social worker obtained her degree in the seventies, one (20%) in the eighties and three (60%) in the nineties. It is clear that three of the social workers have not been in practice for many years, and it may therefore be assumed that their experience of teenage pregnancies is limited.

Fifteen of the sixteen respondents (N=16) received their tertiary training before the Choice on Termination of Pregnancy Act (92/1996) was passed and due to

abortion not being legal on demand the necessity for theoretical knowledge concerning the emotional and psychological consequences of adolescent pregnancy and termination of pregnancy may not have been realised. Extra training in this area would be beneficial. In the case of most professions the responsibility of doing a great deal of self-study with regard to subjects or cases not covered at tertiary level lies with the individual.

#### 4.4.3 Organisation to which affiliated

Eight (50%) of the respondents (n=11) are employed at municipal clinics and three (19%) are employed at a provincial hospital. The former eight respondents are employed at three clinics in Mossel Bay. Five (31%) of the respondents (n=5) are social workers employed by ACVV, Child and Family Welfare and Famsa which are in Mossel Bay.

#### 4.4.4 Years of experience at present organisation

Respondents were required to indicate the number of years during which they had been affiliated to the organisation by whom they are presently employed. This would indicate their experience, and the knowledge they would have of the situation in Mossel Bay, and of the organisation to which they are affiliated.

Of the eleven nursing professionals (n=11), four (36,5%) respondents have been working at the same organisation for more than ten years, with one respondent having worked at the provincial hospital for 24 years. Four (36,5%) nurses have been working for the same organisation for more than five years and three (27%) nurses for less than five years. It is evident that the nurses know the situation in Mossel Bay well, and are therefore well aware of adolescent sexual behaviour, and the number of adolescent pregnancies occurring in Mossel Bay.

Of the five social workers (n=5), only one (20%) social worker has been employed at the same organisation for more than ten years. One (20%) respondent has worked for the same organisation for 3 years. However, the other three (60%) respondents have been employed in their present position for less than a year, and have lived in Mossel Bay for the same period. The social workers interviewed have not been employed in Mossel Bay for the same length of time as the nursing professionals and may therefore not be as aware of the situation with regard to adolescent pregnancies in Mossel Bay. Also the social workers have less years of experience than the nurses. Only two (40%) social workers have been practising social work for more than 10 years, whereas all the nurses have been practising for more than 10 years.

#### 4.4.5 Nature of tertiary training

The respondents were asked whether their tertiary training had included theoretical study of abortions, including the procedure and/or the emotional and physical consequences of an abortion. They were also asked to indicate whether their training had included adolescent pregnancy and the emotional, psychological and physical responses to an unplanned pregnancy.

Only one (9%) of the nursing professionals (n=11) stated that she had had some experience with regard to handling abortions, as a result of receiving training in a psychiatric ward where she worked with some women who had had therapeutic abortions. However, none of the nursing professionals had received any tertiary training with regard to abortions, either the procedure or the emotional consequences thereof. Two (18%) of the nursing professionals stated that their tertiary training had included the emotional, physical and social implications of adolescent pregnancy. Nine (81%) stated that they had not received any theoretical training at tertiary level on adolescent pregnancy. However, of the five (45%) respondents who had completed further training

later in their career, they all stated that they had done additional theory on adolescent pregnancy while completing their studies.

Four (80%) of the social workers (n=5) stated that they had done a very brief section on abortion, but had not done a detailed study of the procedure, nor of the emotional or physical consequences thereof. One (20%) respondent stated that her tertiary training had not included any theory on abortions. This was very surprising as she had still been at University when the Termination of Pregnancy Act 92/1996 was passed. Three (60%) social workers stated that adolescent pregnancy, together with the emotional, physical and social implications had been covered during their tertiary training. However, they all stated that the subject had never been covered in detail. Two (40%) social workers stated that they had not received theoretical training at tertiary level with regard to adolescent pregnancy. It seems therefore that formal training concerning adolescent pregnancy, and specifically abortion, has been neglected. It is therefore evident that it is necessary for those professionals counselling pregnant adolescents to be equipped with the relevant knowledge.

#### 4.5 RESPONDENTS ROLE AND VIEWS ABOUT ADOLESCENT PREGNANCY

The study was undertaken to determine whether the respondents administered pregnancy tests, how many of these tests were positive, and how the respondents would react to an adolescent who was pregnant. In the first three paragraphs of this section only the responses of the nursing professionals (n=11) are relevant since only they carried out pregnancy tests. These questions were posed in order to determine how often nursing professionals were placed in a position where pregnancy resolution or pre-abortion counselling needed to be done.

#### 4.5.1 Pregnancy tests administered to adolescents

Respondents (n=11) were asked to indicate whether they administered pregnancy tests to adolescents. Ten (91%) of the nursing professionals administered pregnancy tests, while 1 (9%) did not. She is a matron who at times does some counselling, but does not do pregnancy tests.

#### 4.5.2. Number of pregnancy tests administered monthly

Respondents were required to indicate the number of pregnancy tests which they administered personally to adolescents each month. The number of pregnancy tests carried out was surprisingly low. Most of the pregnancy tests for adolescents were done at the Provincial Hospital, where the average was between 10 and 20 per month. More than half of the nurses performed between three and five pregnancy tests per month. Only two (18%) of the respondents performed less than three pregnancy tests per month. The following table will indicate the number of pregnancy tests administered monthly by the nursing professionals.

Table 4.2 Number of pregnancy tests administered monthly by nursing professionals

Pregnancy tests per month	N	%
1-2	2	20
3-5	6	60
6-10	0	0
11-20	2	20
TOTAL	10	100

n=10\*

\*One of the nursing professionals does not administer pregnancy.

From table 4.2 it is clear that of the ten respondents who administer pregnancy tests, six (60%) do only 3 to 5 pregnancy tests per month, with only two (20%) doing between 10 and 20 pregnancy tests monthly. Due to the fact that many adolescents tend to deny that they may be pregnant well into the second or third trimester (Trad 1993:399; Lieberman & Davis 1992:367), many do not require a pregnancy test done at the clinics. The nurses simply do an examination, which explains the low number of pregnancy tests performed.

#### 4.5.3 Number of pregnancy tests with a positive result

Respondents were asked to indicate how many of the pregnancy test results were positive, in order to determine how many pregnant adolescents they would possibly have to counsel per month.

The number of positive pregnancy tests were very low. The respondents at the municipal clinics stated that less than half of the pregnancy tests done were positive, whereas the personnel at the Provincial Hospital stated that almost all of the pregnancy tests done were positive. This could be due to the fact that all adolescents requesting an abortion must have a pregnancy test done at the Provincial Hospital before being admitted for an abortion. This would increase the number of positive tests performed there.

#### 4.5.4 Response to the pregnant adolescent

The respondents were asked to indicate how they feel about a pregnant adolescent, whether they felt empathy towards her, were angry with her, felt neutral towards her or had mixed emotions. Their responses to this question would indicate their attitude and personal feelings during counselling. Once again the results for the nursing professionals (n=11) and the social workers



(n=5) will be discussed separately since, due to the differences in their tertiary training, it is evident that there could be differences in their responses.

Five (45,5%) of the nursing professionals (n=11) indicated that they felt empathy for the adolescent since they realised that the pregnancy was in most cases a crisis, and that the pregnancy had serious implications for the adolescent's future. One (9%) respondent indicated that she felt neutral, neither empathy nor anger. Five (45,5%) respondents indicated that they had mixed emotions. In a study completed by Walker (1996:46) she found that the majority of primary health care nurses responded to an unplanned pregnancy with anger and hostility, and were judgmental. This was not the case in this study. None of the nursing professionals stated that they felt only anger towards the adolescent.

Two (18%) of the nursing professionals (n=11) who indicated that they had mixed emotions stated that their anger was directed towards the parents for not educating their children and for not exercising more discipline. However, as Plotnick (1993:324) stated, many adolescents do not use contraceptives due to their fear that their parents might find out that they were sexually active. The way in which parents communicate with their children about sex and sexuality greatly influences the adolescents' decisions about sex. The parent child relationship is of great importance as the two respondents in this study mentioned. Jaccard & Dittus (1993:329) state that despite the importance of the parents role in shaping adolescent behaviour it is believed that they have very little influence or effect on adolescent behaviour. Adolescents tend to rely more on advice from peers, and tend to follow this advice more often than parental advice and guidance.

Three (60%) of the social workers (n=5) stated that they felt empathy towards the adolescent and two (40%) stated that they experienced mixed emotions.

The percentages are similar for nurses as for social workers with regard to mixed emotions, although social workers indicated that they empathised with the client more than the nursing professionals did.

The respondents (both nursing professionals and social workers) who stated that they had mixed emotions stated firstly that they felt sorry for the girl, but that they also felt anger, especially if it was the second or third pregnancy. The respondents reported feeling very disillusioned, and of being left with a feeling of helplessness, because many of the adolescents were not using contraceptives which are freely available. It is very seldom that a pregnancy is due to failed contraceptives. Trad (1993:398) states that adolescents may be developmentally unable to predict the long-term consequences of their behaviour, and therefore do not use contraceptives.

Due to the respondents' positive attitude towards the adolescent, the task of training the respondents will be a lot easier. Their attitude is one of empathy and understanding. The respondents do not need to be trained to cope with negative feelings that they may have towards the client or patient.

#### 4.6 RESPONDENTS ROLE AND VIEWS ABOUT ABORTION

This section of the interview schedule was aimed at establishing the respondents' knowledge of the Termination of Pregnancy Act (92 of 1996), what they believe their role to be according to the Act (92 of 1996), and their personal views with regards to termination of adolescent pregnancy.

##### 4.6.1 Knowledge of the Choice on Termination of Pregnancy Act (92 of 1996)

Respondents were asked to indicate whether they were very knowledgeable about the Act (92 of 1996), or whether they felt that their knowledge was

average or very poor. Although the response to this question may be subjective it remains an indication of what the respondents believe their knowledge to be.

Table 4.3 Knowledge of the Termination of Pregnancy Act (92 of 1996)

Knowledge of the Act	Nurses (n=11)	Social Workers (n=5)
Very knowledgeable	8(73%)	1(20%)
Average knowledge	3(27%)	3(60%)
No knowledge	0	1(20%)
TOTAL	11 (100%)	5(100%)

N=16

Table 4.3 shows that eight (73%) nursing professionals (n=11) indicated that their knowledge of the Termination of Pregnancy Act (92 of 1996) was very good and that they had a clear understanding of the Act. Three (27%) nursing professionals stated that they felt that their knowledge of the Act was average, that they understood the basic outline and conditions of the Act, but not the finer details. Due to the nature of their work, all the nurses were required to study the Act. Initially it was intended that all nursing professionals would have played a large role in the abortion process. However, many protested, refusing to be involved in the process, and therefore did not attend the training when the Act was explained and discussed.

One (20%) social worker (n=5) indicated that her knowledge of the Act (92 of 1996) was very good, while three (60%) stated that their knowledge was average. One (20%) social worker indicated that she had no knowledge of the Act. This was very surprising since she had been studying at the time when the Act was passed. Because the role of social workers is not mentioned in the Act, social workers did not receive any formal training with regard to the implications of the Act. However, social workers are faced with clients who request abortions, and therefore had had to do self-study with regard to the Act.

#### 4.6.2 The respondents' role in terms of to the Act (92 of 1996)

The respondents were asked to state what they believed their role to be in terms of this Act (92 of 1996), whether they should be actively involved in pre-abortion counselling, involved to a certain degree, or not involved at all.

Ten (91%) of the nursing professionals (n=11) stated that they believed that they were expected to be actively involved in counselling. An information package provided by the South African National Council For Child and Family Welfare stated that basic pre-abortion counselling could be provided by any health care worker, and that the counselling was primarily a health responsibility (Halkett 1997; Wessels 1997). It is therefore not surprising that the ten respondents who indicated that they felt that they were required to be actively involved in pre-abortion counselling were, all nurses. One (9%) respondent stated that she felt that she was required to be active to a certain degree only.

Four (80%) social workers (n=5) indicated that they felt the Act did not require their involvement in pre-abortion counselling at all. Only the respondent who stated that she had no knowledge of the Act, said that she did not know what her role was in terms of the Act. The social workers stated that they felt that they could have a vital role to play in pre-abortion counselling. Gameau (1993:182) who stated that a social worker should play an integral part in pre-abortion counselling, supports this. As Van Rooyen (1998:305) stated, social workers were initially to have a direct and legislatively determined role to play in the process of legal abortion. However, this did not take place, and social workers were not mentioned in the final legislation. When asked, the social workers stated that they would be willing to be involved in pre-abortion counselling if they were approached to render this service.

#### 4.6.3 Personal views about termination of pregnancy

Respondents were asked to indicate whether they were against abortion, were neutral or were in favour of abortion. The respondents were asked to respond from a personal perspective and not from a professional one. Twelve (75%) of the respondents (N=16) were personally opposed to abortion. However, some of the respondents who answered that they were opposed to abortion felt that they were not certain whether in some circumstances they would still feel the same way, or whether they would then accept abortion, namely, in the case of rape or incest. As Zastrow (1992:38) states, every situation and every client is unique, and each situation needs to be treated as such. It is very important that the counsellor set aside personal feelings in order to help the client to clarify her own values (Schloessinger-Chesler & Davis 1980:174).

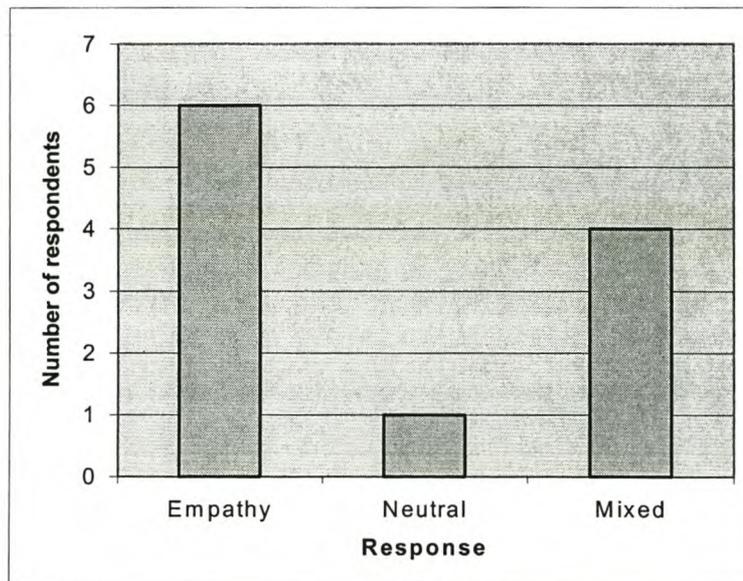
Two (18%) nurses (n=11) indicated that they felt neutral, neither positive nor negative concerning abortion. One (9%) nurse indicated that she was in favour of abortion at all times, and that it is the woman's right to choose. This view is supported by Mayibuye (1996) who state that the prevention of abortion is viewed as violating the woman's right to choose, and forcing those in poverty stricken communities to raise children there. One (9%) nurse stated that she had mixed emotions. She finds abortions emotionally upsetting, but empathises with the women requesting an abortion, and sees the need for abortions in certain cases. Seven (64%) of the nursing professionals were opposed to abortions.

All five (100%) social workers (n=5) indicated that they were personally opposed to abortion. Although they indicated that they would not personally choose an abortion for themselves or their client, they felt that careful consideration needed to be made in the case of rape or incest. It was important to examine each individual situation. Zastrow (1992:38) states that in working

with a client, a social worker needs to perceive and respect the uniqueness of the client's situation.

#### 4.6.4 Response to clients who choose termination of pregnancy

Respondents were asked to indicate how they responded to an adolescent who chose to have an abortion. Once again the respondents were asked to answer from a personal perspective, and not a professional one. They were asked whether they felt sorry for her, neutral towards her decision, angry, or whether they had mixed emotions. The respondents were asked to indicate how they felt and not necessarily how they reacted to the client. Figure 4.1 shows the responses of the nursing professionals with regard to adolescents requesting an abortion.



n=11

Figure 4.1 Responses of nursing professionals to adolescents requesting abortion

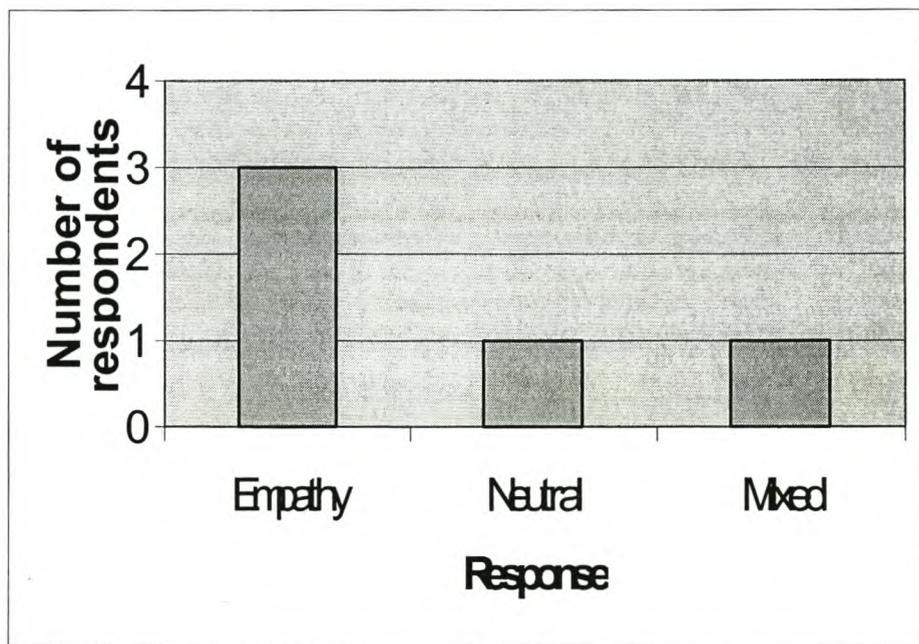
Figure 4.1 clearly shows that the majority of the nurses feel only empathy towards the adolescent. Although some expressed empathy as well as anger, the anger was not always directed at the adolescent only, but also at the parents of the adolescent.

More than half of the respondents (n=11) stated that they felt empathy toward the girl since it was a difficult decision to make, but mostly because they felt that the girl had no idea of the effect that the abortion would have on her. Van der Berg (1996:75) states clearly that a counsellor needs to show genuine empathy in order to encourage the expression of emotions. None of the respondents stated that they felt only anger towards the adolescent.

One (9%) nurse (n=11) stated that she felt neither empathy nor anger towards the adolescent, while one (9%) nurse stated that she felt anger due to the fact that the adolescent saw abortion as her only solution. However, she did state that she never expressed this anger to the client, that over time the anger had decreased, and that she experienced more empathy for the client's situation than she had previously done. Her response therefore was listed with those who experienced mixed emotions. Six (55%) of the nursing professionals stated that they felt empathy towards the girl, with only three (27%) expressing that they had mixed emotions, namely empathy as well as anger. They felt sorry for the girl due to her situation and the fact that it was a very difficult decision to make, but felt anger because the client felt that abortion might be her only solution, and that they viewed abortion as murder. Walker (1996:51) found that the majority of nurses in the study she completed, namely 70% of the respondents, expressed an "overwhelmingly and unambiguously negative response to abortion as well as a deep anger and hostility towards all women who have abortions." This was not the case in this study since only one (9%) respondent expressed anger. However, she did state that she struggled with this initially, but that now she did feel more empathy than anger. Thirty-six

percent of the nursing professionals stated that they had mixed emotions which included anger. The other 55% stated that they felt only empathy towards the adolescent. Once again the positive attitude of the nursing professionals towards the adolescent choosing abortion will make future training easier. This is because they are already able to empathise with the client and do not have to work through negative emotions which could hinder their counselling abilities.

Figure 4.2 shows the feelings of the social workers towards an adolescent requesting an abortion.



n=5

Figure 4.2 Responses of social workers to adolescents requesting abortion

Figure 4.2 shows that three (60%) social workers (n=5) more than half of the respondents, stated that they felt only empathy towards the adolescent. One (20%) social worker stated that she did not feel sorry for the girl, but did not feel anger either. She always expressed empathy as she felt this was her professional responsibility. Her response was therefore listed as neutral. One



(20%) social worker stated that she had mixed emotions. She felt anger due to the fact that the adolescent felt that abortion was her only solution, but at the same time she felt empathy toward the adolescent due to the difficult circumstances and the choice which she had to make.

Although most of the respondents indicated opposition to abortion personally, they were able to set aside their personal views and express empathy for the adolescent who found herself in this difficult position. Compton & Galaway (1989:291) define empathy as "...the counsellor making an active effort to enter into the perceptual frame of the other person without losing personal perspective".

#### 4.6.5 Parental consent with regard to abortion

Respondents were asked to indicate whether they agreed with, felt neutral toward or disagreed with the provisions excluding parental consent in the Choice on Termination of Pregnancy Act (92 of 1996), which permitted an adolescent to have an abortion without parental consent. Table 4.4 shows their responses.

Table 4.4 Respondents personal view with regards to parental consent

View of parental consent laws	Nurses (n=11)	Social workers (n=5)
Support the law	2(18%)	0
Neutral	1(9%)	1(20%)
Against the law	8(73%)	4(80%)
TOTAL	11(100%)	5(100%)

N=16

Table 4.4 indicates that one (9%) nurse (n=11) indicated that she was neither for nor against this provision in the Act, she believed that it was the adolescent's choice. Two (18%) nurses felt that these provisions in the law were to the benefit of the adolescent since, in many cases, an abortion was requested due to rape or incest. The respondents felt that the adolescents trauma would be increased if adolescents had to obtain parental consent. They also felt that disclosure of the pregnancy in some cases would cause more family breakdown than the consequences of the abortion. Kaufmann (1997:38) and Griffin-Carlson & Mackin (1993:3) support this view. They see parental consent provisions as possibly causing more fear, confusion, embarrassment and anxiety amongst adolescents. This could increase family conflicts. Parental opposition to the abortion has been related to greater post-abortion hostility from the adolescent (Major & Cozzarelli 1992:131). It is believed that in some cases parental involvement in the abortion decision fosters secrecy and more illegal abortions, while failing to enhance the decision-making process (Trad 1993:401).

Eight (73%) of the nursing professionals indicated that they strongly disagreed with these parental consent provision of the law. They felt that adolescents especially should speak to someone. They felt that the adolescent should, if possible, share her situation with her parents in order to ensure support after the abortion. These respondents felt that parent-child communication was very important, and that the legal provisions have a negative influence on this communication. These findings substantiate Faber's (1991:699) view, stating that the decision-making process involves not only the pregnant adolescent, but other important individuals in her life as well. Adolescents differ from adults in their decision-making abilities. They often seek advice before making a decision and lack the ability to view situations from the perspective of other significant people (Trad 1993:401). Although adolescents were mostly afraid of

their parents' reactions to their pregnancy, they tended to rely on them for advice and guidance (Faber 1991:715).

Four (80%) social workers (n=5) disagreed with these parental consent provisions, only one (20%) social worker indicated that she felt neutral towards the matter, and that it was the adolescent's choice. Their reasons for answering as they did were the same as those listed for the nurses.

Due to the negative feelings of both the nurses as well as the social workers with regard to the parental consent provisions in the law, which state that the adolescent does not need parental permission to obtain an abortion, it was not surprising that many respondents felt that the adolescent must include another person in the decision making process, as will be discussed in 4.7.2.

#### 4.6.6 Referrals for termination of pregnancy

Respondents were asked whether they referred clients for abortions, and to whom they referred them. All eleven (100%) of the nursing professionals (n=11) referred clients to the provincial hospital for abortions, since this was part of their job-description. The nursing professionals make the appointment for the client at the hospital with an official letter of referral. Once the client has had blood tests at the hospital and the nurses at the hospital have explained the procedure to her she is given the date for the abortion. Halkett (1997) in an information package on abortion counselling, stated that it is very important that individuals who do refer clients for abortions are aware of the necessary procedures required by the hospital or facility performing the abortion. This is necessary so that no delays or misunderstandings occur. The adolescent must also know where to go and confidentiality must be ensured. In Mossel Bay the nurses at the clinics are required to make an appointments telephonically for an abortion to the Provincial Hospital as well as to write a formal letter of referral.

This letter is, then given to the patient to take to the hospital. Sometimes, mostly in cases where the client is very uncertain of her decision the nurses refer the clients to Options Pregnancy Centre for counselling before they make the appointment for the abortion.

Three (60%) of the social workers (n=5) said that they had not yet been in a situation where they had had to refer a pregnant adolescent for an abortion. The clients had opted either to keep the child, or to place the child in adoption. Two (40%) social workers stated that they referred clients who considered an abortion to Options Pregnancy Centre for counselling. Since October 1999 Options Pregnancy Centre has been provided with a counselling room in the Provincial Hospital where they see all patients referred for an abortion for pre-abortion counselling once a week.

#### 4.7 TRAINING IN PREGNANCY RESOLUTION AND PRE-ABORTION COUNSELLING

The respondents were asked to indicate whether they felt that they were adequately qualified to render the service that was expected of them, whether they had received additional training and whether they would be interested in attending additional training if training were offered.

##### 4.7.1 Adequate training for pre-abortion counselling

The respondents were asked to indicate whether they felt that they were adequately qualified to render pre-abortion counselling, especially to adolescents.

Six (55%) nursing professionals (n=11) stated that they felt that they were adequately trained to render this service. Three nurses said that it was due to

their experience that they felt they were adequately trained, not necessarily due to theoretical training or additional training. Five (45%) of the nurses felt that they were not adequately trained to render this service, and were experiencing pressure due to this. Of the five (45%) nurses who stated that they felt they were not adequately trained, two (40%) have been practising nursing for more than 10 years, with three (60%) nurses having practised for more than 15 years. They felt that despite their experience, they were not adequately trained to render this service.

One (20%) social worker (n=5) felt that she was adequately trained to render this service, the other four (80%) felt that they were not. This was surprising since the social workers possess the counselling training needed, but they felt that they had not received specific pre-abortion counselling training and therefore felt that they were not adequately trained to counsel an adolescent who wanted to have an abortion. They had done pregnancy resolution counselling before the Choice on Termination of Pregnancy Act (92 of 1996) was passed, and felt comfortable in rendering this service. However, pre-abortion counselling is a new area of counselling and they felt that they were not adequately trained. The social workers stated that if they were to receive additional training on how to counsel a client who was considering an abortion, they would feel more confident in handling it.

It is evident that although the social workers have counselling training, they felt that they were not adequately trained to render this service. This may be due to the fact that they appreciated the depth of knowledge needed to do specialised counselling. However, the nursing professionals do not have a theoretical counselling background, and therefore may have nothing to compare their counselling with and therefore believe that they are adequately trained theoretically.

#### 4.7.2 Training in rendering pre-abortion counselling services

The respondents were asked to indicate whether they had received additional training, specifically on pre-abortion counselling of the adolescent. They were also asked who had offered this training, and the exact type of training received, as well as the duration of the training.

Only four (36%) of the nursing professionals (n=11) had received additional training after the Choice on Termination of Pregnancy Act (92 of 1996) was passed. This training was provided by the Provincial Department of Health in conjunction with an American reproductive health research unit. The training focused on the counsellors' values and views on abortion, and the fact that they needed always to remain objective in the counselling situation. The training did not focus on the impact of abortion on the pregnant women. The training did not include specific skills on how to counsel a woman requesting an abortion. The focus was on the medical procedure and the nurses' role in explaining this procedure. This training entailed two weeks of theory and two weeks of practical work. It was therefore surprising that six of the nurses had stated that they felt adequately qualified to render this service, since only four had received extra training.

None of the social workers received additional training in rendering pre-abortion counselling services.

#### 4.7.3 Additional pre-abortion counselling training

The respondents were asked to indicate whether they would be interested in attending extra training, and what they would expect from this training.

Ten (91%) nurses (n=11) stated that they would attend additional training, only one (9%) stating that she felt that she had adequate training. Once again this statement was contradictory, since six (55%) nurses had stated that they felt adequately trained to render this service, yet only one (9%) nurse felt that she did not need additional training.

Four (80%) social workers (n=5) stated that they would attend additional training. One (20%) social worker stated that pregnancy resolution counselling and pre-abortion counselling constitute such a small percentage of her work that if she felt unable to counsel a client considering an abortion, that she would refer her.

More than half of the respondents stated that they would expect the training to include information on the emotional responses of an adolescent to an unplanned pregnancy, and how to discuss the different options with the adolescent. Many of the respondents said that they would like a deeper knowledge of adolescent sexual behaviour, and a clearer understanding of the adolescent.

Two (18%) nurses (n=11) stated that they would like to know more about post abortion syndrome, in order to be able to inform the adolescent of possible emotional, physical and psychological after-effects of an abortion. Two (18%) nurses felt that they needed a deeper insight into the effect that the pregnancy has on the adolescents' parents, as well as on the father of the baby, and his parents.

Two (40%) social workers (n=5) stated that they would like more information about post abortion syndrome. The four (80%) social workers who stated that they would attend extra training all said that they had knowledge about adolescents, and their developmental stages and characteristics, but would like to have more information on how a pregnancy affects the adolescent, and

specifically how the decision to have an abortion and the abortion itself affects the adolescent (Phikill & Walsh 1997 and Van der Berg 1996).

#### 4.8 COUNSELLING

The respondents were asked to indicate whether they were actively involved in counselling pregnant adolescents, the type of counselling done with the adolescent, as well as the duration of these sessions.

##### 4.8.1 Involvement of respondents in pre-abortion counselling

Respondents were asked to state whether they counselled pregnant adolescents, and if they did not, who did so in their organisation, or to whom they would refer these clients. All eleven (100%) of the nursing professionals (n=11) stated that they do pregnancy resolution counselling as well as pre-abortion counselling. However, approximately 80% stated that they only did the basic counselling, and then referred the girl to Options Pregnancy Centre. This was mostly due to a lack of time, and not necessarily due to an inability to do the counselling.

Four (80%) of the social workers (n=5) stated that they did pregnancy resolution counselling, and had worked with only one or two clients who had considered an abortion. One (20%) social worker indicated that she had never done pregnancy resolution or pre-abortion counselling (Phikill & Walsh 1997 and Van der Berg 1996).

##### 4.8.2 Type of counselling done

The respondents were asked to indicate the type of counselling done, whether an intervention model was utilised, and whether they had a specific method that they followed.



The nursing professionals had a specific form that they followed. This form required the nurse to assess the clients' personal details, her emotional state, as well as her socio-economic situation. The nursing professionals mostly follow the guidelines on this form. One of the first aspects which the nurses have to deal with is that of the physical pregnancy. The nurse needs to confirm that the girl is pregnant, and also to determine the gestational age of the foetus. In many cases the adolescent's pregnancy might be beyond the gestational age allowed for an abortion. This would be one of the first aspects to mention, so that the adolescent would not focus on abortion as it would no longer be an option for them. The focus from the nurses' perspective would always be on the physical aspect of the pregnancy, since this is their field of expertise.

All eleven (100%) the nurses (n=11) stated that, although they focused on the physical aspect, they tried also to help the girl to come to terms with the knowledge that she was pregnant. They helped her to cope with the pregnancy, and to begin to face the reality of it, and no longer to deny the truth. They stated that many of the adolescents were in shock and were unable to express their emotions and that they are unable to think logically about the situation. This is confirmed by Van der Berg's (1996:77) view that often the adolescent may detach herself from the situation with the result that she does not get involved emotionally or intellectually. Most often the respondents would spend some time with the girl in their office in the hope that she would express some of her emotions. However, if the adolescent was unable to speak due to shock and disbelief, the nurses would ask her to come back the following day, giving her some time to think about the pregnancy. Due to the nurses limited knowledge of crisis intervention or counselling skills, they were often unable to assist the adolescent to explore her feelings. More than half of the nurses stated that they felt helpless and unable to assist the adolescent effectively.

All eleven (100%) of the nursing professionals (n=11) stated that they always asked the adolescent who she had spoken to, whom she would tell, and how she felt they might react. The adolescent was encouraged to speak to a parent, or at least to someone older. The nurses stated that they encouraged the girl to bring her mother with her for her next appointment. If the client felt she could not speak to her mother, the nurses offered to speak to the parents. According to Gameau (1993:188) and Schonberg *et al.* (1989) counsellors should try to persuade the client to involve either the baby's father, or her parents, in the decision making process since they were able to provide support.

All five (100%) of the social workers (n=5) see the client only once the pregnancy has been confirmed. They are not in a situation where they have to inform the client of the pregnancy and therefore the client is rarely still in a state of shock. She has had time to think about her situation, and is coming to see the social worker for guidance and information. The social workers stated that they specifically implemented crisis intervention. Although the client might not be in the initial stages of the crisis, she was still in crisis, and needed help in order to cope with the situation.

Harris (1991:197) states that crisis intervention should be done in stages, which include individual counselling as well as counselling with the family. This is further substantiated by Danziger & Faber (1990) who state that the pregnancy constitutes a crisis for most adolescent girls, as well as for the boyfriend, her parents and his parents, and that professionals should treat it as such, and therefore include them in the decision making process. This was also the view of the respondents, namely, that it is important to incorporate the family, or at least one other individual, in the decision making process.

One (20%) social worker (n=5) stated that trauma debriefing can be utilised, and that it was very important to appraise the client in the perspective of her situation, who she was and what she wanted from life.

All the respondents (N=16) emphasised the importance of helping the adolescent to look at her future and to set goals for herself, and assisting her in exploring the pregnancy, and helping her to understand how the decision she makes will effect her future. Gameau (1993:188) and also Phikill & Walsh (1997:5) stress the importance of discussing future goals with the pregnant adolescent. During the fifth step of crisis intervention discussed in chapter 3, the focus is placed on implementing concrete goals set by the adolescent.

The respondents (N=16) said that they discussed the different options available to the girl. As Marecek (1987:91) states the counsellor should be prepared to explain each of the options in detail. Adolescents should be provided with very concrete information, and be helped to think through all the implications of their decision (Franz & Reardon 1992:170). All the respondents felt that the client must always take responsibility for the decision she made. This is supported by Gameau (1993:188) who states that the importance of pre-abortion counselling is to enable the client to take full responsibility for the choice she makes, as well as for the outcome. Halkett (1997:3) and Van der Berg (1996:77) agree that the client must make the final decision. She must never feel that she allowed herself to be persuaded by someone else, and that the decision was not under her control, or that she felt rushed into making a decision.

All the respondents (N=16) said that they asked the client to go home to think about her options and to come back, sometimes two or three times. Franz & Reardon (1992:167) stated clearly that clients who felt they were rushed into making a decision reported severe psychological problems after the abortion.

Although all the respondents (N=16) felt that it was very important to discuss all the options with the client thoroughly some of the nursing professionals (n=11) felt that they did not have enough knowledge about all the options, especially adoption, and would then refer the client either to Options Pregnancy Centre or to a social worker. In a study completed in America, statistics showed that only 60% of counsellors mention adoption as an option to the client. The same study stated that a teenager to whom adoption had been mentioned as an option was seven times more likely to choose adoption, than were those who received counselling where adoption was not mentioned (Maire 1998).

All the social workers (n=5) felt equipped to discuss all the options with the client, except for the medical procedure with regard to abortion. They felt that they did not have enough knowledge about the abortion procedure to provide accurate information to the client, whereas the nursing professionals said that abortion is discussed in detail, especially the physical procedure and what the girl could expect. It is evident that the social workers are able to do effective counselling with regard to the options. However they lack knowledge with regard to the medical procedures, which is the opposite to the situation of the nurses. It is therefore clear that training would be necessary for both the social workers and the nursing professionals.

#### 4.8.3 Counselling facilities

Nine (82%) nursing professionals (n=11) stated that the counselling takes place in their offices. Two (18%) nurses at the hospital do not have a specific office. However, they always looked for an available office where they could speak confidentially and privately. Schonberg *et al.* (1989) expressed the importance of conveying the information about the pregnancy as well as doing the counselling in a personal and private setting. The adolescent must feel that she can speak freely and express her feelings in privacy.

All five (100%) of the social workers (n=5) stated that the counselling took place in their offices, where the adolescent was able to speak freely, and where confidentiality was ensured.

#### 4.8.4 Duration of counselling sessions

The respondents were asked how long the pregnancy resolution or pre-abortion counselling sessions were generally. Table 4.5 reflects the findings.

Table 4.5 Duration of counselling sessions

Duration of counselling	Nurses (n=11)	Social Workers (n=5)
15-30 min	3(%)	0
30-60min	5(%)	0
60+min	3(%)	5(100%)
TOTAL	11(100%)	5(100%)

N=16

The nursing professionals (n=11) stated that they often felt that they did not have enough time to spend with the client. Three (27%) nurses stated that they often are only able to spend 15 to 30 minutes with a client. Five (46%) nurses stated that they spent roughly half an hour with the girl, and three (27%) said they spent an hour or more with her. The respondents did state however that it would always depend on the situation, that some clients needed more time, and that they would make an effort to spend more time with her. All the nursing professionals stated that they had many patients to see each day, and that they simply did not have enough time to spend with the girl.

All the social workers (n=5) stated that they would spend an hour to an hour and a half with the client. The amount of time that the social workers spent with

the client would differ from that of the nurses, since crisis intervention as a counselling model takes time, and all the social workers stated that this model was utilised most often. They also stated that the time spent with the client would depend on the situation and the emotional state of the client. One of the central values of a counsellor should always be that each person is a unique individual and that each situation is unique and should be treated as such (Compton & Galaway 1989:178). The counsellor must respect the fact that some may need more time and others less. There are no rules with regard to the duration of a counselling session, as long as the client does not feel rushed, and leaves feeling that the counsellor did not have time for them.

#### 4.9 CONCLUSION

In this chapter the data was presented that was gathered from a small sample of nursing professionals and social workers. The empirical study focused on the training, attitude and counselling of adolescents who considered abortion.

The majority of the respondents were nursing professionals who administer pregnancy tests, and are therefore the first people to come into contact with a pregnant adolescent. Most of the nurses have had more than 10 years' experience in their field, and have been administering pregnancy tests for many years, and have therefore counselled many pregnant adolescents. However, since the passing of the Choice on Termination of Pregnancy Act (92 of 1996) many of the nurses have felt that they were not adequately trained to do counselling with a girl who was considering an abortion. Before the Act was passed, if the girl chose to place her baby in adoptive care, she would be referred to a welfare organisation. However, with regard to a girl who chose to have an abortion, the responsibility of the counselling rested on the nurses. The nurses felt that they had little knowledge of the consequences of abortion, and therefore some felt that they were not adequately trained to render this service.

The nurses' responses to pregnant adolescents were however very positive in comparison with studies mentioned in this chapter. The nurses were empathetic and showed understanding. Although most of the nurses stated that they were personally opposed to abortion, they were able to set their personal feelings aside and empathise with their patient.

Social workers, due to the nature of their work counsel pregnant adolescents. The social workers utilise crisis intervention as a counselling model when counselling a pregnant adolescent. The social workers interviewed were personally opposed to abortion, but were able to separate their personal feelings from their professional responsibility towards the pregnant adolescent. The social workers felt that they were adequately trained to do pregnancy resolution counselling, but due to their lack of knowledge with regard to the consequences of abortion and the actual medical procedure, they did not feel they could do pre-abortion counselling.

It is evident that both the nurses and the social workers could benefit from training. The focus would be different. The social workers would need to obtain more information with regards to the medical procedure, as well as the possible consequences of adolescent termination of pregnancy. The same would be true for the nurses. However for the nurses the focus would be on how to implement crisis intervention, and how to share the options available to the adolescent.

## CHAPTER 5

### CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 INTRODUCTION

The goal of this study was to present a theoretical framework for adolescent pregnancy resolution with special reference to pre-abortion counselling. As a result of the findings in the literature and empirical study, conclusions and recommendations will be made.

#### 5.2 CONCLUSIONS

This study has demonstrated the researcher's belief that pregnancy resolution and pre-abortion counselling services are rendered mostly by nursing professionals. Of the sixteen respondents who render these services eleven were nursing professionals, only five being social workers. The study also showed that very little training had taken place in order to equip those who are rendering these services. These conclusions and resultant recommendations will be discussed.

##### 5.2.1 Demographic profile of the respondents

The study showed that many of the nursing professionals in Mossel Bay have been employed at the same organisation for many years. Only about a quarter of the eleven nurses have worked for less than five years for the organisation where they are working at present. This indicates that the majority of the nurses have a comprehensive knowledge of the situation in Mossel Bay, as well as many years' experience, since all the nursing professionals had obtained their diplomas before 1990.



This was however not the case with the social workers. Only one social worker had been employed at the same organisation for more than five years. Less than half of the social workers obtained their degrees before 1990 and the rest obtained their degree in or after 1996. Therefore they have only a few years experience in working in Mossel Bay. They have also not been in practice for many years, which limits their experience with regard to counselling pregnant adolescents.

### 5.2.2 Nature of the respondents' tertiary training

As might have been expected, the majority of the respondents had not received any tertiary training that included dealing with adolescent pregnancy or abortion. This is not surprising since only one respondent had completed her tertiary training after the Choice on Termination of Pregnancy Act (92 of 1996) had been passed. This means that none of the respondents could rely on their tertiary training to have provided guidelines for pregnancy resolution and pre-abortion counselling.

### 5.2.3 Adolescent pregnancy tests

The study has demonstrated that the majority of the respondents, namely the nursing professionals, administer pregnancy tests, and are therefore the first people with whom pregnant adolescents come in contact. The number of pregnancy tests administered at the clinics is surprisingly low, especially when one considers the number of adolescent abortions and live births in Mossel Bay. However, the nurses stated that adolescents often present for a pregnancy test well into the pregnancy, and that they therefore do not perform pregnancy tests, but simply do an examination.

#### 5.2.4 Attitude to adolescent pregnancy

As the empirical study showed, the majority of respondents expressed either empathy or mixed emotions towards a pregnant adolescent. None of the respondents expressed only feelings of anger towards the adolescent. This is very encouraging, since some studies and public opinion seem to believe that those who work with pregnant adolescents show no empathy or understanding towards them.

There is little difference between the nurses and social workers reactions to adolescent pregnancy. In both professional groups, half of the respondents expressed empathy, and the other half expressed experiencing mixed emotions. The most obvious difference was between those who experienced mixed emotions. The social workers expressed anger at the fact that the adolescent should know the consequences of her actions, and should not find herself in a crisis pregnancy. The nurses, on the other hand, expressed anger because the adolescents do not use contraceptives. This increases their feelings of helplessness since much of their time is spent in educating adolescents about contraceptives and contraceptive use.

#### 5.2.5 Choice on Termination of Pregnancy Act (92 of 1996)

As might have been expected, the nursing professionals on average showed that they had a better knowledge of the Act compared to that of the social workers. Since the nursing professionals were initially expected to be involved with the abortion procedure, they were all given copies of the Act and were informed of the details at staff meetings. Even though this was not official training, the Act was discussed at great length amongst themselves. However, once some of the nursing professionals refused to perform abortions only four of the respondents had had any training which improved their knowledge of the Act.

The Act states the role of the nursing professionals clearly and all the respondents felt that they had an active role to play in the counselling of an adolescent who requested an abortion.

The social workers role on the other hand was ignored by the Act, and therefore the social workers had only limited knowledge about the Act. Due to the fact that they felt they had little or no role to play in the abortion process, including the counselling, it was not surprising that they did not pay extensive attention to the Act. Since social workers are not mentioned in the Act, they do not see themselves as playing an active role in the counselling of an adolescent who requests an abortion. The social workers stated that they felt they could play a vital role in the counselling process, and would be prepared to become involved if requested to do so.

#### 5.2.6 Responses to termination of pregnancy and adolescents requesting abortions

The number of respondents who were personally opposed to abortions was surprisingly high. However this indicates the importance of proper training, since abortion is a moral issue, and it is very difficult to put aside moral values when counselling.

Although most of the respondents indicated personal opposition to abortion the majority indicated that they expressed empathy towards the client, that they felt sorry for her, for the situation she was in, and for the difficulty of the decision with regard to the pregnancy which she had to make. For both the nurses and social workers the majority stated that they experienced only empathy towards the adolescent. More of the nurses than of the social workers stated that they experienced mixed emotions, which included anger. This could be due to the

education of social workers. Social workers are skilled in putting aside personal beliefs and values when counselling clients who have views and opinions different to theirs, whereas nurses have very little counselling training and may find this more difficult.

Although some studies reported on the antagonistic views of nurses towards those who chose abortions and nurses who showed no empathy towards the patients whom they saw, none of the nurses in this present study expressed only anger towards their patients. In contrast the nurses were very caring and compassionate towards their patients. Anger was expressed only because of their feelings of helplessness. None of the respondents in this study expressed judgment towards the adolescent and her request for an abortion.

#### 5.2.7 Responses to parental consent for abortion

The majority of the respondents were against parental consent provisions, which state that a minor does not need parental consent in order to have an abortion. They felt that an adolescent is not mature enough to make a decision on her own with regard to her pregnancy. The respondents felt that the adolescent should include another person in the decision-making process. Most authors agree that adolescents need help from their support system to make a decision. The respondents also encouraged the adolescent to include another person in their decision-making.

#### 5.2.8 Training

Slightly more than half of the nursing professionals stated that they felt that they were adequately trained to do pregnancy resolution and pre-abortion counselling. However, only one fifth of the social workers stated that they felt that they were adequately qualified. This was surprising since social workers

have the theoretical background in order to do crisis intervention, and are also able to discuss all the available options with the client. Only a few of the respondents, namely nurses, had received additional training, but it did not focus on counselling but more on the medical procedure. Although many of the respondents stated that they felt that they were adequately trained, only a limited number indicated that they were not interested in attending extra training. The majority of the respondents also stated that they referred clients to Options Pregnancy Centre, which is an indication that they do not feel confident to do the pregnancy resolution and pre-abortion counselling without assistance. Social workers may also be more critical of their ability to do pre-abortion counselling due to their theoretical knowledge, and may be more aware of the social component involved.

#### 5.2.9 Counselling

All the respondents do counselling with pregnant adolescents. Only one respondent had not done any pregnancy resolution or pre-abortion counselling. The social workers stated that they utilise crisis intervention as a counselling model. Once the client has coped with the initial crisis, the different options are discussed in detail. The social workers did state however that they did not feel that they had enough knowledge with regards to possible consequences of abortion, and the medical procedure to do the counselling effectively, and therefore often referred clients to Options Pregnancy Centre.

The nursing professionals do not utilise a specific counselling model but follow the guidelines on a form that has been compiled in order to obtain information from the client. The nurses have no theoretical knowledge of crisis intervention, or how to counsel a person in a crisis effectively. They therefore refer clients either to a social worker, or to Options Pregnancy Centre. However, clients do not always keep their appointments with the other organisations, and it is

therefore important that the nurses are able to counsel them effectively. They may be the last people whom the client sees.

#### 5.2.10 Referrals

The present referral system, where the clinic nurses refer the patient to a social worker or Options Pregnancy Centre for counselling, does not seem to be effective, since many adolescents do not follow up the referral. Also clients who come to the social workers or to Options Pregnancy Centre first, are not being referred to the nursing professionals for counselling with regard to the medical procedure for abortion.

#### 5.2.11 Prevention

Some respondents expressed anger towards parents of teenagers for not educating their children about contraceptives. They also felt despondent since it seems that their prevention programmes concerning contraceptives are not as effective as they would hope, since many adolescents who fall pregnant, do not use contraceptives at all.

### 5.3 RECOMMENDATIONS

On the basis of the conclusions of the study, the following recommendations can be made, which may also serve as guidelines for those counselling pregnant adolescents who are considering abortion.

### 5.3.1 Training

Both social workers and nursing professionals should receive training with regard to the Choice on Termination of Pregnancy Act. The training should include a clear understanding of the above mentioned Act and their role with regard to counselling. The training should be provided with the understanding that it does not require the person attending the training to participate in the abortion procedure, or counselling, if they choose not to. However, the training should be compulsory for any person who works with pregnant adolescents.

The social workers should attend a workshop that explains the medical procedure in detail so that they will be able to convey this information to their clients. Both the social workers and nurses should attend training with regard to the possible physical, emotional and psychological consequences of abortion. This training should also include information about the adolescent, especially a clearer understanding of an adolescent's cognitive development, why they become pregnant, why they do not use contraceptives, and how an unplanned pregnancy affects the adolescent. Attention should also be given to the impact that the pregnancy has on the adolescent's parents, as well as on her boyfriend and his parents.

The nurses should attend training that will explain the importance of crisis intervention as a counselling model, and be instructed in how to implement crisis intervention. Attention should also be given to the explanation of the different options to the adolescent, and the effects of each option on the adolescent.

A team of qualified counsellors should do the training, preferably counsellors who have been involved with pre-abortion counselling. This team could consist

of a medical doctor or nurse to explain the medical procedure as well as the risks involved, and a social worker to explain the counselling, especially the utilisation of crisis intervention. A brief framework such as the one used in chapter 3 would work well as a basic outline.

### 5.3.2 Counselling

Counsellors should be trained in counselling. The counselling format that could be followed would be the same as the steps listed in chapter 3. The most important aspect of counselling is the attitude of the counsellor. The emphasis of the counselling also should be on crisis intervention, and helping the adolescent to reach a decision that would have the least negative consequences for her situation. Due to the fact that abortion on demand is very new to South Africa, little research has been done with regard to abortion for adolescents. However, this should not prevent counsellors from being as well informed as possible about the possible consequences of abortion, as well as the possibility of post abortion syndrome. A counsellor must be able to identify an adolescent who is at greater risk of post abortion syndrome.

### 5.3.3 Referrals

An effective referral system should be developed. Until such time that all the nurses and social workers have been trained to do pregnancy resolution counselling and pre-abortion counselling confidently.

The nurses at present have the knowledge about the medical procedure affecting an abortion. They also administer the pregnancy tests. The social workers, on the other hand, have the ability to do crisis intervention and discuss the different options with the adolescent. A referral system where the adolescent can see the nurse as well as a social worker should be in place.



The adolescent should not be left with a referral letter and be requested to see one or the other, but should be taken to the referral preferably by the counsellor. The ideal situation would be that there should be a social worker at the medical facility where the pregnancy tests are administered, namely the clinics or the provincial hospital. The clinics do not administer pregnancy tests every day and a schedule could be worked out so that a social worker would be available at the clinic for those hours.

#### 5.3.4 Prevention

It is recommended that more time and effort should be spent in educating adolescents about contraceptives and abstinence. More schools should open their doors to organisations that will discuss sexuality with adolescents. The focus should not be only on contraceptives but also on the possible consequences of sexual intercourse. The options, which are available to a pregnant adolescent and how these options affect the teenagers' future, should also be discussed.

#### 5.3.5 Further research

It is recommended that a broader based study be undertaken to investigate the qualifications of those who are counselling pregnant adolescents, and whether they are adequately qualified to render this service. This study has been restricted to investigating a small sample of nursing professionals and social workers, and their role in pre-abortion counselling and therefore a more comprehensive study should be undertaken.

Further research should also be undertaken with regard to the South African situation with regards to abortion in particular, the characteristics of adolescents who request abortion, and the occurrence of post abortion syndrome.

## BIBLIOGRAPHY

- Adendorff, T. 1999. **Statistical information**. Provincial Administration Western Cape: Department of Health.
- Adler, N.E., David, H.P., Major, B.N., Roth, S.H., Russo, N.F. & Wyatt, G.E. 1992. Psychological factors in abortion. **American Psychologist**, 47(10):1194-1204.
- Ahn, N. 1994. Teenage childbearing and high school completion. **Family Planning Perspectives**, 26(1):17-21. (internet source)
- Archer, S.L. (ed). 1994. **Interventions for adolescent identity development**. London: Sage Publications.
- Babbie, E. 1989. **The practice of social research**. California: Wadsworth Publishing Company.
- Bachrach, C. 1998. Mothers who give up babies for adoption – How they fare.
- Black, C. & DeBlassie, R.R. 1985. Adolescent pregnancy: Contributing Factors, Consequences, Treatment and Plausible Solutions. **Adolescence**, 20(78):281-290.
- Bradford, H. 1991. **Her body her life: 150 years of abortion in South Africa**, paper presented to the conference on "Women and Gender in Southern Africa", Durban.
- Cervera, N.J. 1993. Editorial Notes: Serving pregnant and parenting teens. **Families in Society: The Journal of Contemporary Human Services**, 74(6):323.

Coley, R.L and Chase-Lansdale, P.L. 1998. Adolescent Pregnancy and Parenthood. **American Psychologist**, 53(2):152-166.

Compton, B.R. & Galaway, B. 1989. **Social Work Processes**. California: Wadsworth Publishing Company.

Danziger, S. & Farber, N. 1990. Adolescent pregnancy and parenthood. **Eric Digest**. ([http://www.ed.gov/data bases/Eric digests](http://www.ed.gov/data_bases/Eric_digests) – internet source)

Davis, R.A. 1989. Teenage pregnancy: A theoretical analysis of a social problem. **Adolescence**, 24:19-28.

Devenish, C., Funnell, G. & Greathead, E. 1992. **Responsible teenage sexuality**. Pretoria: Academica.

Faber, N.B. 1991. The process of pregnancy resolution among adolescent mothers. **Adolescence**, 26(103):697-716.

Faria, G. Barrett, E. & Goodman, L.M. 1985. Women and abortion: Attitudes, social networks, decision making. **Social Work in Health Care**, 11(1):85-99.

Franz, W. & Reardon, D. 1992. Differential impact of abortion on adolescents and adults. **Adolescence**, 27(105):161-170.

Gameau, B. 1993. Termination of Pregnancy: Development of a High-Risk Screening and Counseling Program. **Social Work in Health Care**, 18(3/4):179-191.

Garber, J.A., Brooks-Gunn, J. & Petersen, A.C. (eds). 1996. **Transitions through adolescence: Interpersonal domains and context**. New Jersey: Lawrence Erlbaum Associates, Publishers.

Golan, N. 1978. **Treatment in crisis situations**. Free Press: New York.

Gold, M., Luks, D. & Anderson, M. 1997. Medical options for early pregnancy termination. **A Family Physician**, 56(2). (internet source)

Griffin-Carlson, M.S. & Mackin, K.J. 1993. Parental consent: Factors influencing adolescent disclosure regarding abortion. **Adolescence**, 28(109):1-10.

Grinnell, R.M. 1993. **Social work research and evaluation**. Illinois: Peacock Publishers.

Halkett, R. 1997. **Choice on termination of pregnancy abortion counselling: An information package**. Johannesburg: South African National Council for Child and Family Welfare.

Handy, J.A. 1982. Psychological and social aspects of induced abortion. **British Journal of Clinical Psychology**, 21:29-41.

Harris, C.J. 1991. A family crisis-intervention model for the treatment of post-traumatic stress reaction. **Journal of Traumatic Stress**, 4(2):195-205.

Hoffman, S.D. 1998. Teenage childbearing is not so bad after all ... or is it? A review of the new literature. **Family Planning Perspectives**, 30(5). (internet source)

Howes, F. & Green, S. 1997. **Buite-egtelike moederskap in die Paarl-Wellington-gebied: Die tiener se versorgingspotensiaal en steunstelsel**. Pretoria: RGN Kooperatiew Navorsingsprogrm oor die Huweliks-en Gesinslewe..

Huey, W.C. 1991. Counseling Teenage fathers: the "maximizing a life experience". **ERIC digest ED 341891**. (internet source)

Interdivisional Committee on Adolescent Abortion 1987. Adolescent Abortion: Psychological and Legal Issues. **American Psychologist**, 42(1):73-78.

Jaccard, J. & Dittus, P. 1993. Parent-Adolescent communication about premarital pregnancy. **Families in Society: The Journal of Contemporary Human Services**, 74(6):329-343.

Kaufmann, K. 1997. **The Abortion Resource Handbook**. New York: Fireside.

Kfir, N. 1989. **Crisis intervention Verbatim**. New York:: Hemisphere Publishing Corporation.

Lachance, L.L. 1997. Teenage pregnancy highlights: An Eric/Caps Fact Sheet. **Kidsource online, @kidsource.com**.

Lieberman, A. & Davis, L.V. 1992. the role of social work in the defense of reproductive rights. **Social Work**,37(4):365-371.

**Life Issues: Connector**, July. Life Issues Institute. (internet source)

Louw, D.A. 1991. **Human development**. Pretoria: HAUM Tertiary.

Maire, S. 1998. The compassionate choice: adoptions benefit mothers and children. **Citizen**. Michigan State. (<http://www.mforum> – internet source)

Major, B. & Cozzarelli, C. 1992. Psychosocial predictors of adjustment to abortion. **Journal of Social Issues**, 48(3):121-142.

Marecek, J. 1987. Counseling adolescents with problem pregnancies. **American Psychologist**, 42(1):89-93.

Mayibuye 1996. **Choice on termination of pregnancy bill.** (<http://www.anc.org.za> – internet source)

Mhlanga, E. 1996. Spesiale boodskap aan die publiek. Departement van Gesondheid.

Mueller, P. & Major, B. 1989. Self-blame, self-efficacy and adjustment to abortion. **Journal of Personality and Social Psychology**, 57(6):1059-1068.

Murry, V. 1995. An ecological analysis of pregnancy resolution decisions among African American and Hispanic adolescent females. **Youth and Society**, 26(3):325-350.

Newman, B.M. & Newman, P.R. 1999. **Development through life: A psychosocial approach.** New York:: Brooks/Cole Wadsworth.

Parad, H.J. & Parad, L.G. 1990. **Crisis intervention: The practitioners sourcebook for brief therapy.** Milwaukee: Family Service America.

Phikill, C. & Walsh, S. 1997. **Equipped to serve: Caring for women in crisis pregnancies.** Martindale Sparta: Frontline Publishers.

Pistella, C.L. & Bonati, F.A. 1998. Communication about sexual behaviour among adolescent women, their family and peers. **Families in Society: The Journal of Contemporary Human Services**, 79(2):206-211.

Plotnick, R.D. 1993. The effect of social policies on teenage pregnancy and childbearing. **Families in Society: The Journal of Contemporary Human Services**, 74(6):324-328.

Polio, D.E. 1995. Use of humor in crisis intervention. **Families in Society: The Journal of Contemporary Human Services**, 76(6):376-384).

Price, I. 1999. Tienerswangerskappe: Tydbom wat SA kan vernietig. **Die Burger**.

Republic of South Africa. Act to consolidate and amend the laws relating to the solemnization of marriages and matters incidental thereto, Act 25 of 1961. **Government Gazette**. Pretoria: Government printers.

Republic of South Africa. Child Care Act. no 74 of 1983. **Government Gazette**. Vol. 216 No 8765. (22 June). Pretoria: Government Printer.

Republic of South Africa. Child Care Amendment Act. no 96 of 1996. **Government Gazette**. Vol. 377 No.17606. (22 November). Pretoria: Government Printer.

Republic of South Africa. Choice on Termination of Pregnancy Act no. 92 of 1996. **Government Gazette**. Vol. 377 No. 17602. (22 November). Pretoria: Government Printer.

Rubenstein, E., Panzarine, S. & Lanning, P. 1990. Peer counseling with adolescent mothers: A pilot program. **Families in Society: The Journal of Contemporary Human Services**, 71(3):136-141.

Rubin, A. & Babbie, E. 1993. **Research methods for social work**. Pacific Grove, California: Brooks/Cole Publishing Company.

Salie, A. 1997. **Abortion legalised from tomorrow**. Cape Town: Cape Times.

Schloessinger-Chesler, J.S. & Davis, S.A. 1980. Problem pregnancy and abortion counseling with teenagers. **Social Casework: The Journal of Contemporary Social Work**, 61(3):173-180.

Schonberg, S.K., Sanders, J.M., Beach, R.K. & Brookman, R.R. 1989. Counselling the adolescent about pregnancy options. Policy Statement. **Pediatrics**, 83(1):135-137. (internet source)

Simkins, L. 1984. Consequences of teenage pregnancy and motherhood. **Adolescence**, 19(73):39-52.

Stevens, B.A. & Ellerbrock, L.S. 1997. Crisis intervention: An opportunity to change. **Eric Digest**. ([http://www.ed.gov/data bases/Eric digests](http://www.ed.gov/data_bases/Eric_digests) – internet source)

Suri, K.B. 1994. The problem of teenage pregnancy: An educational imperative. **Journal of Multicultural Social Work**, 3(3):35-47.

Trad, P.V. 1993. Abortion and pregnant adolescents. **Families in Society: The Journal of Contemporary Human Sciences**, 74(7):397-409.

Van der Berg, R. 1996. **Called to care: A christian counselling perspective on abortion**. Sonoville: Group 7 Trust Publishers.

Van Hasselt, V.B. & Hersen, M. (eds). 1987. **Handbook of adolescent psychology**. New York: Pergamon Press.

Van Rooyen, C.A.J. 1998. Abortion: A study of final-year social work students responses to abortion related issues. **Social Work/Maatskaplike Werk**, 34(3):295-306.



Walker, L. 1996. "My work is to help the woman who wants to have a child, not the woman who wants to have an abortion" Discourses of patriarchy and power among African nurses in South Africa. **African Studies**, 55(2):43-67.

Wessels, T. 1997. **Choice on termination of pregnancy information package**. Johannesburg: South African National Council For Child And Family Welfare.

Wilke. 1998. Why can't we love them both. **Life Issues: Connector**. Life Issues Institute. internet source)

Zakus, G. & Wilday, S. 1987. Adolescent abortion option. **Social Work in Health Care**, 12(4):77-91.

Zastrow, C. 1992. **The practice of social work**. California: Wadsworth Publishing Company.

## APPENDIX 1: INTERVIEW SCHEDULE

## INTERVIEW SCHEDULE: ADOLESCENT PREGNANCY RESOLUTION WITH SPECIAL REFERENCE TO PRE-ABORTION COUNSELLING

## SECTION A: IDENTIFYING DETAILS

1. Occupation: \_\_\_\_\_

2. Gender

Male	
Female	

3. Institution at which you received your degree or diploma

University	
Technicon	
College	

4. Year in which degree or diploma was obtained

\_\_\_\_\_

5. Organisation/department affiliated to:

\_\_\_\_\_

6. How many years have you been affiliated to this organisation/department?

\_\_\_\_\_

7. Did your tertiary training include emotional responses to abortion decisions?

Yes	
No	

8. Did your tertiary training include how to deal with emotional responses of a teenage pregnancy?

Yes	
No	

#### SECTION B: TEENAGE PREGNANCY

9. Do you do pregnancy tests for teenagers?

Yes	
No	

10. Approximately how many pregnancy tests do you do per month?

\_\_\_\_\_

11. Approximately how many of these pregnancy tests are positive?

\_\_\_\_\_

12. How do you feel about teenage pregnancies?

Feel sorry/empathy	
Anger	
Neutral	
Mixed emotions	

#### SECTION C: ABORTION

13. Are you familiar with the contents of the Choice on Termination of Pregnancy Act (92 of 1996)?

Very knowledgeable	
Average knowledge	
No knowledge	

14. What do you understand your role to be according to this Act

Actively involved in counselling	
A small amount of counselling	
Not involved in counselling	

Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

15. What are your personal views about adolescent termination of pregnancy?

Against	
Neutral	
Positive	

16. How do you respond to a client who chooses termination of pregnancy?

Feel sorry for her	
Anger towards her	
Neutral	
Mixed emotions	

17. How do you feel about parental consent: the fact that according to the Act a teenager does not need to disclose her decision to have an abortion to her parents.

Agree	
Neutral	
Disagree	

18. Do you make referrals for abortions?

Yes	
No	

19. If so, whom do you refer clients to

Medical doctor	
Provincial hospital	
Social Worker	

Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

SECTION D: TRAINING

20. Do you feel that you are adequately qualified to render this service?

Yes	
No	

Motivate your answer: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

21. Did you receive additional training on how to counsel a client considering an abortion?

Yes	
No	

22. If you answer yes to the above question who did the training?

Local health department	
Provincial health department	
Outside of health department	

Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

23. What type of training did you receive and what was the duration of the training?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

24. Would you attend extra training if training was made available?

Yes	
No	

25. What would you expect from this training?

Clearer understanding of abortion decisions	
Deeper knowledge of the pressures teenagers face when making this decision	
Type of counselling model which would be most appropriate to use	

Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

#### SECTION E: COUNSELLING

26. Do you do the counselling with a teenager whose pregnancy test is positive?

Yes	
No	

27. If no, does anyone else do the counselling?

Yes	
No	

28. If yes to above question, who does the counselling?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

29. Do you counsel pregnant adolescents who are considering an abortion?

Yes	
No	

30. What type of counselling do you do with these adolescents and which models do you utilise?

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31. How do you discuss the different options with the pregnant teenager?

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32. Where do you do the counselling?

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33. What is the duration of a counselling session?

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34. Final Remarks

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