

**A CASE STUDY OF THE USE OF FEMINIST
PSYCHOTHERAPY WITH WOMEN WHO HAVE
HAD ABORTIONS**

Melanie Horwitz

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ABSTRACT

In this study the use of feminist psychotherapy with a woman who has had an abortion is explored. A survey of the literature shows that this approach to psychotherapy is based on a philosophy that women's pathology is inextricably linked to the patriarchal influences of society that have devalued and disempowered women. Abortion, as a specific women's issue, is contextualised within this framework, illustrating that these influences compound women's physical and psychological distress when having an abortion.

The case study method is employed to explore the use of this feminist approach in a four month period of psychotherapy with a woman who had an abortion. This highlights how patriarchal influences in the family and religion create major stress factors that affect women's experience of abortion. In particular, the conflicts that centre around women's sexuality that are evoked by the abortion are addressed. The study also demonstrates how the use of this approach may bring out the positive meaning of the abortion for women, as in this case where the abortion was seen as the beginning of the important process of separation.

The study concludes that feminist psychotherapy is a beneficial approach to utilise when working with women who have had an abortion.

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TABLE OF CONTENTS

	Abstract	i
	Acknowledgements	ii
Chapter 1:	INTRODUCTION	1
Chapter 2:	FEMINIST PSYCHOTHERAPY	4
2.1	Introduction	4
2.2	Overview of the Development of Feminist Psychotherapy	4
2.3	A Feminist Critique of Psychoanalysis	6
2.4	Feminist Psychotherapy	11
2.5	Criticisms of Feminist Theory	20
2.6	Conclusion	21
Chapter 3:	WOMEN'S PSYCHOLOGICAL EXPERIENCES OF ABORTION: A LITERATURE REVIEW	22
3.1	Introduction	22
3.2	A Framework for understanding Women's Psychological Experiences of Abortion	22
3.3	Abortion as an Experience of Loss	24
3.4	Ambivalence	30
3.5	Guilt	31
3.6	Women's Positive Experiences of Abortion	34
3.7	Conclusion	36
Chapter 4:	RESEARCH METHODOLOGY	37
4.1	Introduction	37
4.2	Discussion of Methodology	37
4.3	Limitations of the Study	41
4.4	Procedure	42
4.5	Data Analysis	43
4.6	Summary	44

Chapter 5:	THE CASE STUDY	45
5.1	The Case of Beth	45
5.2	Case Analysis	52
Chapter 6:	CONCLUSION	68
	References	71

CHAPTER ONE

INTRODUCTION

The purpose of this study is to explore the use of feminist psychotherapy with a woman who has had an abortion. My motivation in utilising this approach originates from my past experiences as a clinician and my personal interest in women's issues. From my previous clinical experience I realised that many of the women with whom I worked saw themselves as 'victims' either in the context of the hospital, their families, their work environments or within themselves. By employing a feminist framework I was able to re-'label' and empower these women as survivors in a world that seeks to control them and strip them of their power.

My personal interest in this framework rests on my experience as a woman in patriarchal society. The ramifications of this has led to the process of searching for my authentic identity as a woman, separate from the behaviours, values and roles prescribed to me by this dominant culture. Feminist psychotherapy embodied this process. Therefore I believe that feminist psychotherapy is an approach which can be of value to both women and men in their search for their true selves.

Feminist psychotherapy developed from the expansion of feminist thought in the 1960's. In recognising that women's social life was controlled by a male-dominated culture known as patriarchy, feminist scholars in psychology began to challenge the traditional psychoanalytic theories. They argued that these theories represented a male view of the psychology of men and women. Feminists thus embarked on re-examining these theories in order to define a psychology of women from a woman's perspective. The knowledge that is still being generated from this endeavour constitutes the framework of feminist psychotherapy.

Chapter Two of this study focusses on defining feminist psychotherapy by firstly, tracing its historical development; secondly, by presenting the feminist critique of psychoanalysis and thirdly, by clarifying the concepts in feminist psychotherapeutic practice.

I have chosen abortion as the subject matter of the case study as it is an experience which is specific to women. Therefore it would seem that a feminist approach would be appropriate in dealing with this specific women's issue.

Abortion also represents an example of a women's health issue in which women's need for power and control is seldom recognised. It has been shown that in countries with strict abortion laws women who undergo abortions endure greater physical and psychological stress (Skowronski 1977; Pipes 1986). According to the feminist standpoint patriarchal influences further increase the psychological trauma of women who have abortions (Dana 1987). These factors indicate that women who have abortions may benefit from therapeutic intervention. Chapter Three examines women's psychological experiences of abortion taking into account these patriarchal influences.

Chapter Four outlines the research methodology used in this study. It comprises an exploratory case study. Since the subject matter and theoretical framework of this dissertation is feminist, the research methodology is informed by principles of feminist methodology. It also incorporates the methodological prescriptions of the psychological case-study method as the use of psychotherapy is involved. Both these approaches challenge the objective, neutral and ahistorical positions of traditional research methods. Instead they have discerned that research involves the researcher's and the subject's subjectivity and values.

The analysis of the case study is presented in Chapter Five. Here I present the data of the case and my interpretations and intervention as a feminist psychotherapist. The latter draws mainly on my theoretical understanding of the literature on feminist psychotherapy and women's psychological experiences of abortion. Finally Chapter Six concludes with evaluating the use of this approach and seeks to define how it has been of therapeutic benefit to the client.

In order to meet the requirements of the principle of subjectivity I have stated my values where appropriate as they have informed this research in fundamental ways. The researcher cannot be neutral and s/he will always carry subjective feelings that will influence the research (Oakley 1981). This approach has also been employed by other feminist and 'new paradigm' researchers (see Stanley and Wise 1983; Marshall 1986). Furthermore in order to challenge the myth of neutrality I have used throughout, the personal pronoun 'I' in place of the more frequently used 'the author'.

CHAPTER TWO

FEMINIST PSYCHOTHERAPY

2.1 INTRODUCTION

This chapter aims at developing an understanding of what is meant by feminist psychotherapy through surveying the literature. The literature reveals that no complete feminist theory of women's psychology has yet been formulated. (Cox 1976; Rohrbaugh 1979; Greenspan 1985). Thus feminist psychotherapy is viewed as a process which is still being developed.

The chapter begins with an overview of the origins of feminist psychotherapy. It shows how it originated alongside the growth of the Women's Movement of the 1960's which sought to liberate women from their oppression in patriarchal society. In psychology, feminists recognised that psychoanalysis represented a male view of women and that it was originally created by a man. The second part of this chapter addresses this feminist critique of psychoanalysis. The feminist paradigm that emerges from this critique shows that women's psychological distress is bound up with the effects of patriarchal culture which views women as second-class citizens. The final part of the chapter seeks to elaborate on the emerging theory of women's psychology through defining feminist psychotherapy.

2.2. OVERVIEW OF THE DEVELOPMENT OF FEMINIST PSYCHOTHERAPY

At the time of the growth of the Women's Movement in the 1960's, two trends developed in the early practice of feminist psychotherapy. These were the growth movement school and the radical therapy movement.

The growth movement school comprised combined approaches of Gestalt, body work, encounter groups and psychodrama (Ernst and Goodison 1981:287). These approaches were valued for validating 'here and now' processes and encouraged women to use confrontation and direct expression with others in order to change their socialised passive behaviours. This trend was utilised mainly in consciousness-raising (C-R) groups which became the medium through which women first became aware of and shared their experiences of oppression in patriarchal cultures. The therapeutic value of C-R groups was that they helped women "differentiate between that which is purely personal and that which is external and therefore social and political rather than psychological and also in helping women get support from other women in defining themselves for themselves" (Lerman in Cox 1976:378).

The second trend in the early practice of feminist psychotherapy was the radical therapy movement. It also comprised C-R groups that mainly utilised a problem-solving approach. Its aim was generated towards action that strove to effect changes in the society that would reduce women's oppression (Ernst and Goodison 1981).

The focus of both these trends highlighted that the external social world affected women's lives. However, it was also realised that although these trends were useful in working with therapeutic groups, they did not necessarily alter women's psychic life. A third trend identified by Ernst and Goodison (1981) was the psychoanalytic feminist movement. This movement recognised that individual work with women required dealing with unconscious processes and the acknowledgement of developmental psychology which were influenced by the external patriarchal world. Thus feminist psychoanalysts embarked on attempting to construct a feminist theory of the psychic life of women. They began this discourse by re-examining psychoanalysis.

2.3 A FEMINIST CRITIQUE OF PSYCHOANALYSIS

Psychoanalysis, as mentioned previously, developed within the dominant culture of patriarchy. It represented a psychological theory of men and women which justified the status quo based on "the law of the father" (Mitchell 1975:xvi). Mitchell (1975; 1984) concedes that however psychoanalysis may have been used, it was not "a recommendation for a patriarchal society, but an analysis of one" (Mitchell 1975:xiii). Thus feminists in psychology began to re-work psychoanalysis in order to reach a feminist theory on women's psychology (Burton 1985).

Some of Freud's concepts were retained such as the concept of the unconscious, the focus on early psychic development and the notion of transference. Although feminists have utilised these concepts in constructing a theory of women's psychology, they were critical of the foundations on which these were developed. Their criticisms of psychoanalysis unravelled,

- the supposition that the formation of sexuality and gender roles of men and women were based on principles of biological determinism;
- the androcentric view that these theories represented.

2.3.1 Theory of Psychosexual Development and Gender Identity

The major feminist critique of psychoanalysis is of its theory of psychosexual development which is based on principles of biological determinism. Notions of psychosexual development, such as penis envy in girls and castration anxiety in boys, were only "premised on knowledge of anatomical difference" (Collier 1982:250). Women were considered to be inferior owing to their lack of a

penis (Mitchell 1975; Lievan 1981; Sayers 1986). Anatomical differences in sex organs were considered to be the foundation for psychosexual development, and the development of gender identity for boys and for girls, as well as the foundation against which superiority and inferiority of the sexes came to be measured.

Psychoanalysts who were originally part of the Freudian school such as Karen Horney and Clara Thompson, were the first to challenge these psychosexual theories. Horney (in Kelman 1967) illustrated that power, and not libido, is the motivating force in women and therefore that most issues in women's unconscious centre around their lack of power (1967:115). From her clinical observations she showed that culture and the social context into which people are born shape their sense of masculinity and femininity (gender identity). She recognised that women across cultures were in a subordinate position to men and that their gender identity developed from this social context (Horney in Kelman 1967).

Thompson (in Green 1986) expanded Freud's theory of penis envy by interpreting it as being symbolic of women's desire for men's power. She emphasised that women were entitled to power in the world. Both Horney's and Thompson's theories began to shift the one-sidedness of Freud's phallocentrism and to conceptualise the formation of sexuality and gender identity in relation to power imbalances between the sexes in society.

Thus the central feminist critique of traditional psychoanalytic theories' view of gender is that it is fixed. The feminist view of gender-identity is that it comprises the identities into which men and women have been socialised. "Here social meaning or ideology, structures the nature and meaning of biology" (Gould 1988:52).

2.3.2 A Theory of Androcentricism

The androcentric nature of psychoanalysis and later psychotherapy, projects the belief that these theories are objective and represent the norm. According to the feminist viewpoint these theories are biased as they project the view that women are lesser beings than men and subsequently devalue women.

The **myth of objectivity** of psychoanalytic theory is one example of concealing this androcentric bias. The psychoanalytic standpoint of objectivity gives it the impression that psychoanalytic theory represents the truth. However, this truth has reflected patriarchal values that perpetuate the power imbalances in society (Bowles and Klein 1983; Squire 1989).

Furthermore, imbued in the androcentricism of psychoanalytic theory are misogynist or sexist views about women. Two areas which illustrate these misogynist psychological views of women are addressed here. The one concerns the women-blaming ethos that has come to be rooted in many of the subsequent psychological theories. The second area concerns the system of women's mental health.

Some instances of the **women-blaming ethos** in psychological theories are projected through the blaming of mothers for the ills in their families. Caplan and Hall-McCorquodale show that mothers continue to be implicated in psychopathologies "ranging from arson to incontinence, drug abuse, infanticide, and bad dreams" (in Crawford and Marecek 1989:154). Mothers as wives, in their attempts to achieve equality in their marriage, are blamed especially through the media, for male impotence, marital conflict and the breaking down of the nuclear family (Crawford and Marecek 1989).

Perceptions of women's sexuality and psychology create myths of women-blaming in cases of rape and battery. With rape, for example, the women-blaming ethos is reflected in the common statements such as 'she dressed seductively' , 'she was looking for it because she went walking alone' and 'if she didn't want to be raped she would have fought back' (Gould 1988).

Female masochism is another concept that has perpetuated the women-blaming ethos. Karen Horney made an important contribution to this concept when she asserted that it was overrated as being "inherent in the anatomical-physiological-psychic characteristics of women" but that instead it should be "considered as importantly conditioned by the culture-complex or social organisation in which the particular women developed" (Horney in Kelman 1973:232- 233).

The myth of feminine evil may also underly the women-blaming ethos (Miller 1986:59). Through it women are mythologised into being calculating and evil. Miller (1986) asserts that because women are stripped of their real power they are often forced to act in ways that are indirect and are labelled as 'manipulative' or 'masochistic'. The myth of feminine evil may also be internalised by women so that they themselves feel 'evil' and bad. For example women's sexuality is plagued by patriarchal definitions of women which imposes its double standard of sexuality onto women. While men are given the freedom to express their sexuality and are valued for doing so, women who express their sexuality openly are equated with terms such as 'whore' and 'seductress' which implies their being evil and devalues them.

Another feminist critique of the androcentric bias of psychology concerns its practice in the **mental health field**. Greenspan (1985) discerns the double standard in mental health practice for women and men. She reports research that

found that when therapists were requested to describe the characteristics of a healthy mature adult (sex unspecified) and the characteristics of a man and the characteristics of a woman, their responses showed that "the characteristics judged for an adult and presumed to reflect an ideal standard of mental health correlated only with those behaviours and characteristics which they judged healthy for men and not with those judged healthy for women" (Greenspan 1985:7). This reflects that the norm of healthy adult behaviour comprises predominantly male characteristics.

Chesler (1976) indicates that women are labelled 'mentally ill' more often than men because men's style of mental illness is to act out an exaggerated male sex-role consisting of aggressive and anti-social acts which are accepted within the dominant culture. Women's mental illness, on the other hand, is seen to take the form of "acting out an exaggerated female sex role which may be characterised as masochistic and hysterical" (Cox 1976:315). Chesler (1976) concludes that "what we consider 'madness' is the acting out of the devalued female role" (Chesler 1976:315). This means that women usually find themselves in a 'no win' situation, they are seen as mentally ill if they do not conform to what is considered to be a healthy female person, and if they do conform to standards of a healthy female they are still not considered healthy according to the norms for a healthy adult person.

2.3.3 Conclusion

The feminist critique of psychoanalysis and subsequent theories of psychotherapy identify that these theories comprise a view of pathology based on principles of biological determinism. These theories postulate further that human pathology is intrapsychic. Feminist critics analysed the androcentric ethic of these theories and uncovered the misogyny imbued in this ethic. This has led to a re-definition of women's psychology in order to create a positive view of women. Feminist

psychotherapy is based on the emerging body of knowledge which has sought to fulfil this aspiration.

2.4 FEMINIST PSYCHOTHERAPY

Thus in feminist psychotherapy it is not the techniques that distinguish it from other forms of psychotherapy, but rather its philosophy which embraces the view that women's internal experiences are affected by the social context of patriarchy (Lerman 1976). This central philosophical premise explains feminist psychotherapy in terms of the following:

2.4.1 Women's Felt Personal and Emotional Failure is Socially Defined

This understanding helps women appreciate that their felt personal and emotional failure is shared by many women and is often socially defined. This understanding has been conceptualised in the dictum that the 'personal is political' (Eichenbaum and Orbach 1982). Eichenbaum and Orbach (1982; 1983) elucidate that this implies that women's subjective life stories tell us something about society, that is, that there is something in the construction of society that created the women's life stories. The 'personal is political' dictum also incorporates an understanding that women's feelings about their emotional failure are not only in relation to gender oppression, but are also in relation to class, race, religious and other forms of oppression that are present in society (Jagger 1983).

In helping women understand their feelings of failure, feminist psychotherapy aims to help women distinguish how the social context has shaped their identities by devaluing their true selves without deducing that women are victims of these social forces.

2.4.2 The Need to Separate the Internal from the External

In order to help women overcome their feelings of personal and emotional failure, feminist therapy focuses on assisting women to separate the internal from the external (Gilbert 1980).

Eichenbaum and Orbach (1982; 1983) assert the importance that the woman discovers how she has been affected by societal influences. She needs to "differentiate between what she has been taught and what may actually be appropriate for her" (Lerman 1976:380). Lerman (1976) notes that this is where feminist therapy differs in the way it works from traditional therapy. In traditional therapy the client is helped to introspect and learn to know themselves better, while in feminist therapy the goal is to help the client look outwards as well as inwards in order to differentiate between what is being imposed by the external and what belongs to their internal.

Dominelli and McLeod (1989) suggest that the aim of this approach is to lessen the degree of self-hatred in women, which often is at the root of their feelings of personal and emotional failure. Wehr (1988) depicts an archetypal image in women as being the self-hater which is the 'internalised inner voice' (Wehr 1988:19). Women have difficulty in realising that this inner voice stems from external oppression. By helping women identify the source of their hatred and negative labelling, feminist therapy can facilitate women learning to free themselves from these devaluing internalisations.

Wehr (1988) warns that a danger of this approach can be in seeing all evil done to women as being projected onto men, as this will mean that women will be oppressing men in the exact way that men have oppressed women. Differences between blaming patriarchy and naming its effects need to be distinguished (Wehr 1988:20-21).

2.4.3 The Need for Change

Gilbert (1980) purports that once the woman has recognised the differentiation between the internal and the external, the emphasis of therapy should be directed towards change instead of adjustment to the status quo. There is much debate within various feminist therapy schools on this principle. The more radical schools believe this is a fundamental aspect of feminist therapy as they regard traditional therapy as seeking to help women adjust to their roles as defined by patriarchy. However there are feminists who warn that this may not necessarily benefit the client as some clients may feel satisfied in their patriarchally defined roles. In agreement with Lerman (1976) my perception of this principle is that where external oppression has defined women's psychological being, it needs to be pointed out to women. This view does not necessitate that clients are required to shift their life patterns or espouse feminism (Lerman 1976:383).

2.4.4 The Acknowledgement of Gender Differences

Feminist psychotherapy acknowledges gender differences and identity. Gilbert (1980) warns that the acknowledgement of gender differences does not imply power imbalances between the sexes. Rather, feminist therapy advocates "the political, social and economic equality of women and men" (Gilbert 1980:250).

This definition of gender reiterates that patriarchy influences the formation of both male and female gender identities, acknowledging that both men and women are oppressed and can therefore benefit from feminist psychotherapy. Men also need to challenge the ways in which the dominant culture has trapped them into the specific roles that it has prescribed for them (Henley and Freeman 1976; Miller 1986).

2.4.4.1 The Role of the Family in the Formation of Gender Identity

The patriarchal family which has been described "as a reflection in miniature of the exploitative power relations" of male-dominated society, moulds the formation of gender identities according to these power relations such that men's gender identity is based on their powerful role in society, while women's gender identity is based on their lack of power and the society's derogatory attitudes towards them (Lewis 1986:31). Thus in the family we find the devaluing or denial of the feminine and the idealisation of the masculine. [The terms "the masculine" and "the feminine" are derived from the Jungian concepts of the same name. These concepts are considered by the feminist viewpoint to be derived from the power imbalances between the sexes in patriarchy and are not 'contextless' as Jung implied (Wehr 1988:7-9)].

Leonard (1985) discusses the father-daughter relationship in the patriarchal family as leading to the daughter's wounding or devaluing. This is because fathers are the first masculine figures in their daughters' lives, the way they relate to their daughter's femininity will affect the way their daughters grow into womanhood. Fathers who "err on the side of rigidity" and are authoritarian tend to squash female qualities. In doing so they control, instil fear and negate their daughters (Leonard 1985:13). Leonard (1985) states further that in families where the father may not have been experienced as threatening by the daughter, her wounding may instead be a consequence of the "patriarchal society which itself functions like a poor father" (Leonard 1985:3). Here the father-daughter wound is:

"a condition of our culture ... Whenever there is a patriarchal authoritarian attitude which devalues the feminine by reducing it to a number of roles or qualities which come, not from the woman's own experiences, but from an abstract view of her - there one finds the collective father overpowering the daughter, not allowing her to grow creatively from her own essence" (Leonard 1985:11).

Thus the devaluing and wounding of women as a gender occurs through the patriarchal structure of the family and of society.

2.4.4.2 The Focus on the Mother-Daughter Relationship

The mother-daughter relationship is also considered to play a major role in women's formation of their gender identities and forms a major focus of feminist psychotherapy.

Within the mother-daughter relationship women's internalised, inferior social positions are passed down from mothers to their daughters. According to Eichenbaum and Orbach (1987) mothers relate differently to their daughters than to their sons, because of the social influences of gender. The daughter will grow and develop according to the mother's conscious and unconscious feelings about herself as a daughter and as a mother. Thus "the psychology of the mother that the infant girl will embody in the process of becoming a person will be imbued with mother's sense of self" (Eichenbaum & Orbach 1982:31).

These authors also see a split occurring in most of the egos of women. This split is caused because the needs of the little girl part of women were not sufficiently met by their mothers when they were daughters. Their mothers, who also carried this split, were sometimes unable to differentiate between themselves and their infants. During these times they would respond inconsistently to their daughters because they would unconsciously respond to the hidden little girl in themselves. The split emerges from mothers unconsciously teaching their daughters that they must not rely on having their emotional needs met. If a mother were to continue to meet these she would be going against what society expects of women. The 'little-girl' thus embodies that side of women's egos that needs nurturance. Because this part

is not sufficiently acknowledged in childhood it splits off and seeks "nurturance and acceptance within (a woman's) inner world" (Eichenbaum & Orbach 1982:35). This becomes the unconscious needy part in many women which they find painful to acknowledge. Therefore they build strong defences around themselves to protect it.

A crucial way in which feminist psychotherapy can enable women to heal the split is to accept their dependency needs, that is, the little-girl part of themselves. Harry Guntrip, an object-relations theorist, emphasises the importance of nurturance in the therapeutic relationship (in Orbach and Eichenbaum 1982). Feminist therapy embraces this concept as it recognises that most women have been socialised into feeling that their little girl part is unacceptable and that therefore it is extremely painful for them to acknowledge this neediness. Orbach and Eichenbaum reiterate that "the cornerstone of feminist therapy is to bring this conflict into the open ... for as it is gradually exposed, the woman will come to understand more about what she searches for in her relationships" (Eichenbach & Orbach 1982:57).

Most women find it difficult to be dependent as this may mean losing themselves. Thus feminist therapists need to provide the woman with the experience of being dependent on the therapist while at the same time allow her to remain an individual.

2.4.5 The Importance of Re-examining Women's Emotional Life in order to Validate Women's Perspectives

In seeking to validate women's experiences from a women's point of view, feminist therapy is concerned with re-examining women's emotional life. The areas re-examined that are considered to be the most fundamental are:

- emotional connectedness
- ego development
- motherhood
- sexuality

Jean Baker Miller (1986) purports that '**emotional connectedness**' to others forms part of women's present psychosocial role. However, this trait is not valued by the dominant culture. Psychoanalysis, in exploring the infant's early tie to the mother acknowledges what women have been doing for centuries. Women themselves often reject their connectedness to others and label it as dependency under the dominant culture. Eichenbaum and Orbach (1982) have also made reference to this connectedness by noting that the first psychological role of women is to 'defer to others'(1982:7). They illustrate that because this position is devalued in the society, it often makes women feel undeserving and unentitled.

The implication for dealing with this in therapy is to help women value this role as well as encourage them towards self-nourishment and autonomy. Miller (1986) warns that a danger may arise from a woman's connectedness to others, as it may lead to her pleasing others to an extent where she may lose herself. This also has implications for the transference relationship as the client may present material which she perceives to be pleasing to the therapist at the expense of verbalising her own authentic experiences.

Women's **ego development** is also re-examined. Miller (1986) postulates that women's egos exist through their connectedness to others. She states,

"Women's reality is rooted in the encouragement to 'form' themselves into the person who will be of benefit to others ... (and) women have been involved in the attempt to transform their drives into the service of another's drives; and the mediation is not directly with reality but with and through the other person's purposes in that reality" (Miller 1986:73)

Nancy Chodorow, a feminist scholar of psychoanalysis, suggests that women's egos tend towards 'boundary confusion' and 'a lack of sense of separateness from the world' (in Wehr 1988:102).

These theorists advocate that instead of negatively regarding the connectedness and boundary confusion of women's egos, feminist psychotherapy needs to acknowledge the value of this state of being. Miller (1986) reiterates that this connectedness be seen as more highly valued than self-enhancement and that "for everyone - men as well as women - individual development proceeds only by means of this connectedness" (Miller 1986:83).

Feminist therapy seeks to re-define women's psychosocial roles, especially that of **motherhood**. Orbach and Eichenbaum (1982; 1983) indicate that although women do not receive any overt training for this role, they are expected to implement it adequately. Furthermore although it is an essential role in ensuring reproduction and maintaining the family, it is devalued in most patriarchal societies. Many women themselves have come to internalise the devaluing of their roles as expressed in the common responses 'I am just a housewife' and 'I'm not working'.

The impact of the Women's Movement has challenged the view that women's essential life task is motherhood and has put forward other alternatives from which women can gain adequate fulfilment. The task of feminist psychotherapy is to facilitate women who are mothers to value their roles as they experience them and also to encourage women who seek alternatives should they decide not to become mothers. It is important too that feminist therapy "does not presuppose that only mothers can be care-givers" (Lerman 1986:12).

The focus on female **sexuality** is another area of feminist therapy's attempt to re-define women's emotional experiences. Most feminist psychoanalytic writers have shown that women's sexual and psychological development is far from being subordinate to men (Rohrbaugh 1979; Greenspan 1985; Miller 1986; Lewis 1989). Many women form negative attitudes about their sexuality as they internalise the dominant culture's view of them. Women need to "challenge society's mixed

message about who they are ... rather than 'choose' to internalise a sense of their own inferiority" (Wehr 1988:17). The mixed message women receive about their sexuality is that on the one hand they are required to be mothers - which implies that they are asexual beings - while at the same time they are also identified as sex objects by the dominant culture (Oakley in Cox 1976:276).

Feminist therapy seeks to free women from these contradictory labels. It encourages women to develop a positive sexual identity and recognise that their sexuality is a fundamental part of their whole being. It also recognises lesbian sexuality in such a way that it is celebrated instead of denied as it often is in patriarchal culture.

2.4.6 The Use of the Therapeutic Relationship

An important aspect of what happens in feminist therapy is reflected in the therapeutic relationship. Gilbert (1980) stresses that the nature of the therapeutic relationship needs to be egalitarian. This differs from traditional therapy in which the therapist is seen as 'The Expert' and the woman client as 'The Patient' (Greenspan 1985). Various ways are recommended through which this goal can be attained. Russell (1989) suggests that the principle of equality is translated in practice through "a willingness to share the self and to share the knowledge that guides practice "(Russell 1989:71). Lerman (1976) points out that it is essential that the "therapist does not assume that her opinions have any greater weight than those of the client "(Lerman 1976:379). Dominelli and McLeod (1989) highlight the need for self-criticism on the part of the therapist as s/he is also caught up in patriarchal life 'imbued with notions of hierarchy'. The therapist also needs to treat 'mistakes' as areas for growth. This can also be taught to the client. These suggestions offer creative ways in which therapists can strive for a more egalitarian relationship with

their clients. However, Rohrbaugh (1979) has noted that there is controversy within the feminist schools on this concept of equality. Some feminists have pointed out that the therapist is in a position of power as she holds knowledge that is unavailable to the client (Greenspan 1985). They suggest that the therapist needs to acknowledge her/his power in the therapeutic relationship and be aware of using it constructively for the client's benefit. Miller (1986) offers a useful concept that describes this, namely, "temporary inequality" (Miller 1986:4). Here the therapist has power at the start of therapy because the client seeks out the therapist's expertise which the client expects to be beneficial. As the therapy progresses the therapist attempts to reduce this power as the client becomes less dependent. The therapist's power is used creatively and not destructively.

Some feminists argue that the therapeutic relationship is enhanced if there is gender-matching. They state that a feminist therapist should be a woman as this will facilitate a more honest exploration by the client. Lerman (1976) asserts that the value of a woman therapist facilitates modelling as the therapist is a model who "knows herself and her psychological boundaries" and can also share with the client in important ways what it means to be a woman in society (Lerman 1976:382). Some feminists argue that only women can do feminist therapy with only women clients. Others propose that feminist therapy can include male therapists and male clients. Dominelli and McLeod (1989) state that a sensitive male therapist can act as a positive model in male and female relationships.

2.5 CRITICISMS OF FEMINIST THEORY

Some criticisms have been levelled at feminist theory. One criticism is that it does not always take into account differences between women and therefore assumes that all women are equal (Squire 1989). Another criticism is that feminism tends to negate that some women do have power under patriarchy. Instead there is an

overemphasis on male power in order not to implicate women in the imbalance of power. In some of the feminist literature no clear distinction is made between biological sex and gender. This has resulted in targeting men (as a sex) as 'the enemy' while overlooking the institutions which create men (as a gender) and gender oppression which is experienced by both sexes.

2.6 CONCLUSION

Feminist psychotherapy involves a theory of women's psychology that seeks to validate women, rather than devalue them as has occurred in the traditional psychotherapies. Its fundamental premise is that it perceives women's internal-psychological experiences to be constructed through the socialisation processes of the external patriarchal world. I have incorporated this premise into my use of the approach in this study by focussing on the following principles discussed in this chapter:

- Helping women see that their psychological experiences are bound up with the way in which patriarchy has defined and controlled them;
- Encouraging women to separate from their internalisations of patriarchy's definitions in order to reach their authentic selves;
- Validating women's selves and their experiences by helping them reclaim those parts of their lives that have been distorted or negated under patriarchy, such as their sexuality;
- Acknowledging the role of the family in perpetuating gender oppression and therefore women's devalued sense of themselves;
- Understanding that mothers carry the oppression of women into their relationships with their daughters, and that therefore they need to be freed from this oppression instead of blamed; and
- Helping women find their own creativity and unique power without instilling the same powerlessness that was done to them onto others.

CHAPTER THREE

WOMEN'S PSYCHOLOGICAL EXPERIENCES OF ABORTION: A LITERATURE REVIEW

3.1 INTRODUCTION

Based on the feminist principles outlined in Chapter Two this chapter aims to provide a theoretical understanding of women's psychological experiences of abortion. This understanding provides the grounds for the choice of feminist psychotherapy applied in the case study.

3.2 A FRAMEWORK FOR UNDERSTANDING WOMEN'S PSYCHOLOGICAL EXPERIENCES OF ABORTION

Abortion is ultimately a woman's problem as it involves her body and her psycho-social role. The present division of labour along gender lines in our society assigns mothering as primarily women's function (see Jagger 1983; Petchesky 1988). Mothering is the term that is used for parenting, yet has maintained its female gender definition because parenting is mainly carried out by women. Therefore abortion is an issue which affects women as they are forced to make a decision about their role of parenting as well as the psychological state of being a mother, that is motherhood.

In present patriarchal society women's experience of and rights with regard to abortion are often distorted and denied . This has occurred through the male-domination of society and the subsequent devaluing of women. For example in South Africa, women were denied power in decision-making when the laws

sanctioning abortion were promulgated. Cope (1983) draws attention to the situation regarding the special commission that was instituted in South Africa to investigate the provisions of the Abortion and Sterilisation Act 2/75. The commission comprised only males - "no woman was appointed to serve on it" (Cope 1983:15).

Therefore in understanding women's psychological experiences of abortion I believe the patriarchal influences of our culture must be considered. Petchesky (1985) has delineated the areas influenced by external patriarchal factors which affect women when they have an abortion. These are:

- women's primary role of motherhood,
- women's sexuality
- women's health (that is, the control of women's health by a male-dominated medical profession) and
- patriarchal religious influences.

These patriarchal influences add to the distress felt and may be considered as compounding stress factors.

Dana (1987) affirms that women's emotional experiences of abortion need to be examined in relation to the interplay of their conscious and unconscious internal experiences. In addition women's external conditioning and position in society must be viewed in order to understand their responses to abortion. Thus women's internal-emotional reactions about abortion will be viewed against the external-social position of women in patriarchal society.

3.3 ABORTION AS AN EXPERIENCE OF LOSS

Abortion involves loss in terms of the loss of the fetus. The response to loss of the fetus may be compounded by responses to other forms of loss in women's lives such as the loss of motherhood, the loss in sexuality and the loss that may result from changes in their relationships to others.

The loss experienced in abortion has also been equated with the loss experienced in a crisis (Smith 1972; Ullman 1972). Lemkau (1988) contends that the extent to which the abortion will represent a crisis depends on a number of factors such as : the woman's personal attitude towards abortion; their religious affiliation; their chronological age and their developmental stage at the time of the abortion; whether they are married or single; their emotional state and psychological history prior to the abortion; and their support networks.

However the loss is experienced and to whatever degree it becomes a crisis, there are certain psychological responses that accompany it such as depression, denial and anger.

3.3.1 Depression

Psychiatric studies before 1960 demonstrated that abortion caused depression in women. After 1960, studies by Kummer (1963), Peck and Marcus (1966), Simon, Senturia and Rothman (1967), as quoted by Ullman (1972), Besley et al (1977) and Notman and Nadelson (1985), showed that most women recovered within the first few months of having an abortion. A later study by Lee (1969) which examined psychological reactions of abortion in 112 women, reported that depression was a common reaction. In this study the depression was linked mainly to women's treatment by medical personnel.

Many of these early studies suggested that abortion was not all that detrimental to women's psychological health and that feelings of depression were absent after the first two months. However, feminist authors on abortion argue that many of these earlier studies did not reflect women's authentic experiences of abortion (Skowronski 1977; Notman and Nadelson 1980; Luker 1984; Pipes 1986; Dana 1987). These authors claim that women felt it was too 'dangerous' to speak about the painful aspects of having an abortion, because "the anti-abortion pressure groups had monopolised the emotional and moral ground"(Dana 1987:155). Simms (1977) confirms in her research on non-medical abortion counselling that women may deny their real feelings about their abortions in order to ensure that they will obtain one. Allen (1985) also reported that women tend to deny what they really feel during pre-abortion counselling in order to attain the counsellor's support of their decision to have an abortion. These studies show that if women acknowledged the painful aspects of abortion it would be seen to invalidate their needs for legal abortion.

Another misleading aspect of the earlier studies was that they only followed up women after the first few months of their abortions. Furthermore the studies did not consider that women's depression at the time of the abortion could be an indication of other unresolved problems that needed to be addressed.

3.3.2 Denial

Denial is a defence against the feelings associated with loss. It is usually part of coming to terms with any experience that involves loss. Women may deny their depression because of external factors such as women's treatment by medical personnel and the pressure to conform to certain criteria in order to obtain an abortion. Remaining silent and "appearing back to normal" are ways in which the denial may manifest (Pipes 1986:115).

Among adolescents who have abortions, the denial may be reinforced by denial in their parents. A study by Horowitz (1978) which investigated adolescent mourning reactions to abortion found that many parents who are unable to come to terms with their daughters' pregnancies viewed its termination as a relief. "This increases their difficulty acknowledging..their daughters' expression of feelings of loss" thereby perpetuating the denial (Horowitz 1978:558). Parents' difficulty in coming to terms with their daughters' pregnancies is usually linked to their denial of their daughters as sexual people (Petchesky 1984). This source of denial may also be in the adolescents themselves. Sherry Hatcher (1973) developed a developmental analysis of adolescent experience of pregnancy and abortion. She suggests that in early adolescence girls have little knowledge of contraception and do not yet perceive their sexuality. When they discover that they are pregnant their denial is extensive as they cannot yet see themselves as sexual beings or as mothers. They also tend to disclaim any responsibility for the pregnancy (Hatcher in Francke 1978).

3.3.3 Anger

Feelings of anger may be another psychological response to the loss felt by women. The anger is a normal response to losing something of value (Dana 1987). Here the anger can be a defence against the painful feelings of loss. Often it is very difficult for women to direct the anger outwards because they feel they are to blame since it was their choice to have the abortion.

Anger can also be a feeling on its own. Smith (1972) noted that some women may feel angry because their contraception failed. She found that "many women who used contraceptives were misinformed about how to use them" (Smith 1972:65). This may lead to feelings of powerlessness and anger towards the medical institutions that render contraceptives.

Pipes (1986) purports that women's anger stems from negative treatment by the medical personnel. Luker (1984) supports this claim in her analysis of the medical profession's influence on women. She asserts that because the doctor is considered as "the ultimate decision-maker for the patient's own good," because of his/her possession of technical knowledge, women's autonomy in a situation that concerns their bodies is lost (Luker 1984:109). Here women's anger is a response to their situation of powerlessness.

Thus anger can be a defence against feelings of loss. It can also be a feeling on its own in situations where women feel stripped of their power. In the latter situations there are yet other representations of loss, that is, the loss of women's autonomy and decision-making abilities.

3.3.4 Loss through Changes in Relationships

The abortion is often accompanied by changes in the relationship with the man involved in the pregnancy. For most couples abortion usually represents a crisis and becomes the make or break point of the relationship (Lee 1969;Pipes 1986).

The abortion may represent an unconscious conflict in women which only becomes conscious after the abortion. For example, a relationship may end when women experience conflict over motherhood and after having an abortion may realise that they do not want to be mothers (Dana 1987). This presents a new life issue for themselves and their partners.

The abortion can also bring men's conflicts to the fore. Skowronski (1977) notes that men are unable to express their feelings about the abortion as they do not want to appear vulnerable and weak. Instead they deny their feelings which may lead women to interpret this as a rejection. The abortion can also bring men to question

whether they want to be with the woman in the future when she might want to have a child (Skowronski 1977; Pipes 1986). Some women only experience the full extent of the loss that occurred from their abortion when their relationships end.

Teenagers who may have been pressurised into having an abortion by their parents may experience a change in their relationships with their parents (Horowitz 1978). Women who tell others who are disapproving of abortion may also experience a loss or change in these relationships (Pipes 1986). Thus feelings that accompany the loss experienced from the abortion may be compounded by those of the loss or change in women's relationships.

3.3.5 Loss of Motherhood

Women who have abortions may mourn the loss of the potential child. Some studies reveal that women may feel "depressed during the month the baby would have been born" (Smith 1972:66). These experiences of mourning are more evident among women with strong religious beliefs and young single women who are ambivalent about whether or not they want to become mothers. For these women losing a child is equated with losing their only chance of becoming mothers (Dana 1987).

"The portrayal of women essentially as mothers" is the myth of motherhood portrayed by patriarchal culture (Dana 1987:159). Women themselves internalise the myth and come to equate womanhood with motherhood. Therefore a woman only feels worthy as a person if she is a nurturer and carer. Having an abortion is then perceived as a contradiction of everything society expects of her and of what she expects of herself. The misleading assumption from this is that having lost their chance of motherhood, women may feel they have also lost their womanhood.

Feelings associated with the loss of motherhood may occur when women mourn the potential child or in the case when women are ambivalent about becoming mothers. Patriarchal expectations on women may also heighten their feelings of the loss of motherhood.

3.3.6 Loss in Women's Sexuality

Feelings associated with loss may be felt through a sense of loss in sexuality. One social factor that affects this form of loss is society's double standard regarding women's sexuality.

Petchesky (1985) offers a useful explanation of how this occurs. She shows that in Western patriarchal society young single women are defined and portrayed either as 'virgin' or 'whore'; while older and married women are usually defined as either 'mother' or 'temptress' (Petchesky 1985:220). These dichotomies trap women into being either sexual and therefore 'bad' or pure and asexual and therefore 'good'. Therefore young women who have an abortion are caught in the double standard that they have done wrong and have therefore **lost** their chance for purity and worthiness for marriage. Married and older women may feel they have **lost** their validation by society as good mothers. Whatever side of the dichotomy women are trapped into, implies a loss to their sexual being and to their worth.

A study conducted on the psychosocial aspects of induced abortion in Sydney, Australia (1972) affirmed that women's depression was linked to their sense of failure in carrying out one of their sexual roles, that is, being pregnant (Francke 1978). Lemkau (1988) speaking from a feminist viewpoint, found that such loss experienced by adolescents represented 'lost innocence' and a confrontation with their sexuality.

3.3.7 Summary

This discussion indicates that most women experience some degree of loss from having an abortion. Often they are unable to acknowledge the loss directly and instead convey it through denial. Feelings accompanying loss may also be represented in other aspects of women's lives such as motherhood and sexuality. Some of these psychological responses of loss are heightened by external patriarchal structures that dictate women's roles, sexuality and health.

3.4 AMBIVALENCE

Ambivalence about whether or not to have an abortion as well as worrying afterwards whether or not it was the right decision, is another common experience of women who have abortions. A study conducted by Ullman (1972) on 598 women who had legal abortions, showed that the majority of them were ambivalent. Another study by Faria et al (1986) indicated that ambivalence is experienced by many women who feel they want a child but at another time. In order to appreciate the source of this ambivalence it is helpful to consider socio-cultural influences.

Most women feel impelled to fulfil the dominant culture's definition of them as mothers. Therefore when faced with unwanted pregnancies they are subsumed with ambivalence as they feel compelled to fulfil their 'legitimated' roles as mothers (Petchesky 1985). Although women might have other needs like finishing a career or choosing not to have children, these are not usually legitimated by society. The ambivalence arises as women get caught between doing what society expects of them and what they want for themselves. Pipes (1986) points out that even though women may have decided on abortion it does not mean that they did not have any maternal feelings to begin with; often circumstances dictate their decision to have an abortion.

A difficulty for women in experiencing ambivalence is that our culture does not facilitate the presence of ambivalence in our psyches. Dana (1987) contends that the dominant socio-cultural force is to 'strive for perfection' (Dana 1987:164). Our experiences are polarised into either good or bad. This does not leave room for ambivalence nor the anxiety that accompanies it.

Thus ambivalence is a common psychological experience of women who have abortions, yet it is a state of being that is not easily allowed by our culture. The ambivalence women experience about their abortions is usually linked to the contradictions of their psycho-social roles of motherhood.

3.5 GUILT

Guilt is another feeling expressed by women who have abortions (Ullman 1972; Besley et al 1977; Dana 1987 and Lemkau 1988). According to Dana (1987) guilt represents anger that is turned inwards on the self. Many women are unable to express this anger because they are unconsciously motivated by condemnatory social, cultural and religious beliefs. "Guilt about abortion continues to be deliberately induced as part of a traditional system of social control...it is superfluous to ask whether patients experience guilt - it is axiomatic that they will" (Lemkau 1988:463).

The legal position on abortion has been posited as affecting the degree of guilt experienced by women (Pipes 1986). In countries with restrictive legislation, women are forced to turn to the option of the illegal, backstreet abortion. These are often implemented by untrained people, in unsterilised environments, who demand high payments for their 'skills' which often threaten women's health (Francke 1978; Bradford 1990). Because of the illegality of these abortions, a criminal element clouds them, making women feel they have committed an evil deed. Thus any guilt

they may already experience from having the abortion is exacerbated.

Patriarchal religious influences have a significant effect in the guilt women experience from their abortions. The guilt is more pronounced in women who have had strong early religious training (Skowronski 1977:109). Research by Adler (1975) and Payne et al (1976) indicate that Catholic and religious women are at greater risk from negative reactions to abortion such as guilt (in Lemkau 1988).

Daly (1973) describes the patriarchal flavour in Catholicism and other religions which lay down condemnatory laws about women who have abortions. She draws attention to the loaded terminology used in the media that forms part of the religious doctrines, such as, "the murder of the unborn child" (Daly 1973:107). Petchesky (1985) illustrates that Catholicism's declaration of abortion defines it "as a mortal sin" (Petchesky 1985:333). She proposes that this definition attributes more value to the fetus than to the woman. Thus strongly religious women internalise society's labelling them as criminals for not upholding its religious laws. The guilt arises as many women "inwardly respect the law they transgress" (Simone de Beauvoir in Schur 1964:376). Having an abortion transgresses their own internal morals. Subsequently their anger towards the source of these morals is turned inward towards their selves in the form of guilt.

Guilt may also arise as women feel they have transgressed their primary role as mothers. The myth of motherhood reinforces an ideal image of motherhood, which entrenches women's fantasies that their abortion contradicts this as they come to feel that they have 'killed' their baby (Dana 1987:159). Petchesky (1985) found that women who have an abortion in the first trimester usually experience less guilt as the fetus is not yet perceived as a 'baby'.

Attitudes of medical personnel who treat women who have abortions, greatly affect the amount of guilt experienced by women. A study that investigated professional staff reactions to abortion found that "professionals whose orientation was primarily medical.. reacted with much more discomfort to abortion work than did their colleagues whose orientation was primarily psychiatric or counselling " (Such-Baer 1974:439).

A reason suggested for this is that medical staff deal only with the physical side of abortion and tend to overidentify with the fetus as the woman remains an 'anonymous entity'(Such-Baer 1974). Thus many women experience their interaction with the hospital or private doctors as traumatic as the abortion itself as they feel disrespected and judged (Pipes 1986; Dana 1987). This may exacerbate any guilt they already feel.

Patriarchal definitions of women's sexuality is another factor that exacerbates the guilt. Having an abortion signifies that a woman has been sexual. It is being sexual that is often condemned by patriarchy's labelling her 'promiscuous' (Petchesky 1985:244). Women internalise this negative labelling of their sexuality and therefore feel guilty about being sexual. Lemkau (1988) notes that the consequences of this guilt sometimes manifests in those women who punish themselves after an abortion by remaining celibate. Linked with the guilt is also fear. After the abortion some women may develop a fear of sexuality and a fear of falling pregnant or of having another abortion (Dana 1987).

Thus guilt is an important psychological experience of women who have abortions. Furthermore I have shown that it is strongly affected by women's religious and social environments as well as by the extent to which they have internalised the society's definitions and condemnations of their being and of their actions.

The three emotional experiences above - loss, ambivalence and guilt - are the most common negative responses expressed by most women before, during and after their abortions. The literature indicates that psychotherapy or counselling may benefit women who have had abortions, in order to facilitate their working through of these emotional responses to the abortion and any other issues which the abortion may have evoked (Simms 1977; Pipes 1986; Dana 1987).

3.6 WOMEN'S POSITIVE EXPERIENCES OF ABORTION

Abortion, like any traumatic event or crisis also has some gains where women may experience positive feelings.

3.6.1 Relief

Some of the literature states that many women experience a great sense of relief after their abortions (Taylor 1973; Simms 1977; Pipes 1986; Dana 1987). The abortion confirms for them the completion of having made a decision. Some women have reported that their relief is related to the affirmation of their fertility, especially in the case of women who feared they were infertile. Other women have expressed their relief at their sense of being in control and making a decision for themselves. This has been empowering for those women who experience themselves as powerless and helpless in their daily lives (Dana 1987).

For some women their relief is in response to being free of the responsibility of caring for an unwanted child. Literature has revealed the negative effects of bringing unwanted children into the world and has confirmed that 'mothers cannot be forced to love unwanted children' (Schultz in Gochros and Schultz 1972:305). Therefore having an abortion affords women the freedom from the responsibility of unwanted motherhood.

Petchesky (1985) draws attention to the present division of labour that exists in child-care. Thus at present women endure for the most part the burden of unwanted children alone. Men do not carry the burden of child-rearing and become excused from these responsibilities. However they often make decisions about child-bearing and child-rearing practices. Until there are no longer gender divisions in child-care and men share equally in its practice, abortion remains centrally a women's problem and one in which women need to have the power to address its complexities (Petchesky 1985:350-356). Therefore many women feel relieved after their abortions as they feel freed from these responsibilities which they did not choose.

3.6.2 Self-discovery

The decision to have an abortion can have some far-reaching implications for a woman's journey to self-discovery. By carrying out the decision women have actively rejected their prescribed role of motherhood. They have risked the stigma and struggle that accompanies their abortion decision in order to pursue other alternatives that may enrich their lives.

For young women who do not feel separated from their mothers and who are ambivalent about this separation, having an abortion can be a major thrust in their attempt to separate (Dana 1987: Lemkau 1988). The unseparate woman may get pregnant unconsciously in an attempt to be like her mother and maintain the symbolic bond. However her ambivalence emerges when she decides to have an abortion. This says to her mother "I am not like you ... you had me - I am not having this one" (Dana 1987:167). Thus the abortion is a statement that symbolises gaining a sense of self separate from the mother.

For teenagers whose sexual activity often remains 'hidden' having an abortion

signifies to their denying parents that they are no longer children and that their expression of their sexuality is part of their growing adult identity (Chesler and Davis 1980; Petchesky 1985).

3.7 CONCLUSION

An overview of the main psychological experiences of women who have abortions has been addressed. A sense of loss, ambivalence, guilt and relief have been the common reactions expressed by women. It was also noted that women's internal psychological experiences of abortion are bound up with patriarchal influences concerned with women's health, roles and sexuality.

In my opinion any clinical intervention with women who have had abortions needs to consider:

- the extent to which the abortion has affected the individual woman;
- acknowledgement that the woman may feel both painful and positive emotional responses;
- exploring past unresolved problems or unconscious conflicts which may be evoked by the abortion; and
- acknowledging the influences of patriarchal oppression on the woman's internal psychological experience of abortion.

Therefore feminist psychotherapy seems to be an appropriate intervention to utilise with women who have had abortions. It takes into account that abortion is a specific women's issue and that it has come to have certain psychological ramifications for women which are compounded by external patriarchal forces. Thus I decided to explore this approach through utilising a case study with a woman who has had an abortion.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 INTRODUCTION

The research method used in this research is the case study method. It aims to explore the use of feminist psychotherapy with a woman who has had an abortion. The study utilises an exploratory-descriptive single case-study design.

The chapter begins with a discussion on the methodology utilised. It then addresses the limitations of the study and sets out guidelines for ensuring that this method has been utilised adequately. This is followed by an account of the procedure of the study. Finally the conceptual framework employed for the case analysis is outlined.

4.2 DISCUSSION OF METHODOLOGY

The methodology employed in this research utilises the psychological case-study model suggested by Bromley (1986), together with principles of feminist research methodology. The rationale for incorporating feminist paradigms into the methodology flows out of the assumption in feminist research that the subject matter of the research addresses women's issues from a woman's perspective which is precisely the aim of this research. In addition some principles of feminist methodology are infused in the psychological case study. Thus a combination of these two methodological trends constitute the use of the case study method in this research.

4.2.1 Research from a Woman's Perspective

According to Bromley (1986) the "psychological case-study is essentially a reconstruction and interpretation of a major episode in a person's life...[it] is an account of how and why a person behaved as he or she did in a given situation" (Bromley 1986:3).

A principle of feminist research that has been utilised in this case study is that the research needs to address a women's experience and life situation from a woman's perspective. This implies making visible women's experience which is either ignored or distorted in traditional research. This is based on the overall goal of feminist research which is to discover a research methodology that addresses the imbalance of power in patriarchal society as reflected in the traditional research paradigms (Kaplan and Yasinski 1980; Bowles and Klein 1983; Wilkinson 1986; Farnham 1987).

Thus the case study in this research represents both a reconstruction and interpretation of a woman's personal experience of abortion and does this from a woman-centred perspective.

4.2.2 Research that is Context-Based

Both the psychological case-study and feminist research incorporate the principle of a context-based research. The feminist paradigm emphasises that research is historical and that the meanings derived from it are socially constructed within a patriarchal culture. Dominant paradigms tend to be ahistorical and are "simplified by methods which lift them out of their contexts, stripping them of the very complexity that characterises the real world" (Parlee in Wilkinson 1986:11). Feminist research, therefore acknowledges that research takes place in a complex social context.

According to Bromley (1986) the psychological case-study provides a wholistic account of the person in her/his situation as it comprises the social context and personality dynamics of the person (Bromley 1986:10). It lends an in-depth and detailed account of a single subject, aiding the understanding of the subject's inner subjective world. Kvale (1986) outlines a characteristic of the method as being that it involves "a historical temporal dimension with a unique intertwinedness of the past, the present and the future dimension"(Kvale 1986:160).

In this research the psychological case study is used to provide such an in-depth understanding of the client's inner world in relation to the ways in which it has been socially constructed within patriarchal culture.

4.2.3 Research is not Value-Free

Feminist researchers challenge what traditional research names as 'neutral' and 'value-free' as representing predominantly a male viewpoint and therefore male values. Feminist research represents a woman's point of view that is

"a system and process of personal and political priorities and **values** that have emerged from women's experience of oppression" (my emphasis) (Klein and Steinberg 1989:xiii).

This principle also acknowledges that there may be multiple perspectives on the truth arising from the subjectivity inherent in the research process (Oakley 1981; Klein 1983; Wilkinson 1986). The psychological case study also supports this claim and acknowledges that although these perspectives may be ambiguous they are still tolerated. This notion contradicts the quantifiable facts of science which strive for the attainment of a single truth (Kvale 1986:109).

4.2.4 Focus on the Relationship between Researcher and Subject

Both the case study in psychotherapy and feminist methodology focus on the relationship between the researcher and the subject of the research.

Feminist research considers the relationship between researcher and subject as one in which they are seen as having equal status. Wilkinson (1986) asserts that the relationship between researcher and subject strives for honesty and the maintenance of a non-hierarchical relationship .

The psychological case-study also acknowledges that there is a special relationship between the researcher and the subject which entails personal involvement of both the therapist and the client (Bromley 1986). However the relationship is not equal owing to the therapist's specialised knowledge and skill.

4.2.5 The Principle of Reflexivity

The principle of reflexivity is embraced in feminist research methodology (Wilkinson 1986:13). It refers to the researcher's self-reflection on the research process. This principle has formed a major component in my use of the case study.

These principles have informed my approach of the case study method in such a way that it encapsulates a research method from a woman's perspective and considers the impact of the patriarchal social context in the research process. Furthermore it acknowledges that the feminist perspective represents one way of implementing psychotherapy and that therefore the utilisation of this approach imbues the research with feminist values.

4.3 LIMITATIONS OF THE STUDY

The main criticism levelled at the case study is that it cannot be made generalisable (Yin 1984; Bromley 1986). Critics have warned of the danger of over-generalising from a small number of cases to the general population at large.

Bromley (1986) however, argues that the case study is not used in order to generalise, but rather it aims to "add knowledge in that general area of interest" (1986:2). He supports this argument by showing that the case study is the method in psychotherapy that has made the most significant contributions to psychological knowledge. By utilising this method I aim to meet the goals of the study by contributing to the body of knowledge on the use of feminist psychotherapy, particularly in the case of women who have had abortions.

Another shortcoming of the case study method is its lack of systematic observational procedures (Yin 1984). In the psychotherapeutic case study documentation is dependent on the therapist's selective memory and notes. Bromley (1986) has argued that the reliability of data gathering in the psychotherapeutic interview can still be ensured through tape-recordings of sessions as well as through monitoring by a supervisor.

Kvale (1986) points out that another aspect of inaccurate observational procedures is the problem of suggestion. That is, the therapist's tendency to validate her/his interpretations by unwittingly influencing the client's behaviour. Kvale (1986) also notes that the issue of the validity of interpretations of meanings has been raised as problematic. However he argues that interpretations can be validated against a person's subsequent behaviour through therapy.

Lack of systematic observational procedures in this study have been guarded against by tape-recordings of the sessions, accompanied by notes that were immediately transcribed after sessions and by regular consultation with a clinical supervisor. The problems of suggestion as well as the validity of interpretations have been monitored through supervision, the client's behaviour and the use of self-reflectivity.

To ensure a rigorous implementation of the study I have been guided by Bromley's (1986) six rules for carrying out the psychological case-study. They are as follows:

- 1) The researcher "must report truthfully on the person, his[her] life and circumstances, and must be accurate in matters of detail,
- 2) The aims and objectives of the case-study should be stated explicitly and unambiguously,
- 3) The case study should contain an assessment of the extent to which the stated aims and objectives have been achieved,
- 4) If, as is often the case, the inquiry deals with episodes of deep emotional significance to the person, then it can be carried out properly only by someone trained and equipped to establish and manage a close, fairly long, and possibly difficult personal relationship,
- 5) The person must be seen in an 'ecological context'; that is to say, a full account must be given of the objects, persons and events in his or her physical, social, and symbolic environment,
- 6) The case report should be written in good plain English in a direct, objective way without, however, losing its human interest as a story." (Bromley 1986:24-25).

4.4 PROCEDURE

The client was selected via a colleague who knew that the subject matter of this research required undertaking psychotherapy with a woman who had had a recent abortion and who was willing to enter therapy. The client was unknown personally to

my colleague, which safeguarded the confidentiality of the therapy.

The data of the case study was collected through the client's self-reporting of events which were tape-recorded in sessions. This was done in consultation with the client. The client was also informed prior to the onset of therapy that the material would be used for research purposes. It was explained that in doing so all identifying information would be disguised to maintain confidentiality. The data was also discussed on a regular basis with a clinical supervisor who was a practising psychotherapist with a feminist background.

The procedure of presenting the case study will first cover a summary of the data which includes the client's case history and material that was presented in sessions. A case analysis will follow this.

4.5. DATA ANALYSIS

The analysis of the data occurred primarily through my retrospective interpretations and synthesis of the case material. However, some interpretations were made from the start of the therapy based on my general understanding of feminist psychotherapy.

The conceptual framework for the analysis and interpretations is based on the feminist principles of psychotherapy and women's psychological experiences of abortion outlined in Chapters Two and Three.

This framework incorporates three major foci:

- the **family context**, involving the idealisation of the masculine and the devaluing or denial of the feminine;
- the **meaning of the abortion in the client's life**;
- the **therapist's experience of the therapeutic process**.

4.6 SUMMARY

The methodology of this study comprises the psychological case-study method. This method is seen to be an appropriate methodology in clinical practice as it provides for an in-depth enquiry into an individual's life. The psychological case study also embraces principles of feminist research which make its use in this particular study relevant since women's experience forms the heart of the subject matter. An important aspect of the use of this method for the case study has been the formulation of conceptual tools to analyse the data. This is in keeping with Bromley's (1986) six rules which advocate that the psychological case-study needs to be explicit and unambiguous.

CHAPTER FIVE

THE CASE STUDY

"What would happen if one woman told the truth about her life?
The world would split open" - Muriel Rukeyes
(in Cox 1976:250).

The case study has been divided into two parts. The first part comprises a presentation of the salient features in the client's history and the material presented in therapy. The way this has been presented relies mainly on the client's self-reporting. The second part covers my analysis of and intervention in the case.

5.1 THE CASE OF BETH

Beth is a 24 year old, single, female, art teacher, who was seen weekly for fifteen sessions over a four month period. She was referred to me via a colleague who knew about the purpose of my research.

5.1.1 The Abortion

Beth had had her abortion five months prior to our contact. She did not feel an urgency to go into therapy as she felt 'okay' about the abortion. However, she conceded that it would be a good opportunity to learn something about it. When therapy began it soon became apparent that the abortion had in fact evoked unresolved issues about Beth's sexuality, her family, her religious beliefs and her sense of self.

To Beth her decision to have an abortion "was never an issue" as she knew that she was in no position to have a child. With the support of her older sister, Jane, she began what she described as "desperate efforts" to obtain an illegal and safe abortion. She was sent from one doctor to the next over a six week period. She felt betrayed by a doctor who had become angry with her for not lying to another doctor that he had recommended to her. Beth felt her contact with all these doctors was the time when she was the most anxious and scared about her abortion.

Part of Beth's anxiety was linked to her relationship with her boyfriend, Steven. He was of a similar age to her and they had been in a long-term relationship for approximately three years. Steven knew that Beth did not use contraception and therefore they were "careful". Sexual penetration rarely occurred and Beth trusted Steven not to ejaculate. Beth felt very angry with him when she discovered her pregnancy. Her feelings toward Steven were ambivalent as she often mentioned that he was the one person she could trust sexually because he did not put any pressure on her to have intercourse. She was also angry with Steven because he wanted her to have the child. Beth felt this was typical of his "unrealistic" behaviour as he had no job, no settled place to live and "he was a mixed-up and paranoid person".

At the end of the six week period Beth had her abortion in a clinic in a neighbouring state where illegal, but safe abortions were performed. She was accompanied by another young woman who was also having an abortion. Beth described the abortion as "shocking". She felt very frightened. The doctor and the nurse were "matter-of-fact" about the procedure which made her feel that the situation was "so normal". She was relieved by their manner as it removed any guilt she may have felt. She also acknowledged that it took away her need to complain about how she was really feeling.

The procedure, a dilator and suction method, had to be carried out twice. Beth was then informed that she was thirteen weeks pregnant instead of eight weeks as she had initially thought. She was shocked when she realised that the fetus was more formed than she had thought and she was also struck by the degree of physical pain she had to endure. Her shock increased during the second procedure when she noticed bits of the fetus in a container on the floor.

Soon after the abortion Beth felt relieved. However, she recalled two occasions, after social gatherings, when she became very "freaked out for no reason". Later in therapy it emerged that these 'freak outs' were connected to her fear, guilt and emotional pain that were evoked by her abortion. Beth was able to connect these feelings to other issues that the abortion represented to her, such as those surrounding her sexuality. She was also worried about her parents finding out as she had not told them. This, together with her conflict over her sexuality, became the central themes in therapy that emerged from her abortion experience.

5.1.2 FAMILY HISTORY

Beth moved back home to live with her parents at the beginning of this year as she was saving money for a trip overseas in the latter part of the year. Beth's family moved from an African country to South Africa thirteen years ago. She was eleven at the time. This was a difficult time for her as she had to make many new adjustments such as attend a new school and make new friends.

Beth is the youngest of four children. She has a brother Andrew (31 yrs), a computer programmer, who is married with two children and lives in Cape Town; a sister Susan (29 yrs), a draughtsperson, who is married with two children and lives overseas; and a sister Jane (27 yrs), an architect, who lives with her boyfriend in Cape Town. As a child Beth was closest to her brother. She felt sorry for him

because father seemed to reject him when he became asthmatic at a young age (10 yrs). Until then Andrew was the favoured child. Beth believes that father's rejection was the reason for Andrew leaving home at age 22 to get married. Beth's oldest sister, Susan, had to get married because she fell pregnant at the age of 18. This was a crisis for the family. Beth has never been that close to Susan because of their age difference. However, she stated that she will be staying with Susan when she goes overseas. At present Beth feels closest to Jane. She admires her as she is independent and "knows what she wants".

5.1.2.1 Relationship with Mother

Beth's mother, in her forties, and a radiologist who has not worked since the family returned to South Africa, is a Catholic. Beth described her as an organised person "who does her duty". Beth felt she had a good relationship with her mother. However, the abortion was the first major event that Beth had not told her mother about because she knew she would disapprove. Beth also feared that her mother would expect her to follow the precedent set by Susan.

In the course of therapy Beth began to present a different picture of her relationship with her mother. She explained "how organised" her mother was and how she had helped her arrange her ticket to go overseas. For the first time she expressed her anger towards her mother for always "doing everything for everyone". She was also upset that her mother had never expected anything from her because "I'm always seen as odd" and "everyone always speaks for me and tells me what to do so they don't expect me to do anything".

5.1.2.2 Relationship with Father

Beth's father is an architect (59 years) and is not Catholic. She described him as an active person who is fun-loving and "like a child". She also felt that he was "special"

and that all the children were "more like dad". All the daughters had chosen careers that were in her father's field.

Beth felt she had a special relationship with her father. There is no expressed affection in the family, except for an incident which stands out in memory when she was about fourteen years old, which was the only time she remembered her father expressing his affection towards her. Another side of Beth's relationship with her father was revealed when she mentioned that he had appeared as very threatening to her as a child when he delivered punishment. The punishment, which was in the form of threats, made her guilt about having been naughty linger, as she never knew if she would be forgiven. Beth likened her guilt feelings about her abortion to this feeling she had towards her father. She felt if she could have "one solid punishment" for having the abortion, then she would no longer feel guilty.

5.1.2.3 Parental Relationship

Beth reported that her parents have a stable marriage. They are both in their first marriage. As a child she could not recall their ever having fought. The only time she recalled there being tension between them was when her father stayed out late at night to go "drinking with the boys" at the time of his entering mid-life. This had made her mother anxious. Later on in therapy Beth reported that her mother organised most things in their lives and that she sensed her father disliked this but seemed to comply.

She described the home atmosphere as being one of "no atmosphere" and there being "an apathetic household". During the course of therapy Beth complained about the "dullness" of her family. The only emotion that seemed to be expressed was humour.

5.1.3 PERSONAL HISTORY

Beth's early history was normal except for some terrifying nightmares and thumb-sucking (which she still does). She remembered a recurring nightmare:

"I was near water and my mother was with me. Then she leaves and goes off in a bubble and is carried with the waves. I am left on the shore."

Beth identified that she experienced a similar feeling as a child whenever her mother left her in someone else's care.

Beth was an average student at school. She had few friends and described herself as being very "shy" and "the unnoticed child". After school she attended art school where she completed a degree in fine art. After that she completed a Higher Diploma in Education. Since then she has been teaching art for two years at a school.

Beth's religion is Catholic although she stated that she has not been very observant. As a child she attended church regularly with all her siblings at her mother's insistence. She values independence and having "good morals".

Beth never received any sexual information from her mother. When she began menstruating at 13 years it had been "a terrifying experience" as she was not prepared for it. She had never used contraception before her abortion and until then "did not even know what the pill looked like". After her abortion she received contraception, although she was very ambivalent about it.

Her first sexual experience was with Steven. Beth was not interested in sex - "that messy stuff". Subsequent to the abortion she had another potential sexual contact

with someone she had known for a short time, but she was unable to go through with it as she had felt scared. She blamed herself for getting into this situation. She felt she had "flirted" with this man. She reported that she had used her abortion "as an excuse for not going to bed with him" and she felt this was a sign of "weakness".

After the abortion Beth's relationship with Steven was ambivalent and asexual. She felt that his reaction to her pregnancy was proof of their differences, yet at the same time she felt responsible for his well-being as he had always relied on her. During the course of therapy Steven moved to live in a nearby town which enabled Beth to separate from him and feel less responsible for him.

5.1.4 PERSONALITY

Beth presented as a tall, attractive and intelligent woman. She saw herself as an "organic" and "sensual" person, although her persona seemed to contradict this. She had a clipped, timid way of speaking and often expressed that she could not make herself understood. She also described herself as "a bit dilly" because she did "crazy things". The crazy things referred to some dangerous situations that she got herself into. Everyone in her family thought these situations were entertaining. She liked being "the joker" with them, but also expressed that at times she wanted to be taken seriously.

Another aspect of Beth's personality that was revealed during the therapy was the presence of a fantasy world. Beth felt good in this world as she "could be anything I wanted to". She could be "melodramatic" or "somebody famous" in it. This and her thumb-sucking she regarded as 'secrets' that she had revealed in therapy.

Beth did not have any intimate relationships with friends. The person she is closest to is Jane. She preferred the company of strangers as she did not feel as

intimidated with them as she did with people she knew. She expressed how she wished she could be confident and say what she felt when she was in groups of people.

5.2 CASE ANALYSIS

This part of the case study constitutes my interpretations of the data presented and intervention with Beth.

5.2.1 The Family Context

If understood within the framework of feminist philosophy the family plays a significant role in perpetuating gender-identities according to the sexist power imbalances inherent in patriarchal society. In Beth's family this **imbalance of power** is reflected by the idealisation of her father, that is 'the masculine' and the devaluing of her mother, that is 'the feminine'.

Beth always spoke very highly of her father stating that he is regarded as "special" by mother and all his daughters. His "specialness" (power) is also reflected in the daughters all choosing careers in his field of work. Father's rejection of his only son when the latter became asthmatic can be viewed as another example of his power as well as his denial of 'weakness' which is usually associated as being part of the female-gendered stereotype. He also seemed to have been absent from the family in many ways. However, he retained his power by representing the valued male world of his work and by being the main financial provider. In addition and contrary to this adult role of the provider, he was also viewed as "a child" by his wife and daughters. This seemed to give him power in the form of freeing him from any responsibility for parenting.

Although Beth's mother had power in running the family as she "organised everything", this work was not valued. Even her career as a radiologist was negated by Beth when she said "none of us wanted to be a nurse like mom". Thus the imbalance of power in Beth's family is displayed by the devaluing of feminine power and the validating and idealising of masculine power.

The **lack of emotional expression** in Beth's family represented a further devaluing and denial of the feminine. This was evident in therapy when Beth explained that she did not want to cry as it would be "embarrassing" and would indicate "weakness". The emotion that was expressed in the family was humour which Beth displayed by her joker role for which she gained approval. It seemed that the emotional fabric of Beth's family is coexistent with the male-gendered stereotype that denies emotions associated with the female-gendered stereotype. Instead, humour is used as a macho facade that defends against these.

Another focus of feminist psychotherapy is **the exploration of the mother-daughter relationship**. Beth's relationship with her mother provides a clearer understanding of how she came to experience her abortion as she did.

The central theme that characterises this relationship is that of "the duty bound" mother and daughter. Each pleases the other out of a sense of what is right and expected without acknowledging their inner feelings and needs in relation to one another. Eichenbaum and Orbach's (1982/7) understanding of the mother-daughter relationship can be applied here.

It can be postulated that Beth's mother has a 'hidden little girl' part which was repressed in her childhood by the way her mother related to her. Beth described her grandmother as "quite hard" and "a worker who worked her whole life in

factories". Therefore it is possible that her grandmother, whose primary function was to ensure her family's physical survival did not meet Beth's mother's emotional needs. Furthermore Beth described her grandmother as a devout Catholic. According to Catholicism's view of women "the vocation of a woman [is] to become a mother" even at the cost to her own needs (Daly 1973:3). Thus grandmother carried out her mothering also in a duty-bound way which she unconsciously passed on to Beth's mother.

Thus Beth has responded to her mother as the dutiful daughter who "out of all the children has always told mom everything". The abortion is the first major event that Beth has kept from her mother as she fears her mother's rejection and its implication that she has been the undutiful and therefore bad daughter. Beth has needed to hide her 'badness', that is, her pain associated not only with having an abortion but also for being sexual, in order to ensure her unconscious striving for her mother's love. Prior to therapy Beth's boundaries with her mother were diffuse and she had not yet separated from her. During the course of therapy Beth's relationship with her mother began to shift as she expressed her deep ambivalence about her abortion. Thus I came to interpret Beth's abortion as representing an attempt to separate from her mother.

The development of Beth's gender identity must be viewed within the family context. Here the idealisation of the masculine and the devaluing and denial of the feminine in Beth's family, contributed to her developing a gender identity that was characterised by an almost masculine persona. This was represented by her denial of painful emotions covered by a facade of humour and denial of her neediness, her conscious striving to achieve "toughness" and her idealising of her father.

Beth's position in her family as the youngest, "the baby girl", is an important factor that has also influenced her gender identity as a female. In this role she learnt to be passive in order to gain parental love. Being "the baby" she never had to make decisions and grew up being "malleable" in her parents' hands. Alongside this was the natural modelling on her mother who is subservient to the doctrines of her patriarchal religion. Thus emerges the female-gendered stereotype of passivity and dependence. This female gender identity together with her vulnerabilities underlie Beth's predominant masculine persona where they remain protected from being devalued.

However, Beth's pregnancy and subsequent abortion involved this feminine domain. The denial and devaluing of her female being, her early sexual history and the influences of her patriarchal religious beliefs helped me discern that her abortion represented a confrontation with her sexual female identity and her conflicts surrounding it.

5.2.2 The Meaning of the Abortion in Beth's Life

Thus against this family context, I perceived that Beth's abortion represented two central psychological experiences for her. These were, firstly, the confrontation with conflicts surrounding her sexuality and secondly, the attempt to separate from her parents.

5.2.2.1 The abortion as a confrontation with conflicts surrounding sexuality

Beth's abortion led to a confrontation with sexual conflicts which were previously denied. This denial functioned mainly to repress natural sexual feelings which were prohibited from being expressed in her family. The secrecy surrounding sex

resulted in it being regarded as "messy", "evil" and "bad". Therefore the overriding response that Beth experienced about her abortion was guilt, that is, the guilt that related to her having been sexual.

The guilt that Beth experienced about being sexual can be understood in terms of **the myth of feminine evil**. In Beth's psyche this myth operated by trapping her into the dichotomy of the sexual and therefore 'bad' woman as outlined by Petchesky's (1985) analysis in Chapter Three. This was illustrated by a painting that she wanted to do of how she had experienced herself on the operating table when she had her abortion. She used an analogy to the German impressionist Edvard Munch who painted women as "evil, sadistic and manipulative" in order to describe how she felt. However, contrary to these evil images, Beth explained that whenever she painted women or thought of women, she could only perceive them as "curved, sensual and tranquil". Thus emerged her conflict between the 'bad' and the 'good' sexual parts of herself.

Beth's internalisation of feminine evil was also illustrated by her perception of her abortion as a punishment for getting involved in "that messy stuff (sex)". She added that "everything bad that has happened since the abortion, I see as happening because I had the abortion ... I'm so guilt-ridden .. that I'm waiting for some sort of punishment." This guilt feeling she associated with the threatening punishment she had received from her father as a child and which she had wished could have rather been tangible. Similarly she felt that if she had received a sound punishment for her abortion she would have been absolved of her guilt.

The influences of patriarchal religion need to be considered in understanding Beth's internalisation of the myth of feminine evil. This was mainly passed on to her through her socialisation of the doctrines of Catholicism carried essentially by her mother. The silence surrounding sex, the traumatic experience of her menarche

and the strong moral ethic in the family "to be good and upright" are some of the ways in which the powerful religious doctrines were imposed on the baby girl.

Whenever Beth spoke about her sexuality, which was with distaste and fear, I had the sense that she had been sexually abused. However, there was nothing in her history that suggested this possibility. I then began to grapple with a deeper understanding of the oppressive nature of patriarchal religion. This is resonated in Daly's (1973) explanation of patriarchal Judeo-Christian religions which define women in terms of "the reality of their 'original sin', that is, their internalisations of blame and guilt" (Daly 1973:49). For Beth her 'sin' was not only the "murderous" deed, but also that she was sexual. Thus I perceived that the 'raping phallus' was not her father or another man, but rather, symbolically, her religion which had violated her right to a healthy sexuality. She had indeed internalised Wehr's (1988) concept of the self-hater archetype which embodied the accusatory "inner voices" of her religion.

The influence of Beth's religion on her sexuality, was also conveyed by her frequent mention of contraception and her ambivalence about whether or not to use it in the future. Catholicism considers the usage of contraception as "sinful" and Beth felt that if she used it she would no longer see herself as "good and upright". Once again the conflict emerges between her good, asexual self and her bad, sexual self.

Even Beth's expression of her transference feelings towards me was imbued with religious images. Her image of me was of "an exorcist..a person with spiritual powers ... power that could bring the devil out of the other person". This projection also carries her internalised evil, as it is only someone as powerful as an exorcist that can rid her of this multitude of evil.

Thus Beth's patriarchal religion inculcated the myth of feminine evil into her experience of herself as a sexual being. This led to a split between the evil, sexual self and the good, moral (asexual) self. Thus in my intervention I embarked on helping Beth begin the process of **healing this split**.

Through exploring Beth's sexuality I aimed to provide the safety for her to explore what had been forbidden and hidden in her past. I hoped that by accepting this 'evil' part of herself I would begin the process of helping her learn to accept and integrate it as part of her whole being. I also focussed on utilising the feminist psychotherapy principle of **separating the internal from the external** as I interpreted that most of Beth's painful experience of her abortion and sexuality arose from the external influences of her religion and culture.

One way of exploring Beth's sexuality was through utilising a body visualisation exercise. This served to help Beth get in touch with her sexuality through expressing how she felt about her body.

A significant image of **the wounded - mutilated woman** emerged that epitomised how Beth experienced her sexuality and ultimately her abortion. Using imagery was necessary in working with Beth as she was unaccustomed to expressing painful emotions. The image she presented was,

"my stomach like a drum turning ... I imagined white bandage, reams and reams and reams of it, covering my stomach."

This image reflected not only the physical wound and mutilation that she experienced from her abortion but also her psychic wounding. This image

resembled her description of her abortion procedure which she recalled as being

"this emptiness in the room you could not do anything except lie there with your legs open ... I could not stop what had already started... what made it worse for me was seeing the contents of the uterus ... I thought it would be fluid ... but it became clear to me.. that little thing .. little pieces of flesh of some kind ... "

The description of her being on the operating table with her legs open is symbolic of her vulnerability and powerlessness at the hands of the doctor's instruments, a parallel that symbolises a rape. In Beth's case where her sexuality is still experienced as almost 'virginal', the doctor's instruments can be symbolically likened to the raping phallus that violently wounds the woman. Many women who have an abortion may experience this association.

It was important to help Beth find a place where she could gain a sense of her autonomy rather than a sense of her powerlessness from her wounding. From supervision I gained a valuable concept, that is, the therapist as an 'awaiting midwife'. In Beth's experience the pregnancy was terminated by an 'interrupting midwife'. She now had to heal the wound left from the abortion by having someone patiently sit with her while she gave birth (without being violated or interrupted) to her own self. By using this concept I managed to set the tone of our work together, and help Beth acknowledge that her healing would involve the labour of her own birth.

The damage done by patriarchal religion was reflected when the image of the 'bandaged stomach' was explored further. This occurred when Beth herself described that the damage done to her stomach was not only from the abortion but also from being sexual.

The following vignette illustrates this.

- BETH: The damage is done ... all you can do is put a bandage on it.
- ME: What is the damage?
- BETH: Having sex with a boy, falling pregnant and being violated ... that's the damage.
- ME: So the damage is not only what is left from the abortion. It is also the damage to your body from having sex.
- BETH: Yes ... I've always thought sex is distasteful. I've always seen myself as a tight person. Its always been embarrassing to talk about sex... That is why I liked Steven ... he never put any pressure on me ... It was sordid to me ... contraception is also sordid ... the whole idea of rushing off and protecting yourself ... Its denying I was having sex because having it meant I was dirty ... always tension around it all, even myself naked. My first horror experience was menstruation.

Here it was important to help Beth distinguish the source of the force causing the damage. The purpose was not to blame her religion for implementing the damage, but rather to help her identify its effects on her life. She acknowledged that since her abortion she had begun to question her religion as she felt it "had made her feel worse about her abortion". However, in the final session Beth was still able to acknowledge some value in her religion when she stated that she wanted to go back to it, but that this would be in a different way.

Another way of helping Beth integrate the split in her sexual being was through utilising Miller's (1986) concept of **relabelling weaknesses as strengths**. For example, I interpreted to Beth that women, when they felt their real power was threatened, were often perceived as evil and capable of manipulating others. Another way to do this was by using her analogy of having a "witch's evil power" in a positive sense, that is, through recognising that a witch's power was both evil and also had a healing, magical quality .

From these interpretations Beth began to make the link to her family and how they had denied her sexual knowledge (one form of women's sexual power). She also

began to make some links to the influences of her religion. In particular she made the link to Catholicism's view of women, that they should be "clean and pure". She developed insight when she admitted that she always thought that she would be like this until she recognised something else when she began to draw women through art. She drew them as curved and sensual. Prior to therapy she had not been conscious of this desire. She knew that this was how she wanted to perceive herself. Thus her process of integration had begun to unfold. Miller's (1986) concept of women's universal process of creating a personal creativity is reflected in Beth's art which forms a part of her unique creative self. Thus at the end of therapy I encouraged Beth to create this part of herself not only in her art but in other aspects of her everyday life.

The image of being wounded facilitated Beth's mourning not only of the loss from her abortion but also the loss of her female sexual being. Through the course of therapy some of the mourning did occur when she recalled three significant events which were all reminders to her of the pain and loss associated with her abortion. It was difficult for Beth to acknowledge feelings of loss since as a Catholic she had committed the ultimate sin and therefore could only feel bad, not sad. One of the significant events occurred when a student's sister had a baby and decided to name it after Beth. Beth perceived this as representing "divine justice" as it signified that "a baby still lived that was connected to (her) that replaced the baby (she) killed." This 'replacement' baby was the punishment, that is, the "divine justice" she felt she deserved for having had the abortion. However, the "divine justice" was also a defence against her awareness of the feelings of loss that she experienced. Slowly Beth came to realise that the abortion had brought her not only badness and guilt but also sadness and loss. Metaphorically the reams of bandage represented her guilt that covered her festering and wounded stomach which represented her pain and loss.

I was aware that Beth would need a lot more time to integrate her conflicts about her sexuality than the time we had together in therapy. It would not have been therapeutic for me to simply impose my way of seeing things onto her. By providing the safety for her to say these things and have them validated as her authentic experience was freeing and healing in itself. This was conveyed near the end of therapy when Beth said that she was going to miss being listened to. I realised that what she was also saying was that she is going to miss telling her true story. Simply talking about her sexuality was the first step towards integrating the split and its conflicts.

5.2.2.2 The abortion as an attempt to separate

The interpretation of Beth's abortion as a confrontation with her sexuality, was indeed a painful revelation for her. There was also a more positive aspect of the experience, namely, that it represented her move towards autonomy and separation.

From the analysis of the family context it was shown that underlying Beth's masculine persona was her needy, dependent, feminine side. Her early history of nightmares of separation-anxiety depicts her primary dependency and neediness on her mother as an infant. Beth's neediness presented itself consciously through her thumb-sucking. On further exploration of the visualisation exercise she revealed that her thumb-sucking was "pleasurable, relaxing and fulfilling". This reverberated with an auto-erotic association of her sexuality as it portrayed the needy child fixated at her mother's breast.

Beth's neediness was also conveyed through her transference towards me. For example, she was unable to end any of the sessions on her own accord.

Despite this unconscious neediness, Beth made her own decision to have an abortion. Before her abortion she had felt unable to express her own thoughts as she always felt others would think them "silly". However, after the abortion she began to see herself as more visible and began "to say what I think".

In order to understand how Beth came to make this major decision it is helpful to consider her **unconscious conflict of ambivalence** about separation.

Dana's (1987) interpretation of young women who fall pregnant and then have an abortion as representing their ambivalence about separating from their mothers, can be utilised in grasping this unconscious conflict in Beth. On an unconscious level Beth's pregnancy and subsequent abortion can be viewed as her ambivalence about separating from her mother and in her case also from her family. Here the pregnancy signals her non-separation from her mother, while the decision to have an abortion represents her being different from her mother, that is, separate.

For Beth her ambivalence was heightened by what she had witnessed happen to her older sister when she had fallen pregnant. Susan had been "pushed out of the family enclave". Beth consciously fears that this would also be her fate if her parents knew that she had had an abortion. It would seem that the issues for Beth's parents, are not only the issues of pregnancy and abortion, but also the fact that their daughters are sexually active.

Yet Beth consciously knows that she is different from her mother and sister as she wants "to do other things" before she has a family. Beth recognised her mother's frustration in carrying out her essential female role when she said: "Mom is frustrated. All she's ever done is look after all of us. She even stopped her career for us." In this way Beth came to consciously break one of the myths of motherhood.

Recognising her difference from her mother (and sister) was sufficient motivation to enable Beth to follow through with her decision to have an abortion and maintain some sense of separateness . However, the ambivalence is still present. This is indicated by her being frightened about the consequences of her parents finding out about the abortion. In the final session Beth said that she felt she had done the "right thing" by not telling her parents. She added that she was certain that she would tell them someday when she felt ready. I have no doubt that she will when more integration of this process of separation occurs.

Another attempt at separating was that by having the abortion, Beth was separating from patriarchal religion rejecting her mother's strong Catholic morals. Although she carried out what she called a "murderous" deed she remained morally bound to her mother's and her religion's laws. This was indeed a massive struggle for her. She constantly recalled situations in which the topic of abortion was discussed in conversation. From these conversations she realised that her shock at her parents' responses represented her 'differentness'. Thus by having the abortion she had risked rejection and victimisation for transgressing her parents' and her religion's laws.

Therapy offered Beth the chance to express her ambivalence and guilt by exploring her fears and fantasies and their consequences. This provided her with a sense of affirmation of her difference and newly-awakened separateness even though she still remained ambivalent. She expressed this towards the end of therapy when she said:

"I do not believe there is a meeting point where both parent and child of parent can agree on the decision to have an abortion. Especially when parents have very high values - that is why I still struggle myself, because I also have high values."

It appears here that Beth had begun to perceive the contradiction of separateness and likeness to her parents. Yet she also recognised the struggle to live this out as she still carried their values inside of her.

Beth's separation process was enhanced by **separation through the process of psychotherapy**. Most significant was the facilitation of her anger towards me over "the trite images" I used in the visualisation exercise. This expression ricocheted in a later session when Beth verbalised that she felt angry towards her mother for "always doing everything for her". Previously Beth denied ever getting angry with anyone in her family. She felt both shocked and relieved that she was able to express this anger.

Two other significant events occurred towards the end of therapy that resonated Beth's new-found striving for autonomy. The first was her decision to visit Steven to talk about their unfinished business since the abortion. She acknowledged that she would not have been able to do this had she not "told someone all this stuff" about herself. When Beth recalled her meeting with Steven it was the first time that she made reference to her potential **child**. This confirmed that she was also more in touch with her body as well as with the real effects of the abortion on her life.

The second event was Beth's decision to have an art exhibition of her work. She had original ideas about how she wanted to structure the opening but was worried about what others would think. However she decided to pursue her own ideas. Thus Beth had a greater awareness of herself and was able to release some of her creativity.

Thus the abortion also had a positive meaning in Beth's life. Paradoxically by killing part of herself she began to give birth to her authentic being. A labour that has been and will continue to be both painful and rewarding.

5.2.3 My Process of the Therapy

Undertaking this therapy has involved certain issues of my process as the therapist. These draw on the therapeutic relationship principles outlined in the literature study on feminist psychotherapy.

The issue of the therapist's power played a significant role in my experience of the therapy. Here I was guided by Miller's (1986) concept of 'temporary inequality' whereby the power of the therapist is used creatively not destructively. Although I aimed to utilise this concept it restricted me in the beginning stage of the therapy as I strove to maintain an egalitarian relationship at all costs. This blocked any creative abilities I had to offer my client. An added concern of mine was that the therapy was part of my research and therefore I feared that using my power would increase the risk of losing the client. However, once I began to take risks and utilise my power creatively so too was Beth able to take more risks. In the last session I realised that I had used my power constructively with Beth when she stated that being in therapy was one of the most meaningful things in her life.

The use of self-disclosure was significant as it enhanced the therapeutic alliance. For example, I shared with Beth that I had some idea of her experience as regards menstruation. Sharing my experience of menstruation with Beth facilitated the process of beginning to free her from the internalised 'mad' and 'bad' labels she experienced about her sexuality. I also shared with her that my religious background is Jewish. This sharing offered her a sense of her difference from me and therefore reinforced her separateness.

The issue of the gender of the therapist is significant in my experience of this therapy. Since Beth's sexuality was hidden and distorted, she needed not only the

safety but also a role model with whom she could explore her private sexual world. Abortion, as discussed previously, is a specific women's issue which Beth was able to convey openly with me because I am also a woman. Beth confirmed this in the final session when she said:

"I could never have spoken about all these things with a man: somehow I felt because you were a woman you could understand."

Being a woman therapist contributed to Beth confronting her relationship with her own mother. Although the therapy was brief, the transference was sufficient for me to be a transitional mother or 'holding midwife' who Beth could internalise in order to establish her inner healer or nurturer. This was also conveyed to me by her image of me as the exorcist. "Once the client begins to feel the care of the therapist she can begin the process of embodying the goodness of the therapist inside herself" (Eichenbaum and Orbach 1983:97). I felt this was achieved to some extent through experiencing the intimacy that developed between us during the middle and end stages of the therapy.

I was deeply moved by Beth's experience of her abortion and her sexuality. Somewhere inside of me I understood her suffering as a woman which enabled me to empathise with her story. My countertransference was evident in the feeling that the healing of Beth's female self contributed to my own process of healing the woman inside of me.

CHAPTER SIX

CONCLUSION

This case study has highlighted a number of issues and insights into utilising feminist psychotherapy with women who have had abortions. I have formulated these insights based on the perceived changes and growth in the client and my experience of the therapy.

Through utilising the feminist approach which acknowledges that abortion can have, in some ways, a positive meaning for women, the client was able to capture the positive meaning of her abortion. This was evident through what was the most significant change in the client, namely, her move towards the process of separation. Here the abortion was used paradoxically. The client was made aware that by killing a part of herself she was able to give birth to her authentic self. This process was enhanced by the feminist psychotherapy focus on the mother-daughter relationship. Through the 'enactment' of this relationship in the therapy, the client was held by a nurturant 'midwife'. This enabled her to become the needy child, who previously had remained hidden, without fear of parental abandonment. It also provided an opportunity for her to negotiate a healthy separation with a mothering figure which helped to facilitate her separation process from her own mother.

The gender-matching between the client and the therapist accelerated the client's positive transference towards me as a nurturant mother figure. It facilitated an intimacy and trust between us that enabled her to share hidden thoughts about her sexuality which she acknowledged would have been more difficult to share with a man. This is not to say that a male therapist could not have reached a similar

intimacy with a woman client. However, by being a woman myself, the therapeutic relationship was enhanced as I could also share the client's struggle as a woman.

Another important feminist understanding of abortion which emerged, is that it may evoke conflicts for women about their sexuality and religion which are usually compounded by powerful distorting and devaluing patriarchal influences. By employing this understanding the fundamental issue that emerged was the client's conflicts about her sexuality. Clearly the patriarchal religious influences which were encapsulated by the client's internalisation of the myth of feminine evil, perpetuated in her family, constituted the source of these conflicts. The internalisation of the devaluing and denial of the feminine in the family, also served to exacerbate these conflicts.

The journey into this material was both painful and frightening for the client. I felt she needed longer to work on this conflict in psychotherapy than the few months for which we had contracted. Evaluating whether beginning this journey was valuable for the client is more difficult. I felt that by unleashing her 'hidden' sexuality she was provided with the safety to unburden some of her private and fearful thoughts and feelings. This process also involved the feminist principle of separating the internal from the external, which for the client facilitated reducing some of her guilt. A secondary value in dealing with the client's sexuality was to make more conscious those parts of her denied and devalued feminine. By having these parts accepted in therapy, the client began a process of gaining a positive sense of her female sexual being and her overall perception of herself as a woman.

The feminist psychotherapy principle of focussing on the therapist's experience of the therapy, has made a significant contribution to my own learning and growth. Utilising the feminist framework was empowering. It confirmed for me that there are alternative ways of understanding and dealing with women's problems. These ways

seek to free women from the patriarchal myths that have imprisoned their psyches and thus help women discover their own identities. This has been reflected in the case study by the client's telling of her unique life story. This unfolding by the client of her life as a **woman** has in particular enhanced my own understanding of the psychology of women.

This research may offer guidelines to other clinicians working with women who have had abortions. These are:

- that the family plays a significant role in perpetuating gender identities based on the sexist power imbalances in society. This may devalue women's experience of their sexuality and of their personhood and may be evoked by their having an abortion;
- that misogynist biases of patriarchal religions, that are strongly perpetuated in the family, are powerful factors in compounding women's distress from their abortions;
- that abortion usually evokes other unresolved issues in women's lives that can be dealt with in psychotherapy;
- that for women who have not yet separated from their mothers or families, the abortion may represent their unconscious attempt to attain this separation;
- that while abortion is usually a traumatic experience that involves depression, anger, fear, ambivalence and guilt, it can also be a positive experience that can lead women to paths of self-discovery that enhance their self-esteem, independence and creativity.

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