# EMOTIONAL DISTRESS IN WOMEN BEFORE AND AFTER THERAPEUTIC TERMINATIONS OF PREGNANCY. AN INVESTIGATION INTO THE NEED FOR PRE AND POST ABORTION COUNSELLING.

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ABSTRACT

The research is an exploratory and descriptive study into emotional distress in women, before and after terminations of pregnancy at the Pregnancy Advisory Service at Groote Schuur Hospital, which aims to assess the need for pre- and post-abortion counselling.

The participants were women seen at the Pregnancy Advisory Service from 1 - 14 December 1993 and 5 - 19 January 1994 and assessed for terminations of pregnancy according to Section 3 (1)(b) of the Abortion and Sterilization Act of 1975.

The research methods were survey research and participant observation.

The results indicated that levels of emotional distress in the short term after termination of pregnancy are much lower than before a termination of pregnancy and as a result most women do not want post-abortion counselling.

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## CHAPTER 1: INTRODUCTION

As a clinical social worker employed at Groote Schuur Hospital's Pregnancy Advisory Service it has concerned me that the women who are assessed for terminations of pregnancy according to the Abortion and Sterilization Act of 1975 do not appear to want post-abortion counselling. This observation has been made during my employment at the Pregnancy Advisory Service over the last year and confirmed by other professionals who have worked at the Pregnancy Advisory Service.

The women who are assessed for legal terminations of pregnancy on psychiatric grounds rarely make contact after they have had abortions and generally do not keep follow - up appointments. This observation has prompted me to question why women do not appear to desire post-abortion counselling immediately after they have had a termination of pregnancy.

This has led me to wonder whether or not post - abortion counselling should be offered as part of the service provided at the Pregnancy Advisory Service.

This study will focus on women who are assessed for legal terminations of pregnancy at the Pregnancy Advisory Service at Groote Schuur Hospital according to Section 3(1)(b) of the Act. The study population will therefore consist of women who have been granted legal terminations of pregnancy on the grounds that the continuation of the pregnancy constitutes a serious threat of permanent damage to the woman's mental health.

The law in South Africa prohibits abortion except on specific grounds which are as follows:

3(1) Abortion may be procured by a medical practitioner only and then only -

(a) where the continued pregnancy endangers the life of the woman concerned or constitutes a serious threat to her physical health.

(b) where the continued pregnancy constitutes a serious threat of permanent damage to the mental health of the woman concerned.

(c) where there exists a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that he will be irreparably seriously handicapped.

(d) where the fetus is alleged to have been conceived in alleged rape or incest.

(e) where the fetus is alleged to have been conceived as the result of unlawful carnal intercourse with a woman who is mentally retarded.

(Section 3(1) of the Abortion and Sterilization Act 1975)

The Abortion and Sterilization Act of 1975 does not specify a limitation on the period of gestation in which a termination of pregnancy can be performed.

Since the introduction of the Abortion and Sterilization Act of 1975, terminations of pregnancy have become a standard procedure in the gynaecological and psychiatric services at the designated State hospitals. The Act aims to restrict abortions by defining strict criteria for terminations of pregnancy. The majority of legal terminations of pregnancy are recommended on psychiatric grounds (Kopenhager et al 1978).

The Act specifies that the patient seeking a termination of pregnancy needs to have the abortion recommended by two medical practitioners, one of whom must be in the service of the State. In the case of rape, a district surgeon must complete the medical certificate where a complaint has been lodged with the police. When the termination of pregnancy is recommended on the grounds that the continuation of the pregnancy will cause permanent damage to the mental health of the pregnant woman, a psychiatrist in the service of the State must issue a medical certificate.

Throughout history the subject of abortion has remained extremely controversial. Over the last 20 years legal abortion in varying degrees has become more acceptable in many parts of the world. As a result of this, two polarized schools of thought have developed, namely pro-choice versus pro-life.

The pro-choice viewpoint is that the pregnant woman should have the right to decide if she wants to terminate an unwanted pregnancy. The pro-life viewpoint is that from conception the fetus has the right to life.

In the South African context it appears that abortion is a controversial issue which is often considered taboo. Thus for a woman attempting to obtain a termination of pregnancy it is often an event which remains secretive and cannot easily be shared with even those closest to her. Thus the woman seeking a termination of pregnancy often does not have a good support system to assist her with the decision to request a termination of pregnancy.

When women present at the Pregnancy Advisory Service with a request for a legal termination of pregnancy they are usually in crisis. An unwanted pregnancy appears to be a crisis which often evokes previous crises in the patients life. As a result of this the patients defences are often lowered. A catharsis occurs and they are amenable to pre - abortion counselling. This is normally in the form of crisis intervention and often addresses issues which are not directly connected with the pregnancy. It seems to me that once the patient has had a termination of pregnancy her defence mechanisms are again raised (i.e. the period of crisis is over) and she is no longer amenable to counselling.

In my experience, for many of the women who are assessed for terminations of pregnancy and counselled at the Pregnancy

Advisory Service it is the first time they have come directly into contact with any form of therapeutic services. The period of pre-abortion counselling thus becomes extremely important in assisting the patient in beginning to be aware of some of her psychological issues and often seems to be the catalyst in encouraging the patient to work on some of the issues in her life.

The objectives of the study are to assess levels of emotional distress experienced by women before and in the short term after they have had a termination of pregnancy and identify the needs expressed by patients for post-abortion counselling based on this assessment. The study will not focus on the long term effects of termination of pregnancy and later needs of patients for counselling, although this will be looked at briefly in the literature review. The study will not look at those patients who have been refused a legal termination of pregnancy.

The two main research questions are as follows:

- How do the levels of emotional distress in women having abortions compare before and after they have had terminations of pregnancy?
- Do women who have had terminations of pregnancy want or need post-abortion counselling?

My first assumption is that the dominant feeling in women who have had terminations of pregnancy is one of relief in the period of time immediately after the abortion thus they do not want post-abortion counselling. My second assumption is that

if women are counselled effectively prior to having a termination of pregnancy they do not want post - abortion counselling in the few weeks immediately after having a termination of pregnancy.

The significance of the study to social work practice is that at Groote Schuur Hospital, as in other contexts, it is generally the role of the clinical social worker prior to the patient's termination of pregnancy to assess the patient according to the requirements of the Act, counsel with regard to other options available around the unwanted pregnancy, provide the patient with support and to offer the patient the option of post-abortion counselling.

Possible implications of the study are that the results can be used to evaluate and improve the service provided to patients at the Pregnancy Advisory Service by indicating what the needs of patients are before and in the short - term after a termination of pregnancy.

It should also assist the professionals who work with patients having terminations of pregnancy to be aware of the levels of emotional distress before and after an abortion, and the subsequent needs of patients as a result of this.

The predicted limitations of the study at this stage are as follows:

-The study is limited to women who have had legal terminations of pregnancy at Groote Schuur Hospital according to Section 3 (1) (b) of the Abortion and Sterilization Act 1975 and therefore it is not generalizable. It does not include women

who have had abortions according to the other sections of the Act or women who have had "back-street" abortions.

-Possible difficulties in obtaining information from patients after they have had a termination of pregnancy as they are no longer within the hospital system.

-Abortion is a controversial and often secretive issue in South African society and this may cause limitations to the study.

The research is an exploratory study. The method used will be survey research and participant observation and involve the use of both questionnaires and interview schedules.

# CHAPTER 2 : ABORTION : A LITERATURE REVIEW

## 2.1 INTRODUCTION TO THE LITERATURE

The literature review has been divided into six sections as follows:

Historical background - this aims to provide information on abortion throughout history to place the research in a historical context.

Moral and Ethical Aspects - Abortion has always posed moral and ethical dilemmas and as a result is a controversial issue. This aims to relate the research to these moral and ethical dilemmas.

Medical Aspects - this aims to provide information on the medical aspects of abortion.

Political and Legal Aspects - An International Perspective. This section looks at political and legal aspects of abortion in other countries.

The South African Perspective - This places the research within a South African context and looks at historical and cultural aspects as well as current political and legal issues.

Psychological Aspects - The primary focus will be on psychological aspects of abortion as this is most relevant to the research. This section looks at previous research done in the field and how it relates to this research. A theoretical perspective on abortion counselling is also presented.

Information has been obtained from books, research publications, journal and magazine articles. The Abortion and Sterilization Act of 1975 has also been referred to. Most of the information obtained from books and journal articles refers to abortion in the British and American context. Information on abortion in the South African context was obtained primarily from unpublished papers and magazine articles as there are not many books and journal articles available.

## 2.2 HISTORICAL BACKGROUND

Historical records indicate that abortion has been practised since the beginning of organized society. Mention of the practice of abortion has been found in the writings of the ancient Chinese, Hebrews, Egyptians, Greeks and Romans (Drower 1977).

Laws governing abortion have varied through history and were a reflection of the contemporary attitude towards abortion at the time. It was with the spread of Christianity that moral objections were raised with regard to induced abortions as they were considered an offence towards God as abortions destroyed what he made (Drower 1977).

Prior to 1803 in Great Britain, English common law permitted abortion provided it was carried out before "quickening" at the sixteenth week of pregnancy. After 1803 abortion became a criminal offence from the time of conception (Pipes 1986).

The movement for legalized abortion in Great Britain has its roots in the Feminist movement after the First World War. In

1929 the Infant Life Preservation Act in Great Britain provided for abortion if carried out in "good faith" when the life of the mother was considered to be at risk. The Abortion Law Association was formed in Great Britain in 1936 in response to the uncertain nature of the English Law and its interpretation (Drower 1977).

As a result of this, the Abortion Act was introduced in Great Britain in 1967. This Act is similar to the South African Abortion and Sterilization Act of 1975 but encompasses a social clause "Account may be taken of the pregnant woman's actual or foreseeable environment" , thus providing broader grounds for abortion and allowing for different interpretations (Charlish 1989).

Legislation concerning abortion in the United States of America was originally guided by British common law. In the 19th century a campaign led by physicians was successful in outlawing abortion and by 1900 abortion was illegal in every State (Staggenborg 1991).

In the 1960's the "pro-choice" movement was developed in the United States of America as a loose coalition of largely feminist activists and organizations. In 1973 abortion on request was legalized in the U.S.A. as a result of the "Roe versus Wade" ruling in the U.S. Supreme Court (Staggenborg 1991).

Prior to introduction of the Abortion and Sterilization Act of 1975 in South Africa the legal position with regard to abortion was poorly defined as the only existing legislation was contained in the Native Territories Penal code of 1886.

This stated that causing the death of a live fetus was punishable unless it was proved to be done in "good faith" for the preservation of the life of the mother (Geldenhuys 1974).

## 2.3 MORAL AND ETHICAL ISSUES

The morality of abortion poses an ethical dilemma to society and raises many controversial issues as opinions as to the morality of abortion are so varied.

In my experience at the Pregnancy Advisory Service, women who are faced with the problem of an unwanted pregnancy tend to feel that they do not really approve of abortion but feel in their particular situation abortion is justified. It seems that opinions as to the morality of abortion are therefore subjective.

One of the most fundamental philosophical questions around abortion is the question of when the fetus becomes a person. This raises the concept of viability. However the question of when does the fetus become viable has been continually debated and the use of viability as a criterion to assist abortion legislation is conceptually unclear. ' This fails to satisfy either side of the abortion debate as both conservative and liberal views on abortion regard fetal development as morally irrelevant (Campbell 1985).

Smetana (1982) conducted a study into women's reasoning about abortion. She says that the complexity of the abortion question arises from a disagreement as to whether or not the

fetus is a human life to be considered in the decision to have a termination of pregnancy, and therefore whether personal or moral considerations should apply.

Smetana (1982) indicates that for those who consider abortion a moral issue, the genetic or spiritual potential of the fetus is enough to consider it as human life equal in value to other human lives, but for those who consider abortion a personal issue, the physical separation of the child at birth from the mother marks the distinction between a person and a lesser form of human life. The dilemma of when the fetus is a human life also underlies the public abortion debate which questions when society should exert control over a woman's reproductive choices, body and autonomous decision making.

Abortion raises many fundamental questions such as issues concerning the rights of the fetus, the meaning, quality and definition of human life, women's role in society, women's reproductive rights, the rights of the individual versus those of society and sexual norms and values. Abortion is a multi-faceted and complex issue which arouses a multiplicity of meaning both as a social issue and in individual women's lives (Smetana 1982).

Tooley (1983) says that views on the morality of abortion are of three main types : the conservative, or anti-abortion position which is that at any time from conception abortion is always wrong, the liberal or pro-abortion position according to which abortion is never wrong, or at least not seriously so, and then the moderate positions where abortion is acceptable in certain circumstances.

Thomson (1979) says that opponents to abortion base their viewpoint on the fact that the fetus has a right to life but overlook the dependency the fetus has on the mother who loses her right to choose should the fetus' rights be considered. Her argument is that we do not have a special responsibility for another person unless we have assumed it. Her feeling is that it is due to the fetus' physical attachment to the mother that abortion is permissable as it is not possible to detach the fetus alive.

Warren (1979) argues that neither the fetus's resemblance to a person, or potential to be a person, provides any basis for the claim that it has a right to life when a woman's right to protect her health, freedom, happiness and even her life by terminating a pregnancy overrides whatever right to life is ascribed to the fetus.

Jennings (1974) raises the question "Where does life begin and when does it end ? " The response has been that some view the fetus in the early stages of pregnancy as nothing more than a "blob of tissue" (pro -choice viewpoint ) whereas others speak of those who terminate pregnancies as "murderers" (pro-life viewpoint).

The pro-choice viewpoint is developed from the Marxist and Feminist perspective of reproductive freedom i.e that women have the right to choose and make their own decisions about childbearing, contraception and abortion (Petchesky 1984). The pro - life viewpoint is derived from fundamental Judeo - Christian philosophy which indicates that the fetus is from

conception a "human person" with a soul and has a right to life, therefore abortion is considered to be murder (Petchesky 1984).

In the writer's opinion one of the most realistic and humane books written on the morality of abortion is that by Gardner (1972), a Christian gynaecologist who is faced with the reality of abortion in conflict with his Christian values. Gardner (1972) provides a framework to understand the reality of abortion, but believes abortion should not be necessary. He proposes that preventative measures such as an increased awareness of contraception, and better support networks for the pregnant woman may help prevent the need for abortion.

The Roman Catholic Church is traditionally absolute in its moral stance towards abortion. Abortion was considered by theologians to be intrinsically evil in any circumstance (Hurley 1974).

Contraception was even forbidden as it was looked upon as an interference with nature, calculated to rob the act of intercourse of its primary objective, conception. However in contemporary discussions Catholic moralists are becoming more flexible and giving greater importance to human experience. The Catholic churches' concern about abortion is the conflict of values, where abortion is seen as intrinsically evil in the eyes of God but has become a need in society (Hurley 1974).

The Protestant churches stand firm on the fundamental principle that the inviolability of the fetus and its rights must be fully safeguarded but unlike the Catholic church they believe that there are other rights to be taken into consideration which may take precedence. It is indicated amongst Christians that the opinion is gaining ground that abortion is morally permissable where there is a clash between the interests of the fetus and those of the mother (Ellis 1974).

The Jewish view of abortion is determined by the halakhic process, an ongoing interpretation and application of legal principles and precedents in the sacred literature of Judaism. In Judaism the fetus is not considered to have a separate status from the mother and is only considered a person after birth. However the fetus is considered a potential life after forty days gestation when the embryo is formed. Abortion is permitted should the life of the mother be endangered as the life of the mother is considered more important than the potential life of the fetus. Abortion is not permitted without reason, and irresponsible termination of pregnancy is regarded as "akin to homicide" (Weiss 1974).

Weiss (1974) suggests that a competent rabbinic authority should be consulted in each request for a termination of pregnancy to determine to what extent the continuation of the pregnancy poses a threat to the life and health of the mother in terms of halakhic criteria as he understands them.

The question of the morality of abortion in Islam has well-defined primary resources in the religious texts. Moslem

jurists have reached the conclusion that abortion is permissable if the mother's life is in danger or as a means of birth control within the first 16 weeks of pregnancy (Nadvi 1974).

South Africa is a country of many cultural diversities. The various moral and ethical issues concerning abortion in the South African context will be discussed at a later stage.

From my observations I would like to conclude that whatever arguments there are for and against the morality of abortion it has been practised throughout history, and will probably always be practised.

The moral and ethical issues around abortion are important to the study in that it is predicted that the ethical viewpoint and religious beliefs of the participants will affect their experience of termination of pregnancy.

My own ethical viewpoint, which is that of pro - choice, is developed as a result of my personal experience of being a woman in a patriarchal society combined with my experience as a social worker working with women who have abortions. This will be reflected throughout this study and results in researcher bias.

## 2.4 MEDICAL ASPECTS

Medical and technological advances in the development of safe, relatively simple and relatively inexpensive vacuum aspiration techniques or the use of prostaglandin suppositories or

injections which make abortion a relatively safe medical procedure have challenged the traditional interpretation of restrictive laws as a termination of pregnancy has become a relatively simple medical procedure. Legal abortion done under medical supervision has been found to involve less risk than carrying a pregnancy to term (Ferriera 1985).

Surgical evacuation of the uterus through vacuum aspiration is the most popular technique for early pregnancy termination. This procedure is normally conducted under general anaesthetic although local anaesthetic is becoming increasingly popular. In this procedure the cervix is dilated and the placenta and fetus are dislodged and extracted. The procedure is safe, and the incidence of infection low (Broome and Wallace 1984).

Later terminations of pregnancy (over 12 weeks gestation) are usually conducted using intra-amniotic methods, inducing early labour and the birth of a dead fetus (Broome and Wallace 1984).

The vast majority of abortions, especially if performed early on, are without physical complications. However in a minority of cases medical complications do arise such as perforation of the uterus, sterility as the result of infection and, on rare occasions, maternal death (Gardner 1972).

Further medical developments have been made with the introduction of RU 486 (the "abortion" pill) in France. RU 486 is a steroidal derivate and is the first known potent antiprogestin. This drug is administered orally and induces abortion in the first trimester without any

surgical intervention. Clinical results so far indicate that RU 486 can be an efficient and safe contragestive agent for medical termination of early pregnancy or as a post - coital menses inducer or menstrual regulator (Baulieu 1985). RU 486 is currently used in Great Britain and France, and has a success rate of 95,6 %. (O' Donnel 1992). It has not yet been made available in South Africa.

Technological advances have resulted in fetuses being viable at about 20 to 24 weeks and can survive outside the womb if they are given the right medical support. In Great Britain the present law indicates that a woman can have a termination of pregnancy up until 28 weeks gestation but due to technological advances many doctors feels that this limit needs to be lowered (Charlish 1991). These technological advances therefore raise new ethical issues around late terminations of pregnancy.

At Groote Schuur Hospital, where this research was conducted, vacuum aspiration (under 12 weeks gestation) and induced labour (over 12 weeks gestation) are the two main medical procedures currently used to induce abortion.

**2.5 POLITICAL AND LEGAL ASPECTS - AN INTERNATIONAL PERSPECTIVE**

Tietze (1983) says that internationally the legal status of induced abortion ranges from complete prohibition to elective abortion at the request of the pregnant woman.

Ten percent of the world's population live in countries where abortion is prohibited without exception, and eighteen percent live in countries where it is permitted only to save the

life of the pregnant woman. These include most of the countries of Africa, the Moslem countries of Asia, almost two - thirds of the countries of Latin America, and five countries in Europe (Ireland, Spain, Portugal, Malta and Belgium). About eight percent live in countries where abortion could be granted on broader medical grounds (Tietze 1983).

Twenty-five percent live in countries where social factors are considered. These include the German Federal Republic, the United Kingdom, Japan, India and most of Eastern Europe.

Countries allowing abortion on request, generally limited to the first trimester of pregnancy, account for thirteen percent. These include most of the rest of Europe, China, the USSR, and the USA (Tietze 1983).

Over the last two decades many countries have liberalized their abortion legislation to various degrees. The reasons for this are varied and include considerations of public health to combat illegal abortion with its associated morbidity and mortality, social justice to give poor women access to abortion previously only available to the wealthy and woman's rights to secure the right for women to control their own bodies (Tietze 1983).

The conflict over abortion has at times been fought in the political arena particularly in the United States of America. The pro - choice movement in the 1960's became active in lobbying for abortion reform and aimed to repeal restrictive

legislation. They organized lobbies and political manoeuvres which were instrumental in liberalising the abortion laws at the time (Smetana 1981).

In 1973 the United States Supreme Court legalized abortion as the result of Roe v. Wade which bypassed the political process in the majority of States. The Court ruled that the State could not intervene in the abortion decision between a woman and her physician during the first three months of pregnancy. (Sarvis and Rodman 1974). As the result of this, political controversy and agitation in relation to abortion has escalated nationwide (Rosoff 1985).

The inconclusive struggle has led to acute frustration amongst right to life activists who have turned away from political action and more conventional types of protest and resorted to violence against abortion clinics and personnel (Rosoff 1985).

Ward (1986) says that the rise of black militancy in the United States of America in the 1960's coincided with the emergence of birth control programmes and sparked a resurgence of the spectre of genocide where birth control and abortion were perceived by many black communities as integral elements of a white genocidal conspiracy directed against Afro - Americans.

The international political and legal issues regarding abortion form a background to which the South African perspective of abortion is developed. It is relevant to the study in relating the personal to the political as abortion is

a feminist issue where women have fought for their rights internationally. This trend is presently being developed in South African society where women's rights are beginning to be addressed in the legal and political arena.

## 2.6 THE SOUTH AFRICAN PERSPECTIVE

There is very little written and even less research that has been done on abortion in the South African context. There is hardly any literature available on the black perspective of abortion, and what I have managed to obtain is mainly from magazine articles and unpublished documents.

Bradford (1991) says that although the Government has said that abortion will never become part of the South African way of life, there is one backstreet abortion approximately every two minutes and abortion has been a South African way of life for the last 150 years. Hilton (1992) says that between 200,000 - 300,000 women seek illegal abortions in South Africa each year at great risk to their health, life and fertility.

Dyer (1979) says that at Baragwanath Hospital in 1978, of a total of 6 274 admissions to the gynaecological wards, 2 881 were for problems associated with "back-street" abortion. Nine of these women died and 26 suffered from severe infection resulting in hysterectomy.

From the period 1840-1910 abortions were normally assisted by the traditional African herbalist who would give the woman, wanting to terminate a pregnancy, traditional oral abortifacients which consisted of herbs or plants (Bradford

It appeared that these traditional abortifacients worked as useless remedies were rapidly winnowed out in many African societies whose medical codes included the tenet of "no cure, no pay". To restore the fertility of the earth in times of drought, Pedi medicine men obtained a fetus by secretly making a woman swallow an abortifacient (Bradford 1990).

Abortion was apparently common among black women, and shocked Victorian officials claimed that abortion was almost universally practised by all classes of family in African society (Bradford 1991).

By the 1870's, commercial abortifacients found their way from Britain and America to South Africa. A Cape doctor claimed in 1883 that abortion occurred frequently through the use of traditional or commercial abortifacients (Bradford 1991).

From 1910-1960 surgical procedures were increasingly used to terminate a pregnancy. From the 1890's White fertility rates were falling, and in the absence of reliable contraceptive methods, this indicates abortion. It became increasingly difficult for Black women to have abortions as the traditional abortifacients were no longer so easily available. As a result of urbanisation and the fact that Black women did not have access to doctors, they were unable to obtain abortions by surgical procedure e.g. in the late 1920's there were no maternity beds for Africans or Coloureds in the Transvaal. Consequently the mortality rate from abortion increased, because Black women were dying from self-induced abortions (Bradford 1991).

Police records in the 1950's indicated that there was approximately one death a week in Johannesburg as the result of induced abortions (Bradford 1991).

From 1960-1990 abortions which were induced as the result of the insertion of Intra-Uterine devices became increasingly common and today are probably the most common type of deliberately terminated pregnancy in South Africa. In 1975 the Abortion and Sterilization Act prohibited abortion except on particular grounds and as a result of this back - street abortion became an increasingly common practice in South Africa (Bradford 1991).

At Groote Schuur Hospital's Pregnancy Advisory Service, Black women seeking terminations of pregnancy are a minority (approximately 5% during 1975-1993). Most Black patients are either students, professionals or domestic workers who have easier access to the hospital resources. In the last year there has been an increase of Black patients requesting legal terminations through the hospital, but it seems that most of these women have already had some kind of exposure to the hospital system. Black patients seen at the Pregnancy Advisory Service have indicated, that it is not difficult to obtain a "back-street" abortion in the Black communities, and it appears that the incidence of illegal abortion is fairly high.

Corfe (1994) says that the Medical Research Council has researched "backstreet" abortion and found that there are abortionists on almost every street in townships.

Sibisi (1974) compares traditional Zulu values around an unwanted pregnancy with Western values. He says that in traditional Zulu society one of the most important functions of marriage is to produce children and that children are considered as social, religious and economic assets. He says that in traditional Zulu culture illegitimacy does not carry the same stigma as it does in Western society as the child is either legitimized by the father's family if it is the couples intention to marry or automatically adopted by the young woman's parents if the reputed father has no intention of marrying her. Traditionally there is a stronger sense of community and an unwanted child is incorporated into the family.

Sibisi (1974) does not discuss the prevalence of abortion but says that the temptation to terminate a pregnancy is high in the following circumstances : if it will affect the woman's education, if the reputed father is a married man or abandons the pregnant woman or if there are severe financial problems.

Sibisi's paper is based on his own opinions and observations and he indicates that he does not feel he is qualified to speak with authority as he has not done any research on the subject.

The National Party had always maintained that South African women do not want easy access to abortion and that abortion will never become a South African way of life (Bradford 1991).

Oosthuizen (1974) discusses the viewpoint of the Dutch Reformed Church which forms the moral backbone of traditional Afrikaner

rule. He says that there is no doubt that Christian ethics maintain that from conception the fetus is a human life.

Nash (1990) says that teenage pregnancy is extremely common in South African Society. She is supported by a study done by Roberts and Rip (1984) in Cape Town and Ciskei who found that 49 % of women had their first pregnancy by the age of 20. This poses obstetric concerns, concern for the infants and psychosocial concerns. These pregnancies largely result from poor education about contraception and are generally unwanted (Nash 1990). Nash (1990) says that therapeutic abortion should be an alternative to the continuation of the pregnancy. Parents will often go to great lengths to obtain this and teenagers generally have lower rates of morbidity and mortality from induced abortion.

Cates et al (1983) cited by Nash (1990) report that when teenagers have had a therapeutic abortion they are more likely to use contraception, less likely to become pregnant again during adolescence and can resume study and career planning.

Nash (1990) compares the restrictive abortion laws in South Africa with general practise of abortion in Northern European countries where as many as 90% of pregnancies in girls under 15 are terminated by abortion at their request. She says that serious consideration should be given to amending the Abortion and Sterilization Act of 1975 to permit legal termination of pregnancy if desired to girls under 16 years, without seeking psychiatric sanction.

Bradford (1990) says that because patriarchal societies have silenced woman's voices for centuries, and reality has been construed as though men are the norm, the exclusive female experience of having an abortion has been largely hidden from history and in the South African context it has been almost ignored.

The issue of abortion has been the focus of some attention in recent media coverage as South African society is in a transitional period where human rights in a democratic government have been brought out into the open. There has been some indication that the policy of the African National Congress which was voted in to power in the April 1994 elections is to liberalize the present Abortion law in keeping with current trends in the rest of the world.

Hilton (1992) says that within current policy development discussions, abortion and prostitution are two issues that keep getting put aside "for further discussion". She says that the ANC is reluctant to commit itself to the issue of abortion yet it has enormous implications for women's rights and health policy in a future democratic South Africa.

Vinassa (1994) indicates that while some members of the ANC leadership insist that the right to choice is a fundamental human right, abortion is set to become a controversial political issue for complex reasons which are buried in religious values, as well as the traditional customs governing the lives of most South Africans.

Vinassa (1994) says that traditionally African society is patriarchal thus women have no control over their own lives, bodies or reproduction. She believes that this will be one of the major obstacles to liberalising the current abortion laws.

Walker cited by Vinassa (1994) indicates that a study conducted amongst Black nurses in Soweto found that the majority rejected abortion on all levels. Vinassa (1994) says that in her interviews with Black women, they felt that abortion is rejected in traditional African society due to the belief that a baby is a gift from God and the ancestors. Opposition to abortion stems from the fact that the father is being deprived of the right to his child rather than the principle that the rights of the fetus are being infringed on.

Vinassa (1994) says that despite this African women are also faced with the dilemma of an unwanted pregnancy and it appears that "back-street" abortion is widely practised.

Vinassa (1994) concludes that although South Africa's restrictive law has spared us the bitter controversy and violence surrounding abortion in Europe and the United States of America, the debate is about to begin in earnest and abortion law reform is set to become one of the major issues in a future South Africa.

Since April 1994, when a new constitution emphasizing human rights was adopted in parliament, abortion has started to become a topic of debate. Present trends indicate that the legalising of abortion is fairly high on the new government's list of priorities.

A regional women's forum was established in June 1994 to publicise a draft bill which includes the following proposals:

- The availability of abortion "on demand" up to the 14th week of pregnancy.
- Abortion available up to the 24th week of pregnancy for health reasons.
- Doctors should be trained in answering questions asked by women seeking abortions and may choose whether they wish to offer the service of a termination of pregnancy.
- A counselling service should be available for both the pre- and post operative phase (Corfe 1994).

## 2.7 PSYCHOLOGICAL ASPECTS

### 2.7.1 INTRODUCTION TO THE LITERATURE

Previous studies on the psychological and emotional effects of abortion on women will be referred to extensively as these are particularly relevant to this study.

There are wide differences of opinion in the literature on the psychological effects of abortion on women which often reflect the author's own moral or ethical stance, personal clinical experience with therapeutic abortion and interpretation of literature on the subject (Drower 1977).

From about 1940-1965 the literature focused on the damaging effects therapeutic abortion had on the mental health of the woman. This appears to be due to the laws prohibiting abortion in most countries at the time, which resulted in data often being unreliable and deeply held personal convictions

frequently seemed to outweigh the importance of any data that was available especially when conclusions were drawn (Simon and Senturia 1966).

However, since about 1970, research done and reports written indicate that therapeutic abortion seldom induces severe negative emotional reactions and that for most women the termination of an unwanted pregnancy is perceived as therapeutic in itself.

Figa-Talamanca (1975) cited by Broome and Wallace (1982) says that:

> "Studies confirm that abortion for the majority of the women is not a threat to their physical and/or mental well being, but all evidence points in the opposite direction. Most women feel relieved, and they return to as good or even better psychological marital and interpersonal relationships than before abortion."

The majority of literature written and research done after 1970 reflects the above-mentioned viewpoint. Some of this research will be discussed in greater detail.

### 2.7.2 PREVIOUS RESEARCH - EMOTIONAL DISTRESS IN WOMEN BEFORE AND AFTER TERMINATIONS OF PREGNANCY.

Some previous studies which are similar to this study will be referred to. These include research done by Dagg (1991), Schmidt and Priest (1981), David (1985), Drower (1977), Lee (1969),and Teichmann et al (1993).

Dagg (1991) reviewed 225 papers published internationally which focus on the psychological sequelae of therapeutic abortion. He

claims that overall results of studies indicated that adverse reactions to abortion occur in a minority of women, and even these seem to be the continuation of symptoms that appeared before the abortion.

Dagg (1991) further indicates that early research emphasized a disease model and tended to concentrate on the medical and psychiatric complications of abortion. The emphasis has now shifted toward a model where research examines the antecedents and psychological sequelae that affect the women who seek terminations of pregnancy.

This shift seems to stem from the liberalisation of abortion laws in many countries. It needs to be noted however, that the present law in South Africa remains conservative, and the study population in this research may differ from women who have terminations of pregnancy in countries where abortion laws are more liberal, as the women in this study who are recommended for legal abortions are assessed within the limits of Section 3(1)(b) of the Abortion and Sterilization Act of 1975.

From his review of studies on the psychological sequelae of abortion Dagg (1991) differentiates between the immediate and more subtle psychological sequelae of therapeutic abortion. He indicates that immediately after an abortion, symptoms of distress and dysphoria do occur in many women but these seem to be a continuation of symptoms from before the abortion and more as result of the circumstances leading to the abortion than as a result of the procedure. Dagg (1991) also says that long

term studies over months and years show similar trends, with the majority of women expressing positive reactions to the abortion and a minority expressing any degree of regret.

Dagg (1991) concludes that emotional distress after a termination of pregnancy normally occurs when a pregnancy is terminated for medical or genetic reasons, when there is a history of psychiatric contact before the abortion, in mid-trimester abortions, and when women experience significant ambivalence about the decision.

Psychological coping styles and resilience also play a role in the psychological sequelae of abortion in that certain defence mechanisms such as repression, denial and projection may hinder a woman working through and resolving the loss of a fetus (Dagg 1991).

Schmidt and Priest (1981) conducted a follow-up study of psychiatric referrals for termination of pregnancy shortly after the implementation of the Abortion Act of 1968 in Great Britain. This study is similar to the research undertaken in that it takes place within a similar legal framework. A sample of 57 women were examined and psychometric testing was used as the measuring instrument. Out of 35 women recommended for terminations of pregnancy, 24 were single, 20 had been separated from one or both parents and 16 had a history of psychiatric problems.

Of the women who were available for follow-up the mean psychometric scores improved early (1 -17 months after assessment) and eventually fell into the normal range

(3 - 6 years later.) An in - depth follow - up study of 10 women was done. A significant finding of this study was the poor success of the follow-up in terms of numbers, which is attributed to an indication of ambivalent feelings aroused in patients about the termination of pregnancy. The personal accounts obtained from the small sample helped to clarify the meaning that a termination of pregnancy had for the woman presenting with an unwanted pregnancy.

> " Many of the women interviewed felt that the termination represented a crisis or turning-point in their lives, following on in some cases a long history of struggle with early life experiences. Pregnancy could be said to have been for these women an attempt to establish some form of equilibrium in the face of intolerable conflict where no other resolution appeared to present itself. The "unwanted" pregnancy may thus represent for some women a vehicle for their restorative and reparative wishes as well as for their destructive wishes. An awareness of the co-existence of these paradoxical feelings is crucial to an understanding of the women who present for TP. (Termination of pregnancy)"
>
> (Schmidt and Priest 1981 : 273)

Schmidt and Priest (1981) also emphasize the importance of the above for the network of professional services to take note of this so that counselling and psychotherapy can be made available as a preventative mental health service which could influence abortion recidivism as well as future psychiatric breakdown.

David (1985) discusses research done on post-abortion and post-partum psychiatric hospitalizations. He says that confusion persists with regard to psychological risks associated with term deliveries and induced abortions due to a lack of epidemiological data on such admissions to psychiatric hospitals.

His research involved tracking down women admitted to psychiatric hospitals in Denmark in the three month period following abortion or delivery and comparing these to general admissions of women of a similar age group. His findings were that women who have had abortions were at a higher risk of being admitted to psychiatric hospitals than women who had delivered. He also found that psychiatric admissions were higher for women who were separated, divorced or widowed.

David (1985) further discusses these findings by saying that many women who have had abortions often did so due to the ending of a relationship and the subsequent lack of social support which led to a greater level of stress around the abortion decision.

David's findings included:

1) Some women do experience post-abortion psychiatric disorder but these are generally reported as isolated case studies.
2) Ambivalence with regard to the decision to have an abortion is an indication of stress and potential future problems.
3) Women experience very little guilt about abortion.

In the discussion around his article at the Ciba Foundation Symposium, David says:

" Psychological reactions to abortion seem to be something that we male physicians and scientists have exaggerated, not the women who have abortions. Our perception is that abortion is an awful experience for women. Although it is a difficult decision most women make it very quickly.....It is not a decision a woman makes frivolously. For some it is quite a maturing experience. It helps them to delay having children until they are ready to have them."

(David 1985 : 162)

Lee (1969) wrote her book "The search for an Abortionist" before abortion was legalised in the United States of America. This study is relevant to this research as the law about abortion in the United States of America at that time was similar to the present law in South Africa.

Lee (1969) found psychological reactions to abortion difficult to assess, as feelings of anxiety and depression could be attributed to the pregnancy itself, the abortion, involvement in an illegal activity or reactions to the crisis in the relationship with the reputed father. In her study of 112 subjects: 61 reported no depression, 11 reported mild depression, 31 reported moderate depression and 9 reported severe depression. The incidence of depression was related to the women's impression of the abortionist, the amount of aftercare and the deterioration of the relationship with the man involved in the pregnancy. Self-blame over carelessness with contraception, religious background and the kind of relationship with the man involved in the pregnancy did not directly relate to the incidence of depression.

Many women indicated that they were far more depressed before the abortion and during the period of making the decision and searching for an abortionist than they were afterward (Lee 1969).

Teichman et al (1993) conducted a recent study in Israel where emotional distress in a group of Israeli women requesting legal abortion was compared with emotional distress in a group of women on the verge of delivery and with a random group of non-pregnant women on measures of anxiety and depression.

The emotional consequences of termination of pregnancy were evaluated by before and after comparisons of the same measures of depression and anxiety in a subgroup of the women who had abortions. The study population was three groups of high school graduates: 77 women who requested legal abortions, 32 women who were in the 40th week of pregnancy and 45 nonpregnant women.

All the women in the pre-abortion group were asked if they would participate in a follow up study three months later, 35 agreed but when actually approached only 17 of these (22% of the original sample) filled out the questionnaires again. This low response limits the conclusions based on the before-after comparison and brings to attention an important problem in research in this field. Teichman et al (1993) postulate that this may demonstrate the negative attitude of these women to the abortion experience and their wish to forget it.

The method of research in this Israeli study is similar to the research to be undertaken and also utilizes the measuring instrument of an Anxiety Rating Scale.

The findings of Teichman et al (1993) were that before abortion women experience increased emotional distress and discomfort in couple relationships and after abortion both were reduced. The comparative study i.e comparing the experiences of women seeking to terminate a pregnancy with other pregnant and non-pregnant women demonstrate differences in emotional experiences in that while pre-aborting women reported significantly higher anxiety and depression, predelivery

women reported only a slightly higher than normal level of anxiety. The reduction of these levels of anxiety and depression in the aborting women after having a termination of pregnancy confirm the idea that the emotional distress experienced by pre-aborting women is temporary and tends to disappear after the abortion.

Zolese and Blacker (1992) summarize some of the previous studies done on the psychological complications of therapeutic abortion. They conclude that although psychiatric or psychological disturbances occur in association with therapeutic terminations of pregnancy they are only persistent, severe and marked in a minority of women - approximately 10%. Further the authors say that research designs for studying the psychological aspects of therapeutic abortion are particularly vulnerable for many reasons, but primarily because women who choose termination of pregnancy are not amenable to endless questions on how they feel, they are less likely to return for follow-up, and baseline assessments before they become pregnant are impossible. It is also important to consider a number of confounding variables such as to what extent these disturbances are unique to the abortion procedure.

Gameau (1993) in a recent paper says that a wide body of literature agrees that women do not experience long-term negative outcomes following a termination of pregnancy.

Thompson (1989) cited in Gameau (1993) says that in a 1989 review of 250 studies on the effect of abortion on women, the U.S. Surgeon General found no evidence to confirm the existence of "post-abortion syndrome". The American Psychological Association on reviewing the same data concluded that abortion inflicts no particular psychological damage on women.

Two previous studies on abortion at the Pregnancy Advisory Service at Groote Schuur Hospital have been conducted by Drower (1977) and Navias (1979). These are particularily relevant to this research as they were done at the same hospital.

Sandra Drower's doctoral thesis "A Survey of Patient's Referred for Therapeutic Abortion on Psychiatric Grounds in a Cape Provincial Hospital" was completed in 1977, shortly after the introduction of the Abortion and Sterilization Act of 1975 at Groote Schuur Hospital's Pregnancy Advisory Service. The aims of this study were :

> "(1) to seek to isolate those features which distinguished patients in a group recommended for therapeutic abortions on psychiatric grounds from those who were refused such recommendations; (2) to isolate those factors in the psycho-social history which appear to have influenced the decisions made and (3) to conduct a follow-up study of both groups in order to study the late sequelae of the decision."
>
> (Drower 1977)

The third aim of Drower's study is particularly relevant to this study as she discovered that there was more evidence of disturbed behaviour in the group that were recommended legal terminations, but that after the pregnancy was terminated emotional distress receded with the passage of time.

In her follow-up study, relief was initially reported by most patients, and at long term follow-up, little depression, guilt or anxiety was admitted and there was no serious psychiatric sequelae (Drower 1977).

Navias (1979) in an informal follow-up study of women who had abortions at the Pregnancy Advisory Service at Groote Schuur Hospital reports similar findings i.e. that none of the women who had abortions reported emotional problems afterwards.

### 2.7.3 OTHER LITERATURE RELATED TO THE PSYCHOLOGICAL EFFECTS OF ABORTION

This section will discuss some of the other literature, apart from previous research, on the psychological effects of abortion.

Pipes (1986) says that many surveys done on the psychological effects of abortion fail to take into account that an abortion can be used to help women to discover things about themselves that they need to change in order to live more satisfying and fulfilling lives. She says that an unwanted pregnancy prompts women to start asking questions about their sexuality, fertility, motherhood and the reality of pregnancy.

Pipes (1986) further indicates that women do experience a sense of loss after having a pregnancy terminated, which is often an echo of previous losses and this needs to be acknowledged. Society's disapproval of abortion encourages women who have had a termination of pregnancy to suppress their feelings which results in inhibiting the process of working through the experience.

Gardner (1972) says that ignorance of the outcome of abortion arises from the risk of observer bias in the investigation, i.e the dual role of the researcher as counsellor. Due to this it is difficult to find out the woman's real feelings after the operation as she may suppress her feelings of guilt in order to prove that she could cope with a termination of pregnancy but may be unable to cope with a continuation of the pregnancy (Gardner 1972).

Horwitz (1990) says that women's psychological experiences of abortion are bound up with patriarchal influences concerned with women's health, sexuality and role in society.

Further, Horwitz (1990) says that abortion is often accompanied by a sense of loss. A loss of motherhood, loss through changes in relationships, and loss in women's sexuality. This loss is often accompanied by depression, denial, ambivalence, guilt and anger. However, abortion like any crisis, may also be perceived by women as being a positive experience where relief and self-discovery are the primary psychological responses.

For many women an abortion confirms the completion of having made a decision and being in control of their own fertility, thus it can be an empowering experience for many women who experience themselves as powerless and helpless in their daily lives. For some women the sense of relief is in response to being free of the responsibility of caring for an unwanted child (Horwitz 1990).

Horwitz (1990) continues by saying that the decision to have an abortion can have implications for a woman's journey to self-discovery as by carrying out the decision, she actively rejects the prescribed role of motherhood and is able to pursue other alternatives that may enrich her life.

### 2.7.4 ABORTION COUNSELLING

Gameau (1993) says that social work intervention with women having terminations of pregnancy draws on a number of approaches including crisis intervention, problem-solving, psychoeducation and bereavement and loss theory.

Pre-abortion counselling utilizes the crisis intervention model as women seeking to terminate a pregnancy are generally in crisis. This involves an immediate focus on the crisis situation, an evaluation of the current predicament and planning of social work intervention (Golan 1978).

A problem-solving approach is utilized where the desire to terminate the pregnancy is perceived as being the solution to the unwanted pregnancy. Psychoeducation is used to provide the patient with information about contraception, resources available and the medical procedure for termination of pregnancy. Social workers involved in abortion counselling need to have knowledge about bereavement and loss theory as women having terminations of pregnancy are often faced with the ending of a relationship as well as the loss of the fetus.

Navias (1979) says that the social worker is the pivot of the medical team providing services to women seeking

terminations of pregnancy due to her role in providing emotional support during the process. One of the most important tasks is to help the patient deal with the reality of the situation and offer her the opportunity to discuss her feelings and alternative courses of action prior to the termination of pregnancy.

Navias (1979) perceives the role of the social worker in counselling women prior to a termination of pregnancy as being therapeutic as well as diagnostic as unwanted pregnancies can be symptomatic of other problems.

Gameau (1993) describes a social work service for women presenting for elective termination of pregnancy developed by the Social Work Department of the Queen Elizabeth Hospital in Adelaide, South Australia. They used a high social risk identification and screening process and developed a protocol describing essential elements of clinical social work practice.

Gameau (1993) emphasizes the importance of pre-abortion counselling through social work intervention, the goal of which is healthy resolution. It is important that the woman wanting a termination of pregnancy understands the meaning of her decision, makes a choice for which she feels responsible and finds ways to cope with the decision and the choice.

Also, Gameau (1993) feels that social work has an important contribution to make towards empowering and supporting women in this time of crisis and assisting them with a long-term satisfactory outcome, by assisting with the decision making process.

Gameau (1993) identifies women at risk for post-abortion problems as those who are ambivalent about abortion, who feel coerced into the decision, have been deserted by the father of the pregnancy, have little psycho-social support, have poor decision making skills, have a history of emotional abuse or are in the mid-trimester of pregnancy.

Navias (1979) says that after-care is important and involves maximum use of hospital and community resources. She does not indicate whether patients who have had terminations of pregnancy return for post-abortion counselling or not.

Horwitz (1990) says that when women who have had abortions enter therapy at a later stage the experience of having had a termination of pregnancy can be used therapeutically to assist them to discover for themselves the meaning the unwanted pregnancy and subsequent termination of pregnancy had for them.

The same author suggests that clinical intervention with women who have had abortions needs to consider the extent to which the abortion has affected the individual woman, acknowledge that the woman may feel both painful and positive emotional responses, explore earlier problems or unresolved conflicts which may be evoked by the abortion and recognise the influences of patriarchal oppression on the woman's internal psychological experience of abortion (Horwitz 1990)

Horwitz (1990) proposes that feminist psychotherapy is an appropriate intervention with women who have had abortions as

it takes into account that abortion is a specific woman's issue and has certain psychological ramifications for women which are compounded by external patriarchal forces.

## 2.8 CONCLUSION

Before 1970, studies done on the psychological effects of abortion focused on the negative effects of abortion, but more recent findings in both local and international studies of the psychological effects on abortion indicate that women experience higher levels of emotional distress before a termination of pregnancy which are subsequently lowered after the procedure.

In the present South African context, it appears that abortion is still a secretive and controversial issue. The present legislation, the Abortion and Sterilization Act of 1975, limits women with unwanted pregnancies who seek abortions, from seeking counselling before and after the abortion as in most cases having an abortion is illegal and women run the risk of being criminally prosecuted should it be known.

In my experience, through being employed as a Social Worker at the Pregnancy Advisory Service at Groote Schuur Hospital, I have observed that amongst the general population little is known about the effects of abortion and there appears to be an assumption that for women having terminations of pregnancy it is a traumatic experience.

As a result of recent proposed changes to the Abortion and Sterilization Act of 1975 there is a need for further research

to be done in the area to assess what the needs of South African women having terminations of pregnancy are with regards to abortion counselling.

Based on the research findings and the proposed changes to legislation in the South African context the present research is conducted to find out if emotional distress is lower after a termination of pregnancy in women having abortions in the present South African context, and to ascertain the role of the social worker in abortion counselling.

# CHAPTER 3 : RESEARCH METHODOLOGY

## 3.1 CONCEPTUALISATION OF THE RESEARCH

When I started working at the Pregnancy Advisory Service at Groote Schuur Hospital it was my intention to start a post-abortion counselling service for the women assessed for terminations of pregnancy. However I soon noticed that patients did not appear to want this service and seldom kept follow-up appointments after they had had a termination of pregnancy. The few women who were seen afterwards seemed to be on the whole relieved and perceived the abortion as therapeutic in itself. The literature read around the issue was on the whole consistent, where most previous research indicated that, a legal termination of pregnancy performed in adequate medical conditions, was not found to have a negative effect on the psychological well-being of the woman. Literature, usually written before 1970, discussed the "post-abortion syndrome" as a major source of emotional distress. This led to curiosity about emotional distress in women before and after a termination of pregnancy and the implications for social work intervention in the South African context.

## 3.2 BIAS OF THE RESEARCHER

My own bias is that after having counselled women requesting a termination of pregnancy and observing the distress an unwanted pregnancy can cause, I have become pro-choice in my own moral conceptualisation of abortion and believe that a woman should have the right to choose to terminate a pregnancy if she so desires in the first 12 weeks of pregnancy.

## 3.3 STATEMENT OF HYPOTHESES

After working at the Pregnancy Advisory Service at Groote Schuur Hospital for a year counselling and assessing approximately 40 - 50 women a month for terminations of pregnancy I have come to wonder why patients do not return for post-abortion counselling. In the follow-up that I have done prior to the current research, the patients seen appeared to be relieved about the termination of pregnancy and perceived the experience both of pre-abortion counselling and having the pregnancy terminated as being beneficial to them. As a result of the ethical issues around abortion one would presume that having a termination of pregnancy would cause some level of emotional distress to the woman concerned.

My hypotheses are therefore as follows:

1.The level of emotional distress in women wanting a termination of pregnancy is lower after an abortion.
2.When women have been counselled prior to a termination of pregnancy they do not want post-abortion counselling.

## 3.4 RESEARCH DESIGN

The research is an exploratory and descriptive study and the research design is survey research and participant observation.

The research method is qualitative research as it intends to generate theoretically richer observations and depth of understanding which are not easily reduced to statistics (Rubin and Babbie 1993).

Measures such as the Hamilton Anxiety Scale and a mental status examination will be used to supplement the information obtained in the questionnaires and interviews with the participants.

## 3.5 DISCUSSION OF METHODOLOGY

The research methodology that will be used in this study is participant observation and survey research.

### PARTICIPANT OBSERVATION

The researcher was working in the area of abortion through her position as a social worker in the Pregnancy Advisory Service at Groote Schuur Hospital, counselling women seeking to terminate their pregnancies. Many women seeking terminations of pregnancy were therefore accessible to the researcher. The researcher is therefore in the dual role of researcher/ counsellor, thus can observe levels of emotional distress in women before and after termination of pregnancy. A mental status examination adapted from the Maudsley framework, will be utilized to record these observations and make them as objective as possible.

### SURVEY RESEARCH

Survey research is the most appropriate method to compare emotional distress in women before and after terminations of pregnancy.

The survey method with the use of both questionnaires and face-to-face interviews will be used to conduct the research. A standard instrument, the Hamilton Anxiety rating scale, will be used to measure emotional responses and levels of distress in the sample population.

## 3.6 DESCRIPTION OF STUDY POPULATION AND SAMPLE

The study population is a group of 40 women assessed for terminations of pregnancy at Groote Schuur Hospital's Pregnancy Advisory Service in the periods 1 December - 14 December 1993 and 5 January - 19 January 1994. The sample is an availability study and includes every woman who lives in Cape Town assessed in this time period. Women who do not live in Cape Town are to be excluded from the sample due to predicted difficulties in follow-up.

Although the sample is not a probability sample it will include every woman, under 12 weeks gestation and living in Cape Town, seen at the Pregnancy Advisory Service at Groote Schuur Hospital in the time period 1 December - 14 December 1993 and the 5 January - 19 January 1994 and granted a termination of pregnancy according to Section 3 (1) (b) of the Abortion and Sterilization Act of 1975.

## 3.7 MEASUREMENTS

The measurements to be used are as follows:

A questionnaire is to be issued to the sample population prior to assessment obtaining identifying information. (See Annexure A - Questionnaire 1.)

An interview schedule assessing emotional distress prior to the termination of pregnancy. (See Annexure A - Interview Schedule 1.)

An interview schedule assessing emotional distress in the short term (6 weeks to 3 months) after the termination of pregnancy. (See Annexure A - Interview Schedule 2.)

Mental status examinations to record levels of emotional distress in women before and after termination of pregnancy.

The Hamilton Anxiety Scale (see Annexure A) is also to be used to supplement information in the interview schedule and will be administered before and after the termination of pregnancy to measure changes in anxiety levels.

Two case studies will be included in Annexure C, to provide more detail of a sample of the respondents.

## 3.8 LIMITATIONS OF THE STUDY

It is predicted that there may be limitations to the study as follows:

1. Abortion is an ethical issue which is often the cause of controversy. People have differing views on abortion varying from pro-life to pro-choice. For women wanting an abortion it becomes a confidential issue which they may even have difficulty in sharing with those closest to them. As a result of this women may be reluctant to provide information about how they feel about having a termination of pregnancy.

2. It will be difficult to obtain information from patients after they have had a termination of pregnancy as once they have had medical assistance they are no longer within the hospital system.

3. The study is limited to one hospital in South Africa when there are several more with a similar service. The study only

considers women who have had a legal termination of pregnancy at Groote Schuur Hospital in Cape Town according to Section 3 (1)(b) of the Abortion and Sterilization Act of 1975 so is not generalizable. It does not include women who have had abortions according to other sections of the Act or women who have had "back-street" abortions.

4.The law is presently in transition due to constitutional changes and a proposed new abortion bill may affect the relevancy of the research.

5.There is not much literature available on abortion in the South African context at present which limits discussion about the cross-cultural aspects of abortion.

6.The researcher's dual role of researcher and counsellor may affect the responses of the participants in the study.

7.The sample population is small. The descriptive analysis does not provide a basis for generalising beyond this study.

# CHAPTER 4 : RESULTS AND DATA ANALYSIS

## 4.1 SUMMARY OF THE RESEARCH PROCESS

A questionnaire (Annexure A - Questionnaire 1) was issued to all the women (N = 40) seen at the Pregnancy Advisory Service between 1 to 14 December 1993 and 5 to 19 January 1994.

Once the questionnaires were completed the respondents were assessed and counselled around the crisis of the unwanted pregnancy by the clinical social worker.

Twenty-five patients were seen by the researcher after it had been decided by the psychiatrist that they fell within the provisions of Section 3 (1) (b) of the Abortion and Sterilization Act of 1975. Interview Schedule 1 and the Hamilton Anxiety Scale were completed at this interview after the decision about having a termination of pregnancy had been made but prior to the actual procedure. More detailed information on two of these respondents is presented in Annexure C.

Appointments were made for the respondents to return to the Pregnancy Advisory Service for the follow-up study 6 weeks to 3 months after the termination of pregnancy. Fifteen of the respondents participated in the follow-up study to determine emotional distress in women after termination of pregnancy. Levels of emotional distress and desire for post-abortion were measured using Interview Schedule 2, the Hamilton Anxiety Scale and mental status examinations.

## 4.2 DATA COLLECTION

### QUESTIONNAIRE 1 - IDENTIFYING DETAILS AND DEMOGRAPHIC INFORMATION

The questionnaire (see Annexure A - Questionnaire 1) was issued to 40 women at the Pregnancy Advisory Service between 1 - 14 December 1993 and the 5 - 19 January 1994 while they were waiting for their appointments with the social worker. The women were told about the research that was to be done and asked if they would like to participate. They were reassured about confidentiality. The respondents completed the questionnaires themselves while sitting in the waiting room at the Pregnancy Advisory Service. Consideration was made for those who were illiterate or for whom English was not their mother tongue. All the questionnaires were completed by the respondents by marking the appropriate response although several did ask the researcher for assistance. Forty questionnaires were completed in this manner. At this initial stage all the women agreed to participate in the research.

### PRE-ABORTION COUNSELLING

After the questionnaire was complete pre-abortion counselling was provided to all of the respondents at the Pregnancy Advisory Service at Groote Schuur Hospital. Pre-abortion counselling utilizes a crisis intervention model. When women are faced with the dilemma of an unwanted pregnancy they are generally in a state of crisis.

The role of the clinical social worker at the Pregnancy Advisory Service with regard to pre-abortion counselling is as follows:

1. To enable the patient to express her feelings about the crisis of an unwanted pregnancy.
2. To explore with the patient her reasoning for requesting a termination of pregnancy.
3. To assist the patient in a non-judgemental manner to explore other alternatives to a termination of pregnancy such as adoption and continuing with the pregnancy.
4. To provide the patient with information about contraception and other resources when required such as homes for unmarried mothers, adoption agencies and other relevant community resources.
5. To provide support throughout the whole process.

Thirty-nine patients were sure they wanted an abortion even when alternatives were explored with them and one woman decided that she would continue with the pregnancy. This woman had wanted an abortion for economic reasons and when she was informed about the alternatives such as a home for unmarried mothers and adoption she changed her mind.

One women had a miscarriage so no longer needed to be assessed for a termination of pregnancy and two patients did not return and were later found to have had terminations of pregnancy elsewhere. Two patients qualified for a legal abortion on other grounds included in the Abortion and Sterilization Act

of 1975 (one agreed to lay a charge of rape and one obtained an abortion on medical grounds). Nine patients were denied terminations of pregnancy as they did not meet the provisions of the Act. These patients were not included in the research.

There was a significantly high number of women who presented with pregnancies as the result of rape. All of these women were counselled accordingly, and also referred to Rape Crisis for further intervention. Annexure C includes two case examples to highlight some of the issues.

## EMOTIONAL DISTRESS IN WOMEN PRIOR TO A TERMINATION OF PREGNANCY

Of the original sample of 40 women, there was a fall out of 15 respondents so that only 25 women participated in this part of the research. The levels of emotional distress were assessed by interviewing the respondents after the decision had been made by the psychiatrist that they qualified for a termination of pregnancy according to Section 3 (1)(b) of the Abortion and Sterilization Act 1975. This excluded the variable of anxiety as a result of the women not knowing if they were able to have a legal abortion.

The 25 patients who were interviewed were each seen for approximately 45 minutes to an hour. (This does not include the pre-abortion counselling which was generally an hour in

duration). This interview included the questions asked in Interview Schedule 1, the Hamilton Anxiety Scale and a mental status examination (see Annexure A). Follow-up appointments were made with these 25 patients for 6 weeks to three months after they were to have a termination of pregnancy. All these patients agreed to return and participate in the research. Annexure C provides more information about two of the cases.

EMOTIONAL DISTRESS IN WOMEN AFTER TERMINATION OF PREGNANCY.

Of the twenty-five women who participated in the first part of the survey i.e emotional distress in women before termination of pregnancy, only fifteen participated in the follow - up research. Seven respondents kept their follow-up appointments as contracted without being reminded. One patient came for her follow-up appointment later claiming to have forgotten about it. Seven patients participated in the follow-up study through telephonic interviews. These interviews included the questions asked in interview schedule 2, and levels of emotional distress were measured with the Hamilton Anxiety Rating Scale and mental status examinations.

Of the ten remaining patients who did not participate in the follow-up study, six were no longer contactable despite attempts at telephoning them and writing call in letters and four did not keep further appointments made and were never able to

respond when contacted telephonically due to reasons such as being unable to talk about the issue from work, etc. The eight patients who returned to the Pregnancy Advisory Service for the follow-up interview were very willing to participate in the research and appeared to talk quite openly about their feelings around the termination of pregnancy. The eight women with whom face to face follow-up interviews were conducted were seen for approximately an hour to an hour and a half.

Most of the seven patients who participated in the follow-up research by providing telephonic interviews claimed they did not have the time to come in for face to face interviews at the Pregnancy Advisory Service due to demands of job or family. The seven telephonic interviews were approximately twenty minutes to half an hour each.

The Data was recorded on the set of instruments displayed in Annexure A and also in the patients' psychiatric folder at the Pregnancy Advisory Service.

For the purposes of data analysis the study population will be grouped as follows:

**Group A :** Respondents who returned to the hospital for follow-up appointments.

N = 8

**Group B :** Respondents with whom follow-up telephonic interviews were done.

N = 7

**Group C :** Respondents who did not participate in follow-up.

N = 10

For the purposes of this research Group A and B will be the focus of the research but attention will be given to group C as it is important to attempt to form an understanding why this group of women did not respond to the follow-up i.e emotional distress in women after termination of pregnancy.

## 4.3 METHOD OF DATA ANALYSIS

Univariate analysis (the examination of the distribution of cases on only one variable at a time) and multivariate analysis (the comparison of subgroups indicating the relationships between the variables themselves) were both used (Rubin and Babbie 1993). The data has been analyzed descriptively, but where possible, tables have been used for further illustration.

## 4.4 FINDINGS

### 4.4.1 FINDINGS - QUESTIONNAIRE 1 (IDENTIFYING DETAILS AND DEMOGRAPHIC INFORMATION)

Questionnaire 1 (see Annexure A) was completed by the respondents themselves by marking appropriate responses. This purpose of this questionnaire was to obtain demographic information, relationship with the reputed father and use of contraception. Forty women completed the questionnaire initially but only the responses of the 25 who were granted legal abortions according to Section 3 (1) (b) of the Abortion and Sterilization Act of 1975, are included here.

The results are recorded in tables, followed by comments on the information presented in the tables. The percentage of the whole sample who participated in the research is in brackets, next to the number of patients who gave a particular response. The responses are grouped into groups A, B and C. Group A are the patients who participated in follow-up through office interviews, Group B are the patients who participated in follow-up through telephonic interviews and Group C are the patients who did not participate in follow-up. Two case examples are included in Annexure C to provide more in-depth information.

QUESTION 1 - HOW OLD ARE YOU ?

TABLE 1 - AGES OF WOMEN REQUESTING TERMINATION OF PREGNANCY

| N (%) | | | | TOTAL |
|---|---|---|---|---|
| GROUP | A | B | C | |
| 17 - 22 | 3 (12) | 0 (0) | 4 (16) | 7 (28) |
| 23 - 29 | 3 (12) | 4 (16) | 5 (20) | 12 (48) |
| 30 - 40 | 2 (8) | 2 (8) | 1 (4) | 5 (20) |
| OVER 40 | 0 (0) | 1 (4) | 0 (0) | 1 (4) |
| TOTAL | 8 (32) | 7 (28) | 10 (40) | 25 (100) |

The range of women was between 17 and 45. Most of the respondents were in early adulthood between 17 and 29 (N=19 or 76%).

QUESTION 2 - WHAT IS YOUR MARITAL STATUS ?

TABLE 2 - MARITAL STATUS OF WOMEN REQUESTING TERMINATIONS OF PREGNANCY.

| | N(%) | | | TOTAL |
|---|---|---|---|---|
| GROUP | A | B | C | |
| SINGLE | 6(24%) | 3(12%) | 9(32%) | 18(72%) |
| MARRIED | 1(4%) | 3(12%) | 0(0%) | 4(16%) |
| DIVORCED | 1(4%) | 1(4%) | 1(4%) | 3(12%) |
| WIDOWED | 0(0%) | 0(0%) | 0(0%) | 0(0%) |
| COHABITING | 0(0%) | 0(0%) | 0(0%) | 0(0%) |
| TOTAL | 8 (32%) | 7 (28%) | 10 (40%) | 25 (100%) |

The majority of the subjects were single (N = 18 or 72%). None of the respondents were widowed or reported live-in relationships at the time of the pregnancy. It was interesting that all of the married women participated in the follow-up research.

QUESTION 3 - WHAT RELIGION ARE YOU ?

TABLE 3 - RELIGIOUS AFFILIATION OF WOMEN REQUESTING TERMINATIONS OF PREGNANCY.

| | N(%) | | | TOTAL |
|---|---|---|---|---|
| GROUP | A | B | C | |
| PROTESTANT | 2(8%) | 2(8%) | 3(12%) | 7(28%) |
| ROMAN CATHOLIC | 0(0%) | 0(0%) | 2(8%) | 2(8%) |
| MOSLEM | 1(4%) | 0(0%) | 0(0%) | 1(4%) |
| OTHER | 5(20%) | 5(20%) | 5(20%) | 15(60%) |
| TOTAL | 8(32%) | 7(28%) | 10(40%) | 25(100%) |

The "other" group refers to women who were members of charismatic Christian churches, Jewish or agnostic.
It was significant that neither of the Roman Catholic patients returned for follow-up appointments. There were no other significant findings.

QUESTION 4 - WHAT IS YOUR EDUCATION LEVEL ?

TABLE 4 - HIGHEST LEVEL OF EDUCATION IN WOMEN HAVING TERMINATIONS OF PREGNANCY

| | N (%) | | | TOTAL |
|---|---|---|---|---|
| GROUP | A | B | C | |
| STANDARD 8 OR 9 | 3(12%) | 2(8%) | 3(12%) | 8(32%) |
| MATRIC | 1(4%) | 1(4%) | 5(20%) | 7(28%) |
| COLLEGE/TECHNIKON | 1(4%) | 4(16%) | 1(4%) | 6(24%) |
| UNIVERSITY | 3(12%) | 0(0%) | 1(4%) | 4(16%) |
| TOTAL | 8(32%) | 7(28%) | 10(40%) | 25(100%) |

All the women in the sample had passed Standard 8, so the average educational level was higher than that of the general population. Most of the participants that had a university degree or college/technikon diploma returned for follow-up office interviews. There was no other significant findings.

QUESTION 5 - WHAT IS YOUR HOME LANGUAGE ?

TABLE 5 - HOME LANGUAGE OF WOMEN HAVING TERMINATIONS OF PREGNANCY.

| NO. (%) | | | | TOTAL |
|---|---|---|---|---|
| GROUP | A | B | C | |
| ENGLISH | 5(20%) | 6(24%) | 8(32%) | 19 (76%) |
| AFRIKAANS | 2(8%) | 1(4%) | 1(4%) | 4 (16%) |
| XHOSA | 1(4%) | 0(0%) | 1(4%) | 2 (8%) |
| TOTAL | 8(32%) | 7(28%) | 10(40%) | 25(100%) |

The majority of the respondents (N = 19 or 76%) indicated that English was their first language. Xhosa was the home language for only two of the respondents.

QUESTION 6 - WHAT IS YOUR "ETHNIC CLASSIFICATION" ?

TABLE 6 - ETHNIC CLASSIFICATION OF WOMEN HAVING TERMINATIONS OF PREGNANCY

| N(%) | | | | TOTAL |
|---|---|---|---|---|
| GROUP | A | B | C | |
| WHITE | 3(12%) | 3(12%) | 3(12%) | 9 (36%) |
| COLOURED | 4(16%) | 4(16%) | 5(20%) | 13 (52%) |
| BLACK | 1(4%) | 0(0%) | 2(8%) | 3 (12%) |
| TOTAL | 8(32%) | 7(28%) | 10(40%) | 25 (100%) |

It was significant that so few black patients participated in the research. This does not reflect the population of Cape Town, but does reflect the ethnic classification of women who request abortions at the Pregnancy Advisory Service at Groote Schuur Hospital.

QUESTION 7 - WHERE DO YOU STAY ?

TABLE 7 - RESIDENTIAL AREA OF WOMEN HAVING TERMINATIONS OF PREGNANCY.

| | N(%) | | | TOTAL |
|---|---|---|---|---|
| GROUP | A | B | C | |
| SOUTHERN SUBURBS | 1(4%) | 4(16%) | 4(16%) | 9(36%) |
| NORTHERN SUBURBS | 2(8%) | 2(8%) | 2(8%) | 6(24%) |
| CAPE FLATS | 4(16%) | 0(0%) | 1(4%) | 5(20%) |
| KHAYELITSHA/LAGUNYA | 1(4%) | 0(0%) | 1(4%) | 2(8%) |
| MITCHELL'S PLAIN | 0(0%) | 0(0%) | 0(0%) | 0(0%) |
| OTHER | 0(0%) | 0(0%) | 3(12%) | 3(12%) |
| TOTAL | 8(32%) | 6(24%) | 11(44%) | 25(100%) |

The women who participated in the study lived in several different areas in Cape Town. The majority of the women lived in the Southern or Northern suburbs (N = 15 or 60%).

The Cape Flats refers to the area of Cape Town which includes most of the "coloured" townships, excluding Mitchells Plain.

The "other" areas refer to areas within the geographical boundaries of Cape Town, but not included under the other headings, such as Simonstown, Fishhoek and Hout Bay. The three respondents in this category did not return for follow-up appointments which could be attributed to the distance they would have had to travel to get to the hospital. It was significant that the sample population included only two respondents from the Black townships of Khayelitsha/Lagunya, and no respondents from Mitchell's Plain as these are the most densely populated areas which are served by Groote Schuur Hospital.

QUESTION 8 - WHAT IS YOUR MONTHLY INCOME ?

TABLE 8 - MONTHLY INCOME OF WOMEN HAVING TERMINATION OF PREGNANCY.

| | N(%) | | | TOTAL |
|---|---|---|---|---|
| GROUP | A | B | C | |
| < R500 | 4(16%) | 3(12%) | 3(12%) | 10(40%) |
| R500 - R1000 | 1(4%) | 1(4%) | 4(16%) | 6(24%) |
| R1000 - R1500 | 1(4%) | 0(0%) | 3(12%) | 4(16%) |
| R1500 -R2000 | 0(0%) | 1(4%) | 0(0%) | 1(4%) |
| R2000 -R2500 | 1(4%) | 1(4%) | 0(0%) | 2(8%) |
| > R2500 | 1(4%) | 1(4%) | 0(0%) | 2(8%) |
| TOTAL | 8(32%) | 7(28%) | 10(40%) | 25(100%) |

The largest group of the respondents had a monthly income of less than R500 (N=10 or 40%). Overall, the respondents who returned for follow-up appointments had higher earnings.

QUESTION 9 - WHAT WAS YOUR RELATIONSHIP WITH THE REPUTED FATHER OF THE PREGNANCY AT THE TIME OF CONCEPTION ?

TABLE 9 - RELATIONSHIP WITH REPUTED FATHER

| | N(%) | | | TOTAL |
|---|---|---|---|---|
| GROUP | A | B | C | |
| HUSBAND | 1(4%) | 3(12%) | 0(0%) | 4(16%) |
| STEADY BOYFRIEND | 1(4%) | 1(4%) | 4(16%) | 6(24%) |
| CASUAL RELATIONSHIP | 5(20%) | 1(4%) | 2(8%) | 8(32%) |
| "DATE" RAPE | 0(0%) | 1(4%) | 1(4%) | 2(8%) |
| UNREPORTED RAPE | 1(4%) | 1(4%) | 3(12%) | 5(20%) |
| TOTAL | 8(32%) | 7(28%) | 10(40%) | 25(100%) |

The four married women reported that the reputed father of the pregnancy was their husband. A significant proportion of women (N = 7 or 28%) reported that they had fallen pregnant as the result of rape: two as the result of "date" rape and five as the result of unreported rape. It is of concern that only two of the seven women who were raped participated in the follow-up research. All the respondents who were rape survivors were referred to Rape Crisis. A case example of one of the respondents who had been raped is presented in Annexure C.

QUESTION 10 - WERE YOU USING CONTRACEPTION ?

QUESTION 11 - IF YES, WHAT CONTRACEPTION WERE YOU USING ?

TABLE 10 - CONTRACEPTION USE IN WOMEN HAVING TERMINATIONS OF PREGNANCY.

| | N(%) | | | TOTAL |
|---|---|---|---|---|
| GROUP | A | B | C | |
| NO | 2(8%) | 3(12%) | 6(24%) | 11(44%) |
| YES - PILL | 3(12%) | 1(4%) | 1(4%) | 5(20%) |
| IUCD | 0(0%) | 1(4%) | 0(0%) | 1(4%) |
| CONDOM | 2(8%) | 1(4%) | 0(0%) | 3(12%) |
| OTHER | 1(4%) | 1(4%) | 3(12%) | 5(20%) |
| TOTAL | 8(2%) | 7(28%) | 10(40%) | 25(100%) |

Eleven of the respondents (44%) reported that they had not been using contraception at the time of conception. One of these was a married woman who was the only woman over 40, who was not on contraception as she thought she was going

through menopause and was infertile. She was in Group B. One of these respondents had been in a steady relationship and two had fallen pregnant as the result of a casual or short term relationship. None of the seven women who had been raped had been on any form of contraception.

Most of the respondents (N = 14 or 56%) indicated that they had been using some form of contraception. It is noteworthy that such a large number of respondents had used some form of contraceptive protection at the time of conception.

### 4.4.2 FINDINGS - INTERVIEW SCHEDULE 1 (AFTER DECISION TO HAVE ABORTION CONFIRMED BUT BEFORE MEDICAL PROCEDURE)

This Interview Schedule 1 (see annexure A) was used in the second interview with the respondents after it had been decided by the psychiatrist that they met the legal requirements for a termination of pregnancy according to Section 3(1)(b) of the Abortion and Sterilization Act of 1975 but before the operation was done. This included questions asked by the researcher to the respondents on reasons for wanting the pregnancy terminated, family background, previous treatment, previous pregnancies, attitude towards the pregnancy and desire for post-abortion counselling.

Most of the results have been presented descriptively, but tables have been used to illustrate results in some instances. Group A are the patients who participated in the follow-up research by returning for office interviews, Group B are the

patients who participated in the follow-up through telephonic interviews and Group C are the participants who did not return to participate in the follow-up study. Annexure C includes two case studies to illustrate the findings.

## QUESTION 1 - WHAT ARE THE PATIENT'S REASONS FOR REQUESTING TERMINATION OF PREGNANCY ?

### PRIMARY REASONS

The women who participated in the study generally had multiple reasons for wanting a termination of pregnancy. The majority of responses (N = 18 or 72%) were emotional reasons where the patient felt that she would be unable to cope emotionally with the pregnancy or baby. For all these patients this was the primary reason they wanted a termination of pregnancy.

Seven responses (28%) were that a termination of pregnancy was wanted as the pregnancy had occurred due to a traumatic rape experience. These were the primary responses of all the patients who had fallen pregnant as the result of rape. In these cases the rape was unreported and the patients were suffering significant post-rape trauma. All of these patients were referred to Rape Crisis.

In Group A, seven respondents (28%) indicated they wanted a termination of pregnancy primarily for emotional reasons, and one respondent (4%) wanted a termination of pregnancy primarily because she had fallen pregnant as the result of unreported rape. In Group B, five respondents (20%) wanted a termination of

pregnancy primarily for emotional reasons, and two respondents (8%) wanted a termination of pregnancy primarily because they had fallen pregnant as the result of rape. In Group C, six respondents (24%) wanted a termination of pregnancy primarily for emotional reasons, and four respondents (16%) wanted a termination of pregnancy primarily as the pregnancy resulted from rape.

It was of concern that four of the respondents (16%) who had been raped did not return for follow-up appointments. All of the respondents indicated that either emotional reasons or rape was their primary reason for requesting a termination of pregnancy.

SECONDARY REASONS

Eight responses (four in Group A, 2 in Group B and 4 in Group C) were that a secondary reason for wanting a termination of pregnancy was due to a relationship ending and a subsequent lack of support from the reputed father. Seven responses (three in Group A, 1 in Group B and 3 in Group C) were that a secondary reason for wanting a termination of pregnancy was for financial or economic reasons i.e the patient could not afford to have a baby. Six responses (three in Group A, 2 in Group B and 1 in Group C) were that the pregnancy had occurred despite the use of contraception. Two responses (one in Group A and 1 in Group B) were that a lack of family support contributed to the request for a termination of pregnancy.

QUESTION 2 - WHAT IS THE FAMILY BACKGROUND OF THE PATIENT ?

Six of the participants (1 in Group A, 4 in Group B and 1 in Group C) indicated that they had stable family backgrounds and continued to have positive relationships with their family of origin. In these cases they were able to confide in their family about the pregnancy and request for termination of pregnancy and obtain support. For these patients this was the only response in this category. It was interesting that most of these respondents participated in the follow-up study.

Nine patients reported a dysfunctional family background where there was significant emotional, physical or sexual abuse. Eight patients reported poor relationships within the family. Three patients had been raised in single parent families and six patients had been raised in families where the parents had been divorced. One patient had been raised in a foster family.

In Group A, two reported that their parents were divorced, two reported that they came from a dysfunctional family background, one reported poor relationships within the family, one reported a combination of a single parent family and poor relationships within the family and one was raised in a foster placement as her single mother was abusive towards her and they had a poor relationship.

In Group B, one reported a dysfunctional family background, one reported poor relationships within the family and one reported divorced parents and poor relationships within the family.

In Group C, two reported a dysfunctional family background, three reported poor relationships within the family, one reported a single parent family with poor relationships between family members, two reported a dysfunctional family background and divorced parents, and one reported a dysfunctional family background with divorced parents and poor relationships within the family.

It appears that a large proportion of respondents have had difficulties in their families of origin. It is not known if this reflects the general population or not.

QUESTION 3 - WHAT PREVIOUS TREATMENT HAS THE PATIENT HAD ?

TABLE 11 - PREVIOUS TREATMENT IN RESPONDENTS

| N(%) | | | | TOTAL |
|---|---|---|---|---|
| GROUP | A | B | C | |
| LONG TERM PSYCHIATRIC | 0(0%) | 0(0%) | 0(0%) | 0(0%) |
| SHORT TERM PSYCHIATRIC | 1(4%) | 3(12%) | 3(12%) | 7(28%) |
| CLINICAL PSYCHOLOGIST | 3(12%) | 3(12%) | 2(8%) | 8(32%) |
| SOCIAL WORKER | 2(8%) | 0(0%) | 0(0%) | 2(8%) |
| NO PREVIOUS TREATMENT | 2(8%) | 2(8%) | 5(20%) | 9(36%) |
| TOTAL | 8(32%) | 7(28%) | 10(40%) | 25(100%) |

It was interesting that such a large proportion of respondents (N =17 or 68%) had had previous psychological or psychiatric treatment or social work intervention.

QUESTION 4 - HOW MANY PREVIOUS PREGNANCIES HAS THE PATIENT HAD ?

TABLE 12 - NUMBER OF PREVIOUS PREGNANCIES IN WOMEN HAVING TERMINATIONS OF PREGNANCY?

| | N(%) | | | TOTAL |
|---|---|---|---|---|
| GROUP | A | B | C | |
| NONE | 3(12%) | 4(16%) | 7(28%) | 14(56%) |
| ONE | 3(12%) | 1(4%) | 1(4%) | 5(20%) |
| TWO | 1(4%) | 1(4%) | 2(8%) | 4(16%) |
| THREE | 1(4%) | 1(4%) | 0(0%) | 2(8%) |
| TOTAL | 8(32%) | 7(28%) | 10(40%) | 25(100%) |

For the majority of the participants this pregnancy was their first pregnancy (N=14 or 56%). None of the respondents in the sample had had a previous termination of pregnancy although one had had attempted an unsuccessful illegal abortion prior to seeking a termination of pregnancy at the Pregnancy Advisory Service.

QUESTION 5 - HOW DOES THE PATIENT FEEL TOWARDS THE PREGNANCY ?

Anger and hurt were the predominant feelings towards the pregnancy. Anger refers to internal feelings of outrage and irritation that the respondents felt towards themselves for falling pregnant (i.e. they blamed themselves for falling pregnant). Hurt refers to feelings of emotional pain and injury which the patients felt when they believed the pregnancy was caused by others.(i.e. a rape perpetrator or ex-boyfriend).

Seventeen patients (5 in Group A, 4 in Group B and 8 in Group C) felt angry about the pregnancy. Thirteen participants (4 in Group A, 4 in Group B and 5 in Group C) felt hurt about the pregnancy. All of the women who had been raped felt hurt about the pregnancy. Nine patients (3 in each of the Groups) did not want to think about the implications of the pregnancy should it continue, thus their attitude towards the pregnancy was denial. Three respondents (2 in Group A and 1 in Group C) felt guilt about the pregnancy. It was significant that the three women who felt guilty about the pregnancy were devout, one (in Group A) was a Moslem, one (in Group A) was a "born-again" Christian, and one (in Group C) was a devout Roman Catholic.

QUESTION 6 - DOES THE PATIENT WANT POST-ABORTION COUNSELLING ?

QUESTION 7 - IF YES, WHAT ARE THE REQUIREMENTS FOR POST-ABORTION COUNSELLING ?

TABLE 13 - DESIRE FOR COUNSELLING AFTER TERMINATION OF PREGNANCY

| N(%) | | | | TOTAL |
|---|---|---|---|---|
| GROUP | A | B | C | |
| NO | 0(0%) | 1(4%) | 0(0%) | 1(4%) |
| YES<br>INDIVIDUAL AT P.A.S | 4(16%) | 4(16%) | 8(32%) | 16(64%) |
| GROUP AT P.A.S | 0(0%) | 0(0%) | 0(0%) | 0(0%) |
| IN-PATIENT TREATMENT | 0(0%) | 0(0%) | 0(0%) | 0(0%) |
| CLINICAL PSYCHOLOGIST | 4(16%) | 4(16%) | 2(8%) | 8(32%) |
| OTHER RESOURCE | 0(0%) | 0(0%) | 0(0%) | 0(0%) |
| TOTAL | 8(32%) | 7(28%) | 10(40%) | 25(100%) |

Twenty four of the respondents (96%) said that they would like to have counselling after the termination of pregnancy. The respondent (in Group B) who did not want counselling after the abortion was a married women with a good support system and she did not feel that she would need counselling as she did not see having a termination of pregnancy as being traumatic for her. She felt that she was making an informed decision and perceived having an abortion as being therapeutic in itself.

None of the patients felt they would need inpatient treatment after the termination of pregnancy. There was no demand at this stage for a post-abortion support group. For the respondents that had been raped their responses were in addition to referral to Rape Crisis.

### 4.4.3 FINDINGS - INTERVIEW SCHEDULE TWO (SIX WEEKS TO THREE MONTHS AFTER TERMINATION OF PREGNANCY)

Interview Schedule Two (see Annexure A) was used in the follow-up interviews with the patients and included an assessment of motivation to participate in follow-up research, and questions on how the termination of pregnancy was experienced (legal procedure, medical procedure and emotional support), attitude to abortion and desire for post-abortion counselling. The results have been presented descriptively but in some instances tables have been used for further illustration.

MOTIVATION TO PARTICIPATE IN FOLLOW-UP STUDY

Four patients would not participate in the follow-up study and gave their reasons as either being too busy at work or not having time. Six patients did not keep their follow-up appointments and could not be contacted i.e they had changed address or did not respond to call-in letters or telephone messages. These ten patients (40%) did not participate in the follow-up study (Group C).

Eight of the participants returned for follow-up appointments as contracted (Group A). All of these participants were highly motivated to participate in the research.

Six of the participants cancelled their appointments due to difficulties of coming in to the Pregnancy Advisory Service, but agreed to participate in the research through telephonic interviews. One of the patients was difficult to get hold of but when eventually contacted agreed to participate in the follow-up study through a telephonic interview (Group B).

Therefore fifteen patients (60%) participated in the follow-up study. In view of the omission of Group C in the follow-up study, the percentages are calculated as N = 15 (100%), and to the nearest whole number.

QUESTION 1 - HOW DID THE PATIENT EXPERIENCE THE LEGAL PROCEDURE ?

The majority of the participants (N = 11) had two responses, They found the legal procedure anxiety-provoking and felt unhappy with the law as it stands as a psychiatrist had to make the decision, and also found the state hospital procedure difficult. Six of these were in Group A, and five were in Group B. Three participants (1 in Group A and 2 in Group B) were satisfied with the legal procedure and state hospital procedure.

One participant (in Group A) found the legal procedure anxiety provoking and was unhappy with the current law but was satisfied with the state hospital procedure.

It was interesting that the majority of the respondents felt that the present law was too restrictive even though in their case they had been granted a legal termination of pregnancy.

QUESTION 2 - HOW DID THE PATIENT EXPERIENCE THE MEDICAL PROCEDURE ?

TABLE 14 - EXPERIENCE OF MEDICAL PROCEDURE

| N(%) | | | TOTAL |
|---|---|---|---|
| GROUP | A | B | |
| TRAUMATIC-ONGOING | 1(7%) | 0(0%) | 1(7%) |
| TRAUMATIC-RECOVERED | 3(20%) | 3(20%) | 6(40%) |
| AS ANY OPERATION | 2(13%) | 2(13%) | 4(26%) |
| EASIER THAN EXPECTED | 2(13%) | 2(13%) | 4(26%) |
| TOTAL | 8(53%) | 7(47%) | 15(100%) |

Only one patient (in Group A) had found the medical procedure of a termination of pregnancy extremely traumatic and was still very distressed by the experience. This patient had been raped and presented with a significant amount of emotional distress after the termination of pregnancy. A case study of this respondent is presented in Annexure C.

QUESTION 3 - WHO PROVIDED EMOTIONAL SUPPORT DURING THE EXPERIENCE ?

Fourteen of the participants gave more than two responses. Fourteen of the patients (all of Group A and seven in Group B) found the hospital staff supportive. Eight of the patients (6 in Group A and 2 in Group B) reported mutual support from other patients who were having terminations of pregnancy at the same time as them.

Six patients (4 in Group A and 2 in Group B) reported a significant amount of support from their friends. Four patients (3 in Group A and 1 in Group B) reported support from their families and three patients (1 in Group A and 2 in Group B) indicated that the reputed father was supportive. For one participant, who had been the victim of rape (in Group B), the only support she received was from hospital staff as embarrassment about the rape experience had led her to have difficulties telling her family or friends about the experience.

It was significant that most of the respondents had fairly good support systems during the time of the termination of pregnancy. It was interesting that the one patient, who had been raped, and whose only source of support was hospital staff had a significant level of emotional distress after the termination of pregnancy.

QUESTION 4 - HOW DID HAVING AN ABORTION CHANGE THE PATIENT'S ATTITUDE TO IT ?

Nine participants (4 in Group A and 5 in Group B) responded that their attitude to abortion had always been that it should be a women's choice (i.e. pro-choice) Five of the participants (3 in Group A and 2 in Group B) said that they had been pro-life in their viewpoint on abortion until they had been in the position of wanting to terminate the pregnancy. This experience had led them to become pro-choice. One participant (in Group A) who was also the only Moslem woman, remained pro-life in her attitude towards abortion but believed a termination of pregnancy was justified in her situation.

QUESTION 5 - WHAT WAS THE EFFECT OF HAVING AN ABORTION ON THE PATIENT'S GENERAL FUNCTIONING ?

All of the participants indicated that the termination of pregnancy was positive and there was an improvement in their general level of functioning as compared to before the abortion.

QUESTION 6 - DOES THE PATIENT HAVE ANY PROBLEMS IN THE FOLLOWING AREAS THAT SHE ATTRIBUTES TO THE TERMINATION OF PREGNANCY ? (I.E. WORK, RELATIONSHIPS WITH FAMILY, RELATIONSHIPS WITH FRIENDS, ALCOHOL/SUBSTANCE ABUSE, STUDYING, RELATIONSHIPS WITH MEN, OR SEXUAL RESPONSE).

None of the respondents experienced any problems in the areas of work, relationships with family, relationships with friends, or alcohol/substance abuse which they attributed to the termination of pregnancy. One respondent (in Group A) experienced problems in studying as the result of the termination of pregnancy. This respondent was also one of the women in the study who had been raped and had a significant level of emotional distress as a result of this. She felt she could no longer concentrate on her studies due to the experience of rape, unwanted pregnancy and termination of pregnancy. A case study of this respondent is presented in Annexure C.

Five of the respondents (3 in Group A and 2 in Group B) experienced problems in their relationships with men and sexual response as the result of the abortion. These women were scared of having a repeat experience.

QUESTION 7 - DOES THE PATIENT WANT POST ABORTION COUNSELLING ?

QUESTION 8 - IF YES, WHAT ARE THE REQUIREMENTS FOR POST-ABORTION COUNSELLING ?

TABLE 15 - REQUIREMENTS FOR POST-ABORTION COUNSELLING AFTER TERMINATION OF PREGNANCY.

| N(%) | | | TOTAL |
|---|---|---|---|
| GROUP | A | B | |
| NO | 6(40%) | 6(40%) | 12(80%) |
| YES | | | |
| INDIVIDUAL AT P.A.S | 0(0%) | 0(0%) | 0(0%) |
| GROUP AT P.A.S. | 0(0%) | 0(0%) | 0(0%) |
| INPATIENT TREATMENT | 0(0%) | 0(0%) | 0(0%) |
| CLINICAL PSYCHOLOGIST | 1(7%) | 1(7%) | 2(13%) |
| OTHER RESOURCE | 1(7%) | 0(0%) | 1(7%) |
| TOTAL | 8(53%) | 7(47%) | 15(100%) |

The majority of participants indicated that they did not desire post-abortion counselling as they perceived the abortion as therapeutic in itself.(N = 12 or 80%)) Only three of the respondents (20%) wanted post-abortion counselling. Two of the women who wanted post-abortion counselling had been raped. One of these women, (in Group A) was referred to another resource, Rape Crisis, as she had significant post-rape syndrome. This woman had found the termination of pregnancy traumatic, and had not recovered from the experience. In this woman's case she was relieved at

having the pregnancy terminated but finding it difficult to cope with the fact she had been raped and required counselling for this. Annexure C includes a case study of this woman. The other woman who had been raped (in Group B) had already started therapy with a clinical psychologist. The other respondent (in Group A) who wanted post-abortion counselling, was not distressed by the termination of pregnancy but the experience had encouraged her to go into therapy to find the meaning the pregnancy had for her and she was referred to a clinical psychologist.

None of the respondents wanted to return to the Pregnancy Advisory Service for post-abortion counselling as they associated it with a traumatic experience they wanted to forget.

Although the majority of the respondents did not want post-abortion counselling in the short-term after the termination of pregnancy, they were provided with information about resources for post-abortion counselling or informed that they could return to the Pregnancy Advisory Service if they felt they needed to.

It was significant, that when interviewed before the termination of pregnancy, the majority of the respondents (96%) felt that they would need post-abortion counselling, but after the termination of pregnancy, only three respondents

(12% of the total, or 20% of the women who participated in the follow-up study) wanted post-abortion counselling. For most of the respondents, the termination of the pregnancy was the resolution of the crisis of the unwanted pregnancy.

**4.4.4 FINDINGS - THE HAMILTON ANXIETY RATING SCALE.**

This scale was used as a supplementary measure of emotional distress (see Annexure A). The Hamilton Anxiety Scale was developed by Hamilton in 1959, as a clinical scale to measure both psychic and somatic manifestations of anxiety. It consists of 14 clinical features of anxiety that are organized on 5-point scales reflecting a continuum from "very severe"(4) to "not present"(0) (Derogatis and Wise 1989). The total score can range from 0 - 56, with the range of 28 - 56 indicating a moderate to very severe level of anxiety where treatment is indicated.

Findings on the Hamilton Anxiety Scale are presented in a table in Annexure B. In this research, findings prior to a termination of pregnancy indicated mild to moderate levels of anxiety for all of the respondents even though they knew that the abortion had been granted according to the provisions of Section 3(1)(b) of the Abortion and Sterilization Act of 1975. Very few patients reported somatic anxiety but scores for psychic anxiety were fairly high. The 25 patients on whom the Hamilton anxiety scale was used ranged from scores of 5 - 30. The mean score was 18.65. The median score was 21. Three

of the respondents, (one in Group A and 2 in Group C) had scores of between 28 - 30 which fell within the pathological range of anxiety. Two of the respondents had very low scores of > 6. It was interesting that both of these women were married and had good support systems.

When anxiety levels were measured in the follow-up interviews after the terminations of pregnancy there was a significant reduction in levels of anxiety. Of the 15 women who participated in the follow-up study, scores ranged from 0 -15. The mean score was 4.2. The median was 4. Four of the respondents exhibited no symptoms of anxiety after termination of pregnancy. One of the respondents (in Group A) had a score of 15 which was of concern. This respondent had been raped and experienced the termination of pregnancy as traumatic and had still not recovered from the experience.

For all of the respondents, levels of anxiety were much higher before, and reduced after the termination of pregnancy.

**4.4.5 FINDINGS - MENTAL STATUS EXAMINATION**

A mental status examination of the respondents was done in the interviews before and after the abortion and was based on the participants emotional responses in the interview as well as what information they reported. Group A refers to the respondents that returned to the hospital for follow-up interviews, Group B refers to the respondents who participated in the follow-up research through telephonic interviews and Group C refers to the women who did not participate in the

follow-up research. In view of the omission of Group C in the "after" table the percentages will be calculated as N = 15 (100%), and to the nearest whole number. The findings are presented in tables, with brief comments about significant findings.

MOOD

TABLE 16 - MOOD IN WOMEN BEFORE AND AFTER TERMINATIONS OF PREGNANCY

| | BEFORE | | | | AFTER | | |
|---|---|---|---|---|---|---|---|
| GROUP | A | B | C | TOTAL | A | B | TOTAL |
| DEPRESSED | 7(28%) | 2(8%) | 6(24%) | 15(60%) | 1(7%) | 1(7%) | 2(13%) |
| ANGER | 1(4%) | 2(8%) | 3(12%) | 6(24%) | 0(0%) | 0(0%) | 0(0%) |
| ANXIETY | 0(0%) | 3(12%) | 2(8%) | 5(20%) | 0(0%) | 1(7%) | 1(7%) |
| NORMAL | 0(0%) | 0(0%) | 0(0%) | 0(0%) | 7(47%) | 5(33%) | 12(80%) |
| TOTAL | 8(32%) | 7(28%) | 10(40%) | 25(100%) | 8(53%) | 7(47%) | 15(100%) |

MOOD - BEFORE TERMINATION OF PREGNANCY

For fifteen of the respondents, depression was the most evident emotion. Five respondents indicated that their primary emotion was anger and five respondents indicated that their primary emotion was anxiety.

MOOD - AFTER TERMINATION OF PREGNANCY

Twelve respondents (80%) fell within the normal mood range. Two respondents were depressed and one respondent was anxious. It was significant that these three women had all been survivors of rape.

SLEEP DISTURBANCES

TABLE 17 - SLEEP DISTURBANCES IN WOMEN BEFORE AND AFTER TERMINATIONS OF PREGNANCY

| | BEFORE | | | | AFTER | | |
|---|---|---|---|---|---|---|---|
| GROUP | A | B | C | TOTAL | A | B | TOTAL |
| NORMAL | 1(4%) | 3(12%) | 1(4%) | 5(20%) | 8(53%) | 6(40%) | 14(93%) |
| INSOMNIA | 4(16%) | 3(12%) | 6(24%) | 13(52%) | 0(0%) | 1(7%) | 1(7%) |
| E.M.A | 2(8%) | 1(4%) | 3(12%) | 6(24%) | 0(0%) | 0(0%) | 0(0%) |
| HYPER | 1(4%) | 0(0%) | 0(0%) | 1(4%) | 0(0%) | 0(0%) | 0(0%) |
| TOTAL | 8(32%) | 7(28%) | 10(40%) | 25(100%) | 8(53%) | 7(47%) | 15(100) |

SLEEP - BEFORE TERMINATION OF PREGNANCY

Five respondents reported no sleep disturbances. The majority of respondents reported insomnia (N = 13 or 52%). Six respondents reported early morning awakenings and one respondent reported hypersomnia.

SLEEP - AFTER TERMINATION OF PREGNANCY

Only one respondent, who had been raped (in Group B) reported disturbed patterns of sleep (insomnia) while the other fourteen respondents reported normal patterns of sleep.

DECREASED APPETITE

TABLE 18 - DECREASED APPETITE IN WOMEN BEFORE AND AFTER TERMINATION OF PREGNANCY

| | BEFORE | | | | AFTER | | |
|---|---|---|---|---|---|---|---|
| GROUP | A | B | C | TOTAL | A | B | TOTAL |
| DECREASED | 8(32%) | 3(12%) | 8(32%) | 19(76%) | 0(0%) | 1(7%) | 1(7%) |
| NORMAL | 0(0%) | 3(12%) | 0(0%) | 3(12%) | 8(53%) | 6(40%) | 14(93%) |
| INCREASED | 0(0%) | 0(0%) | 2(8%) | 2(8%) | 0(0%) | 0(0%) | 0(0%) |
| ERRATIC | 0(0%) | 1(4%) | 0(0%) | 1(4%) | 0(0%) | 0(0%) | 0(0%) |
| TOTAL | 8(32%) | 7(28%) | 10(40%) | 25(100%) | 8(53%) | 7(47%) | 15(100%) |

DECREASED APPETITE - BEFORE TERMINATION OF PREGNANCY

The majority of respondents (N=19 or 76%) reported decreased appetite. Three respondents, all in Group B, had normal eating patterns, while two, both in Group C, reported increased appetite and one, in Group B reported an erratic appetite.

DECREASED APPETITE - AFTER TERMINATION OF PREGNANCY

Fourteen respondents reported normal appetite. The one respondent (in Group B) who reported a decreased appetite was the same woman who had insomnia, and had fallen pregnant as the result of rape.

CONCENTRATION

TABLE 19 - IMPAIRED CONCENTRATION IN WOMEN BEFORE AND AFTER TERMINATIONS OF PREGNANCY.

| | BEFORE | | | | AFTER | | |
|---|---|---|---|---|---|---|---|
| GROUP | A | B | C | TOTAL | A | B | TOTAL |
| YES | 8(32%) | 4(16%) | 10(40%) | 22(88%) | 0(0%) | 1(7%) | 1(7%) |
| NO | 0(0%) | 3(12%) | 0(0%) | 3(12%) | 8(53%) | 6(40%) | 14(93%) |
| TOTAL | 8(32%) | 7(28%) | 10(40%) | 25(100%) | 8(53%) | 7(47%) | 15(100%) |

IMPAIRED CONCENTRATION - BEFORE TERMINATION OF PREGNANCY

The majority of respondents (N = 22) indicated that their concentration was impaired as a result of the unwanted pregnancy while three, all in Group B, indicated that their concentration had not changed.

IMPAIRED CONCENTRATION - AFTER TERMINATION OF PREGNANCY

Only one respondent (in Group B) indicated that her concentration was impaired after the termination of pregnancy. This was the same woman who had insomnia, decreased appetite and had fallen pregnant as the result of rape. A case study of this woman is presented in Annexure C.

SUICIDAL IDEATION

TABLE 20 - SUICIDAL IDEATION IN WOMEN BEFORE AND AFTER TERMINATIONS OF PREGNANCY

| | BEFORE | | | | AFTER | | |
|---|---|---|---|---|---|---|---|
| GROUP | A | B | C | TOTAL | A | B | TOTAL |
| YES | 2(8%) | 1(4%) | 7(28%) | 10(40%) | 0(0%) | 0(0%) | 0(0%) |
| NO | 6(24%) | 6(24%) | 3(12%) | 15(60%) | 8(53%) | 7(47%) | 15(100%) |
| TOTAL | 8(32%) | 7(28%) | 10(40%) | 25(100%) | 8(53%) | 7(47%) | 15(100%) |

SUICIDAL IDEATION - BEFORE TERMINATION OF PREGNANCY

Ten respondents (40%) reported suicidal ideation as the result of the unwanted pregnancy while fifteen (60%) reported no suicidal ideation.

SUICIDAL IDEATION - AFTER TERMINATION OF PREGNANCY

None of the respondents reported suicidal ideation after the termination of pregnancy.

LOSS OF ENERGY

TABLE 21 - LOSS OF ENERGY IN WOMEN BEFORE AND AFTER TERMINATION OF PREGNANCY.

| | BEFORE | | | | AFTER | | |
|---|---|---|---|---|---|---|---|
| GROUP | A | B | C | TOTAL | A | B | TOTAL |
| YES | 8(32%) | 6(24%) | 8(32%) | 22(88%) | 0(0%) | 1(7%) | 1(7%) |
| NO | 0(0%) | 1(4%) | 2(8%) | 3(12%) | 8(53%) | 6(40%) | 14(93%) |
| TOTAL | 8(32%) | 7(28%) | 10(40%) | 25(100%) | 8(53%) | 7(47%) | 15(100% |

LOSS OF ENERGY - BEFORE TERMINATION OF PREGNANCY

Twenty two respondents (88%) reported a loss of energy as a result of the unwanted pregnancy while three (12%) indicated that the unwanted pregnancy had not affected their energy levels.

LOSS OF ENERGY - AFTER TERMINATION OF PREGNANCY

Fourteen patients reported that their energy levels had returned to normal after the termination of pregnancy while one, in Group B, who had been raped and reported other symptoms of depression, indicated that she continued to experience a loss of energy.

COMMENT ON PRE - ABORTION COUNSELLING

Satisfaction with pre-abortion counselling was not measured as it was not possible for this to be done objectively due to the dual role of the researcher as counsellor. However all of the respondents agreed that pre-abortion counselling was necessary to enable them to express the feelings they had about the unwanted pregnancy, to enable them to confirm their decision to have a termination of pregnancy, to provide support through the process and information about other resources.

On the whole this group of women perceived the termination of pregnancy as being the solution to the dilemma of an unplanned and unwanted pregnancy and felt that they had benefited from pre-abortion counselling.

## 4.5 FACTORS INFLUENCING RESULTS

The researcher in her dual role as researcher/counsellor found it difficult for pre-abortion counselling to be evaluated. This introduced the concern about subjectivity due to the researcher's position as a clinical social worker at the Pregnancy Advisory Service.

The poor response rate also influenced results as only 15 of the 25 respondents (or 60%) participated in the follow up research. Of these 15, only seven (or 28%) came for face to face interviews and although another eight patients (or 32%) gave telephone interviews these were limited in terms of the assessment of levels of emotional distress as it was easier for the participants to be dishonest or withhold some of their emotions and the telephone removed some of the elements of a relationship.

The results were influenced by the high proportion of women in the sample who had fallen pregnant as the result of rape. This particularily influenced the results of emotional distress after the termination of pregnancy as levels of emotional distress remained fairly high for some of the women who had been raped. It is also of note that this research does not look at the long-term effects of termination of pregnancy. How the respondents responded to the experience of having had an abortion in the long term is therefore outside the scope of this research.

# CHAPTER 5 : DISCUSSION

## 5.1 INTRODUCTION

In this study an attempt has been made to assess levels of emotional distress in women before and after terminations of pregnancy, and based on these levels of emotional distress, whether women having terminations of pregnancy want post - abortion counselling.

Despite the limitations of the research and the poor response rate the results appear to be remarkably uniform and similar to findings in previous research in the same field.

It is not possible for research findings to be precise and unaffected by bias in the area of therapeutic terminations of pregnancy considering the ongoing controversy surrounding abortion. The researcher's bias as well as the possibility of women denying possible negative emotional reactions to justify having a termination of pregnancy contribute to this. However the research does highlight certain important issues.

## 5.2 DISCUSSION OF FINDINGS

DEMOGRAPHIC DATA

The majority of the respondents (N = 19 or 76%) were in the developmental stage of early adulthood, were either single or divorced (N = 21 or 84%) and did not desire motherhood due the huge responsibilities of single parenting and the pursuit of other life goals such as education or career. Petchesky (1985) says that women are faced with the burden of child-

rearing, particularly with the high rates of single parenthood worldwide. When women are faced with an unplanned or unwanted pregnancy, abortion may free them from the responsibilities of child-rearing that they do not choose.

Religious affiliation did not make much difference in the levels of emotional distress experienced by and observed in women having terminations of pregnancy at the Pregnancy Advisory Service at Groote Schuur Hospital, although the respondents who felt guilty about the termination of pregnancy were more devout than the rest of the sample. Neither of the Roman Catholic patients returned for follow-up appointments, which may suggest feelings of guilt as the Roman Catholic church forbids abortion.

The demographic data in questionnaire 1 (see Annexure A) reflects a sample of the population of Cape Town's women who seek terminations of pregnancy at Groote Schuur Hospital.

It is apparent that there is a minority of Black women in the sample which leads to concern about the accessibility of the service to the black population group.

Bradford (1990) indicates that abortion is as common amongst the Black population group as it is amongst other population groups, but that traditional methods, or illegal "back-street" abortions are used rather than approaching the state health services.

In the gynaecological wards at Groote Schuur Hospital there is a higher number of women, particularily from the Black population group who are admitted for incomplete abortions than there are legal terminations of pregnancy performed. It is almost impossible to obtain statistics because women who have had "back-street" abortions would not admit to the practice as it is illegal. The three Black respondents in the sample were of a fairly high level of education and the health services were probably more accessible to them than to the majority of the Black population.

All of the participants in the research had over a Standard 8 education. This leads to great concern as to why many of South Africa's women who were either illiterate or had a poor education did not request terminations of pregnancy,

Despite a fairly high level of education for most of the respondents the income level was comparatively low with the majority of the respondents (N = 16 or 64%) earning less than R1000 per month. Many of the respondents were either unemployed or could not find suitable employment, often leading to concerns that they could not afford to have a child. This reflects the present economic crisis in South Africa.

In the South African context, a legal and safe termination of pregnancy is only available to a considerably small section of the population and can therefore be considered elitist. It is therefore of great concern that the majority of women in South Africa faced with an unwanted or unplanned pregnancy will risk

their lives and fertility by seeking a "backstreet" abortion in very dangerous conditions because the present law does not readily make provision for women to have a termination of pregnancy in medically safe conditions.

Women who are forced to obtain "backstreet" abortions, as this is the only way out of the crisis of an unwanted pregnancy, are also not exposed to support or counselling before or after a termination of pregnancy, which leads to concerns about their ongoing mental health.

Contraception was used by most of the participants which indicates a high level of sexual responsibility, which is crucial in these times to prevent unwanted pregnancies and children and also to prevent the spread of sexually transmitted diseases such as AIDS and syphilis.

The patients who were not contraceptively protected at the time of conception had valid reasons such as believing themselves to be infertile or falling pregnant as a result of rape.

It was of particular concern that seven of the participants (28%) were survivors of either "date" rape or unreported rape. This was not a predicted result of the research as women who have been raped qualify for a legal termination of pregnancy according to Section 3(1)(d) of the Abortion And Sterilization Act of 1975 if the rape is reported thus they should not need to be assessed by a psychiatrist.

The women in this study who had been raped were not willing to report the rape due to the added trauma of having to report the case to the police and appearing in court. This has implications for the levels of emotional distress experienced by these respondents who had to deal with the trauma of a rape experience, an unwanted pregnancy, and the procedure to obtain a legal termination of pregnancy.

EMOTIONAL DISTRESS IN WOMEN PRIOR TO TERMINATION OF PREGNANCY

It was significant that many of the women in the sample (N = 17 or 68%) have had previous treatment, in that it appears that a higher proportion of women seeking terminations of pregnancy through the Pregnancy Advisory Service, have had contact with mental health services, than those in the general population. However the fact that these women have had previous treatment may have contributed to them meeting the criteria for a legal termination of pregnancy according to Section 3(1)(b) of the Abortion and Sterilization Act of 1975.

Another possibility is that it is as a result of having previous treatment that these women were more aware of the prospect of being able to obtain a termination of pregnancy than women in the general population.

The women who obtained legal terminations of pregnancy at the Pregnancy Advisory Service at Groote Schuur Hospital are probably more vulnerable to emotional distress than those who did not, as they met the requirements as assessed by a psychiatrist to obtain an abortion as the continuation of

the pregnancy constituted a serious risk of permanent damage to their mental health (Section 3 (1)(b) of the Abortion and Sterilization Act 1975).

Some women who had terminations of pregnancy at Groote Schuur Hospital showed symptoms of severe emotional distress prior to a termination of pregnancy. The majority of women had significantly high levels of anxiety and depression as measured on the Hamilton Anxiety Scale and Mental Status Examinations. This distress was due to the fact that the pregnancy was unplanned and unwanted and thus posed a crisis in the women's lives. This can be compared to Teichmann's (1993) results in a similar study of Israeli women where levels of emotional distress, anxiety and depression were increased prior to a termination of pregnancy.

The levels of emotional distress in women presenting for terminations of pregnancy were significantly high to warrant some form of therapeutic intervention. Ten of the respondents (or 40%) reported suicidal ideation with possible intent if the crisis of the unwanted pregnancy was not resolved which was of particular concern. There was some differentiation in the women's coping mechanisms and those who were well-adjusted and had positive relationships did not experience such high levels of emotional distress as those who had difficulties in other areas of their lives and poor support systems.

The high levels of emotional distress in women presenting for terminations of pregnancy evoked other painful issues in the women's lives, past and present. As a result of this when the respondents were seen prior to a termination of pregnancy other issues as well as the unwanted pregnancy were the focus of short-term therapeutic intervention. These involved issues ranging from problems as diverse as previously unrevealed sexual abuse in childhood, to relationship, financial and work related problems.

An unwanted pregnancy is often an attempt for a woman to establish some form of equilibrium in the face of a life crisis such as a relationship ending, career problems or problems in relationships with their family of origin (Schmidt and Priest 1981). Many of the respondents in this study felt that the unwanted pregnancy represented a crisis in their lives which forced them to assess their present life situation. As a result of this, all of the respondents were provided with information about resources available for both problems directly related to the pregnancy, such as rape or emotional distress due to the ending of a relationship or indirectly related problems such as difficulty in dealing with previous life crises, unemployment or child-rearing problems.

EMOTIONAL DISTRESS IN WOMEN AFTER TERMINATION OF PREGNANCY

The response rate for the follow-up study was less than anticipated as only 15 (60%) of the women who participated in the research on emotional distress in women before termination

of pregnancy participated in the follow-up research, although they indicated that they would participate. However, in similar studies such as that of Schmidt and Priest (1981) and Zolese and Blacker (1992) a poor response rate to follow-up research is also apparent.

It is of concern as to why ten patients (40%) did not participate in the follow-up as they may have been more or less distressed than the patients that responded.

The poor response rate in the follow-up interviews could be due to the fact that many women who have had a termination of pregnancy cope with it by a process of denial. Zolese and Blacker (1992) say that denial mechanisms can be an adaptive or maladaptive response, but either way follow-up interviews can threaten the stability of this psychological adjustment - thus proving to be unwelcome.

The poor response rate provides us with information about women's attitudes towards a termination of pregnancy as by failing to return for follow-up appointments the participants may have been experiencing feelings of denial, repression or ambivalence towards the termination of pregnancy.

Schmidt and Priest (1981) say that a poor success of the follow-up in terms of numbers can be seen as one of the pieces of information gathered as the lack of co-operation may be an indication of the ambivalent feelings aroused in the patients by the experience.

During the interviews with the 15 respondents (60%), that did participate in the follow-up study, they discussed with intensity the circumstances surrounding the termination of pregnancy and the positive influence it had had on their lives. These women felt that an unwanted pregnancy and the subsequent decision to have an abortion led them to review their important relationships - with boyfriends or husbands, children and family of origin. In observing these women, significant positive feelings and an improvement in functioning after the termination of pregnancy were apparent.

Schmidt and Priest (1991) say that an unwanted pregnancy may thus represent for some women a vehicle for their restorative and reparative wishes as well as their destructive wishes and an awareness of the co-existence of these paradoxical feelings is crucial to an understanding of women who present for terminations of pregnancy.

In the follow-up interviews with these 15 respondents, levels of emotional distress were markedly lowered, and symptoms of anxiety and depression were no longer present in most cases in the short-term after the termination of pregnancy. The women had returned to their premorbid level of functioning.

The only areas of functioning in which a few of the respondents had difficulties after a termination of pregnancy were in their relationships with men and sexual responses. However this seems to be both a healthy protective

device against a repetition of a subsequent unwanted pregnancy, and a short-term reaction to having had a gynaecological procedure.

The minority of participants (two or 8%) who continued to experience high levels of emotional distress after the termination of pregnancy were all survivors of rape. For this group of women, the termination of pregnancy had resulted in some relief but they remained distressed due to post-rape syndrome.

Thus it appears that levels of depression and anxiety experienced prior to an abortion recede within a few weeks after a termination of pregnancy. This is comparable to the findings in similar research such as that conducted by Teichmann et al (1993), Schmidt and Priest (1983), and Dagg (1991).

When seen prior to a termination of pregnancy, most of the respondents indicated that they wanted post-abortion counselling once the procedure was completed. However after the termination of pregnancy was completed, there was an overwhelming sense of relief and most of the participants changed their minds and no longer wanted post-abortion counselling. This appears to be due to the resolution of the crisis of an unwanted pregnancy which was resolved for the women by a termination of pregnancy. It seems that women do not want counselling immediately after a termination of

pregnancy due to a desire to get on with their lives and put the experience behind them. Although this may be a defence mechanism of denial it appears to be a healthy one.

Of the three patients that did want post-abortion counselling, two were rape survivors and wanted counselling about the rape experience which resulted in an unwanted pregnancy and termination of pregnancy. The other respondent was able to use the experience of a termination of pregnancy to enter therapy to explore the meaning the pregnancy had for her. Horwitz (1990) says that having an abortion can often lead to a woman entering therapy as it has implications for self-discovery as she is able to pursue other alternatives that may enrich her life.

Long term emotional reactions to abortion were not looked at in the research. Dagg (1991) indicates that longer term studies indicate that while symptoms of initial distress and dysphoria may persist they gradually recede with the majority of women expressing positive reactions to the abortion and only a minority expressing any degree of regret.

## CHAPTER 6 : CONCLUSION AND RECOMMENDATIONS

The research has highlighted a number of issues and insights into the levels of emotional distress in women before and in the short-term after a termination of pregnancy.

The research indicates that most women who have had a termination of pregnancy appear to have a positive subsequent adjustment in the short-term. The unwanted pregnancy poses a crisis in the woman's life that is resolved by the termination of the pregnancy.

There was a high number of respondents in the sample who had fallen pregnant as the result of rape which affected the overall levels of emotional distress experienced after a termination of pregnancy. This finding identified a high risk group that needs to be studied further.

Although the study examines a specific population i.e. those having terminations of pregnancy according to Section 3 (1) (b) of the Abortion and Sterilization Act 1975 at the Pregnancy Advisory Service at Groote Schuur Hospital and can therefore not be extrapolated to the general population, the results presented here show similarities to other studies of the same nature in other countries.

In previous research on emotional distress in women who had had a termination of pregnancy, Dagg (1991), Schmidt and Priest (1981), David (1985), Drower (1977) and Teichmann (1993) found that levels of depression and anxiety in women having elective abortions were lowered after a termination of pregnancy.

From the results it appears that women who present with requests for termination of pregnancy and are provided with pre-abortion counselling have a positive subsequent adjustment after the procedure is completed. As a result of this they do not need or want post-abortion counselling.

## RECOMMENDATIONS

This research may offer guidelines to social workers and other professionals who work with women who want a pregnancy terminated, or who have had a termination of pregnancy as follows:

1. The results of the research indicate that pre-abortion counselling is extremely important. Pre-abortion counselling is in the crisis intervention model as women seeking a termination of pregnancy are in crisis due to the unwanted pregnancy. Pre-abortion counselling gives women the opportunity to ventilate, to deal with the emotional distress evoked by the crisis of an unwanted pregnancy, to explore the meaning of the pregnancy for them and confirm their decision. It also enables the woman to make an informed choice about a termination of pregnancy by educating her about other

alternatives such as adoption, homes for unmarried mothers and other community resources available for support. It enables the woman to feel accepted and also assists her in being able to make decisions about where she can get support from during the crisis. It is important for social workers to be able to provide women having abortions with information about resources they may find useful if they need help in future. Social workers counselling women who present for terminations of pregnancy need to understand a request for an abortion as a period of crisis in the woman's life which can provide a focus for counselling or therapeutic intervention. Women presenting for terminations of pregnancy are often more willing in this period of crisis to work on certain issues in their lives and are more accessible to therapeutic short term intervention than they would be after the termination of pregnancy when they have raised their defence mechanisms again and have mobilized their internal resources to get over the experience (Golan 1978).

It is therefore recommended that the focus of social work intervention be prior to a termination of pregnancy when women need crisis counselling and support with regard to making the decision to have an abortion.

2. This research indicates that most women do not want post-abortion counselling. However social workers working in clinical practise with women who have had abortions need to

be aware of the range of both positive and negative feelings evoked in women as the result of a termination of pregnancy and how the experience can be used in therapy to explore other related issues. It is recommended that the opportunity for counselling after a termination of pregnancy be offered to women even if they should not choose to accept the offer.

3. This research indicates that the present legislation does not meet the needs of women faced with unwanted pregnancies. Perhaps with a more lenient law which allows women greater control over their own bodies and reproductive rights the issue of abortion may lose some of its secretiveness and women may be able to share their feelings more openly. It is recommended that the present constitution addresses the issue of abortion and realistically recognises the need for legal abortion in an appropriate medical setting.

4. This research indicates that the option of a termination of pregnancy in an appropriate medical setting is not available to the majority of South African women. It is recommended that women faced with an unwanted pregnancy and subsequent desire to have a termination of pregnancy be provided with health care resources to have an abortion, and thus this option be made more accessible to all sectors of the population by providing adequate medical and counselling facilities in different areas of the country.

5. The present legislation regarding the availability of a termination of pregnancy for women who have been raped seems to be inadequate. This is reflected by the large percentage of women in this sample who had fallen pregnant as the result of rape. This was not the focus of the research although it has been found to be a problematic area. It is recommended that there be more research done into the alarmingly high rate of women who have been raped seeking abortions according to Section 3(1)(b) instead of through Section 3(1)(d) of the Abortion and Sterilization Act of 1975.

6. A study over a longer period of time would be useful to assess the long term effects of therapeutic abortion on women.

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ANNEXURE A - QUESTIONNAIRE AND INTERVIEW SCHEDULES.

QUESTIONNAIRE 1

This questionnaire is for the purpose of research and your answers will be treated with the strictest confidentiality. Please answer all questions by marking the response that applies to you.

1. How old are you ?

a) 10 - 16
b) 17 - 22
c) 23 - 29
d) 30 - 40
e) over 40

2. What is your marital status?

a) single
b) married
c) divorced
d) widowed
e) live-in relationship

3. What religion are you?

a) Protestant
b) Roman Catholic
c) Moslem
d) Other

4. What is your education level?

a) Primary School
b) Standard 6-8
c) Standard 8 or 9
d) Matric
e) College/Technicon diploma
f) University degree
g) Other

5. What is your home language?

a) English
b) Xhosa
c) Afrikaans
d) Other

6.What ethnic classification?

a) Black
b) White
c) Coloured
d) Other

7. Where do you stay?

a) Southern Suburbs
b) Northern Suburbs
c) Cape Flats
d) Mitchells Plain
e) Khayelitsha/Lagunya
f) Other

8.What is your monthly income?

a) Under R 500
b) R500 - R 1000
c) R1000 - R1500
d) R1500 - R2000
e) R2000 - R2500
f) over R2500

9. What was your relationship with the reputed father of the pregnancy at the time of conception?

a) Husband
b) Steady boyfriend
c) Casual/Short-term relationship
d) "Date" rape
e) unreported rape
f) Other

10. Were you using contraception ? YES / NO

11. If yes, what contraception were you using?

a) The pill
b) The injection
c) I.U.C.D. (the loop)
d) Condom
e) Other

INTERVIEW SCHEDULE - PART 1 (After decision to have abortion confirmed but before the medical procedure)

1. What are the patient's reasons for requesting T.O.P.?

a) Emotional reasons - the patient feels she would be unable to cope with the pregnancy or baby.
b) Financial / Economic reasons
c) Lack of support from reputed father
d) Lack of support from family
e) Failed contraception
f) Rape situation

2. What is the patient's family background ?

a) Stable family background
b) Single parent family
c) Parents divorced
d) Dysfunctional family
e) Poor relationships in family
f) Adopted / Fostered child

3. What previous treatment has the patient had ?

a) Long term psychiatric treatment
b) Short term psychiatric treatment
c) Clinical Psychologist
d) Social Worker
e) No previous treatment

4. How many previous pregnancies has the patient had ?

a) None

b) One

c) Two

d) Three

e) Four

5. How does the patient feel towards the pregnancy ?

a) Denial

b) Anger

c) Hurt

d) Guilt

6. Does the patient want post-abortion counselling ? YES / NO

7. If yes, what are the requirements for post-abortion counselling ?

a) Individual counselling at Pregnancy Advisory Service

b) Post-abortion support group at Pregnancy Advisory Service

c) Referral for in-patient treatment

d) Referral to private therapist

e) Referral to another resource

INTERVIEW SCHEDULE 2 (Six weeks to three months after termination of pregnancy.)

Motivation to participate in follow-up study.

a) Returned for follow up appointment as contracted

b) Contacted telephonically to cancel appointment but agreed to make another appointment

c) Telephonic interview

d) Patient contactable but would not participate

e) Patient could not be contacted (e.g. changed address etc)

1. How did the patient experience the legal procedure ?

a) Patient found this anxiety provoking - felt unhappy with the law as a psychiatrist had to make the decision.

b) Patient satisfied with the legal procedure.

c) Patient found the state hospital procedure difficult.

d) Patient satisfied with the state hospital procedure

2. How did the patient experience the medical procedure ?

a) Extremely traumatic - remains distressed.

b) At the time traumatic - but has recovered.

c) No more traumatic than any other operation.

d) Much easier than what was expected.

3. Who provided emotional support during the experience ?

a) Reputed father supportive

b) Family supportive

c) Hospital staff supportive

d) Other T.O.P. patients provided mutual support

e) Friends supportive

4.How did an abortion change the patient's attitude to it ?

a) Anti-abortion to Pro-choice

b) Pro-choice to Anti-abortion

c) Always been pro-choice

d) Always been Anti-abortion

5. What was the affect of having an abortion on the patient's general functioning ?

a) Positive-improvement in patients level of functioning

b) Negative-deterioration in patients level of functioning

c) No change

6.Does the patient experience any problems in the following areas that she attributes to the termination of pregnancy (i.e. she did not have problems in these areas before the pregnancy)

| | | | |
|---|---|---|---|
| a) Work | YES / | NO / | N/A |
| b) Studying | YES / | NO / | N/A |
| c) Relationship with family | YES / | NO / | N/A |
| d) Relationship with friends | YES / | NO / | N/A |
| e) Relationship with men | YES / | NO / | N/A |
| f) Sexual response | YES / | NO / | N/A |
| g) Alcohol/Substance Abuse | YES / | NO / | N/A |

7.Is post-abortion counselling wanted ? YES / NO

8.What are the requirements for post-abortion counselling ?

a)Individual Counselling at P.A.S.

b)Post-abortion support group at P.A.S.

c)Referral for inpatient treatment

d)Referral to private therapist

e)Referral to another resource

PART 3 - CURRENT MENTAL STATUS (Before and After T.O.P.)

a) MOOD

i. Depressed

ii. Anxious

iii. Angry

iv. Normal

b) SLEEP

i. Normal

ii. Early morning awakenings

iii. Insomnia

iv. Hypersomnia

c) APPETITE

i. Increased

ii. Decreased

iii. Erratic

iv. Normal

d) CONCENTRATION IMPAIRED YES / NO

e) SUICIDAL IDEATION YES / NO

f) LOSS OF ENERGY YES / NO

# HAMILTON ANXIETY RATING SCALE

MILD — Occurs irregularly and for short periods of time
MODERATE — Occurs more constantly and of longer duration requiring considerable effort on part of subject to cope with it
SEVERE — Continuous and dominates subject's life
VERY SEVERE — Incapacitating

Place an X in the appropriate space

| | | Not Present 0 | MILD 1 | MOD. 2 | SEVERE 3 | VERY SEVERE 4 |
|---|---|---|---|---|---|---|
| 1. ANXIOUS MOOD | Worries, anticipation of the worst, fearful anticipation, irritability | | | | | |
| 2. TENSION | Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax | | | X | | |
| 3. FEARS | Of dark, of strangers, of being left alone, of animals, of traffic, of crowds | | X | | | |
| 4. INSOMNIA | Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors | | | X | | |
| 5. INTELLECTUAL (Cognitive) | Difficulty in concentration, poor memory | | X | | | |
| 6. DEPRESSED MOOD | Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing | | | X | | |
| 7. SOMATIC (Muscular) | Pains and aches, twitchings, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone | | X | | | |
| 8. SOMATIC (Sensory) | Tinnitus, blurring of vision, hot and cold flashes, feelings of weakness, prickling sensation | | | X | | |
| 9. CARDIOVASCULAR SYMPTOMS | Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat | | | X | | |
| 10. RESPIRATORY SYMPTOMS | Pressure or constriction in chest, choking feelings, sighing, dyspnea | | | | | |
| 11. GASTRO-INTESTINAL SYMPTOMS | Difficulty in swallowing, wind, abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation | | | X | | |
| 12. GENITOURINARY SYMPTOMS | Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence | | | | | |
| 13. AUTONOMIC SYMPTOMS | Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair | | | X | | |
| 14. BEHAVIOUR AT INTERVIEW | Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, belching, brisk tendon jerks, dilated pupils, exophthalmos | | | | | |

No of X's in each column: [ ] [ ] [ ] [ ] [ ]

Multiplication factor: (x0) (x1) (x2) (x3) (x4)

Column Scores: [0] + [ ] + [4] + [ ] + [ ] = [ ]

Total Score

One rates each of these groups of features, as you can see on the scale format on a simple five point scale:
0 If the group of features is entirely absent;
1 If they are mild;
2. If they are moderate;
3 If they are severe;
4 If they are very severe and grossly disabling.

To obtain the patient's score on the Hamilton scale, you simply add up the total scores you have awarded him or her on each of the 15 items. Thus the total score can range from 0 to 56.

ANNEXURE B - DATA - HAMILTON ANXIETY RATING SCALE

LEVELS OF ANXIETY IN WOMEN BEFORE AND AFTER TERMINATIONS OF PREGNANCY

| GROUP A - WOMEN WHO RETURNED FOR FOLLOW-UP OFFICE INTERVIEWS. | | GROUP B - WOMEN WHO PARTICIPATED IN FOLLOW-UP TELEPHONICALLY. | | GROUP C - WOMEN WHO DID NOT PARTICIPATE IN FOLLOW-UP. |
|---|---|---|---|---|
| BEFORE | AFTER | BEFORE | AFTER | BEFORE |
| 14 | 2 | 12 | 3 | 21 |
| 8 | 5 | 6 | 0 | 14 |
| 30 | 15 | 25 | 6 | 18 |
| 13 | 6 | 5 | 0 | 17 |
| 16 | 4 | 23 | 0 | 22 |
| 22 | 4 | 12 | 0 | 29 |
| 23 | 6 | 21 | 6 | 17 |
| 25 | 4 | | | 29 |
| | | | | 22 |
| | | | | 23 |

ANNEXURE C

CASE STUDY 1

This case study discusses the one respondent who had been raped, and presented with high levels of emotional distress before and after the termination of pregnancy. The reason that this case has been presented is that due to the extreme distress of this women she was the focus of social work intervention.

Anna, a 19 year old coloured woman, lives in Lavender Hill (one of the low-income council flat areas on the Cape Flats). She was referred from the local day hospital with a confirmed pregnancy of nine weeks gestation. When Anna was first seen at the Pregnancy Advisory Service she was in a severe state of distress. She was an extremely reticent young woman who found it difficult to talk about her problems at the beginning of the pre-abortion counselling interview but then became very tearful and ventilated her feelings about her present situation as well as her earlier difficulties. In the pre-counselling interview it was difficult for the social worker to engage Anna as she was very distrustful.

Anna reported that she had fallen pregnant as the result of a rape which had occurred near her home on her way back from her job at a clothing factory. Anna had not told anyone about the rape or subsequent pregnancy. She had considered a "back-street" abortion and had found out there was a woman in her area who would do it for R100 which she could not afford.Other alternatives such as adoption were explored but she was adamant she wanted an abortion.

Anna had been raised in an overcrowded home situation. She reported that she had never known her father as he had left her mother when Anna was an infant. Her mother had had a drinking problem and had died of tuberculosis when Anna was 14 years old. Anna was the youngest of eight children and she had lost contact with her brothers and sisters who were scattered around Cape Town. Since the death of her mother Anna had stayed with various families who she had met through her membership at the New Apostolic church. At the age of 16, Anna had a para-suicide attempt by taking a mixture of pills she had found. She was sick for a few days but had not had any treatment. Despite a difficult adolescence Anna had managed to complete Standard 9. She had left school the previous year to find employment as the family with whom she was staying no longer were prepared to support her. Anna was attempting to complete her matric through night school. Anna said she had felt unhappy and lonely for most of her life.

Anna did not want to report the rape as the perpetrator was a well known gang member in the area and she was scared of being further harmed. She also felt that the devout elderly woman with whom she was presently staying would not be very supportive about the rape experience and Anna's desire to terminate the pregnancy.
Anna was not on any contraception as she did not plan to have a sexual relationship. She had had a boyfriend at school with whom she had been sexually active. She had never seen anyone for help before. During the interview Anna was depressed, reported a loss of appetite and insomnia. She had considered suicide as a way out of

her present situation. Anna wanted an abortion because she felt she could never love a child that was conceived as the result of rape, and she could not financially support a child on her salary of R450 per month. Anna said she would like to have post-abortion counselling after the termination of pregnancy and she was also referred to Rape Crisis. At the pre-abortion interview, Anna had a score of 30 on the Hamilton Anxiety rating Scale.

Anna returned for her follow-up interview as contracted. She reported that she had found the medical procedure of a termination of pregnancy traumatic, but was satisfied with the legal procedure and the state hospital procedure. The only support she had during the termination of pregnancy was the hospital staff. Anna had found pre-abortion counselling very helpful as it provided her with support and information with regard to her present crisis and also assisted her in expressing her feelings about her past difficulties. She felt very relieved that she had had the pregnancy terminated but was still showing symptoms of depression, as the result of the rape. Overall her level of emotional distress had lowered as the result of the termination of pregnancy and she no longer had suicidal ideation. Anna had also lost the motivation to continue with her studies as she had difficulty concentrating. She had a score of 15 on the Hamilton Anxiety Rating scale. Anna wanted post-abortion counselling, and was being seen by a counsellor at Rape Crisis. She did not want to come back to the hospital as it was too far from where she stayed.

CASE STUDY 2

This case study discusses a respondent who participated in the follow-up study, who like the majority of the respondents had a positive subsequent adjustment to a termination of pregnancy in the short term.

Linda, a 27 year old, single, white woman lives in Vredehoek, a suburb near the centre of Cape Town. She presented at the Pregnancy Advisory Service with a confirmed pregnancy of six weeks gestation.

At the initial interview Linda presented as a confident professional woman who was employed in a local advertising agency after completing a BA (Hons) degree four years ago. She had fallen pregnant from a young man with whom she had a relationship of 5 months. This relationship had ended when she had informed him that she was pregnant. She had been on the contraceptive pill and could not understand how she had fallen pregnant as she said she had taken it regularly. She was very angry about her situation.

Linda had seen a Clinical Psychologist for about six months when she was at university due to depression. The present crisis had evoked these past feelings. Linda felt that she could not cope emotionally with a pregnancy or baby at this stage of her life. She was also due for a promotion at work and felt she would lose her job if they found out she was pregnant. She was experiencing several other stressors in her life such as her father's recent retrenchment, financial debt and the rejection she experienced as a result of the ending of the relationship with the reputed father.

Linda had had a stable family background. Her parents were still happily married and she was the eldest of three siblings. She had spoken to all of her family members about her pregnancy and desire for a termination of pregnancy and they were supportive. She had considered going to England to have an abortion there but was already experiencing financial difficulties and could not afford it. Linda lived in a house with three other career-minded women and she had also spoken to them about her situation. Linda was agnostic and had no moral objections to abortion. Linda said she felt it would be unfair to bring an unwanted baby into an already overcrowded world.

When Linda was assessed before the termination of pregnancy she was extremely anxious and depressed. She reported a loss of appetite, early morning awakenings, a loss of energy and was unable to concentrate at work. She reported no suicidal ideation. Linda had a score of 22 on the Hamilton Anxiety Rating Scale.

Linda returned for the follow-up appointment but only after she had missed her first appointment and was reminded. She expressed ambivalence about returning as she was considerably angry about the strictness of the law and that a psychiatrist had to make a decision she felt capable of making herself. She had experienced the medical termination of pregnancy as no different from any other operation under general anaesthetic but was angry that the procedure had to be done at a state hospital. Linda had a lot of support during the termination of pregnancy from her parents,

hospital staff and friends. She felt very relieved that she had the pregnancy terminated. Her functioning had returned to normal and she felt she had "grown-up" as the result of the experience. Linda had a score of 4 on the Hamilton Anxiety Rating Scale. She did not feel that she needed post-abortion counselling, although she indicated that her experience of previous therapy and pre-abortion counselling was positive and she would not hesitate to seek help if she felt it necessary. Linda had recently been promoted at work and had started dating again. She said that what had changed was that she did not feel she wanted a boyfriend or sexual relationship for a while as she was scared of having a repeat experience.